Workshops Session 1

Did They Just Say That? Practical Strategies to Address Discrimination Towards Trainees and Create a Culture of Allyship Within Psychiatry Residency Programs

Presenters
Sarah Mohiuddin, MD
Adrienne Adams, MD, MSc
Neha Sharma, DO

Educational Objectives

1. Attendees will learn about the lived experiences of discrimination and microaggression that minority trainees face during training

2. Attendees will identify various forms of discrimination through the use of video narratives, including gender, sexual identity and racial/ethnic discrimination as well as different sources of discrimination including other faculty, staff/nurses, and patients.

3. Attendees will identify practical strategies faculty and training directors can use to intervene and support trainees who experience discrimination.

4. Attendees will learn about creating a culture of allyship within training programs as well as serving as an ally as a training director.

Practice Gap

Minority trainees often describe experiences with discrimination during the course of their medical training as well as during residency and fellowship. These include a range experiences including refusal of care, decreased perception of clinical skill or acumen, inappropriate verbal comments on physical appearance, receiving less trust from staff or patients, and being mistaken for non-physicians (7). These occur during the course of day-to-day clinical experiences or interactions with staff, nurses, other physicians and patients (6). Often, trainees do not feel comfortable addressing or reporting these experiences to their training directors and training programs (6). In addition, training directors and faculty may not know how to recognize or respond to a discriminatory event (3) Few studies address how training programs and training directors can create a culture of allyship that allows trainees to report these experiences. In addition, training programs and faculty often lack an understanding of how to address and support minority trainees in real-time when these events occur.

Abstract

Discriminatory experiences towards trainees occur frequently during the course of training. Residents report discriminatory comments and actions from patients, other residents, faculty, and hospital staff. Previous studies suggest that these experiences impact trainee decisions related to program continuation and an overall sense of well-being. Despite increasing emphasis on diversity, equity and inclusion, many faculty and

training directors do not know how to recognize these events or respond to them appropriately. Current studies suggest under-reporting of discriminatory events given that trainees also perceive risk for negative outcomes from training program following reporting. This workshop serves to help training directors recognize these events, intervene to support their trainees and build a culture of allyship within their training programs. Establishing allyship and addressing discrimination requires a series of steps which this workshop seeks to illustrate through the use of video narratives of discriminatory experiences that trainees face. The first set of videos will focus on a portion from the AACAP series on "Difficult Conversations of Racism and Social Inequities in Child Psychiatry Training" followed by polling and small group discussion on strategies to enhance allyship within training programs. The second set of videos will highlight specific experiences of minority trainees based on gender, race/ethnicity, religion and sexual/gender minority status followed by polling and small group discussion on practical strategies in addressing the event, including specific language to utilize during the event and supporting the trainee after the event. This workshop seeks to help educate training directors on discriminatory behavior towards trainees and help to create a culture of allyship within training programs that meets the needs of our minority trainees.

Agenda

This workshop is aimed at psychiatry program directors, psychiatry clerkship directors, and other medical educators interested in discussion on discrimination towards minority trainees. After a brief review of statistics, we will have 2 facilitated small group breakouts. The first breakout session will be to identify challenges in building a culture of allyship within training programs. The second session will be to discuss specific discriminatory events towards trainees and how to address these events in real-time.

0:00-0:05 Introduction

0:05-0:15 Brief presentation on types of discrimination trainees face and challenges in allyship within training programs

0:15-0:25 Breakout: Video and Facilitated discussion on challenges with respect to allyship

0:25-0:30: Review from break out. Polling to assess perception/challenges

0:30-0:45 Breakout: Videos of specific discriminatory events and discussion of intervention strategies

0:45-0:55 Presentation of strategies. Polling to assess how likely attendees are to implement various strategies.

0:55-1:00 Q&A and time for evaluation

Scientific Citations

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Workshops Session 1 (con't)

When the supervisor needs a supervisor: your guide to training supervisors in best practices

Presenters
Amber Frank, MD
Aimee Murray, PsyD
Anne Ruble, MD
Donna Sudak, MD
David Topor, PhD

Educational Objectives
By the end of the session, participants will be able to
1) Describe common challenges in psychotherapy supervision faced by residency and fellowship programs.
2) Identify several potential approaches to manage these common challenges.
3) Develop an action plan to address at least one supervisory challenge relevant to their home program.

Practice Gap
Individual supervision of psychotherapy cases is a cornerstone of psychotherapy education for residency and fellowship programs. Program Directors and Directors of Psychotherapy Training are tasked with oversight of their trainees' psychotherapy supervision, including recruiting supervisors, helping address problems in supervision, and providing ongoing faculty development for psychotherapy supervisors. However, training directors may feel less equipped to manage aspects of psychotherapy supervision that fall outside of their personal areas of expertise. This workshop will provide participants with the opportunity to increase confidence in managing common supervision challenges, including recruiting and developing a supervisor pool, managing problems in the supervisor-supervisee dyad, and special issues in psychotherapy supervision, e.g. interdisciplinary collaboration, virtual supervision, and diversity, equity, and inclusion.

Abstract
Despite the importance of the supervisory relationship, there has been little uniformity in its implementation and a paucity of evidence about the most effective supervisory behaviors. Nevertheless, there exists a literature about principles of adult learning that may be applied to supervision to enrich and make the experience more robust. Several recent studies point to supervision as vital to the process of psychotherapy adherence and quality, as well as its relationship to improvement in patient outcomes.

This workshop is derived from the work of a subgroup of the AADPRT Psychotherapy Committee, which generated a list of common challenges and core issues in psychotherapy supervision and created a series of practical guides for the membership. This workshop will review a subset of these common challenges and core issues.

Attendees will also discuss specific roadblocks to effective supervision in their program and develop an action plan. Participants will explore challenges within the supervisor-supervisee dyad as well as systems-level supervision concerns relevant to training directors. Discussion topics will include managing impasses or conflict between supervisors and supervisees, recruiting and developing your psychotherapy supervisor pool, and improving diversity, equity, and inclusion fluency for supervisors. Newer challenges in supervision occurring in the context of an increase in virtual supervision and teletherapy during the past year will also be explored. The workshop will be active in nature, utilizing breakout rooms, scenarios and discussion to review key points.

Agenda

- Welcome, introductions, and overview of challenges in supervision – 10 min
- Small group scenarios and discussion – 35min
- Individual program action planning - 10 min
- Session debrief and questions - 5 min

Scientific Citations

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2. Sholomskas, DE, Syracuse-Siewert, G., Rounsaville, BJ, Ball, SA, Nuro, KE, Carroll, KM. We don't train in vain:A dissemination trial of three strategies of training clinicians in cognitive-behavioural therapy. Journal of Consulting and Clinical Psychology 73: 106-115, 2005
3. Crocker E, Sudak M. Making the Most of Psychotherapy Supervision: A Guide for Psychiatry Residents. Academic Psychiatry. 2017;41(1):35-39. doi:10.1007/s40596-016-0637-5
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Workshops Session 1 (con't)

The Self-Compassionate Healer: An interactive self-compassion curriculum and COVID-19 support community for fostering greater resilience and well-being in residency training

Presenters
Kristin Leight, MD
E Cabrina Campbell, BA, MD
Mary Elizabeth Yaden, MD, MS

Educational Objectives
- Define self-compassion and review the evidence for its role in clinician/trainee resilience and well-being
- Engage participants in self-compassion practices, including a brief guided meditation and writing exercise
- Describe utility of self-compassion in the COVID-19 era of residency training and practices incorporated with the Penn Psychiatry training program
- Provide guidance/materials for participants to adapt or recreate this intervention at their home institution

Practice Gap
Over the last several years, the number of academic citations that include self-compassion has risen exponentially and currently surpasses over 20,000. While there is a robust literature on positive outcomes associated with self-compassion, we are at the vanguard of implementing and measuring self-compassion interventions in both clinical and psychiatric educational contexts. The setting of the COVID-19 pandemic has reinforced the need for evidence-based practices that protect trainees and clinicians from burnout and distress. Our workshop joins a first wave of interventions to focus on self-compassion within medical or psychiatric education. Although mindfulness has been readily assimilated in both therapeutic and educational practices, self-compassion is still a novel personal resource for both patients and clinicians. Our goal is to bridge this practice gap by providing foundational information about self-compassion and to offer active coping strategies for working directly with emotions like shame that arise in the context of burnout by employing self-compassionate techniques. We also provide the case example of a COVID-19 based support group and community that drew heavily from the self-compassion literature.

Abstract
Although mindfulness has become ubiquitous throughout clinician wellness initiatives, self- compassion is a rising star of wellness education. While incorporating the foundations of mindfulness, self-compassion moves beyond non-judgmental awareness to provide skills for transforming one's own suffering into compassion and connection. In fact, a recent large-scale study of residents demonstrated that self-compassion had a unique role in predicting burnout above the effects of mindfulness. Self-compassion is comprised of three primary components: awareness of when suffering or burnout arises,

a recognition that suffering is a shared human experience, and finally a willingness to meet suffering with warmth and kindness instead of resistance or shame. Psychiatric training values cultivating compassion for the suffering of others; however, it rarely teaches the skills of meeting one's own failures or losses with tenderness and understanding. Moreover, the tendency to be self-critical and hard-driving towards oneself often comes more readily to those in medicine.

The COVID-19 era of residency education allowed us to pilot a social support intervention, a weekly voluntary virtual wellness group, the drew heavily on the core tenets of self-compassion. Our workshop aims to introduce participants to the science of self-compassion through a didactic introduction, as well as to guide them through practices that allowed for our COVID inspired support group to communicate and reinforce participant self-compassion. We will also introduce writing exercises, and other techniques aimed at developing greater emotional resilience outside of a support group structure. This workshop will not only offer a language for medical educators looking to talk about loss, failure, and shame that were ever more salient experience during the pandemic but also orient participants to tools to be used within their own curriculum, including handouts, scripts, and scales. Our workshop adapts evidence-based practices in cultivating self-compassion specifically for use in psychiatric residency programs across trainee level.

Agenda

0:00 Introduction
0:05 Didactic Presentation: Science of self-compassion
0:20 Discussion: Self-compassion in the psychiatry residency training during COVID-19
0: 30 Exercise: Cultivating self-compassion through contemplative practice or journaling. Guided meditation and writing exercise.
0:40 Debriefing self-compassion exercises
0: 45 Discussion: Teaching self-compassion for patients and colleagues
0:55 Question and Answer Session

Scientific Citations

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Workshops Session 1 (con't)

Becoming an expert in feedback delivery: practical solutions to commonly experienced barriers

Presenters
Samar McCutcheon, MD
Alan Szymanski, MD

Educational Objectives
At the end of the workshop, participants will be able to:
1. Identify the importance of feedback for trainees
2. Understand the difference between evaluation and feedback
3. Engage in a self-inventory of individual obstacles to feedback delivery
4. Implement individualized strategies to overcome common feedback barriers

Practice Gap
Providing feedback is widely recognized as an integral part of a supervisor's role in training residents and medical students. Residents evaluate the feedback they receive in their programs in their annual ACGME surveys. Effective feedback has been shown to improve clinical performance, professionalism, documentation and communication skills. However, there are often few faculty development opportunities available to supervisors that focus on identifying and overcoming individual barriers to feedback delivery. This workshop will encourage participants to reflect on which feedback barriers they experience, and will provide participants with actionable strategies to minimize these barriers.

Abstract
Despite the widely accepted importance of feedback in training, trainees often report receiving too little feedback from their supervisors. This is likely due to the number of barriers to delivering feedback that supervisors experience. The goal of this workshop will be equip participants with the strategies they need increase the effectiveness of their feedback delivery. To start the workshop, we will review the importance of feedback and describe the differences between feedback and evaluation, which are often (incorrectly) used interchangeably.

To explore which feedback barriers supervisors may encounter, workshop participants will engage in a self-inventory of their individual obstacles to feedback delivery, utilizing the polling functionality of Zoom. Several feedback barriers exist, but some of the most commonly cited barriers include a lack of time, fear of damaging rapport with the trainee, working with a resistant trainee and a lack of personal comfort with feedback delivery.

Armed with this inventory, we will present workshop participants with high-yield, evidence-based solutions tailored to each of these feedback barriers. We will be utilizing breakout rooms to stimulate small group discussion. Within the evidence-based

solutions there will also be examples of the different feedback methods and styles that can be implemented to target relevant barriers. We will conclude with a large group debrief to focus on the take-home points and answer participant questions. Participants will also receive a “cheat sheet” with each barrier and strategies to address them at the end of the workshop. Program directors are also welcome to disseminate this information throughout their residency programs to assist their teaching faculty.

This workshop will be interactive, practical and will be beneficial to all participants who work with trainees and want to improve their understanding of and comfort with feedback delivery.

Agenda

1. Introductions, goals & objectives (5 mins)
2. What is feedback and why should we care about providing it? (5 mins)
3. What are the different feedback methods and styles? (10 mins)
4. Self-inventory of feedback barriers- participants will utilize the Zoom polling function to identify the barriers they most commonly experience (5 mins)
5. Small group discussions to address solutions to your largest barrier to feedback delivery utilizing Zoom breakout rooms (20 mins)
6. Large group debrief/questions (10 mins)
7. Participant review (5 mins)

Scientific Citations

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Workshops Session 1 (con't)

The Impact of Patient Suicide on Trainees and Early Career Psychiatrists: How Do We Respond

Presenters
Zheala Qayyum, MD
Rachel Conrad, MD
Maggie Schneider, MD, PhD
Lee Robinson, MD
Jeffrey Hunt, MD

Educational Objectives
- Participants will understand the impact of patient suicide on trainees in psychiatry, with a focus on appreciating the expected emotional and psychological responses.
- Participants will explore how academic and non-academic medical settings respond to patient suicide.
- Participants will be better prepared to respond to the needs of trainees as supervisors, in the event the trainee's patient dies by suicide.
- Participants will appreciate the challenges of transition into independent practice in the context of completed suicides during the early years out of training.

Practice Gap
Suicide is now the second leading cause of death in adolescents and young adults. Center for Disease control and National Institute for Mental Health have reported continued rise of 34 % in the suicide rates over the twenty years. Many of our trainees will experience this during their General Psychiatry residency years or during their Child and Adolescent Fellowship training. However, the supervision and guidance around managing the emotional burden is highly variable. The impact of patient loss is often unrecognized and many training institutions do not have formal programmatic supports in place for such an occurrence. Timely oversight and support from supervisors can provide a safe place to explore and process the difficult experience of patient loss due to suicide. The improved comfort and knowledge of supervisors around providing this type of supervision in particular can have a positive impact on trainee experience and learning. Furthermore, focus on adolescent cases will better prepare trainees to respond to the current increase in suicidal behavior in that population. However, there are no formal guidelines that indicate what should be expected in supervision by the trainee.

Abstract
Objectives:
We hope to discuss how trainees experience the loss of a patient due to suicide; the comfort and preparedness of supervisors about providing supervision in such circumstances; exploring the challenges faced by the training program; propose recommendations that can assist supervisors and training directors in the event of

patient suicide. We also aim to highlight the challenges of transitioning into independent practice in the context of completed suicides during the early years out of training.

Background:
Suicide has become the second leading cause of death in adolescents and young adults ages 10-34 in the US. About 30-60% of General Psychiatry Residents experience patient suicide during their training; however, currently there are no formal guidelines for either the supervisor or supervisee in educational practice.

Methods:
A qualitative study was completed utilizing individual semi-structured interviews of trainees and supervisors identified by criterion sampling. Participants were recruited from General Psychiatry resident training and Child & Adolescent Psychiatry fellowship programs in New England. Eligible participants included: current psychiatry trainees and trainees who graduated in the last 2 years who have experienced the death of a patient they cared for from suicide; participants also included supervisory psychiatrists of psychiatry trainees when their patient committed suicide. Inductive thematic analysis of the transcribed interviews was performed to identify emerging themes.

Results:
Thematic analysis of the interview data identified two primary groups of themes; one cluster of themes highlighted the importance of adequate preparation and institutional support to handle patient loss by suicide. Trainees spoke to the importance of institutions providing accommodation around work load and call modification during the immediate aftermath. Supervisors expressed perceiving limited formal preparation for supporting trainees around this experience. A second cluster of themes defined factors that eased or complicated the experience; loss of a patient of similar age was noted to cause greater distress. Validation and normalization from supervisors, including disclosure of their own experience of loss, was protective.

Conclusions:
There is a significant lack of preparation on the part of institutions, on how to deal with the aftermath of a patient suicide. Key factors appear to influence the distress associated with the experience, and these findings together may inform the development of educational, programmatic and mentorship interventions to best support this process.

Agenda
1. Introduction
2. Physician experiences of patient suicide
3. Presentation of pertinent research and available data
4. Discussion regarding the impact of patient suicide on trainees and early career psychiatrists
5. Small group discussions of strategies for improving supports for trainees
6. Proposed recommendations & Concluding remarks

Scientific Citations

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Workshops Session 1 (con't)

Creative Partnerships: Navigating the Disciplinary Process

Presenters
Ann Schwartz, MD
Adrienne Bentman, MD
Deborah Spitz, MD
Sallie DeGolia, MD, MPH

Educational Objectives
1) Identify the timeline of the disciplinary process
2) Recognize the key elements of a remediation plan and disciplinary letter
3) Develop tools to address common challenges and missteps in the disciplinary process
4) Identify means to limit collateral damage among residents

Practice Gap
Feedback on prior disciplinary workshops suggests that new program directors and even those with some experience are challenged by the complexities of the disciplinary process and need basic, step-by-step instructions in order to make the process work effectively. This workshop is designed to meet that need while containing the impact of the process on fellow residents.

Abstract
For all program directors, the disciplinary process is challenging. Initial faculty assertions of misbehavior or incompetence may evaporate, arrive after submission of a passing evaluation, or become lost in the shuffle among rotations and sites. When confronted, the resident may be scared, misrepresent the issues, or be entirely unaware of the concerns. In spite of guidelines that seem clear, implementing the disciplinary process can leave the program director in a "grey zone" of confusion, surprises and difficult choices which can challenge even the most seasoned among us.

Following a brief overview and outline of the disciplinary process, we will discuss the process of writing letters of deficiency and developing remediation plans. Samples of both will be shared and discussed. The workshop will also address common challenges in the disciplinary process including:
1) Addressing concerns with resident performance including poor insight, difficulty receiving feedback, executive dysfunction, poor boundaries, underlying psychiatric or substance use disorder to name a few.
2) The case of poor performance but limited written documentation (though lots of verbal feedback from faculty in the hallway)
3) Challenges in implementing a plan to address deficiencies (which requires intensive resources, faculty time, mentoring)
4) Problematic structural issues in the Department (low faculty morale, complex institutional requirements)

We will discuss solutions to these problems and share techniques and experiences that have worked! The role of mentorship and coaching will be emphasized as there is something to be gained in the process, often by everyone involved.

In a discussion about pitfalls and collateral damage, we will address the effects of disciplinary actions on other residents in the program and discuss how to manage the challenging and complicated feelings of vulnerability and fear that may arise in the context of remediation or dismissal of a fellow resident.

Agenda
10 min, Introduction and the basics of the disciplinary process (discovery to resolution) (DeGolia)
10 min, Remediation plan and the contents of a disciplinary letter (Spitz)
10 min, Challenges and missteps in the Disciplinary Process (Schwartz)
15 min, Pitfalls and Collateral Damage (Bentman)
15 min, Discussion, QA and wrap-up (all)

Scientific Citations
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Workshops Session 1 (con't)

"Teamwork Makes the Dream Work:" How to Teach Residents to Work with Psychiatric Nurse Practitioners (And How to Work with Them Ourselves!)

Presenters
Kari Wolf, MD
Rashi Aggarwal, MD
Rebecca Lundquist, MD
Art Walaszek, MD
Bill Sanders, MD

Educational Objectives
1. Understand the training requirements for psychiatric nurse practitioners school
2. Brainstorm models of collaboration with psychiatric nurse practitioners that optimizes value to our patients and the health care system with both disciplines working at the top of their license
3. Develop an educational plan for one's home institution to ensure psychiatry residents and fellows are prepared to supervise and collaborate with psychiatric nurse practitioners upon graduation

Practice Gap
To quote Henry Ford: "Coming together is a beginning. Keeping together is progress. Working together is success."

The growing shortage of psychiatrists has exacerbated problems with access to psychiatric care in America. As a result, many states and payers have begun lumping all licensed mental health professions into one of two buckets: Prescriber or Therapist. However, the training and expertise of the various mental health disciplines varies greatly with all of the disciplines bringing unique attributes to the care of our patients.

Because many health care agencies lack understanding of the unique attributes that psychiatrists bring to psychiatric care, those health systems are choosing to hire psychiatric nurse practitioners in lieu of or in addition to psychiatrists as a less costly option to meet their workforce needs.

Abstract
As psychiatrists, many of us don't understand the training and skills that psychiatric nurse practitioners learn during their schooling. This deficiency can lead to frustrations when asked to work with or supervise psychiatric nurse practitioners. As educators, if we don't understand how to effectively supervise and collaborate with psychiatric nurse practitioners, we will not be able to develop a curriculum to help our trainees prepare for the likely scenario they will encounter upon graduation.

In this workshop, participants will build understanding of the training and skill set of the various mental health disciplines who prescribe medications. This knowledge can be

used by workshop participants to develop curricula for our trainees to ensure psychiatrists graduating from residency understand the level of knowledge and skills psychiatric nurse practitioners are expected to achieve during training. The workshop will then identify potential gaps in knowledge and skills that psychiatric nurse practitioners may demonstrate upon completion of their training and use that gap analysis to create curricula within our home institutions to ensure our trainees are prepared to effectively and safely collaborate with and supervise psychiatric nurse practitioners.

Agenda

A pre-recorded video outlining the core components and variability of psychiatric nurse practitioner schooling will provide the foundational knowledge for small group discussions during the workshop. This basic understanding of the skills and training will allow the participants to work in breakout groups to brainstorm models of effective collaboration between the two disciplines.

The larger workshop will come together to share learnings from those small groups. Then, returning to small group brainstorming, this workshop will facilitate the identification and development of key curricular elements to embed in the training programs of our workshop participants.

Agenda:
I: Introductions and Background data (5 minutes) to include high-level overview of pre-recorded didactic
II: Poll Everywhere to understand current level of interaction with psychiatric nurse practitioners in participants' home department (5 minutes)
III: Break-out group discussion to brainstorm models of effective collaboration (20 minutes)
IV: Large group summarization of learnings in small group (5 minutes)
V: Break-out group exercise to brainstorm identification and development of key curricular elements (20 minutes)
VI: Debrief, questions, and Wrap-up (5 minutes)

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Workshops Session 2

Subspecialty Recruitment: Innovative and Collaborative Strategies to Address Shortages and Improve the Pipeline

Presenters
Rebecca Klisz-Hulbert, MD
Shambhavi Chandraiah, FRCP (C), MD
Carrie Ernst, MD
Nihit Kumar, MD
Shriti Patel, BA, MD

Educational Objectives
By the end of this presentation, participants will be able to:
1. Understand and interpret the scope of the shortage of psychiatry subspecialists in the U.S. and the recruitment challenges that psychiatry fellowships face.
2. Describe innovative strategies that stakeholders can implement to enhance subspecialty recruitment.
3. Identify and generate collaborative strategies for promoting psychiatry subspecialties.
4. Select at least one such strategy to implement in their own programs.

Practice Gap
While the shortage of psychiatrists in the U.S. is significant, the shortage of psychiatry subspecialists is especially dire. Out of nearly one million physicians in the country, serving a population of 330 million, there are fewer than 10,000 child and adolescent psychiatrists (CAP), roughly 1300 geriatric psychiatrists, and about 800 addiction psychiatrists. Psychiatry subspecialists are also distributed inequitably, with many areas (especially rural) experiencing shortages. For example, 41 states are reported to have "severe" shortages of CAP, defined as 17 or fewer child and adolescent psychiatrists per 100,000 children. 72% of U.S. counties do not have a single CAP. Two states do not have a single geriatric psychiatrist. There are no addiction psychiatrists in four states, and none in 92% of counties.

The ACGME 2020 Data Resource Book notes that while there was an expansion by about 33% for psychiatry programs from 2015 to 2020, the increase in subspecialty programs was far less - 18% for addiction psychiatry, 12% for CAP, 14% for forensic programs, and 10.5% each for geriatric and consultation-liaison (C/L) fellowships. In the past 4 years general psychiatry has seen a 24% increase in resident recruitment, but specialty fellowships have not followed suit with geriatric psychiatry dropping by 28%, and addiction psychiatry by 2.5%. The APA Resident Census for 2019-2020 shows that numerous fellowship positions went unfilled: an estimated 40% of addiction psychiatry positions, 38% of consultation-liaison psychiatry positions and 36% of forensic psychiatry positions. National Residency Matching Program data for 2020 shows that nearly 18% of CAP positions went unfilled. Over the past 5 years, the number of CAP

(826->889), forensic (72->80), and C/L (79->86) fellows has remained relatively flat, whereas the number of geriatric psychiatry fellows decreased drastically by 28% (58->42) – despite the projection that 20% of the U.S. population will be over 65 by 2030.

There has also been a reduction in the proportion of international medical graduates (IMGs) entering the general psychiatry match which affects the pipeline for fellowships. In 2020, only 20% of all general psychiatry residents were IMGs with the distribution of IMGs in fellowships being: 55% for geriatrics, about 30% for each of CAP and C/L, and 20% each for addiction psychiatry and forensic. Since traditionally IMGs make up a significant proportion of subspecialty fellows (especially in geriatrics), a decrease in overall IMGs may negatively impact all fellowships.

Additionally, 12% of general psychiatry program directors (PDs) were new. Subspecialty PDs also had significant turnover; 17% of addiction PDs, 15% CAP of PDs, 11% of geriatric PDs, 9% of C/L PDs and 8% of forensic PDs were new. New fellowship directors have a steep learning curve which can also impact ideal recruitment.

In summary, while general psychiatry residencies are enjoying a competitive match, fellowships are enduring unfilled slots which may be exacerbated by a decrease in the pipeline. Consequently, innovative strategies involving early and sustained collaborations to improve this pipeline are urgently needed.

Abstract
More medical students are matching into psychiatry in recent years, as general psychiatry programs also continue to expand. Despite this robust interest in psychiatry, recruitment into subspecialty fellowships has not been as successful or has actually declined. In addition to systemic barriers such as inadequate financial incentives for additional subspecialty training, the potential necessity of an additional move for further training, and decreased IMGs in a more competitive general psychiatry match, there are numerous local and regional barriers to subspecialty training. These may include inadequate exposure to subspecialty patients and practice settings early in training; limited access to board certified specialized teaching faculty; lack of sustained, high-quality mentorship; potentially under-informed new program directors; and insufficient information available to trainees about subspecialty opportunities and employment. While the COVID-19 pandemic necessitated innovative approaches to teaching and supervision, it has also brought increased and unique opportunities to engage with trainees in novel and exciting ways that can be particularly favorable for subspecialty fellowships

This workshop is sponsored by the AADPRT Recruitment Committee and includes representation from many ACGME approved psychiatry fellowships as well as a general psychiatry program director. Presenters will take an initial poll to determine the makeup of the audience (general PDs, fellowship PDs, coordinators, etc.). Data on the shortage of subspecialists in the U.S. and the current status and potential reasons for the difficulty of recruitment into fellowships will be presented. Using poll data, participants will be divided into small heterogeneous groups (of general and subspecialty

participants) to share their own programs' current subspecialty recruitment strategies followed by a guided discussion of barriers that exist for optimal subspecialty recruitment in their organization. Presenters will then demonstrate innovative and collaborative approaches that educators can deploy to aid in fellowship recruitment thereby also helping address the shortage of subspecialists. Presenters will discuss techniques to increase visibility, influence and mentoring, with specific examples from a variety of subspecialties. Interventions will be presented that include strategies targeted towards medical students and psychiatry residents, as well as readily accessible approaches that can be implemented at the institutional, regional and national level to increase the number of trainees pursuing fellowships. Strategies presented will focus on innovative virtual techniques developed by our programs in the past year that make subspecialty rotations and experiences more widely accessible, as well as collaborative methods taken from other specialties in medicine. Then in breakout groups, participants will explore novel approaches that they can use in their own programs to increase the number of trainees entering subspecialty training. Lastly, general psychiatry program participants will connect with one or two subspecialty faculty and/or coordinators to encourage future collaboration.

Agenda

0:00 - 0:05	Introduction and Poll
0:05 - 0:10	Overview of subspecialty recruitment statistics
0:10 - 0:25	Breakout #1: Facilitated discussion on barriers to subspecialty recruitment
0:25 - 0:40	Presentation of innovation and collaborative strategies for promoting recruitment of fellows
0:40 - 0:55	Breakout #2: Facilitated discussion on how to use these strategies to promote subspecialty recruitment; participants will establish collaborative relationships with participants from other roles
0:55-1:00	Conclusion and Q & A

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Workshops Session 2 (con't)

Skills for mentoring women faculty and residents

Presenters
Lindsey Pershern, MD
Kim Lan Czelusta, MD
Joan Anzia, MD

Educational Objectives
1. Identify the importance of effective mentoring of women faculty and residents
2. Recognize the unique issues for women faculty and trainees in academic psychiatry
3. Use provided mentoring resources to create a mentoring plan to address these challenges

Practice Gap
Mentorship in the academic environment provides the foundation for professional growth and development. Effective mentoring relationships provide support and guidance and contribute to wellness, career advancement and overall satisfaction. This relationship benefits both mentor and mentee. Success in mentoring depends on many factors including mentor-mentee pairings, development of the mentor-mentee relationship, and collaborative goal-setting. Lack of mentor training contributes to ineffective mentoring programs, mentor fatigue/burnout and difficulty retaining junior faculty. These challenges disproportionately impact women faculty, who are overly represented at the instructor and assistant professor rank and who more frequently leave academics due to barriers to promotion. Women faculty often have reduced access to mentoring in general, but also may receive mentoring that does not address gender-related challenges. Effective mentors understand their roles and responsibilities to mentees in the realms of career development, sponsorship, coaching and support. Mentors must also recognize unique issues for women in the academic environment, especially in cross-gender mentoring relationships. These include; 1) consideration of promotion and tenure clocks while navigating personal decisions regarding families, 2) gender bias, discrimination and sexual harassment, 3) gender differences in negotiation for resources and pay and 4) gender differences in visibility of accomplishments, networking opportunities and sponsorship. Skill-building around these issues improves awareness and understanding of mentors to improve the mentoring relationship. In addition, mentors are positioned to have a positive impact on the departmental and institutional culture to support recruitment and retention of women faculty. For trainees, the visible support and retention of female faculty role models benefits the system as a whole.

Abstract
In this workshop, we will ask participants to reflect on personal experiences in mentoring relationships to consider the roles and responsibilities of mentors, the value of mentoring others and the challenges in being a mentor. Participants will be asked to consider personal experience or knowledge of the challenges faced by women in the

academic environment, especially during the COVID pandemic. Workshop leaders will transition to review data on these challenges including statistics related to women in academic medicine and their unique needs in mentoring. Considering these unique issues, we will provide an overview of skill-building resources for mentors of women and links to resources. Important skills for success as a mentor include; 1) Assessment of mentee needs using mentoring surveys/checklists, active listening and communication techniques, 2) Setting expectations in the mentoring relationship and asking for feedback, 3) Development of individualized career plans and 4) creating networking and sponsoring opportunities. We will engage participants in an activity to practically consider the priorities of a mentor in a mentoring scenario that highlights issues related to women and develop a strategy using the proposed tools/resources. As a large group, we will review the work of small groups and experience with the mentoring tools and resources. We will ask participants to identify a goal in their development of mentoring skills after the workshop. We will also create a voluntary network of mentors to share experiences, provide support and lessons learned in their mentoring relationships.

Agenda
00:00 - 00:05 – Introductions and poll of participants to assess needs/interests of the participants in terms of mentoring others and roles/responsibilities at their institution
00:05 – 00:20 – Presentation of effective mentoring models/tools
00:20 – 00:40 – Small group activity – Participants will select a specific topic related to issues for women faculty and trainees and work as a small group to create a strategy for effective mentoring around their chosen topic. Participants will be divided in small groups based on their selected topic, given a case vignette and access to resources for this task.
00:40-00:55 – Facilitated large group discussion – Small groups will report to the large group and share their groups strategic plan
00:55- 00:60 – Conclusions and participant review

Scientific Citations
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Workshops Session 2 (con't)

The Time Is Always Right To Do What Is Right: Creating Sustainable Anti-Racism Efforts for Change

Presenters
Paul Rosenfield, MD
Ana Ozdoba, MD
Myo Thwin Myint, MD
Allison Glasgow, MD
Kousanee Chheda, MD

Educational Objectives
1. Identify the need for anti-racism efforts in the field of psychiatry
2. Learn about a model and strategies utilized to start anti-racism efforts in residency programs
3. Develop a commitment and plan to implement anti-racist efforts in your programs

Practice Gap
While there is currently great interest in advancing anti-racism initiatives due to the public awareness of recent police brutality and of systemic inequities in medical care and health outcomes, academic medical centers and training programs have made limited progress in addressing racism. Obstacles exist such as larger societal and political structures that perpetuate racism, long-standing systems within medicine that provide inequitable care, and limited efforts to recruit under-represented groups into medical careers.

There is a gap between knowledge of healthcare inequities and structural racism, and systematic efforts to address it in medical and psychiatric training and to advocate for changes. Residency training programs play an essential role in helping shape the next generation of psychiatrists to understand and engage in anti-racist efforts. This workshop will provide ideas on how to bridge that gap and help stimulate creative thinking for programs to take their next steps.

Abstract
Many residency programs across the country have initiated or accelerated efforts to fight racism since the killings of Breonna Taylor and George Floyd led to outrage, protests and calls for action across the country. But how do programs figure out how to channel the energy into productive and effective strategies? What are the areas in which we can make an impact as psychiatrists? How should we decide where to start? How can we support sustainability of the efforts and commitments to change? In this session, we will provide a framework for evaluating priorities, engaging stakeholders and implementing a course of action. We will share anti-racism strategies, including education, clinical reflections, and advocacy efforts developed at our programs, and offer an opportunity for participants to brainstorm and develop their own plans through breakout discussions.

Agenda

Introduction (15 min)

- Identify practice gap and need for anti-racism efforts in training
- Share framework for implementing change
- Describe the projects three different residency programs (Tulane, Montefiore, Mount Sinai Morningside/West) have implemented

Breakout room discussions with moderators (30 min)

- Have you worked on anti-racist initiatives at your institution?
- What stage are you in and what successes have you had?
- What are some of the challenges that you are facing or anticipate?
- Who are the stakeholders that you have involved or need to involve in your efforts?
- What are you hoping and planning for your next steps?
- Write down a next step you can commit to after the meeting

Return to share ideas (10 min)

Conclusions (5 min)

Scientific Citations

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Workshops Session 2 (con't)

Bias at the Bedside: A Toolkit for Upstanders

Presenters
Adrienne Gerken, MD
Veronica Faller, MD
Nadia Quijije, MD
Marla Wald, MD
Heather Vestal, MD, MSc

Educational Objectives
1. Understand the impact that bias incidents can have on trainees, institutional culture, and patient care.
2. Recognize the different types of bias and mistreatment that might occur in a clinical setting.
3. Use specific strategies to respond to mistreatment in a professional manner, in real time and after the event.
4. Develop a strategy for implementing "upstander" training for faculty and trainees.

Practice Gap
In the training environment, the importance of respect for others, regardless of race, gender, sexual orientation, religion, accent, age, or weight, cannot be overstated. Unfortunately, a growing body of literature suggests that mistreatment of trainees in the form of implicit or explicit bias from patients and families is prevalent in clinical and educational settings, and has effects on physician demoralization, burnout, and patient care (Leisy et al 2016). Moreover, faculty and resident educators who witness such events may feel unsure of how to effectively respond (Goldenberg et al 2018). In the spirit of furthering efforts in diversity, equity, and inclusion, we therefore challenge participants not only to recognize bias incidents, but to address them both in the moment and after the event occurs.

Abstract
In this workshop, we will lead participants in practicing strategies to identify and address incidents of bias toward trainees. We will begin with a discussion about bias in the teaching hospital, drawing from individual experiences and research, highlighting some of the unique challenges that may arise in psychiatric settings. We will then engage participants in role-plays where they can practice what they might say in the moment when witnessing or experiencing bias in the clinical setting as well as practice supporting trainees after these events occur. The workshop will conclude with a large group discussion during which participants can collaborate and share reflections on responding to incidents of bias in the teaching hospital setting, as well as discuss strategies to implement this type of training in their home institutions. Educators will leave feeling empowered to use specific strategies in clinical encounters and teach them to others. Participants will leave with concrete tools they can implement in their home institutions to create an "upstander" culture.

Agenda

5 minutes: Introduction, including audience feedback exercise on individual experiences with bias and mistreatment (using PollEverywhere)
10 minutes: Interactive PowerPoint presentation addressing the current literature and frameworks for recognizing bias incidents
25 minutes: Small-group role-playing exercises to practice responding to biased comments
15 minutes: Large group discussion
5 minutes: Participant review

Scientific Citations

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Workshops Session 2 (con't)

The Birds, The Bees, and The Zoom: Innovative Multi-site Implementation of a Pediatric Sexual Health Curriculum Using Standardized Patients and Videoconferencing

Presenters
Dorothy Stubbe, MD
Linda Drozdowicz, MD
Andres Martin, MD, MPH

Educational Objectives
At the end of this workshop, participants will be able to:
1. Understand the importance of talking about sexual health as psychiatrists, using a recently published curriculum that includes standardized patient videos and that is available for distribution and site-specific adaptation.
2. Discuss clinical methods to de-stigmatize conversations about sexual health with patients and families to improve safety, developmentally and emotionally appropriate and satisfying sexual behavior.
3. Practice teaching sexual health education to trainees using a model videotaped standardized patient module;
4. Consider implementation opportunities for multi-site educational seminars on crucial, and poorly resourced, topics in the field.

Practice Gap
Sexual health has great potential to impact and be impacted by other aspects of health. However, many physicians rarely broach the topic of sexuality and sexual functioning, especially with young or developmentally disabled patients. This oversite and discomfort in talking about sexual health is sustained by a dearth of sexual health education in medical training (Faulder et al, 2004). Clinicians often feel awkward and ill-equipped to address matters of sexuality with confidence. Just as with history-taking about other sensitive topics, the physician requires skills in discussing, educating, de-mystifying and normalizing discussions about sexual health and behavior (Drozdowicz et al, 2020; Merrill et al, 1990; Rubin et al, 2018).

Medically accurate, quality sex education supports healthy sexual maturation. It reduces unprotected sex, pregnancy, sexually transmitted diseases, and the potential for sexual victimization. It also improves rates of sexual satisfaction, a key element of sexual health. Lack of attention to sexual aspects of emotional and physical health may perpetuate the stigma surrounding sexuality; unintentionally limit access to care around a stigmatized topic; and decrease medication adherence for medications that cause sexual side effects (NIH, 2014).

In residency and fellowship training in psychiatry, few programs adequately address the skills and competencies related to taking a sexual history and educating patients about

sexual health and sexually satisfying experiences. This may be particularly true when treating youth or developmentally disabled individuals. However, there are barriers to training residents in high quality, comprehensive, medically accurate, evidence-based sex education. These include parental and societal stigma about sexuality in youth and those with disabilities. Some believe that addressing sexual topics may lead to more illicit sexual behavior. Other barriers include the lack of quality training materials, methods, and faculty comfortable and knowledgeable in this field (Hall et al, 2016).

To address this gap in training and practice, the authors developed an educational module enhanced by videotaped depictions of expert clinicians interacting with professional actors performing as standardized patients. Originally designed to be a didactic presentation at one site, the module evolved due to the limitations imposed by the Covid-19 pandemic. It was ultimately presented via synchronous videoconferencing to 16 different child and adolescent psychiatry training programs across the country. This project provides proof-of-principle for the use of multisite educational initiatives through synchronized videoconferencing. Measurable improvement in outcomes pertinent to the clinical practice of child and adolescent psychiatry were demonstrated (Drozdowicz, et al, 2020), and the module allowed trainees at many programs to avail themselves of the same, high-quality teaching on a specialized topic. This workshop will address the gap in training in sexual health through an interactive workshop to highlight training content, as well as effective, high-impact, multisite dissemination of this crucial and poorly resourced clinical topic.

Abstract

There is a strong relationship between sexual health and general health. Sexual health is associated with improved mental health, more satisfying relationships, and increased education and employment (Office of the Surgeon General, 2001; WHO). Sexual and mental health are bidirectionally influential. For example, depression is a comorbidity of sexual dysfunction, and sexual dysfunction is associated with an increased risk of major depression. The relationship is further complicated by the potential of many psychotropic medications to induce sexual dysfunction. Yet, sexual health is often overlooked by psychiatrists, particularly those working primarily with youth or those with developmental disabilities.

Children and adolescents, particularly those with special needs, may not have ready access to the quality, age- and developmentally-appropriate information that they require. For example, for children with autism spectrum disorder, good sex education offers practical information about basics of hygiene, and when to seek medical attention for sexual symptoms. Sex education can be particularly important to minimize the increased risk of victimization of individuals with developmental disabilities. It may also prevent problematic sexual behaviors, such as public masturbation, unwanted touching or inappropriate internet use which can result in legal consequences (Ford,2017; Office of the Surgeon General, 2001).

Child and adolescent psychiatrists have the opportunity to provide high quality, evidence-based education to our patients and their families about age appropriate

sexuality and sexual health. However, to understand and address the needs of young and special needs patients, psychiatrists need to have competence in taking a sexual history, a good fund of knowledge about normal sexual behavior and sexual health, and comfort in talking about an inherently uncomfortable topic. Few training programs address these topics directly in their curriculum, and there are few quality training materials to demonstrate model sexual health educational interventions.

This workshop presents an accessible training module on teaching residents to address issues of sexual health in their therapeutic encounters. The module uses videotaped standardized patients interacting with expert clinicians who model educational and therapeutic interactions with young patients with a social disability. The authors previously disseminated this model curriculum in a research protocol with child and adolescent psychiatry training programs across the country via synchronous videoconferencing (Drozdowicz et al, 2020). The workshop will describe the model, positive results, and provide "train the trainers" experiences to help further disseminate this curriculum. In addition, the methodology and benefits of providing multi-site teaching opportunities via videoconferencing for model curricula on topics with few or poorly accessible experts, will be explored.

Agenda

- Introduction and polling needs-assessment: to identify participants' comfort level and experience in talking to children and teens about sex and sexual health and teaching these skills. (10 minutes)
- Discussion of the topic of sexual health education and importance to patient care. Use clips of the training videos of standardized patient interviews with skilled clinicians to prompt a discussion on best practices to de-stigmatize a discussion about uncomfortable sexual health topics. (25 minutes)
- Breakout rooms for interactive discussion about key teaching points from the video, role play of addressing potential parental concerns about sexual health education, and discussion of techniques for utilizing standardized patients and synchronous videoconferencing for other topics of interest to participants. (15 minutes).
- Participant review and take-home points. (10 minutes)

Scientific Citations

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Workshops Session 2 (con't)

Zooming to Class: How to Engage Learners Online

Presenters
Deborah Cabaniss, MD
Rita Morales, MD

Educational Objectives
After participating in this workshop, learners will
1. Have a repertoire of techniques to use to engage learners in online teaching.
2. Have an understanding on how and when to use online teaching techniques to enhance learning, engagement, and community.
3. Be able to plan a faculty development workshop on online teaching for their faculty.

Practice Gap
Distance learning has been around for decades (1), and surveys indicate that it can be as effective as in person education (2). Few psychiatry educators, however, had much exposure to it until this year, when the exigencies of the COVID-19 pandemic required us to pull our residents out of seminar rooms. Then, within weeks, we were all thrust into the unknown territory of online education. Necessity is the mother of invention, so we quickly converted our curricula to online platforms, but often without changing or adapting to the new medium. Thus, an immediate practice gap is that educators need to learn how to utilize online teaching techniques to engage learners and create an educational community - and they need to know how to convey this information to their instructors via faculty development. These skills are vital for the current moment, and will likely continue to be crucial as online learning finds a permanent place in our educational repertoire.

Abstract
In March of 2020, just weeks after the 2019 AADPRT meeting in Dallas, psychiatry residency programs around the country abruptly pulled their residents out of classrooms in response to the COVID surge. Suddenly, curricula that had been carefully planned for seminar settings were all on Zoom. We made it happen, but often without adapting to the new medium.

Now, almost a year later, we can come together again to share best practices and hone our online teaching techniques. How can the bells and whistles of Zoom help us to engage our learners and create an inviting classroom community? Which techniques enhance which kinds of learning? How and when should we use them? How can we teach them to our faculty?

Join us for an interactive workshop in which we review online teaching techniques, engage in online learning activities, and share best practices. Even after we are back in the classroom, online learning is likely to continue to have a presence in our programs. Let's get good at it!

Agenda

1. Introduction to the workshop
2. Community building activity in break-out rooms
3. Learning activity #1 - a chief resident shares her online teaching best practices.
4. Learning activity #2 - a faculty member shares her online teaching best practices.
5. General community sharing of best practices in break-out rooms and chat.
6. Group exercise to help program directors create a faculty workshop to teach faculty to teach online

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Workshops Session 2 (con't)

So You Developed a Great Course, Now What? How to Create an AADPRT Model Curriculum for the COVID-19 Era

Presenters
Paul Lee, MD, MPH
Robert Lloyd, MD, PhD
Jacqueline Hobbs, FAPA, MD, PhD

Educational Objectives
Upon completion of this workshop, participants will be able to 1) describe the purpose and benefits of developing a "model" curriculum 2) identify critical components included within a model curriculum 3) transform their courses into resources meeting model curriculum standards, with particular attention to distance learning application 4) discuss considerations for delivering content online.

Practice Gap
Psychiatry residency and fellowship programs are required by ACGME to provide comprehensive training to ensure that all graduates demonstrate requisite professional attitudes, behaviors, knowledge, and skills. With an ever-expanding list of training requirements, many programs lack the knowledge, skills, and resources necessary to teach all required content. To address these challenges, AADPRT developed the Curriculum Committee to solicit, review and share high quality teaching resources among its members. However, translating courses into "model" curricula that can be implemented by other programs is not as simple as passing along a PowerPoint file. Many new residency and fellowship program directors have recently joined AADPRT. Anecdotally, many of these members have reported not having formal training in developing educational materials which could be implemented by other programs. These members would benefit from guidance in how to transform their work into a comprehensive curriculum. Additionally, with the need for physical distancing due to COVID-19, many educators need to develop new skillsets to be able to develop and effectively conduct online educational activities.

Abstract
Now that you have developed a great course for your own program, it's time to further capitalize on your work by adapting the course content into a form which is usable by other institutions: a comprehensive curriculum. There are several advantages to disseminating your course curriculum. Sharing the content allows others to benefit from your contribution and provide feedback to further strengthen the material. Additionally, well-designed, peer-reviewed curriculum is a scholarly product that will directly assist faculty with academic promotion at most institutions. Finally, having a model curriculum on the AADPRT website will help to establish you and your program as content experts. The AADPRT Curriculum Committee encourages AADPRT members to submit high quality, comprehensive curricula for peer review in order to share well-designed and complete curricula with its membership - all in a spirit of scholarship, reciprocity, and

collegiality. You may already have excellent course content that is working well at your individual programs that you would be willing to share so that others may benefit. However, these curricula may need some revision and shaping in order to fit the criteria for a model curriculum: 1) organization/coherence, 2) comprehensiveness, 3) quality of educational materials, 4) innovation, 5) inclusion of a curriculum guide, 6) evaluation tools, 7) bibliography, and 8) adaptability/portability—i.e. suitability for a variety of settings including those with limited resources. As programs continue to adjust to the need for physical distancing due to COVID-19, curricula often need to be adapted to allow their effective implementation in virtual learning environments. In this workshop, participants will receive an overview of the steps for developing a model curriculum, along with hands on assistance in transforming their own teaching materials into a formal model curriculum submission, with an additional focus on considerations for designing distance learning activities.

Agenda

This workshop will be interactive with individual and small breakout group participation and feedback. Participants are encouraged to bring their own curricula to this workshop. The majority of the workshop will be dedicated to virtual consultation with Curriculum Committee members in order to help participants develop their current ideas and existing curricula into a “model” curriculum submission.

15 min: Large group didactic presentation on the benefits of developing an AADPRT model curriculum and steps to designing one, including distance learning considerations.

35 min: Facilitated individual/small breakout group work sessions to plan and/or problem-solve participants’ development of model curricula.

5 min: Large group discussion of “take-away” points and final questions.

5 min: Workshop evaluation.

Scientific Citations

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Workshops Session 3

What Stays, What Goes: A Preliminary Post-Mortem of Match 2021

Presenters
Lia Thomas, MD
Anna Kerlek, MD
Jessica Kovach, MD
Daniel Gih, BS, FAPA, MD
Sandra Batsel-Thomas, MD

Educational Objectives
1. Review the 2020 residency recruitment season and identify the trends in application numbers
2. Evaluate the virtual interview season and determine opportunities for innovation
3. Generate next steps for recruitment in 2021 by preliminarily establishing best practices

Practice Gap
The 2020 residency and fellowship recruitment seasons were unlike others experienced before. With the Coalition for Physician Accountability's Work Group making the recommendations to allow only virtual interviews, program directors and administrators were tasked to create a new kind of interview experience. Because program directors in psychiatry value residents' feedback, interactions with faculty, interactions with housestaff, and interpersonal skills above other application elements, this presented a challenge for psychiatry. However, it was also a significant opportunity for innovation.

As a result, all training programs made changes to their recruitment tactics and interviews, and many found themselves asking the following questions:
What do we wish to keep and/or change from our traditional years of in-person interviewing?
How do we use best use available technology to create an interview day experience and to best yield data to assess "fit?"
How do we re-create meaningful resident and applicant interactions should virtual recruitment continue?
What modifications in logistics (e.g. timing, numbers of interviews) and processes (e.g. how do I showcase my program) should continue next year?

We already know that some anxieties surrounding the 2020 Recruitment Season have abated; preliminary data showed only a small increase in the number of applications per allopathic student (from approximately 50 to 53). As we move to the upcoming Match and continue to have ongoing virtual meetings, Program Directors will have acquired a great deal of insight into their processes, and yet we have much to learn.

Abstract
The 2020-21 recruitment cycle created a colossal series of changes brought on by the ongoing pandemic and the need to ensure interviews could be done safely. Many changes were implemented quickly, and all program directors embarked on a process that many had unlikely considered before. There was a steep learning curve in technology use and introspection about recruitment. Change, while stressful, can be a driver of innovation. However, for true progress to be made, there must be time for reflection to assess what changes worked and what changes were not effective.

As this season's match concludes in the next several weeks, an opportunity exists to draft preliminary plans for the next Match cycle. Based on the 2018 data (pre-COVID) from the NRMP Program Director Survey the following are the top four rated factors in ranking applicants; residents' feedback, interactions with faculty as well as house staff, and interpersonal skills during the interview. This workshop will provide PDs and APDs an opportunity to reflect on their experiences, and to identify more optimal practices. Our review includes the use of virtual open houses before ERAS opened, strategies to showcase diversity and improve recruitment of underrepresented minority applicants, post-interview communication in the virtual world, and the ethics of providing "swag" if in-person interviews are permitted next year.

In addition, other medical specialties have utilized or proposed additional methods such as secondary applications, capping the number of interviews, or first-round interviews that are less labor intensive; we will discuss briefly as future areas of exploration in our discipline of Psychiatry.

We will first present an overview of the 2020-2021 landscape of the recruitment system. We will utilize poll questions to stimulate reflection and participants will select breakout rooms to attend. The breakout rooms will focus on specific "hot topics." Groups will share innovations and the results of those innovations. Groups will prepare to present their consensus on innovations that should be preserved or dropped or to identify conflicts related to the topic.

Agenda
5 minutes: Overview of the 2020-21 landscape of the psychiatry recruitment season

5 minutes: Identify the "hot topics" as described above or additional ones that attendees generate

5 minutes: Poll/reflection questions - After we introduce the hot topics; we can poll the audience for their top 3-5 (depending on attendance)
Three 10-minute breakout rooms to discuss what stays, what goes; groups come to a general consensus, and/or identify conflicts.

10 minutes of discussion; groups to identify next steps for these "hot topics" in next Match cycle

Final 5 minutes: designated time for evaluation and feedback

Scientific Citations

1. Special Joint Statement on 2020 Recruitment from AADPRT and ADMSEP: https://www.aadprt.org/application/files/1015/9009/1630/admsep_aadprt_statement_5-17-20.pdf
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Workshops Session 3 (con't)

Struggling with faculty recruitment and retention? Let us help you!

Presenters
Tanya Keeble, MD
Deborah Cowley, MD
William Sanders, DO

Educational Objectives
By the end of the session participants should be able to:
1. Describe two salary and benefit structures that have been successful in faculty recruitment and retention.
2. Outline three ways to compensate for faculty salary and benefit gaps
3. Describe best practices in developing a robust academic culture of trust and teamwork
4. Describe one best practice model for faculty mentorship and career development

Practice Gap
Results from the 2019 American Association of Directors of Psychiatric Residency Training (AADPRT) Workforce Task Force survey indicate that faculty recruitment and retention is a major issue for residency and fellowship training programs
Both residency PDs (76.2%) and fellowship PDs (68.9%) cited difficulty with recruitment and retention of faculty.
Most comments discussed difficulty in recruiting faculty, with a prominent theme of noncompetitive academic salaries compared to the private sector. Some also commented that this was a barrier in retaining faculty, especially with junior faculty moving into better paid jobs. Additional themes in faculty recruitment and retention included workload, non-compensated teaching time, location, and chronic short staffing.
Best practices for faculty recruitment and retention across both academic and community programs have not been previously described or developed. This workshop aims to draw both from the existing data and from audience members to address that gap.

Abstract
The 2019 American Association of Directors of Psychiatric Residency Training (AADPRT) Workforce Task Force survey indicated that faculty recruitment and retention is a major issue for residency and fellowship training programs. Never fear, this workshop will come to your rescue!
We will address known barriers to faculty recruitment and retention, and demonstrate and discuss innovative solutions. Audience members will learn about available, but typically less well known salary and benefit structures that have been successful in other programs. They will share ideas about how to bridge remaining salary and benefit gaps that exist in the educational environment. The workshop will discuss transparency,

trust and teamwork in program culture as this is often the hidden ingredient to a happy faculty. And finally, if that were not enough, we will also highlight mentorship and career development as work satisfaction and faculty retention strategies. This workshop is highly interactive, using polling, paired, and large group discussion to enhance audience contributions.
Facilitators will highlight several models that have been effective at small, medium and large programs in community and university based settings. In the course of the workshop, participants will develop a shared resource document, to be distributed at conclusion of the session.

Agenda
Before the workshop, audience participants will receive an overview of the data from the 2019 AADPRT workforce survey regarding faculty recruitment and retention.
10 mins – introductions, outline objectives, describe agenda for meeting. Large group poll to understand their barriers to recruitment and retention of faculty to enable workshop facilitators to address audience concerns.
15 mins – presentation of some useful resources to address salary and benefit differences - large group discussion about how audience members have engaged with their recruitment team and senior residents.
10 mins – pair group discussion about how to address remaining salary and benefit gap with report out.
20 mins – break out pairs discuss challenges and successes in creating and sustaining an educational culture, and creating programs that optimize retention of high quality faculty. Chat function used to generate written material to be used for the resource document. Large group report out.
5 mins – close and summary of data form workshop for development into a resource document.

Scientific Citations
"Growing the Psychiatry Workforce through Expansion or Creation of Residencies and Fellowships: the Results of a Survey by the AADPRT Workforce Task Force"
Full author list: Mara Pheister, MD; Deborah Cowley; William Sanders; Tanya Keeble; Francis Lu; Lindsey Pershern; Kari Wolf; Art Walaszek; Rashi Aggarwal

DeGolia SG, Cagande CC, Ahn MS, Cullins LM, Walaszek A, Cowley DS. Faculty development for teaching faculty in psychiatry: where we are and what we need. Acad Psychiatry 2019; 43(2):184-190.

Workshops Session 3 (con't)

Operationalizing Holistic Review in the GME Context: A Practical Guide to Implementing a Program-Specific Holistic Review Process

Presenters
Colin Stewart, MD
J. Corey Williams, MA, MD
Katrina DeBonis, MD
Kristine Goins, MD
Neha Sharma, DO

Educational Objectives
- Describe various methods for implementing a Holistic Review Framework (HRF) in both psychiatry residency and psychiatry fellowship admissions.
- Decide which aspects of a HRF would be most feasible and appropriate for their program.
- Craft a training program mission statement that speaks to diversity enhancement and strategize ways to keep the statement highly visible
- Clearly define the experiences, attributes, competencies, and metrics (EACMs) which best align to their program's mission statement with a focus on elements related to diversity, inclusion, and equity
- Strategize how they will incorporate the lived experiences of minority groups and/or self-identified race and ethnicity into holistic review
- Examine the ways in which systematic bias (e.g. structural racism, sexism) manifests in various elements of the ERAS application
- Create a value system that both aligns with their program's mission and values and addresses systematic bias in each element of the ERAS application

Practice Gap
Medical admissions and hiring practices have always been fluid with the broader social and political context. In this national time of reckoning with structural racism, program directors and recruitment committees need to re-examine their application screening, interviewing, and ranking processes to ensure greater inclusion and equity in the recruitment process. This is also in line with the need presented by the institution of the ACGME's new Common Program Requirement as of July 2019 focused on recruiting and retaining a more diverse and inclusive workforce. The AAMC's Holistic Review Framework (HRF) has been adapted in some form by up to 91% of medical schools (Urban Universities for Health, 2014) but there is minimal evidence of its use in GME recruitment and only one published article discussing its use in psychiatry recruitment (Barceló et al 2020). Articles on the use of a HRF in GME recruitment have noted limited time and resources as the primary barriers to implementing holistic review in the GME context (Aibana et al, 2019).

Additionally, while the HRF is helpful as an overall structure, each program must then do its own work to identify the experiences, attributes, competencies, and metrics (EACMs) which align with the program's mission and values. Programs that have reported on their use of a HRF have not consistently noted using a systematic process to determine the differential weights of each EACM using methods that take into account systematic bias known to be baked into various elements of the ERAS application (Aibana et al, 2019) (Barceló et al 2020) (Wusu et al 2019). Programs that use metrics as their primary means of filtering applications also systematically exclude the value of the lived experiences of minority groups in the applicant review process. Including these experiences in a program's HRF entails specific legal and operational considerations. Program directors would benefit from learning how to operationalize sustainable holistic review practices in the GME context, how to develop program-specific mission and values-aligned EACMs, and how to incorporate antiracism principles to better account for systematic bias in various ERAS application elements as a part of their overall efforts to diversify their trainee cohorts and create a more inclusive, equitable recruitment process.

Abstract
This workshop will help both psychiatry residency programs with hundreds or thousands of applicants as well as psychiatry fellowship programs with only dozens of applicants identify various methods for utilizing a Holistic Review Framework in the GME context via an overview of methods used by the adult residency program at UCLA and the child and adolescent psychiatry fellowship at Georgetown. Attendees will then break into small groups to choose from among those methods which would be most feasible and relevant in their home institutions. Next, we will present examples of institution-specific mission statements and describe a method for developing your own mission statement. Attendees will then briefly consider what would be core elements of a mission statement aligned with the goals and values of their home institution. Presenters will then describe both the EACMs developed at UCLA and Georgetown and the processes utilized to develop them. Finally, there will be a large group discussion in which participants report their next steps both verbally to the large group and in the group chat. The chat will then be saved and distributed to attendees afterward.

Agenda
0:00-0:05- Introduction to presenters and outline of agenda
0:05-0:15- Description of HRF implementation methods at UCLA relevant to programs with large numbers of applicants
0:15-0:25- Description of HRF implementation methods at Georgetown relevant to programs with small numbers of applicants
0:25-0:35 - small group exercise focused on helping programs choose which implementation methods would be best suited for their program
0:35-0:40- brief presentation of mission statements/values of UCLA and Georgetown training programs and overview of handout on developing your mission statement
0:40-0:45- think-pair-share exercise focused on developing a program mission statement that includes elements related to diversity, equity, inclusion, and justice

0:45-0:55- presentation on developing a broad, diverse, variably weighted set of EACMs based off of your mission statement while also considering the ways in which various elements of the ERAS application are prone to systematic bias
0:55-1:00- large group discussion and wrap up

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Addams, A. N., Bletzinger, R. B., Sondheimer, H. M., White, S. E., & Johnson, L. M. (2010). Roadmap to diversity: integrating holistic review practices into medical school admission processes. Association of American Medical Colleges.

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Workshops Session 3 (con't)

To Retreat or Not to Retreat: Strategic Use of Resident Retreats as a Virtual or In-Person Wellness Tool

Presenters
Victoria Kelly, MD
Thomas Roach, DO
Nathan Massengill, MD
Adam Rowe, MD
Kristi Skeel Williams, MD

Educational Objectives
1. Identify the role resident retreats have in improving resident wellness, leadership, and cohesion
2. Review executive coaching strategies from the business field and recognize components that can be incorporated into resident retreats
3. Discuss impact of COVID on retreats, including technological and virtual issues
4. Identify challenges & potential solutions to resident retreat planning

Practice Gap
"Coming together is a beginning. Keeping together is progress. Working together is success." – Henry Ford

The Merriam-Webster dictionary defines a retreat as "a period of group withdrawal for prayer, meditation, study or instruction under a director" [1]. A retreat provides residents a time to bond with their colleagues, which fosters physician and program wellness. This bonding experience helps residents build better working relationships with their peers, which lowers burnout rates [2]. Resident retreats help trainees master the Accreditation Council for Graduate Medical Education (ACGME) and American Board of Psychiatry & Neurology's (ABPN) psychiatry core competency expectations of 'Interpersonal and Communications Skills', 'Professionalism', and 'Systems-Based Practice' [3].

Searching Pubmed for "resident retreat," "wellness" and/or "burnout" yielded only 15 results. Of those, one result found radiology residents to have improved camaraderie after a retreat [4]. Another result found emergency medicine residents had increased team building, resident bonding, and faculty-resident bonding after an "Amazing Race" style retreat [5]. Several more results pertained to pharmacy students and family practice. Although one article discussed using a research retreat to improve career development opportunities for psychiatry residents, it focused on a regional conference rather than the traditional residency retreat [6]. Most notably, no literature was found providing guidance to programs on planning retreats or psychiatry-specific data on residency retreats. This is especially meaningful, given that 43.9% of psychiatry residents in 2018 noted symptoms of burnout [7].

Chief residents are often sent to “Leadership” trainings, where the most valued skills learned are giving feedback, delegating duties, building teamwork, managing time, making presentations, being on rounds, coping with stress, teaching at the bedside, writing memos, and managing meetings [8]. However, there is a lack of formal training in leadership skills at the program level. A resident retreat is a useful tool for program leadership (director, coordinator, chief resident) to develop or reinforce leadership skills and address the specific and unique needs of the individual program. The ability to function as a physician leader and demonstrate interprofessional skills are addressed in the ACGME Adult Psychiatry milestones of MK6 (Practice of Psychiatry) and SBP1 (Patient Safety and the Health Care Team), PBLI1-2.1A & 2.2A (Development and execution of lifelong learning through constant self-evaluation), and PBLI3 (Teaching) [9].

Formal education and discussion of retreat planning as a wellness tool will empower program directors and chief residents to be more prepared in addressing challenges residents encounter. Having a strategic plan for resident retreats allows for demonstration of managerial skills, fosters interpersonal and professional growth, and addresses burnout all within a bonding experience. Resident retreats also assist in the cultivation of professional development as found within the ACGME milestones PROF2 (Accountability to self, patients, colleagues, and the profession), and ICS1 (Relationship development and conflict management with patients, families, colleagues).

Abstract

“In order to understand the world, one has to turn away from it on occasion." – Albert Camus, The Myth of Sisyphus and Other Essays

In the changing climate of healthcare, resident psychiatrists are expected to conquer challenging professional and interpersonal terrains while progressing academically, often without formal training in how to do so. [10]. Poor work-life balance, the changing role of the physician in the healthcare setting, and dealing with conflicts in professional and personal lives, have all been shown to contribute to burnout in physicians. Burnout is a well-known, but not well-defined, problem that has been shown to be particularly high in residents including during the COVID-19 pandemic. Now more than ever, trainees need formal guidance on how to prevent burnout and develop professionally while navigating this ever-changing landscape.

Interventions designed to increase well-being and decrease burnout include individual level approaches directed toward enhancing individual well-being as well as systemic interventions aimed at changing workplace factors such as culture, leadership, autonomy, and workflow. These workflow factors include assistance with administrative burdens, increasing physician autonomy) [11]. For residents, factors that contribute to burnout require interventions. These include demands on time, lack of control, work planning, organization, inherently difficult job situations, and interpersonal relationships [12]. In 2015, a national panel of United States multispecialty residents and fellows specifically recommended resident retreats as a way to increase resident wellness activities [13]. One of the best ways to improve the performance of a medical practice

team is to hold a team retreat [14]. A major goal of a retreat is to encourage socialization in an informal setting, allowing barriers to be broken down, and improving teamwork [15]. In medicine, this may indirectly impact patient care due to teamwork factors affecting patient handoff and coverage issues.

Program directors, coordinators / administrators, and chief residents have a unique opportunity to use resident retreats strategically in several ways: as a wellness tool, to evaluate the program's strengths / weaknesses / opportunities / threats, to identify individual professional development needs, to promote bonding, and potentially enact larger departmental change. Incorporating cues from the corporate world provides resident retreats with the general framework that can be adapted to the unique needs of the individual psychiatry residency programs.

To address this need, our interactive workshop will discuss corporate & coaching approaches, potential benefits & impact on residency programs, and technological and virtual means to enhance the retreat experience. Participants in the workshop will have the opportunity to examine their own program and discuss challenges & potential solutions for an effective retreat. Upon completion of this workshop, the participant should have an increased knowledge base and confidence in the ability to strategically plan a resident retreat that will benefit the residents and the program.

Agenda

1. 10 minutes – Introduction, Overview, and Why a retreat is important (wellness, milestones & competencies, professional development, and borrowing from the business world)
2. 10 minutes – Breakout – How a retreat could make your program better
3. 10 minutes – Strategic planning and building your retreat - components of agenda, structure, goals like leadership support, program evaluation, teambuilding, and consideration of lasting gains
4. 10 minutes – Virtual and technological resources for retreats
5. 10 minutes – Breakout – challenges that programs face to making retreats happen successfully
6. 5 minutes – Wrap up and questions
7. 5 minutes – Workshop revie曾

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Workshops Session 3 (con't)

Identity, Race, and Power - Starting with Self

Presenters
Jennifer O'Donohoe, MD
Katie Gradick, MD
Mauricio Laguan, BA
Karen Manotas, MD
Kristen Durbin, MD

Educational Objectives
1. Define the primary tenants of identity with a focus on the construct of social identity
2. Describe ways that a lack of self and systemic awareness of identity and power contribute to racist policies in training and patient care
3. Participants will examine and reflect on their own social identity
4. Explore obstacles and benefits to antiracist work within healthcare settings

Practice Gap
Disparities in health care are not new and the pandemic has brought this issue into sharp focus for medical professionals as well as the general public. Despite there being ongoing discussions of the importance of addressing these disparities at every level of medical and graduate medical education, they persist. The ACGME charges training programs with addressing this issue through access to relevant outcome data, increasing diversity among trainees, and education[1]. This is challenging because the practice of modern medicine is built on a foundation of scientific and medical racism; without awareness of this history, it is difficult to identify racist policies, protocols or practices that negatively impact our patients [2]. Likewise, without exploration of our own identity, foundation, and history, we will struggle to choose antiracism even in situations when it will benefit our trainees and patients. Traditional didactic lectures and creating cultural competency curriculums do not seem to have made the desired impact on health disparities [3]. Program directors need to dedicate time and space for reflection and interactive learning when it comes to issues of Identity, Race, and Power. With increased dialogue and awareness, there will be increased opportunities to choose antiracism. Program directors need to have access to tools that can assist them and trainees to feel prepared and supported when these challenging situations arise.

Abstract
The goal of this workshop is to help attendees reflect on the interplay between Identity, Race and Power, specifically within the context of psychiatry training. The workshop will start with an ice breaker designed to engage the participants and start building psychological safety within the group. We will then set norms for the workshop. These are important steps given the sensitive nature of the topic. We will use interactive zoom polling to assess the level of comfort participants have with antiracist work and self-reflection. A small didactic portion will clarify definitions and give context to the work. The expectations for the breakout session will also be set during this time. Initially,

participants will use a structured worksheet to explore their own social identities and then share in a dyad using the chat function. The break out groups will then discuss the participants experience with the worksheet as well as the benefits and obstacles to antiracist work. These breakouts sessions will be facilitated by the presenters and moderators if needed. There will be a brief presentation of the Stop, Talk, Roll tool, which was created at the Georgetown School of Medicine to help medical students and residents with difficult conversations. Wrap up will include intention setting.

Agenda

1. Introduction: Interactive ice breaker and setting norms via zoom (15 min)
2. Didactic including definitions, brief narratives and set up for break out (10 min)
3. Completion of identity worksheet and share in breakout session (10 min)
4. Break out session continued in small groups discussion of obstacles (10 min)
5. Presentation of the tool – Stop, Talk and Roll – brief didactic (5 min)
6. Wrap up (5 min)
7. Participant review (5 min)

Scientific Citations

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3. Applying Antiracist Concepts to Clinical Practice: https://www.sciencedirect.com/science/article/pii/S0890856720318402?dgcid=author
4. Health Care Disparities: a Practical Approach to Teach Residents about Self-Bias and Patient Communication: https://pubmed.ncbi.nlm.nih.gov/31215015/

Workshops Session 3 (con't)

Assessing Psychodynamic Psychotherapy

Presenters
Erin Crocker, MD
Deborah Cabaniss, MD
Randon Welton, MD
Sindhu Idicula, BA, MD

Educational Objectives

- By the end of this workshop participants will be able to:
- Discuss what priorities, attitudes, and techniques define competency in psychodynamic psychotherapy
- Describe psychodynamic psychotherapy evaluation forms created by the American Association of Directors of Psychiatry Residency Training's (AAADPRT) Psychotherapy Committee
- Practice using AADPRT tools to evaluate the conduct of psychodynamic psychotherapy
- Evaluate the usefulness of the AADPRT tools to evaluate psychodynamic psychotherapy

Practice Gap

Psychodynamic Psychotherapy has long been a cornerstone of psychiatric practice. The ACGME requires that psychiatry residents demonstrate competency in psychodynamic psychotherapy. The ACGME's Psychiatry Milestones include "providing psychodynamic psychotherapy to patients with moderately complicated problems" as one of the Level 4 anchor points for Patient Care 4 - Psychotherapy. Measuring competence in psychodynamic psychotherapy presents a challenge to psychiatry residency programs. This challenge has increased as fewer psychiatrists have extensive training or experience in psychodynamic psychotherapy. There are no widely available tools to assist in directly measuring competence in psychodynamic psychotherapy.

Abstract

The Accreditation Council for Graduate Medical Education requires that all graduating psychiatry residents are competent in managing and treating patients using brief and long-term cognitive behavior therapy, supportive psychotherapy, and psychodynamic psychotherapy. Developing didactics covering the basics of psychotherapy is relatively straightforward. Evaluating knowledge about psychotherapy can be conducted through simple multiple-choice questions. Measuring competency in psychotherapy is more difficult. Cognitive Behavior Therapy can be assessed using the Cognitive Therapist Rating Scale. AADPRT's Psychotherapy Committee has previously created tools to assess competency in Supportive Therapy. Assessing competency in psychodynamic psychotherapy, however, presents a new challenge. Often competency is merely assumed based on the number of hours a resident spends providing therapy.

Assessment of psychodynamic psychotherapy competency is often relegated solely to the individual psychotherapy supervisor based on discussions of the care provided or observing video/audio recordings of therapy sessions. This interactive workshop presents new assessment tools created by the AADPRT Psychotherapy Committee. One of the tools evaluates the resident's demonstrations of the priorities and attitudes of a psychodynamic psychotherapist while the other assesses the resident's use of psychodynamic interventions. The tools will be explained and then participants will practice using the tools to evaluate video examples of psychodynamic psychotherapy. Participants will then share ideas for improving the usefulness of these tools.

Agenda

- Introduction and goals (Didactic presentation): 5 minutes
- The difficulties in demonstrating competency in psychodynamic psychotherapy (Didactic presentation with polling): 5 minutes
- How might competency in psychodynamic psychotherapy be demonstrated? (Large Group Discussion): 5 minutes
- Introducing the tools (Didactic presentation): 10 minutes
    - Psychodynamic Psychotherapy – Priorities
    - Psychodynamic Psychotherapy – Interventions
- Video presentations of psychodynamic psychotherapy (video): 10 minutes
- Using the Psychodynamic Psychotherapy Tools to rate psychodynamic psychotherapy (Small group discussion via breakout rooms): 10 minutes
- Improving the tools (Large Group Discussion): 10 minutes
- Closing comments (Large Group Discussion): 5 minutes

Scientific Citations

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Workshops Session 3 (con't)

Creating quality research opportunities for general program residents

Presenters
Lindsey Pershern, MD
Mary Camp, MD
Adriane DelaCruz, MD

Educational Objectives
1. Outline the ACGME requirements for scholarship and its value in residency training
2. Describe components of a resident research training experience for all categorical residents
3. Consider strategies to address barriers to implementing a resident research experience
4. Develop a framework for creation of a research experience in their own program

Practice Gap
The ACGME common program requirements mandate the involvement of residents in scholarly activity. Residency programs are required to implement a curriculum in research literacy and evidence-based practice and provide resources to support scholarly activity, but little guidance is provided on best practices or desired outcomes of this requirement. The emphasis on active participation in scholarship is warranted, as classroom teaching of research principles has clear limitations in the absence of research experiences. Scholarly experiences provide residents with tools to understand and critically evaluate the research literature. Some specialty-specific requirements for scholarship allow experiences with research, quality improvement, education and advocacy, while others have refined this to participation in research . Individual programs define their expectations of residents based on their own goals and interpretations of scholarship. This has led to significant heterogeneity of scholarly curriculum, experiences and outcomes across training programs. Several aspects of research programs within residencies have a positive impact on scholarly productivity. Structured education programs that provide protected time for resident research activity produce more publications per resident than those that do not protect time. Providing dedicated research mentors increases productivity in research, as well as improving the resident's understanding of research principles. For psychiatry programs, proposed models include creation of formal programs that scaffold teaching of research principles and skills, coordination of mentoring relationships and scholarly experiences. In programs with variable resources, many face challenges in identification and development of mentors and finding appropriate activities with the infrastructure to support resident involvement. A strategic plan to support resident scholarship requires consideration of goals, resources, and expected outcomes.

Abstract
Prior to the development and implementation of a PGY2 research rotation, our training program provided a research related curriculum and specified, as a graduation

requirement, completion of a scholarly project. In addition to a dedicated research track, we promoted general program resident involvement in multiple research electives. Support of the scholarly project included recommendations for types of projects, facilitation of resident-mentor pairings and required presentation of projects in the annual senior poster day. All graduating residents completed scholarly projects. Few of these projects, however, resulted in publications or presentations outside of the institution, despite encouragement and support towards this goal. We developed the required research rotation in which PGY2 residents developed a research project as a group with guidance and mentorship from clinical researchers and then rotated serially for 4 weeks at a time, working on a group research project. The overall goal of the project was the development of a research project that would result in a published research article and poster presentation. Structural components of the rotation included: 1) Protected time for residents, 2) Dedicated research mentors 3) Peer group work on the same project, and 4) Research design using existing data. Over the last 4 years, we piloted variations in the structure of mentorship and coordination of resident research groups to land on a successful model that we now maintain. Residents are grouped based on the schedule over the year and the timeline of the research project. Research mentors work together to supervise groups while coordinating between themselves to maximize efficiency as well as maintain project progress. Now in its 4th year, the research rotation has yielded 7 scholarly publications and improvements in residents' perceptions of research-related skills and appreciation for research and its impact on clinical practice specifically among non-research track residents. In this workshop, we will present on our program and its structure and provide activities for participants to consider creation of a structured research opportunity for residents in their own program.

Agenda

00:00- 00:10 – Introductions and Polling of audience to assess participant needs: We will use polls to orient participants to the role of research experiences in residency training and barriers to involving residents in research during training

00:10 – 00:20 – Presentation of Required Research Rotation structure and outcomes

00:20-00:40 – Small group activity – Participants will select to join a small group to review and brainstorm strategies to overcome barriers in the following areas:

- Recruiting and retaining research mentors
- Faculty development for research mentors
- Protecting resident time for research
- Measuring outcomes of a research experience
- Preparing residents for research participation
- Residency research project design

00:40 – 00:55 – Large group discussion, conclusions and resources

- Participants will have a framework for planning/executing a plan at their home institution

00:55-00:60 – Participant review of session

Scientific Citations

1. ACGME Program Requirements for Graduate Medical Education in Psychiatry. Accreditation Council for Graduate Medical Education. 2016.
2. Wood W, McCollum J, Kukreja P, Vetter IL, Morgan C, Hossein Zadeh Maleki A, Risenberg LA, Graduate medical education scholarly activities initiatives: a systematic review and meta-analysis. BMC Medical Education (2018). Dec 22; 18 (1): 318. doi: 10.1186/s12909-018-1407-8
3. Hebert RS, Levine RB, Smith CG, Wright SM, A Systematic Review of Resident Research Curricula. Academic Medicine (2003). 78 (1): 61 – 68.
4. Byrnes A, McCormack F, Diers T, Jazieh AR, The Resident Scholar Program: A Research Training Opportunity for Internal Medicine House Staff. Journal of Cancer Education (2007). 22 (1). 47-49.

Workshops Session 4

Innovative Strategies to Implement the ACGME Common Program Requirement on Diversity and Inclusion

Presenters

Consuelo Cagande, MD
Adrienne Adams, MD, MSc
Paul Lee, MD, MPH
Auralyd Padilla, MD
Francis Lu, MD

Educational Objectives

The objective of this workshop is to provide a framework for programs to implement true diversity and inclusion within its leadership roles. We will present the results of a quantitative study, which sought to identify the demographic characteristics of one of the more influential national organizations, the AADPRT membership. We will also present data of from a sample of psychiatry trainees, and determine whether any demographic factors predicted satisfaction levels with current institutional and departmental efforts to support Diversity & Inclusion (D&I) as well developmental advancement. The data further explored PDs' demographics, curricula, and opinions on their program's diversity and support for inclusion. Furthermore, we will discuss aspects of developing and studying effectiveness of programs to combat the concept of "leaky pipeline" a phenomenon of a decreasing proportion of URM at each juncture along the educational "pipeline", which begins with a group comparable to the demographics of the U.S. population but dwindles to a "trickle". The result is a small number of underrepresented individuals in higher education positions such as faculty members in academic medicine. We will review the model approach to systematic recruitment for a robust diverse and inclusive organization. Lastly, we will have break out-group discussion on individual program challenges and solutions and develop similar framework for their own programs.

Practice Gap

Several organizations have noted the lack of D&I and have begun ushering in novel efforts to address disparities. In 2019, the Accreditation Council of Graduate Medical Education (ACGME) implemented D&I requirements into its Common Program Requirements. There has been no systematic investigation into the diversity among psychiatry Program Directors throughout the U.S. There has also been no description regarding the perceptions of PDs on D&I. Efforts to recruit, retain, and mentor underrepresented minorities in academia are still limited. In addition, there has not been an identified gold standard approach for D&I recruitment into organizations thus resulting in inconsistency among memberships.

In either case, continued efforts to actively recruit, retain, and mentor underrepresented minorities in academic psychiatry are imperative. This symposium will address these gaps based on the results of the study and examples of successful efforts supporting URM in the pipeline but are not present for those interested in academic psychiatry.

Abstract
Several organizations have noted the lack of diversity and inclusion (DI) and have begun ushering in novel efforts to address this issue. In 2019, the Accreditation Council for Graduate Medical Education (ACGME) implemented for the first time a diversity and inclusion accreditation standard into its Common Program Requirements. Efforts to recruit, retain, and mentor underrepresented minorities (URM) in academic psychiatry are still limited. There is no identified gold standard approach for recruitment of diverse faculty into organizations thus resulting in inconsistency among memberships. Continued efforts to actively recruit, retain, and mentor URM in academic psychiatry are imperative. This session will address these gaps based on the results of a study by the American Association of Directors of Psychiatry Residency Training (AADPRT) Committee on Diversity and Inclusion and examples of successful efforts supporting URM in the pipeline but are not present for those interested in academic psychiatry. Our objectives are: 1) provide a framework for national organizations to implement true diversity and inclusion within its membership and leadership roles, 2) present the results of a quantitative study, which sought to identify the demographic characteristics of one of the more influential national organizations, the AADPRT membership, 3) discuss aspects of developing and studying effectiveness of programs to combat the concept of "leaky pipeline" which begins with a group comparable to the demographics of the U.S. population but dwindles to a "trickle," 4) review the model approach to systematic recruitment for a robust diverse and inclusive organization and 5) break out into small groups for more in depth discussion and develop similar framework for their own programs.

Agenda
0:00 Welcome and Introduction - Consuelo C. Cagande MD (2 mins)
0:02 Poll (2 questions, 2 mins)
0:04 Pre-recorded lectures (25mins):
- Adrienne Adams MD, MS- Introduction/Setting the Framework of the AADPRT study (5 mins)
- Paul Lee MD - Presentation of the results of the study (5 mins)
- Consuelo Cagande MD Review of novel approaches to address diversity and inclusion (5 mins)
- Auralyd Padilla MD-Review of the AADPRT Committee on Diversity and Inclusion Model for recruitment of diverse faculty (5 mins)
- Francis Lu MD – Discussant (5 mins)

0:30 Break Out Rooms (15mins)
0:45 QAs (15mins)
0:60 End

Scientific Citations
James R, Starks H, Segrest VA, Burke W. From leaky pipeline to irrigation system: minority education through the lens of community-based participatory research. Prog Community Health Partnersh. 2012 Winter;6(4):471-9.

Bolden AL, Leclerc J, Dunbar S, Imon M. Identification of Support and Barriers to Health Professions Among Underrepresented Minority Youth. 2016. https://nsuworks.nova.edu/hpdrd/2016/events/155/. Accessed 15 Feb 2020.

Gonzaga AMR, Appiah-Pippim J, Onumah CM, Yialamas MA.A Framework for Inclusive Graduate Medical Education Recruitment Strategies: Meeting the ACGME Standard for a Diverse and Inclusive Workforce. Acad Med.2019 Nov 5

Workshops Session 4 (con't)

Operationalizing Holistic Selection of Psychiatry Residents in the Absence of USMLE Step 1 Scores: The Nuts and Bolts

Presenters
Robert Marvin, MD
Laurel Bessey, MD
Ryan Finkenbine, MD
Marla Hartzen, MD
Yoon Soo Park, PhD

Educational Objectives
1. Define and operationalize holistic resident selection
2. Use program-specific mission statement and aims to identify and balance selection metrics
3. Develop and implement screening rating instruments
4. Promote diversity and inclusion using holistic resident selection

Practice Gap
Resident selection practices in psychiatry have long relied on using licensure examination scores as the basis to identify the initial cohort for interviews. The 2020 national survey by the National Resident Matching Program has shown that United States Medical Licensing Examination (USMLE) scores remain the main focus of initial selection,(1) reinforcing a similar survey finding among psychiatry training directors.(2)

This focus on licensure scores has been associated with neglect for holistic characteristics such as an applicant's experiences, attributes, and academic achievements. Importantly, narrow reliance on test scores may demonstrate insouciance toward valued aspects of diversity and inclusion in psychiatry training and the practicing workforce.(3) The field of psychiatry is moving toward new challenges as it embraces a larger, more competitive applicant pool, while considering non-traditional competencies for training the next generation of psychiatrists.(4)

In March 2019, the USMLE announced that it will no longer report numeric Step 1 scores and will only report pass-fail decisions beginning in its 2022 administrations.(5) This decision will undoubtedly have significant impact in medical education, necessitating a revised processes for resident selection that has traditionally relied heavily on Step 1 scores. The change also presents an important opportunity for training programs to expand recent efforts to promote holistic resident selection. Translating best-practices for holistic resident selection – based on mission-aligned selection processes that consider an applicant's experiences, attributes, and competencies rather than a test score – have not been operationalized for implementation on a national level.

This interactive virtual workshop aims to leverage the experience, judgment and scholarship of the collaborative Psychiatry Educational Assessment Research Learning (PEARL) consortium to target holistic selection of psychiatry residents and plan for the absence of USMLE Step 1 scores. Presenters will offer best-practice guidelines, tools and resources to operationalize holistic resident selection practices that attendees can implement at their home residency training programs

*The Psychiatry Educational Assessment, Research, and Learning (PEARL; http://psychpearl.org/) consortium is a practice-based research network funded by the American Board of Psychiatry and Neurology to answer research questions and translate scientific findings into practice. There are six residency training programs part of this research collaborative.

Abstract
Holistic resident selection refers to a resident review process that considers the candidate as a whole, using criteria for admission aligned with the mission and aims of the training program and incorporating learner experiences, academic performance, and additional values the learner contributes to the educational program.3 Prior resident selection approaches have relied heavily on licensure examination performance, notably the USMLE Step 1 scores;(1) training director surveys have previously shown that Step 1 scores may be the single most important factor for interview invitations.(1,2)

The USMLE series of examinations were designed as a criterion-referenced assessment, with the goal to assess readiness for supervised training, rather than use for selection purposes. Studies have also shown that the predictive qualities of the USMLE are mixed, with poor association for clinical performance and professionalism.(6) The National Board of Medical Examiners (NBME) and the Federation of State Medical Board (FSMB) announced that starting in January 1, 2022, the Step 1 score will be reported as pass or fail only.(5) The change in USMLE score reporting policy provides a unique opportunity to promote holistic review processes that can be generalized and adapted for implementation in different training programs.

This interactive workshop, aimed to operationalize holistic resident selection, will offer a practical “nuts and bolts” approach to holistic selection methodologies that can be readily implemented at each participant’s training program. Participants will be provided with the materials and tools necessary to develop a successful holistic recruitment plan. The materials include guidelines for multi-method selection processes with structured interviews/multiple mini-interviews (MMI) and situational judgment testing (SJT) that supplement traditional metrics for selection.(7.8) These materials will incorporate best-practice guidelines and practical tips (from the literature and program-specific examples), including didactic and interactive sessions using mission statements specific to each participant’s program. Participants will be guided in interactive breakout rooms to apply their program-specific mission statement and aims to models of holistic review and will be facilitated to translate methodology into practice. This workshop will provide guidance, thereby hopefully reducing anxiety, for training directors and programs aiming to conduct holistic review, deliver consensus-building methods/processes to identify

institutional values, and facilitate translation of conceptual ideas to operationalize selection.

Agenda

1. Introduction and Welcome (5 minutes)
2. Brief Didactic Session: Background on holistic review and changes in USMLE: what works and what does not work (5 minutes)
3. Interactive Discussion – resources and selection tools: Overview of multi-selection processes for holistic resident selection (10 minutes)
4. Interactive Breakout Room: Activity using holistic resident selection (25 minutes)
   a. Interactive portfolio review of applicant profiles
   b. Breakout room interactive activity by program size
5. Discussion and Questions using Polling Functions (15 minutes)

Scientific Citations

1. National Resident Matching Program. Results of the 2020 NRMP Program Directory Survey. Washington, DC: National Resident Matching Program; 2020. https://mk0nrmp3oyqui6wqfm.kinstacdn.com/wp-content/uploads/2020/08/2020-PD-Survey.pdf. Accessed 27 October 2020.
2. Chang AK, Morreale M, Balon R. Factors influencing psychiatry resident applicant selection for interview. Acad Psychiatry. 2017;41:438-9.
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4. Walaszek A. Keep calm and recruit on: Residency recruitment in an era of increased anxiety about the future of psychiatry. Acad Psychiatry. 2017;41:213-20.
5. United States Medical Licensing Examination. Change to pass/fail score reporting for Step 1. Philadelphia, PA: USMLE; 2019. https://www.usmle.org/incus/#decision. Accessed 27 October 2020.
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7. Andolsek KM. Improving the medical student performance evaluation to facilitate resident selection. Acad Med. 2016;91(11):1475–9.
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Workshops Session 4 (con't)

Problem Residents and Resident with Problems: Distress and Accommodations in the Age of COVID

Presenters
Kim Lan Czelusta, MD
Michael Jibson, MD, PhD
Daryl Shorter, MD
Laurel Williams, DO
James Lomax, MD

Educational Objectives
1) Review guidelines in the assessment and management of a resident with difficulties caused or exacerbated by external stressors,
2) Systematically develop an intervention plan, in collaboration with GME office, legal counsel, and human resources, to achieve specific, desired outcomes,
3) Compare different approaches in mitigating unintended consequences of the pandemic.

Practice Gap
Training directors spend significant time assessing residents with a variety of difficulties that interfere with residents' training. This workshop is designed to increase the knowledge and skill of participants by reviewing residency programs' options when a difficult resident situation arises. Collaboration with General Counsel, GME, and Human Resources is often critical when an accommodation is requested or a negative action is implemented.

Abstract
This workshop is a reconfiguration of prior workshops about strategies and ethical obligations of the training director with problem residents and resident problems. Ethical issues can arise when there are conflicts of interests between our efforts to nurture residents and our obligations to protect the public. Discussions will highlight a differential approach to addressing a resident having difficulty and options to support performance improvement before a reportable decision (like probation or dismissal) is made. The format will be an overview of the subject followed by some resident situations that involve behaviors exacerbated by the added stress of COVID. The cases will demonstrate different perspectives at different institutions. After the general presentation, the audience will be divided into five breakout groups, each led by a workshop presenter. In each group, participants will have the opportunity to share their own experiences, and the workshop presenters will guide the group consultation.

Agenda
1. Didactic: Brief review of guidelines to approaching a resident with difficulties. Referenced document will be available through AADPRT website. (15 min)

2. Case discussions: Current and former residency directors will present resident behaviors that were exacerbated by the pandemic. (15 min)
3. Breakout groups for group consultation: Workshop attendees will be divided into five breakout groups, each led by an experienced current or former training director. (25 min)
4. Participant review (5 min)

Scientific Citations

1. https://www.ama-assn.org/practice-management/physician-health/4-ways-covid-19-causing-moral-distress-among-physicians
2. https://www.nejm.org/doi/pdf/10.1056/NEJMp2024834?articleTools=true Jo Shapiro, M.D., and Timothy B. McDonald, M.D., J.D. Supporting Clinicians during Covid-19 and Beyond — Learning from Past Failures and Envisioning New Strategies, New England Journal of Medicine.

Workshops Session 4 (con't)

Twitter and Instagram: Delivery of Prodigious Information to Applicants to Benefit Residency Recruitment

Presenters
Daniel Gih, MD
Rick Wolthusen, MD
Jeana Benton, MD
Riley Machal, BS,MD
Heather Vestal, MD

Educational Objectives

- Examine proactive use of social media for residency recruitment.
- Inventory a program's unique missions and strengths.
- Employ an initial plan to increase a training program's online presence.

Practice Gap

Social media is ubiquitous and becoming more commonly used by physicians and leaders. According to a 2018 report from the Pew Research Center, the typical American uses 3 social media platforms regularly and social media use increases with each generation. Social media use is reported by 88% of Americans 18 to 29, 78% of Americans age 30-49, 64% of Americans age 50 to 64, and 37% of Americans age 65 and older (Smith 2018). In healthcare, there is increasing social media utilization by academic health centers, provider organizations, medical journals, research centers, and individual physicians and educators (Liu et al. 2019, Logghe et al. 2018).

There is an active and growing medical education community on social media platforms such as Twitter and Instagram. As such, some training programs are using social media to help shape a program's image and publicize activities of the program to prospective applicants. Program directors and coordinators can strategically use social media as an engaging and helpful venue to obtain information. This may be more important given recent discussions highlighting the financial inequities of the recruitment process in previous years, desirability of broadening applicant pools, and travel restrictions related to the current pandemic. However, programs may face barriers or resistance to utilizing social media as a communications and marketing tool, including limited knowledge about or comfort with social media platforms, perceived lack of time to make posts, and uncertainty about the utility or benefits of this modality.

Abstract

Residency program directors and program coordinators are uniquely positioned to utilize social media to promote their departments, trainees, and programs. Beyond individual benefits such as career development and networking, program directors and coordinators can use social medial platforms such as Twitter or Instagram to enhance recruitment. Applicants may be interested in learning about achievements, residency experiences, activities, and curricular innovation directly from the training

representatives rather than message board sites. As increasing percentages of students and physicians are using social media, AADPRT members can harness Twitter and Instagram to achieve their educational and recruitment goals.

This workshop will offer a primer on the tenets of two commonly used social medial platforms, the potential appeal, and advantages of each, and will help motivate programs to draft a social media strategy. The material will be customized for novices to social media, but intermediate and advanced users are also welcome to participate.

Agenda

1. Introduction (15 minutes): a discussion of social media platforms, terminology, and principles for the creation of a program Twitter and Instagram account. Commonalities and difference will be highlighted. A handout will be supplied that include steps on account creation.

2. Small Group (30 minutes): facilitators will divide the audience into at least two breakout groups. Attendees are encouraged to access social media on their devices during the breakout groups for real-time lookups. Facilitators will also highlight common pitfalls to avoid.

3. Teach/report back (10 minutes): attendees will share their Twitter profiles/tweets and key principles they learned in their small groups. Facilitators will encourage participants to consolidate their learning through a post-workshop challenge.

4. Protected time for evaluation (5 minutes)

Scientific Citations

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Workshops Session 4 (con't)

Good Grief!: Interactive Tools to Engage Our Residents in Learning About Grief During COVID and Beyond

Presenters
Alana Iglewicz, MD
Alison Cesarz, MD
Abigail Clark, MD
Keren Friedman, MD
Anju Hurria, MD

Educational Objectives
By the end of this workshop, participants will be able to:
1. Describe the importance of teaching about grief in the context of the COVID pandemic
2. Identify the clinical presentations of acute, integrated and complicated grief
3. Engage residents in learning about grief through the viewing and discussion of film and TV clips
4. Apply interactive tools and techniques for teaching about grief in residency programs

Practice Gap
In the context of COVID and its varied associated losses, people look towards psychiatrists and other mental health care professionals for guidance and support regarding themes of grief. Yet, we rarely prioritize a focus on grief in psychiatric education and, more broadly, in medical education. This lack of prioritization is partly based on avoidance of an evocative topic, fear of medicalizing a natural and adaptive process, and lack of perceived expertise on the topic. This is especially the case for one form of grief called complicated grief (CG)—a prolonged form of grief associated with considerable medical and psychiatric morbidity. The COVID pandemic highlights the critical need for engaging our psychiatry residents in learning about grief and gaining respective clinical skills.

Abstract
This interactive workshop will focus on how we as educators can engage psychiatry residents in learning about the topic of grief. The COVID pandemic highlights the importance of ensuring that psychiatry residents graduate with the comfort, agility, sophistication, and skills needed to address grief in clinical settings. Currently, every single human being is going through myriad losses related to COVID—both figurative and literal. Between the loss of a sense of safety, social connections, financial stability, and the rhythms by which we are used to living our lives, we are grieving collectively. For those who have lost loved ones during this pandemic, many did not have the chance to be present for the final moments of their loved ones' lives, to say their goodbyes, and to follow grief rituals that could have supported them in their mourning process.

Beyond the current pandemic, themes of loss and associated grief are inherent in psychiatry. These themes include the loss of relationships, loss of employment, loss of identity, loss of mental health, and, of course also, the loss of a loved one. Yet, due to multiple factors outlined in the practice gap, we often avoid teaching about grief. When we do teach about grief in medical and psychiatric education, we often cover it in a cursory fashion. However, those who do focus on teaching about grief find it to be one of the most meaningful parts of psychiatric education. A focus on this topic is evocative, leads to much introspection, and sets the stage for both psychiatric educators and psychiatry residents alike to reflect on their own lives, do a mental inventory of the life they are leading, and ponder what contributes to their own meaning and purpose in life.

During this 60-minute virtual workshop, participants will be engaged in learning about techniques and tools for teaching about grief in psychiatric education. In order to fully engage participants in these goals and to have participants leave the session with tools that they can apply to teachings about grief in their own programs, the workshop will be interactive. The workshop will consist of participant discussions followed the viewing of short grief themed clips from film and TV shows; reading a brief, powerful narrative writing piece about suicide bereavement and complicated grief therapy; and listening to resident testimonials about learning in a year-long elective grief clinic. Being that film and literature is often imbued with themes of loss, the workshop will conclude with participants and presenters sharing and discussing their recommendations for film, literature, and resources about grief. Additionally, grief resources on different types of bereavement, including COVID, general, and suicide bereavement, will be shared with participants.

Agenda
The proposed timing is as follows:

0:00-00:05 Background and context about teaching about grief in psychiatric education, especially during COVID (Didactic and Interactive Polling)

00:05-00:15 Viewing of short clip from the movie "Up" followed by participant discussion about key themes of grief in psychiatric education (Video and Large Group Discussion)

00:15-00:20 Description of acute, integrated, and complicated grief (Didactic Presentation)

00:20-00:35 Participants read a 1.5 page narrative writing piece on suicide bereavement and complicated grief therapy followed by discussion (Small Group Discussion)

00:35-00:40 Viewing of two brief clips from popular TV shows that highlight "what not to do" in regard to grief support, followed by a discussion of the reasons why we may avoid teaching about grief (Video and Large Group Discussion, which will convert to Small Group Discussion if there are greater than 30 participants)

00:40-00:50 Descriptions about participating in an elective grief clinic (Resident Testimonials)

00:50-1:00 Participant discussion and sharing of impactful films and literature about grief that can be utilized in medical education; sharing of resources about grief; and wrap up (Large Group Discussion)

Scientific Citations

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Workshops Session 4 (con't)

Take the pain out of planning: Design a highly effective virtual learning session in 10 minutes

Presenters
Kaz Nelson, MD
Lora Wichser, MD
Jonathan Homans, MD

Educational Objectives
Learning Objective 1: Apply the "Minnesota Arc" as a conceptual framework for effective learning.
Learning Objective 2: Learn skills to evaluate learners' receptiveness to learning objectives for any given educational activity.
Learning Objective 3: Efficiently create an effective virtual education session which incorporates evidence-based learning theory.

Practice Gap
The consequences of "cognitive overload" in medical training are becoming more apparent. Passive learning strategies involving a traditional hour lecture consisting of 70 PowerPoint slides filled with facts and figures have been demonstrated to be ineffective and potentially contribute to stress and negative health. While educators may embrace the theory underlying active learning, many educators struggle with the actual facilitation and structuring of active learning sessions, especially in the virtual or online space. In light of the COVID-19 Pandemic, there has never been a greater need for effective, clear and efficient education which can be delivered virtually.

Abstract
The "Minnesota Arc" is a conceptual framework, originally developed to rapidly teach early learners the skills of interacting with distressed or "difficult" patients. This framework has also been applied in leadership to facilitate interactions with distressed stakeholders. This workshop extends the basic "Minnesota Arc" concept even further to support and equip educators to effectively engage with distressed and potentially cognitively overloaded learners. The "Minnesota Arc" integrates the science of human cognition and educational theory which allows for quick translation of these concepts to educators of all levels. Application of this framework in the virtual or online space facilitates highly efficient and effective planning and implementation of effective learning sessions.

Agenda
In this 90 minute workshop, we will conduct a 20 minute needs assessment through small and large group discussion (think/pair/share), 10 minutes of large group discussion summarizing key themes and clarifying learning objectives. We will then show a 2 minute video illustrating a key concept, followed by 10 minutes of presented material. The remaining 45 minutes will be spent in a combination of large and small

group work where participants will be able to create a virtual learning session through application of the Minnesota Arc.

Scientific Citations

1. Brown, Peter C. Make It Stick : the Science of Successful Learning. Cambridge, Massachusetts: The Belknap Press of Harvard University Press, 2014.
2. Young, JQ, J Van Merrienboer, S Durning, and O Ten Cate. “Cognitive Load Theory: Implications for Medical Education: AMEE Guide No. 86.” Article. Medical Teacher 36 (5): 371–84. https://doi.org/10.3109/0142159X.2014.889290.
3. [Redacted]. The Interview Arc 2.0: A Model for Engaging Learners in the Patient Interview Through Both Virtual Self-Directed Training and Direct Coaching. Association for Academic Psychiatry Annual Meeting, Milwaukee, WI. September 7, 2018.
4. [Redacted]. Teaching Teachers the Interview Arc: A Concise and Elegant Model for Engaging Learners in the Patient Interview. Association for Academic Psychiatry. Denver, CO. September 7, 2017.

Workshops Session 4 (con't)

Narrative Medicine, Wellness, Stigma Towards Mental illness, and the use of Video Vignettes: An Experiential Workshop

Presenters
Marsal Sanches, FAPA, MD, PhD
Vineeth John, MBA, MD
Amanda Helminiak, MD
Brandi Karnes, MD

Educational Objectives
1) To demonstrate the feasibility of a narrative medicine didactic activity for psychiatry residents, utilizing a video vignette

2) To discuss the possible role of narrative medicine interventions in addressing stigma towards mental illness among psychiatry residents and other health care providers

Practice Gap
In recent years, as concerns have been raised regarding the excessive focus on evidence-based medicine, in contrast with a lower emphasis on the humanistic aspects of medical practice, narrative medicine has been the object of considerable attention. In addition to its positive effects on practitioner's communication skills, it has been proposed that narrative medicine seems to positively impact patient's outcomes and quality of life. Several medical schools are in the process of implementing narrative medicine into their formal curriculum, and some residency programs have implemented narrative medicine curriculums. Nevertheless, research on narrative medicine is still at an embryonic stage, with considerable variations as for methodological aspects, nature of interventions, and outcome measures. Evidence regarding the teaching of narrative medicine to health care providers is even more limited, with different proposed approaches. In addition, narrative medicine seems to be the perfect tool to address stigma towards mental illness among health care providers, which has important implications with respect to quality of care.

Abstract
Narrative medicine has been found to produce positive effects on practitioner's communication skills and also to positively impact patient's outcomes and quality of life. In the present workshop, we describe our experience with a pilot didactic intervention aiming at introducing the concept and practical aspects of narrative medicine to psychiatry residents, utilizing a video vignette. We will start with a brief presentation on general aspects of narrative medicine, followed by the discussion of the potential role of narrative medicine as a tool to improve wellness during residency. Next, the audience will have the opportunity to watch a video vignette depicting an actor playing the role of a patient with a mental disorder. That will be followed by a brief narrative medicine exercise, with active participation from the audience. Last, some results regarding the

potential role of narrative medicine in reducing residents' stigma towards mental illnesses will be presented and critically analyzed.

Agenda

1) Introduction to Narrative Medicine – Vineeth P. John, MD, MBA (10 minutes)
2) Resident wellness and narrative medicine – Amanda Helminiak, MD (10 minutes)
3) Exhibition of video vignette (10 minutes)
4) Narrative medicine exercise – Marsal Sanches, MD, PhD (10 minutes)
5) Narrative medicine and stigma towards mental illness- Brandi Karnes, MD (10 minutes)
6) Q&A (10 minutes)

Scientific Citations

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Clemente AS, Santos WJ dos, Nicolato R, Firmo JOA. Stigma related to bipolar disorder in the perception of psychiatrists from Belo Horizonte, Minas Gerais State, Brazil. Cad Saúde Pública [Internet]. 2017 [cited 2019 Aug 2];33(6). Available from: http://www.scielo.br/scielo.php?script=sci_arttext&pid=S0102-311X2017000605010&lng=en&tlng=en

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Workshops Session 5

Step 1 changing to pass/fail: An opportunity to improve resident recruitment and selection?

Presenters
Martin Klapheke, MD
Anna Kerlek, MD
Katherine Martin, MD
Jeffrey Rakofsky, MD
Rachel Russo, MD

Educational Objectives
The educational objectives we wish to achieve by the conclusion of the workshop are that the audience will be able to:

1. Describe the emerging literature on the anticipated impact of the move of Step 1 to pass/fail on program directors' evaluation and selection of residency candidates to interview.
2. Critique the current content of the Medical Student Performance Evaluation (MSPE) as an aid to selecting residency applicants to interview.
3. Identify the pros/cons of initiation of a national Psychiatry Standardized Letter of Evaluation (SLOE) and the optimal contents of a Psychiatry SLOE.

Practice Gap
Current/pending practice: Residency directors have the challenging job of sifting through an increasing volume of residency applications and determining whom to offer an interview and ultimately whom to rank. Offers are generally made on a mix of subjective and objective measures. Objective measures traditionally have included such items as class rank, clerkship rotation grades, and USMLE step 1 and 2 scores. However, with the pending change of Step 1 to pass/fail in early 2022, as it stands now program directors will have fewer objective metrics to use in the selection of residents.

Optimally, most program directors strive to perform a "holistic application review" in which they take a flexible and individualized way of assessing an applicant's capabilities. Directors are eager to look beyond standardized test scores. In fact, the literature has been inconsistent in showing that these scores predict later success in residency. However, to achieve their goal, directors will require a more diverse set of metrics that helps them to distinguish candidates from each other. Such metrics might include student progress on Entrustable Professional Activities (EPAs) or on the milestones for Psychiatry in undergraduate medical education proposed by The Association of Directors of Medical Student Education in Psychiatry (ADMSEP). The creation of a SLOE for psychiatry is another possibility.

Abstract
The change of Step 1 to pass/fail (no sooner than January 2022) will significantly impact the ability of residency programs to assess applicants. It furthermore may lead to unintended consequences, such as increased difficulty in objectively evaluating applicants and putting students from less prestigious medical schools at a disadvantage thereby propagating inequities. Thus, this change provides a challenge, catalyst, and opportunity for improvement in (a) medical student assessment, including workplace-based assessment, and (b) meaningful communication between all stakeholders in the UME to GME transition to better inform program directors about student performance.

Currently the MSPE and letters of recommendation are important components of the applicant evaluation process. However, they have the potential for conflict of interest given that medical schools may feel pressure to represent their students well since their national ranking depends on how their students match. Likewise, students may avoid seeking certain assistance if they fear it will end up on their MSPE.

A standardized psychiatry specialty letter of evaluation (SLOE) with a focus on multiple measures of knowledge, clinical skills, and attitudes during workplace-based assessments of the most relevant Psychiatry-specific competencies or Entrustable Professional Activities (EPAs) might provide an overall improved means of assessment of applicants for residency training. Ideally a SLOE would provide program directors more objective information about each individual applicant's trajectory of professional development (not unlike the goal of milestones in GME). However, increased reliance on workplace-based evaluations must utilize assessments that are valid and psychometrically sound.

This workshop seeks to (a) review the relevant literature on the change to Step 1 and the current use of a SLOE by several specialties, (b) seek the input of program directors on the value of the current content of the MSPE as an aid to selecting residency applicants to interview, (c) discuss the pros/cons of initiation of a national Psychiatry SLOE, and (d) craft a "wish list" for the content of this letter.

Agenda

1. Introduction / Review of current literature (Step 1 pass/fail, use of other measures such as EPAs, ADMSEP milestones) – 10 minutes, Katherine Martin MD, Anna Kerlek MD.
2. How to optimize use of the current MSPE as an aid to select applicants to interview – 5 minutes, Rachel Russo, MD.
   Utilization of Poll Questions, Answers on a 5-point Likert scale of Strongly Agree to Strongly Disagree:
   - "I am satisfied with the current content of the MSPE as part of my criteria for selecting residency applicants to invite for interviews."
   - "The information contained in MSPEs is trustworthy."
   - "The AAMC should modify the content and/or format of MSPEs."
3. Overview and pros/cons of current SLOE utilized by Emergency Medicine and Internal Medicine – 5 minutes, Martin Klapheke MD.

4. Breakout groups led by all 5 presenters – 20 minutes, moderated by Anna Kerlek, MD
   a) Breakout groups to specifically discuss whether a Psychiatry SLOE should be instituted and, if so, its optimal content – 15 minutes
   b) Zoom poll questions – 5 minutes:
      - "Implementation of a required Psychiatry SLOE should be considered."
      - "If a Psychiatry SLOE is implemented, my 'wish list' for content includes the following items:" a list of options will be provided (Zoom poll allows for multiple answers).
5. Return to larger group/discussion of generated ideas – 15 minutes, moderated by Jeffrey Rakofsky, MD
6. Conclusions/next steps/potential action plan for psychiatry educators – 5 minutes

Scientific Citations

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2. Ryan M, Brooks E, Safdar K, et al. Clerkship grading and the U.S. economy: What medical education can learn from America's economic history. Academic Medicine: July 7, 2020 - Volume Publish Ahead of Print - Issue - doi: 10.1097/ACM.0000000000003566
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5. Youmans Q, Essien U, Capers Q. A test of diversity—What USMEL pass/fail scoring means. New England Journal of Medicine 2020;382:2393-2395.
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Workshops Session 5 (con't)

Growing GRAS—Group Reflection and Support for Faculty Wellness in a Global Pandemic

Presenters
Megan Zappitelli, MD
Neha Hudepohl, MD
Karen Lommel, DO, MS

Educational Objectives
At the conclusion of the session, participants will be able to:
1. Describe the process of creating a support and reflection group for psychiatry faculty.
2. Identify the components required to develop a Group Reflection and Support (GRAS) session.
3. Appreciate the experience of a GRAS session participant.
4. Create and lead a support and reflection group that can be used to support healthcare professionals in any clinical setting.
5. Identify ways that they can incorporate a GRAS program into their home institution.

Practice Gap
The practice of healthcare is ever-changing. The constant change, while essential, can be stressful and is a contributing factor to physician burnout. All of this is true, even without a global pandemic. Considering the rapid and drastic changes that have happened due to the COVID-19 virus, burnout and physician stress seems to be at an all-time high. While burnout and wellness are frequently part of the curriculum within training programs, intentional and structured wellness activities for faculty are lacking. Wellness activities can be viewed as time consuming and burdensome, and therefore often have the opposite of the intended effect and further contribute to faculty burnout. An efficient, helpful, and generalizable tool is needed to help program leadership model activities that support faculty wellness and can be used to support all healthcare workers, particularly in the unsettling time of COVID-19.

Abstract
Almost overnight, the global COVID-19 pandemic changed many lives as well as the practice of psychiatry. The rapid and drastic change both at home and at work contributed to uncertainty and anxiety for many, particularly for those who work in healthcare. In effort to provide faculty support and to help others in the healthcare system, the speakers created a Group Reflection and Support (GRAS) series. These sessions were modeled after clinician support groups from Maine Medical Center (1,3) and were modified to fit the needs of the psychiatry faculty. A template for hosting the meetings was created and was used for each session. By using the template, each session only took minutes of preparation time, and the session was easily customizable to the audience and the time allowed for each session. Due to the social distancing

restrictions of COVID-19, all sessions were held virtually; however, they can be easily adjusted for face to face meetings. The GRAS sessions were incorporated in various faculty meetings and were well received by the faculty and resulted in a noticeable change in faculty morale.

During this workshop, the speakers will outline the methods that were used to create the GRAS series, and will lead participants in a GRAS session. By modeling the methods used to create and lead a session, participants will be able to facilitate GRAS sessions at their home institution following the session. Additionally, participants will be asked at the end of the session to reflect on ways that they can modify the sessions to fit the needs of their home department. Finally, participants will learn ways to generalize the sessions so that their faculty can help other departments and healthcare workers to decrease burnout and to improve wellness across all facets of the changing healthcare system.

Agenda

0:00: Introductions and review of educational objectives
0:05: Brief PowerPoint and overview of the speakers' experience creating the Group Reflection and Support (GRAS) sessions.
0:10: Attendees will participate in an example GRAS session.
0:30: Small group break out sessions will be held for participants to discuss their experience of the session and ways to incorporate GRAS sessions into their own departments or into other healthcare settings to improve provider wellness.
0:40: All attendees will rejoin the main group and will be invited to share their experience and post-conference action plan.
0:50: Question, Answer, and Wrap Up—Participants will have an opportunity to engage in a question and answer session to summarize and conclude the workshop.

Scientific Citations

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3. Price, D. COVID 19 Clinician Support Group. Maine Medical Center 2020.
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Workshops Session 5 (con't)

Diversity 3.0: Emphasis on Equity with Your Training Program

Presenters
Colin Stewart, MD
Kristine Goins, MD
Sarah Mohiuddin, MD
Simon Chamakalayil, MD
Aaron Reliford, MD

Educational Objectives
1. Participants will understand the meaning and significance of equity, and how it can be demonstrated within residencies and fellowships
2. Participants will examine and assess current inequities within their residency and fellowship programs, as well as barriers to change
3. Participants will be able to describe common opportunities to create and advocate for equity within their programs in the areas of mentorship, sponsorship, leadership, diversity efforts, clinical activities, scholarly productivity, and research
4. Participants will learn about the intersections between equity and inclusion to foster the alignment of goals
5. Participants will examine ways to evaluate their progress in advancing equity efforts

Practice Gap
Several significant problems remain within the physician workforce including inadequate diversity, decreased recruitment of underrepresented minorities, inequities in advancement, attrition, and increased rates of burnout. In general, there is low representation of physicians identifying as women, racial and ethnic minorities in medicine, sexual and gender minorities, and people with disabilities when compared to numbers in the general population. However, studies have confirmed that when health care providers have life experience that more closely corresponds to the experiences of their patients, patients report greater satisfaction with their care and are more likely to adhere to medical advice. These effects have been seen in studies addressing racial, ethnic, and sexual minority communities when the demographics of health care providers reflect those of underserved populations. Consequently, the role of physicians from these underrepresented groups in patient care is critical to advancing health equity for underserved communities. Accordingly, the Accreditation Council for Graduate Medical Education (ACGME) updated their common program requirements for residency and fellowship programs in July 2019, stating ‘‘The program's annual evaluation must include an assessment of the program's efforts to recruit and retain a diverse workforce.’’ While recruitment and retention of underrepresented faculty are essential, faculty responsibility "tax" or disparity often persists in responsibility for achieving diversity efforts, racism, isolation, mentorship, clinical activities, and

promotion. This workshop will help attendees understand the importance of equity and learn tangible ways of creating equity within their residencies and fellowships.

Abstract
This workshop will introduce participants to the Diversity 3.0 framework with a specific focus on the assessment of existing inequities within programs and methods for both addressing those inequities and creating new opportunities to build equity. We will start by defining common equity-related terms to give attendees a common language from which to start their equity-building work. Next, we will provide program-specific examples from the University of Michigan and Georgetown University of both how to develop equity within your program from the bottom up and how to maintain authenticity when responding to top-down directives related to diversity, inclusion, and equity. Then we will introduce participants to a comprehensive organizational equity assessment tool from Michigan St. University (MSU) and provide them with a list of other organizational equity assessment tools. Participants will then have an opportunity to use the MSU organizational assessment tool to evaluate their own program and discuss with other participants methods for addressing existing inequities as well as creating new opportunities to build equity. We will then transition back into a large group discussion with small groups reporting on lessons learned from their small group experience. Finally, participants will be asked to prioritize the equity-related goals they've developed that could potentially be included in the list of program goals within their Annual Program Evaluation and to post their goals in the large group chat. Workshop facilitators will utilize the polling function twice during the course of the workshop to assess familiarity with various equity-related terms and to assess current use of organizational equity assessment tools. The large group chat will be saved by the facilitators and the list of prioritized equity-related goals will be distributed to all participants.

Agenda
0:00-0:05- Introductions, agenda, and learning objectives
0:05-0:15- Poll asking about familiarity with various terms. Then provide definition of terms eg Diversity 3.0 Framework, equity, equality, diversity, inclusion, justice, allyship, sponsorship.
15-30: How to combine bottom up and top down approaches to building equity: examples from two programs. 7.5min/program
0:30-0:35- Assessment tools for programs: poll asking about current use of assessments. MSU tool and send list other tools on organizational equity & book list.
0:35-0:50- Small group exercise focused on examining current inequities in their program as well as new opportunities to build equity
0:50-0:60- Large group report out from small groups. Will ask participants to take a minute to prioritize equity-related goals and then put them in the chat (chat will be saved and distributed to participants afterward)

Scientific Citations
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Workshops Session 5 (con't)

Residency Website Design: Meeting the needs of today's residency applicants

Presenters
Elizabeth Ann Cunningham, DO
Saira Kalia, MD
Robert Caudill, MD

Educational Objectives
1. Identify aspects of a residency website that are identified as important for residency applicants
2. Evaluate residency website design elements
3. Inspire enhancement to your own residency program website design

Practice Gap
There is an identified gap between what information is provided within residency websites and what residency candidates are seeking to learn from residency websites (Chen et al 2018, Gaeta et al 2005, Ruddell et al 2020). This workshop aims to narrow that gap by providing information about critical aspects of website design, active review of residency website, and encourage enhancement to residency program's own website designs.

Abstract
In this era of rapid advancement in technology, most residency programs use websites and social platforms. Many medical journals, from The New England Journal of Medicine to Journal of American Medical Association, now share updates on Facebook, post informational videos on YouTube, and tweet new and free content on Twitter. Residency programs have also adapted to shifts in technology for resident recruitment. In light of recent virtual residency interviews, there is a need for programs' ability to shape a user friendly, informative and engaging residency webpage for recruitment and selection.

Chen and colleagues (2018) executed an anonymous online survey of 2016 plastic and reconstructive surgery applicants to assess if the program websites were meeting applicant needs. They noted that 98% of the survey responders used the website; however, they found an incongruence between applicant needs and actual website content. Similar findings of gaps in information provided on residency websites are noted in other studies as well (Gaeta et al 2005, Ruddell et al 2020).

This workshop reviews residency website content gaps identified in the literature, critical elements of residency website design, and an active review of a residency program website. Participants can apply the knowledge gleaned from this interactive workshop to enhance their own residency website for future recruitment seasons.

Agenda
Introduction (5 min)
Didactic (10 min)
Polling (5 min)
Small group break outs for website review (20 min)
Large group report back (10 min)
Polling (5 min)
Q/A (5 min)

Scientific Citations
1. T.J. Gaeta, R.H. Bikhahn, D. Lamont, N. Banga, J.J. Bove. Aspects of residency programs' web sites important to student applicants. Acad Emerg Med, 12 (2005), pp. 89-92

2. Ruddell J.H., Tang O.Y., Persaud B., Elorai E.M., Daniels A.H., Ng T. Thoracic surgery program websites: bridging the content gap for improved applicant recruitment. J Thorac Cardiovasc Surg. July 17, 2020

3. Chen VW, Hoang D, Garner W. Do Websites Provide What Applicants Need? Plastic Surgery Residency Program Websites Versus Applicant Self-reported Needs. Plast Reconstr Surg Glob Open. 2018 Oct 2;6(10):e1900. doi: 10.1097/GOX.0000000000001900. PMID: 30534485; PMCID: PMC6250462.

Workshops Session 5 (con't)

Leadership Training for Trainees by Trainees

Presenters
Hermioni Amonoo, MD
Heather Ward, MD
Natalie Feldman, MD

Educational Objectives
Explain the components of an effective leadership development curriculum
Apply leadership development literature to a psychiatry residency curricula
Discuss considerations for customizing and designing unique leadership development activities at home institutions

Practice Gap
Although physicians have important leadership roles throughout their careers, leadership skills training is limited in medical education settings. Psychiatrists are poised to lead efforts in addressing this gap, as most psychiatrists routinely lead multidisciplinary teams of clinicians. We designed and implemented a resident-led leadership development curriculum for psychiatry residents. In this workshop, participants will learn principles of effective leadership development curricula and participate in an example session from the curriculum.

Abstract
Organizations1, 2 and physicians3-6 have called for increased physician leadership, as physician leadership has been associated with improved patient7 and financial outcomes.8 Residency training has been proposed as an ideal time for physician leadership development.9 Indeed, the Accreditation Council for Graduate Medical Education includes leadership as a core competency, requiring residents demonstrate the ability to "work effectively as a member or leader of a health care team or other professional group."10 However, evidence suggests that upon graduation, residents are not prepared for leadership roles.9, 11

There have been a number of leadership development curricula implemented in residency training programs.12-20 In a recent systematic review of postgraduate medical education (PGME) leadership curricula, most curricula were classroom-based (17/21), small group discussions (15/21) with a clinical faculty instructor (13/21) and were isolated. Authors observed that PGME leadership education often lacked a conceptual leadership framework, had poor evaluation outcomes, and focused primarily on skills and abilities that were analytical, conceptual, or theoretical in nature rather than character development and emotional intelligence.21

We therefore designed and implemented a six-session longitudinal leadership curriculum for psychiatry residents that focused on values and foundational leadership skills22, including character development and emotional intelligence. In this workshop,

attendees will learn about the essential components of a leadership development curriculum and participate in a session from our curriculum that involves small group discussion. At the end of the session, we will reconvene for reflection and discussion of attendees' ideas for implementation of similar leadership curricula.

Agenda

I. Introduction (5 min): We will briefly summarize the literature on components of effective leadership development.
II. Leadership Development Curriculum & Outcomes (10 min): We will describe the purpose and structure of our leadership development curriculum for psychiatry residents. We will also share data on residents' perspectives on the leadership curriculum.
III. Small Group Workshop (20 min): We will divide participants into small groups. Attendees will participate in an example leadership development session from our curriculum on "Core Values in Leadership," where participants will read a brief article on leadership versus management then discuss qualities of effective leaders from their own personal experiences.
IV. Conclusion (15 min): Attendees will reconvene in a large group for Q&A and to discuss ideas for implementation of resident-led leadership initiatives in their own programs. If time allows, we will also discuss our own plans to expand leadership curricula at our own institutions.

Scientific Citations

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Workshops Session 5 (con't)

(Virtual) Intern Speed Mentoring

Presenters
Jacqueline Hobbs, MD, PhD
Robert Averbuch, MD
Uma Suryadevara, MD
Gary Kanter, MD
Britany Ratliff, MS

Educational Objectives
Upon completion of this workshop, participants will be able to 1) Design a virtual speed mentoring program that fits the needs of their program, 2) Practice a mock virtual speed mentoring activity, 3) Recognize the importance of mentoring for intern/resident and faculty well-being.

Practice Gap
Developing a consistent, sustainable, and effective intern/resident mentoring program can be a daunting challenge for any program or program director, whether new or seasoned. This has especially become more of an issue during the COVID-19 pandemic that has limited in-person interactions and has been a source of threat to overall well-being. Attracting and encouraging residents to enter academic practice is also a major gap in the workforce pipeline. Our goal is to empower and assist program directors and other teaching faculty in their efforts to develop or re-develop intern/resident mentoring in the pandemic age by providing foundational education, skills practice, and resources.

Abstract
High quality and consistent mentoring is essential to the overall development and maturation of physicians, both academic and non-academic. Psychiatry residency training programs can struggle to establish and maintain robust mentoring programs. Time constraints, distance between training sites, limitations on numbers of interested or experienced mentors, and the ability to match mentor-mentee pairs are just some of the obstacles facing programs. The COVID-19 pandemic has placed limitations on academic and social gatherings which can further limit mentoring activities. Our goals were to create a mentoring program that would eliminate some of the aforementioned obstacles, provide a means to enhance faculty connections with interns, particularly those on non-psychiatry services, to provide a sense of identity and connection during COVID-19-required social distancing, and to ultimately enhance resident career development. We developed a quarterly intern speed mentoring program that began in orientation and has been accomplished via a virtual meeting platform.

We divided 15 residents (14 interns and 1 new PGY-2) into groups of 3 and assigned one of our seasoned teachers and mentors to each group. Our kickoff session was composed of a large group viewing of a TED Talk depicting the themes of psychiatrist

purpose and the role that a resident can play in the welfare of their patient, followed by breakout groups to discuss the content with the mentor. The first quarter session, focused on well-being and resilience, was the first speed mentoring session where groups of 3 interns rotated among 5 mentor breakout rooms. Topics of discussion ranged from new babies, studying for Step 3, DIY projects, and “how hard it can be to be the new intern on the block”. Subsequent speed mentoring sessions have focused on different topics in each mentor breakout: curiosity, leadership, using literature in patient care, resident as teacher, patient safety/quality improvement, clinical decision-making, and career development. Feedback to date has been positive, noting a sense of being able to really “catch up” with mentors. A mechanism to capture feedback has been built into the sessions via polling.

This workshop will focus on the value of mentoring and being mentored as well as how a good mentoring program can also be a great way to sustain or enhance both trainee and mentor well-being and possibly attract residents to academic careers. The co-leaders will elaborate on their own hands-on experience with intern speed mentoring, its advantages and disadvantages. This workshop and the leaders will provide guidance, support, templates, resources, and encouragement for members to reach their goals for developing their own intern/resident speed mentoring program. Each participant will have participated in a mock intern speed mentoring session by the end of the session so that they too can then develop theirs based on the model.

Agenda
This workshop will be interactive with individual and small-group (breakout) participation and feedback.
Introduction/Didactic/Polling: 13 minutes
Individual/Small-Group Speed Mentoring Breakout Session #1:8 minutes
Individual/Small-Group Speed Mentoring Breakout Session #2: 8 minutes
Individual/Small-Group Speed Mentoring Breakout Session #3: 8 minutes
Individual/Small-Group Speed Mentoring Breakout Session #4: 8 minutes
Large-Group Debrief: 5 minutes
Wrap-Up/Q&A: 5 minutes
Feedback and evaluation (via polling): 5 minutes

Scientific Citations
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https://link.springer.com/article/10.1007%2Fs40596-016-0658-0

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Workshops Session 5 (con't)

Addictions teaching beyond the detox unit: Innovative ways to foster trainee and patient engagement

Presenters
Ann Schwartz, MD
Sandra DeJong, MD,MSc
Amber Frank, MD
Alena Balasanova, MD
Anne Ruble, MD

Educational Objectives
1) Briefly describe the current ACGME requirements and expert recommendations for training in addictions
2) Describe different ways of meeting these requirements and recommendations in a variety of general psychiatry settings, including both outpatient, acute services, and community rotations
3) Explore how to incorporate the use of both medications and psychosocial interventions for addictions treatment in a variety of settings
4) Identify two to three concrete ways to enhance addictions training in one's home program

Practice Gap
Substance use disorders occur at high rates in almost all fields of medicine- particularly psychiatry, where up to half of patients with another mental health diagnosis also meet criteria for a substance use disorder. In spite of this, addiction psychiatry is woefully under-represented in both undergraduate and graduate medical education programs. Through discussions with educational leaders, we have brought together interested educators to share experiences and resources to assist others in enhancing the teaching of addiction in residency programs by highlighting opportunities for teaching and training in addictions within the structures and services already available to general psychiatry residencies.

Abstract
Although half of patients with a mental health diagnosis meet criteria for a substance use disorder, addiction psychiatry is woefully under-represented in both undergraduate and graduate medical education programs. There continues to be an insufficient number of subspecialty trained addiction physicians to meet the current national crisis in opioid and other addictions. In addition, most program directors report feeling under-resourced in teaching addictions. Given the prevalence and frequent presentation as co-morbidities of other psychiatric disorders, increased and innovative training in substance use disorders will need to be a core domain of psychiatric residency training to ensure that psychiatric graduates are competent and prepared to treat addictions.

Traditional month-long rotations on inpatient units specializing in medically-supervised withdrawal (aka “detox”) can provide a strong education in substance intoxication and withdrawal syndromes, however trainees may not gain adequate exposure to medications for addiction treatment (MAT) or longer-term psychosocial treatments for substance use disorders in these settings. In addition, while many program directors envision a 1-month addictions experience in a facility for medically-supervised withdrawal or addiction-based service, there are actually multiple ways to meet this requirement. Programs have numerous opportunities for integrating addictions teaching into existing training rotations and services that incorporate and include MAT.

This workshop will utilize educationally-based vignettes to highlight opportunities for teaching and training in addictions within the structures and services already available to general psychiatry residencies. During our session, participants will work in small breakout groups to discuss the various ways that addictions training could be integrated within general psychiatry settings. Each small group discussion will be facilitated by a member of the AADPRT Addictions Committee. After reconvening as a large group, we will discuss the cases.

Following the case vignette discussion, participants will enter breakout rooms and bring their own program challenges to the groups to discuss ways to address them. The workshop will conclude with the workshop presenters summarizing innovative strategies and initiatives designed to integrate addictions teaching into general psychiatry settings and improve the teaching of addiction psychiatry.

Agenda
Welcome - presenters and participants introduce themselves – 5 minutes

Small breakout group discussion re: vignettes that highlight opportunities for teaching and training in addictions within the structures and services already available to general psychiatry residencies - 15 minutes

Large Group discussion to share ideas about the vignettes and presentations from the presenters and discussion about available resources.– 10 minutes

Small breakout group discussion on participants’ own challenges in incorporating teaching in addictions in their program followed by a large group discussion about addressing these challenges – 20 minutes

Wrap-up and questions – 10 minutes

Scientific Citations
Renner J. How to train residents to identify and treat dual diagnosis patients. Biol Psychiatry. 2004;56:810-816.

Balasanova AA. Disrupting traditional training to decrease stigma. The Clinical Teacher 2020; 17:354-356

Schwartz AC, Frank A, Welsh J, Blankenship K, DeJong SM. “Addictions training in general adult psychiatry training programs: Current gaps and barriers.” Academic Psychiatry 2018; 42:642-647.

Workshops Session 6

"Show me the money", a toolkit for funding GME expansion

Presenters
Lindsey Pershern, MD
Art Walaszek, MD
Jed Magen, DO,MS
William Sanders, DO

Educational Objectives
1. Describe GME funding structures
2. Search for and identify appropriate sources for GME funding specific to a proposal for GME expansion or creation of a new program
3. Create a strategy for securing and sustaining funding of GME positions

Practice Gap
In the United States, the psychiatric workforce in the United States is projected to decline to a concerning deficit over the next 20 years. Even conservative estimates of the needs and shortages predict a deficit of more than 10,000 psychiatrists in the year 2030 (1). Our current psychiatric workforce is inadequate, with 77% of US counties considered to have a "severe shortage" of mental health providers (2). The statistics related to the burden of untreated psychiatric illness are clear, but often not paired with interventions to increase access, spending or efficiency (3). The primary bottleneck in the physician pipeline is the presence of GME positions, which are required for doctors graduating from allopathic, osteopathic and international medical schools. To address this issue, many have considered efforts to increase supply by increasing positions for psychiatry residency training. The AADPRT Workforce Taskforce surveyed training directors and found that > 53% of respondents had either created a new training program or expanded an existing ACGME-accredited training program in the last 5 years. The vast majority (85%) of these positions were created in response to the shortage of providers in their area, state or region. The major challenge reported both by those who developed or expanded programs, and by respondents who reported not doing so despite wanting to, was finding funding (4).

Abstract
The AADPRT Workforce Taskforce was created in 2019 to study obstacles to increasing the psychiatric workforce. The taskforce surveyed AADPRT members who were residency or fellowship program directors about their experiences developing new programs or new positions within existing programs. From the results of the survey and through our experience providing workshops on this topic, we have identified the importance of knowledge and skill in accessing potential GME funding sources. For those who want to create or expand GME programs, the access to funds is a significant hurdle. Medicare has accounted for the majority of GME funding since the mid-1960s, with a CMS cap implemented in 1997 on the number of residents that could receive direct funding. With these limitations, the AAMC has advocated for removal of caps with

emphasis on consideration of specialties with significant workforce issues and primary care service importance, including Psychiatry(5). Other major GME funding entities include the Veterans Health Administration, the Department of Defense, and the Health Resources and Services Administration. Beyond federal sources of funding, GME expansion can be funded by state and local monies. The challenge for program leadership is identifying these sources and advocating for the funding of their initiatives. Many in our survey cited limited guidance and resources for navigating this complex landscape as a barrier4. In addition to funding to expand GME in the beginning, program leaders need viable plans for sustainability. Psychiatry training directors reported loss of funding contributing to the unfortunate closure or loss of an existing residency in our survey4. In this workshop, we will provide participants with background information related to the funding of GME positions, including the basic rules of GME funding, the evolution of federal funding structures and opportunities within federal, state and local systems. The workshop will provide practical information and skill-building activities to inform and empower participants toward opportunities for GME expansion.

Agenda

00:00 - 00:10 – Introductions and poll of participants to assess needs/interests of the participants in terms of GME creation vs expansion and backgrounds/demographics and roles at their institution
00:10 – 00:25 – Presentation of GME funding history and the evolution of federal funding structures and opportunities within federal, state and local systems
00:25 – 00:40 – Small group activity – Small groups will be given an individual case scenario related to GME funding and use information we provide in presentation and links to resources to consider important steps in identifying funding sources for GME positions and steps to applying for and successfully qualifying for funds
00:40-00:55 – Facilitated large group discussion – Small groups will report to the large group and share their groups strategic plan
00:55- 00:60 – Conclusions and participant review

Scientific Citations

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Workshops Session 6 (con't)

Clinical Skills Evaluation: Data-Informed Strategies to Improve Interrater Reliability Within and Across Programs

Presenters
Michael Jibson, MD, PhD
Kaz Nelson, MD
Heather Schultz, MD, MPH

Educational Objectives

- Attendees will review and discuss 2 studies on CSE interrater reliability and validity.
- Attendees will review and sample tools available on the AADPRT website to improve inter-rater reliability.
- Attendees will discuss and outline methods to improve inter-rater reliability in their own programs.

Practice Gap

Since its implementation in 2006, the Clinical Skills Evaluation (CSE; aka CSV) has been a requirement both for programs and individual residents. Initial training experiences were conducted at AADPRT in 2009, 2010, and 2012, and a variety of training materials were placed on the AADPRT website. Since the 2020 meeting, 2 studies of validity and interrater reliability have been completed and a new set of tools for training faculty in the CSE have been added to the AADPRT website . These will provide useful information and tools to assist program directors in assessing the reliability of their assessments internally and compared with other training programs. Familiarity with the CSE process is essential for newer program directors and education faculty, and an introduction to the new training materials on the AADPRT website will benefit more experienced directors as well.

Abstract

Since 2006, the Clinical Skills Evaluation (CSE; aka CSV) has been a requirement both for programs and individual residents, with programs responsible for training faculty to conduct the assessments. The purpose of this workshop is to provide program directors and faculty with tools to assess and improve the validity and interrater reliability of CSEs conducted within their programs and compared to other programs. We will review and discuss survey and performance data from AADPRT trainings and from 4 large programs that provide evidence for the validity and reliability of the assessment, but also show areas of vulnerability involving individual faculty and within each program. We will introduce and discuss a new set of tools on the AADPRT website designed to assist programs in training faculty and optimizing their use of CSEs. We will break into small groups to discuss how to use these data and tools to strengthen faculty training and optimize CSE assessments in individual programs.

Agenda

- 20 min: Large group review and discussion of validity and interrater reliability data.
- 25 min: Large group review and interactive introduction to new AADPRT training tools.
- 15 min: Small group discussion of implementation issues in individual programs.

Scientific Citations

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Workshops Session 6 (con't)

Assessing an IMG Application: Diamonds and Pearls

Presenters
Vishal Madaan, MD
Manal Khan, MD
Consuelo Cagande, MD
Donna Sudak, MD

Educational Objectives
1. Recognize the nuances of assessing an International Medical Graduate (IMG) residency application
2. Employ techniques to assess communication skills and cultural competence
3. Identify features of IMG applications that predict success in psychiatry training
4. Develop an assessment tool/check list specific to IMG application

Practice Gap
There is a paucity of literature and training, including in Psychiatry, on how to assess IMGs for a residency, with majority of the focus on the certification and immigration process. IMGs are vital to the provision of care to the underserved and enrich the diversity of practicing psychiatrists. Given the increasing number of United States Medical Graduates (USMG), it is now even more competitive for IMGs to obtain residency positions. Given that IMGs constitute about 30% of trainees in general psychiatry and sub-specialties, psychiatry training directors must thoroughly review applications beyond USMLE scores to find IMGs who will be a good fit and be successful in training.

Abstract
"What do I look for in an IMG application?" This is one of the most common questions a program director (PD) may have when reviewing hundreds of applications. There is a paucity of literature to guide PDs regarding this issue. Most of the focus is on certification and immigration process for IMG applicants, and not on recommendations for the PDs. PDs must assess the quality of the medical school to the quality of work experience in the United States. In addition, how to their medical school grades translate into the US context. Furthermore, how do IMGs compare to US medical graduates? How do you define IMG success? What value would the IMG(s) add to your program? This session aims to answer many similar questions. Dr. Madaan will introduce the topic and discuss the scope and importance of the topic. Dr. Cagande will discuss the nuances of assessing an IMG application and review techniques to assess communication skills and cultural competence. Dr. Sudak will point out highlights of the application that predict success in training. Dr. Khan will discuss her role as a senior trainee in triaging the IMG applications. Based on these topics, the audience will review sample applications and develop their own checklist specific to their program needs. Ultimately, the session will provide the audience an understanding of IMG applications and a skill set and tool to use when assessing IMG trainees. As residency program

leaders, we know that a good fit with a diverse pool of applicants is essential for the success of the trainee (diamond) and the program (pearl).

Agenda

1) Welcome/overview of agenda/poll: Dr. Madaan (3 min)
2) Learn the nuances of assessing an IMG residency application: Dr. Cagande (5 min)
3) Identify features of IMG applications that predict success in psychiatry training: Dr. Sudak (10 min)
4) Breakout session 1: Review sample applications in real time and reflect upon unique aspects of IMG application assessment (15 min)
5) Employ techniques to assess communication skills and cultural competence: Dr. Cagande (5 min)
6) A trainee's perspective: Dr. Khan (5 min)
7) Breakout session 2: Develop an assessment tool/check list specific to IMG application in small groups (15 min)
8) Regroup, feedback and questions: Dr. Madaan (2 min)

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Workshops Session 6 (con't)

Program Approach and Toolkit for Intervention for the Struggling Resident: From Identification, Remediation, and Probation, through Dismissal

Presenters
Scott Klenzak, MD
Kevin Lamm, MD
Sree latha krishna Jadapalle, MD
Kenneth Fleishman, MD
Reanna Benedict, MS

Educational Objectives
- Define and review transformative learning theory
- Understand how transforming the preceptor's and learner's frame of reference can be a more inclusive, discriminating, self-reflective, and integrative learning experience for the struggling learner
- Identify the areas (cognitive, conative, and emotional) and dimensions (habits of mind and viewpoint) encompassed by a person's frame of reference
- Identify the learning area in which the learner is struggling: instrumental, impressionistic, normative, or communicative learning
- Identify the four processes of learning (elaborate an existing point of view, establish new points of view, transformation of point of view, transform ethnocentric habit of mind) and how to create outcomes-based individualized learning plans based on the learner's needs and ability to learn.
- Understand how autonomy and self-recognition of one's learning objectives and goals can gage a learner's ability to be successful
- Identify when the struggling learner needs to be evaluated for ADA support and accommodations
- Understand how documentation is key to keeping ADA and clinical and medical knowledge separated when moving through the process of remediating and/or dismissing a resident
- Identify stakeholders beyond teaching faculty and program leadership to include in the remediation and/or dismissal process of a resident
- Be able to create an academic excellence plan and corrective action plan to help steer the process of remediation

Practice Gap
"Wellness must be a prerequisite to all else. [Learners] cannot be intellectually proficient if they are physically and psychologically unwell." [1] Responsiveness to resident issues seen in the clinic setting permits the residency program to maximize the educational environment and meet the ACGME milestones. Today, residency programs are called upon to respond to a growing number of complex and challenging issues in medical education that affect both the individual resident's health and the health of the residency. This is especially evident when remediating and/or dismissing the struggling learner.

Drawing from education research and design, transformative learning represents a powerful model to address the struggling learner. The central idea of this approach aims to effectively change both the teacher and learner's frame of reference. [2] When used properly, transformative learning helps identify the standard for judging the quality of medical education as well as conditions that facilitate or impede learning. It provides the preceptor with the understanding of the nature of resident learner's process for learning and areas of reference which can hinder that learning in order to select appropriate educational practices to remediate. Transformative learning allows a residency program to identify with the struggling learner, helps move beyond clinical and medical knowledge issues, and also encompasses ADA considerations. One of the most challenging situations that a program and program director can face is the struggling learner who also has significant ADA accommodations. Navigating this remediation and disciplinary process while trying to balance the needs of the resident along with the standards of the program and profession requires patience, humility, and significant program time and resources. If not done properly, this process can affect morale of fellow residents as well as faculty. While HR, Legal, Department and Program Leadership, and the Sponsoring Institution may all play a role in the process, ultimately the Program Director must lead, direct, manage and own the outcome. The transformative learning approach provides one way to understand, document and separate the learning issues from ADA. This helps protect the residency program if and when a resident is dismissed who also has ADA accommodations.

Abstract
This workshop will provide a model and toolkit for programs to approach and manage the struggling learner. One of the most challenging parts of the job for new and even seasoned program directors lies in guiding the remediation and disciplinary process of a struggling resident. The workshop will introduce and review the transformative learning approach. This approach provides a framework the Program Director can follow to hold the resident and the program accountable. Most importantly, it can help the Program Director, faculty, and the resident reframe the identified concerns and focus the remediation plan. We will address the process from the perspective of a new, small community-based psychiatry residency program. Larger, more established programs may have more experience and resources available but may still benefit from reviewing action plans and policies.

We will share our program experience in the remediation process from beginning to end and highlight important considerations, pitfalls, and approach at each step in the process. We will discuss the identification process including rotation evaluations and CCC committee meetings. We will review the importance of meticulous, contemporaneous documentation of notes, emails, and memorandum of records for the resident file. We will examine using the milestones help focus and craft a learning plan. We will review when (earlier the better) and who to involve in the remediation process.

We will explore how the transformative learning approach can be used throughout the remediation process and how this approach can be critical during the dismissal process.

We will share several examples of academic excellence plans and corrective action plans (both informal, formal and probationary) with assessable goals and objectives, including ADA considerations. The plans present a logical, ideal, and purposeful process to reframe the resident's reference on learning and begin to develop autonomous thinking through assignments and faculty mentorship.

Placing a resident on formal probation and crafting a corrective action plan (CAP) represent critical steps for the resident, CCC and program. We will review sample plans based on instrumental and communicative learning with the goal of self-reflective assessment through task-oriented problem solving. Autonomy and ownership of the process should be used as key indicators and metrics of the resident's ability to succeed. We will review the role and direction of the GME Office/leadership, the Sponsoring Institution, Department Leadership, Program Director and CCC decisions as well as the Human Resources and Legal departments. Each of these key stakeholders must be included and consulted, however the Program Director and CCC must ultimately drive the process.

If needed, the transformative learning approach provides a framework for the Program Director and CCC to document and help protect the residency program during the dismissal process of the resident. The process documents the program's thoughtful and meaningful attempt to remediate the resident in good faith without bias. Both the academic excellence plan and corrective action plan help provide measurable learning-outcomes based on clinical and medical knowledge. The plans also document consideration of the resident's ADA accommodations.

Agenda

1. Introduction & Didactics: 25 minutes
2. Resident Vignette Activity: 20 minutes
3. Q&A: 10 minutes
4. Feedback & Evaluation: 5 minutes

Scientific Citations

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[4] Mezirow, J., and Associates (eds.). Fostering Critical Reflection in Adulthood. San Francisco:
Jossey-Bass, 1990.
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Workshops Session 6 (con't)

Confronting Racial Violence from Patients: How Can We Support Residents, Supervisor, and Institutional Responses

Presenters

J. Corey Williams, MA, MD
Yvonne Uyanwune, MD
Matthew Goldenberg, MD, MSc
Robert Rohrbaugh, MD

Educational Objectives

At the end of this session, the attendee will be able to...

1. Recognize incidents of racism by patients, families, and guests, and the patterns that emerge in clinical settings

2. Describe the potential implications of unaddressed racism for learning environment, patient safety, and resident mental health

3. Describe an approach using communication scripts for responding to racist comments or requests in the moment

4. Explore best practices for teaching residents approaches to responding racist comments or requests

5. Describe the essential components of comprehensive institutional policies for reviewing, documenting, and responding to racist incidents

Practice Gap

Racism directed at physicians by patients, family members, and guests is a significant challenge for physicians in training. In one survey of nearly 2,000 medical residents, 25% reported being targets of racial/ethnic discriminatory behaviors (Fnais et a., 2014). Furthermore, evidence suggests that the current political climate has emboldened some people and groups towards more unapologetic hate speech suggesting that incidents of personally mediated racism is on the rise (Southern Poverty Law, 2014).. The literature on responding to this form of racism, often referred to as microaggressions or disruptive patient behavior, is inadequate as these recommended frameworks fail to name the racism as a form of violence, verbal assault, or hate speech. Incidents of personally mediated racism from patients, family members and guests necessitate a specific framework as these incidents are regulated by a different set of power dynamics and medical-legal considerations. To date, there is no consensus on a standardized process for recognizing, responding to, reporting and reviewing incidents of personally mediated racism directed against physicians that occur within hospitals and other treatment settings. One JAMA article surveying the impact of patients' bias behavior demonstrated a desire for more education and training on how to respond as many trainees and

faculty do not receive any formal teaching on how to respond to incidents of discrimination (Wheeler et a., 2019).

Abstract
Personally-mediated racism directed towards psychiatry trainees can have deleterious consequences for trainee mental health, the learning environment, patient safety, and workforce retention. While literature exists on responding to microaggressions or disruptive patients, these frameworks typically do not address the specific impacts of racial violence or how to repair the harm that is done. When patients intentionally engage in personally-mediated racism, there is specific language and comprehensive frameworks available that can guide trainee, supervisor, and institutional responses; in addition to medical-legal considerations. In this interactive workshop, participants will be challenged to envision how incidents of personally mediated racism from patients should be addressed at their own institution. We will provide real-life case examples from trainees' lived experiences of discrimination. These case examples will help to illustrate the themes of racial violence and scope of the problem as well as to serve a platform for discussing strategies. We will promote the notion that incidents of racist hate speech should be referred to as verbal assaults or racial assaults as to increase both the team's and institution's responsiveness. We will then present the communication framework, ERASE, as a guideline for empowering trainees to use communication scripts when redirecting racist hate speech. Then, we will work with participants to plan post-incident team debriefs to support targets of racism, reinforce team safety and community. The presenters will reinforce the need for institutional accountability, provide information on medical-legal considerations for institutional policy, and provide an example of responsive policy. Participants will be working in small groups to develop plans to advocate for institutional policies by drafting a basic sample policy to bring back to the home institutions. Participants will leave the workshop with a clearer framework for how to respond to incidents of racial violence at multiple levels and develop an advocacy plan for engaging leadership around policy development.

Agenda
0:00-0:05- Introductions
0:05-0:10- Case examples
0:10-0:20- Presentation on the scope of the problem/polling questions (10 min)
0:20-0:35- Small group: How should the resident respond? (15 min)
0:35-0:40- Whole group share with key points (5 min)
0:40-0:50- Presentation on ERASE framework (10 min)
0:50-1:00- Small group: How should the unit respond? (10 min)
1:00-1:05- Whole group discussion with key points (5 min)
1:05-1:20- Small group discussion: How should the institution respond? Developing policy samples to take back to their institutions (15 min)
1:25-1:30 - Q &A; Workshop evaluation (5)

Scientific Citations

1. Wheeler M, de Bourmont S, Paul-Emile K, et al. Physician and trainee experiences with patient bias. JAMA Intern Med. 2019;179:1678-1685.

2. Fnais, N., et al. (2014). Harassment and discrimination in medical training: a systematic review and meta-analysis. Academic Medicine, 89(5), 817-827.

3. Southern Poverty Law Center. Hate groups increase for second consecutive year as Trump electrifies radical right. https://www.splcenter.org/news/2017/02/15/hate-groups- increase-second-consecutive-year-trump- electrifies-radical-right. Published February 15, 2017. Accessed December 28, 2018.

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7. Williams, J. C., & Rohrbaugh, R. M. (2019). Confronting racial violence: resident, unit, and institutional responses. Academic medicine, 94(8), 1084-1088.

Workshops Session 6 (con't)

Approaching Differences Differently: Race and Culture in Psychiatry Training during the New Era of Protest

Presenters
Jason Cheng, MD
Belinda Bandstra, MA, MD
Lauren McClairen, MD
Roy Collins, MD, MPH

Educational Objectives
- Attendees will be able to compare and contrast different approaches to race and culture in psychiatric training, in characteristics including their suitability for various educational contexts.
- Attendees will be able to describe how the concept of cultural humility can be applied to these approaches to empower psychiatry residents.
- Attendees will each come up with at least one action item related to this workshop, regarding a change they plan to implement at their home programs.

Practice Gap
The recent racial turmoil brought on by police killings of unarmed Black victims has brought to the forefront issues of race and privilege. Because of the large effect these recent events have on many patients and providers-in-training, it is important for psychiatry faculty to be able to thoughtfully address these and other issues of differences, both in provider-patient and supervisor-trainee relationships. Indeed, the ACGME requires that psychiatry programs cover "aspects of American culture and subcultures, including immigrant populations, particularly those found in the patient community associated with the educational program, with specific focus on the cultural elements of the relationship between the resident and the patient, including the dynamics of differences in cultural identity, values and preferences, and power." However, supervision about how to address differences is not uniformly taught at every psychiatry residency program, though it is covered in DSM-5 with the cultural formulation appendix. The fact that it is in an appendix and that it has developed over time are obstacles to psychiatry faculty being familiar with it. An additional obstacle is the fact that discussions about racial and certain other differences are affectively charged in America, so there is a motivation, both in general life and in training programs, to avoid discussing it. To combat this default avoidance, there must be a deliberate effort to cover this area consistently in residency curricula, both formally and informally.

Abstract
In this workshop, we will cover principles of how to discuss cultural differences, including but not limited to race and privilege, in psychiatry residency training. This session draws on the experience at two institutions in different regions of the country, one of which is historically black, and features faculty and residents from each

psychiatry program. The importance of examining differences in both provider-patient and supervisor-trainee relationships will be addressed. Cultural conversations may happen in collective processing spaces, in didactic teaching spaces, and in individual or group supervisory spaces. The presentation will cover how to set up an atmosphere in which residents feel more comfortable discussing such issues in each of these kinds of spaces. With regard to collective processing spaces, we will address how and when to create explicit room to discuss current events, such as the recent racial turmoil. With regard to didactic teaching spaces, we will discuss addressing these topics even in the absence of immediate current events, through the DSM-5 cultural formulation and other relevant material incorporated into residency didactic curricula in a personal and relevant way. With regard to individual or group supervisory spaces, we will address approaches in evaluation, medication management, and psychotherapy supervision. In keeping with the concept of cultural humility, we will cover the importance of making room for the experience and expertise trainees have in this area to teach each other and supervisors. Participants will discuss what they can bring back to their own programs, as well as how to address anticipated obstacles.

Agenda

1. Introduction (3 min)
2. Zoom breakout discussion of attendee experiences (5 min)
3. Collective processing spaces at Meharry Medical College and Stanford University with interactive polling and directed use of Zoom chat (10 min)
4. Didactic spaces at Meharry Medical College and Stanford University with interactive polling and directed use of Zoom chat (10 min)
5. Supervisory spaces at Meharry Medical College and Stanford University with interactive polling and directed use of Zoom chat (10 min)
6. Discussion comparing and contrasting different approaches, both within and between the two institutions (7 min)
7. Zoom breakout discussion of action plans for attendees' home programs, then sharing in large group (10 min)
8. Participant feedback (5 min)

Scientific Citations

1. ACGME Program Requirements for Graduate Medical Education in Psychiatry. https://www.acgme.org/Portals/0/PFAssets/ProgramRequirements/400_Psychiatry_2020.pdf?ver=2020-06-19-123110-817.
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3. Hansen H, Braslow J, Rohrbaugh RM. From Cultural to Structural Competency-Training Psychiatry Residents to Act on Social Determinants of Health and Institutional Racism. JAMA Psychiatry. 2018 Feb 1;75(2):117-118.
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6. Flores JM, Qayyum Z. Intentions vs. Experiences: Opening the Door to Fundamental Conversations About Diversity, Intersectionality, and Race. Acad Psychiatry. 2020 Sep 29.
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Workshops Session 6 (con't)

The WELL Toolkit: Meet ACGME well-being requirements more meaningfully!

Presenters
Sansea Jacobson, MD
Brian Kurtz, MD
Cristin McDermott, MD

Educational Objectives
1. Describe at least two take-home methods to improve the likelihood that trainees would seek supportive services when they need it.
2. Be familiar with a needs assessment methodology to determine systems-level contributors to burnout within your training community.
3. Choose specific educational resources within the WELL Toolkit to help meet the new ACGME Core Program Requirements on physician well-being more meaningfully.

Practice Gap
Over the course of the past decade, the area of physician well-being, particularly resident physician well-being has become an increasingly acute focus. As of July 2019, all graduate medical education programs across the United States are required to meet new national standards related to well-being. The guidelines are defined by the Accreditation Council for Graduate Medical Education (ACGME) in the Core Program Requirements. The well-being requirements focus on promoting engagement in work; developing policies and programs to encourage optimal well-being for residents and faculty; and providing access to confidential treatment, among other interventions. Furthermore, as per Section VIc, physicians must be able to: recognize the symptoms of; know how to seek appropriate care for, and; alert designated personnel when residents or faculty are displaying signs of: fatigue, burnout, depression, substance use, risk for suicide, and risk for violence. While there are many well-being resources already in existence, prior to the creation of the WELL Toolkit there had not been a comprehensive educational resource on these topics specific to physicians, medical trainees, and the practice of medicine.

Abstract
Many GME programs struggle with the resources to simultaneously conduct faculty development on well-being while implementing effective and practical strategies to enhance faculty and trainee well-being. In this session, we highlight a resource to help: The WELL Toolkit (https://gmewellness.upmc.com).

While there are many excellent well-being resources already in existence, the WELL Toolkit is unique in that it was designed for physicians by physicians with evidence-based content that is specific to the practice of medicine. Version 1.0 of the toolkit was created in collaboration with more than 80 content experts from across the nation. The contents of the toolkit are free and downloadable online. While some of the materials

are geography-specific, the content is intended to be easily modifiable by outside institutions. The mission was not to simply meet the new national guidelines from the ACGME, but to do so meaningfully with an educational resource that is informed by adult learning theory, practical, and easily digestible.

In the WELL Toolkit introduction, there is guidance on how to take steps towards destigmatizing help-seeking behavior and decreasing obstacles to support physicians within our training programs and institutions. Since stigma and concerns regarding confidentiality are two of the primary barriers to care, we need to make sure that physicians are properly informed. Attendings and trainees not only need to know HOW to access help, but they need to know the practical implications for doing so (e.g. How will seeking help impact their licensure, hospital privileges, malpractice insurance? What would happen if a physician needed to take time off? Who would need to know? How would clinical coverage be handled.) By utilizing this section of the WELL Toolkit, program directors and well-being champions can help change the culture of maladaptive perfectionism by destigmatizing and demystifying the process of help-seeking by physicians.

There are also six educational modules in the WELL Toolkit related to (1) burnout, (2) fatigue, (3) depression, (4) suicide, (5) substance use (6) risk for violence; and specifically how these core subjects pertain to physicians. Residents need to know that physicians are not immune to mental health struggles. In fact, physicians experience substance use disorders at the same rate as the general population (10-12%), and are at significantly higher risk for both depression (12-20%) and suicide (i.e. male physicians at 1.41x; female physicians at 2.27x higher than the general population). Program Directors need to be equipped with research findings that help keep our trainees safe (e.g. while resident suicide is rare, the highest risk is in the first two years; with a temporal pattern in the first and third quarters of the academic year).

Learners of this workshop will have a hands-on virtual exploration of the WELL Toolkit. They will be engaged interactively to imagine how specific modules might be modified to meet the individualized needs of their own training communities. In doing so, participants will become familiar with the toolkit contents, ultimately increasing the likelihood that they will implement content from this invaluable evidence-based educational resource at their home institutions.

Agenda

- Introduction to the WELL Toolkit (5 minutes)
- Topic #1 - Decreasing Barriers to Help-Seeking (5 minutes)
- Small Group #1 (15 minutes)
- Report Out (5 minutes)
- Topic #2 - Strengthening Your Well-Being Curriculum (5 minutes)
- Small Group #2 (15 minutes)
- Q&A and Closing (5 minutes)

Scientific Citations

- ACGME Common Program Requirements, Section VI “The Learning and Work Environment,” specifically Section VI.C “Well-Being.”https://www.acgme.org/Portals/0/PFAssets/ProgramRequirements/CPRs_2017-07-01.pdf
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