



## **Creation of a new program or track or expansion of a program RESOURCE GUIDE**

AADPRT Workforce Committee 2026

(updated from the original guide that was released in 2020)

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This guide serves as a resource for Institutions interested in the creation of new residency/fellowship programs or expansion of existing programs. This guide reviews some of the core considerations, practical steps and lessons learned. We include input from those with expertise, as well as survey data from AADPRT members.

AADPRT offers ACGME consultation services, workshops during the annual meeting on topics related to creation of new programs and expansion of existing programs, and resources on topics of interest in the Virtual Training Office (VTO). We recommend that unaccredited programs in the initial stages of development consider non-accredited program membership or affiliated membership to gain access to the wealth of information available to AADPRT members as well as the camaraderie of being able to call on fellow members with questions and concerns. This is accomplished by contacting the executive director of AADPRT at [exec@aadprt.org](mailto:exec@aadprt.org) and/or by checking the membership page of the AADPRT website.

### **GENERAL TIMELINE FOR NEW PROGRAM GESTATION**

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*NOTE: In general, it takes approximately four to twelve months **after submission** for a program to move through the site visit, review, and decision phases. To apply for ACGME accreditation, programs must submit an application, have a site visit, and the report must be completed and submitted by the agenda closing date to be on the docket for the ACGME Psychiatry Review Committee (RC) meeting which happens just twice a year (note that these meetings have historically occurred in February and April with agenda closing dates of November and January). Following the meeting, the RC emails their decisions to the program director, designated institutional official (DIO), and program coordinator. A Letter of Notification—which provides detailed findings, citations, or areas for improvement—is then posted in the Accreditation Data System (ADS) section of the ACGME website within 60 days following the meeting.*

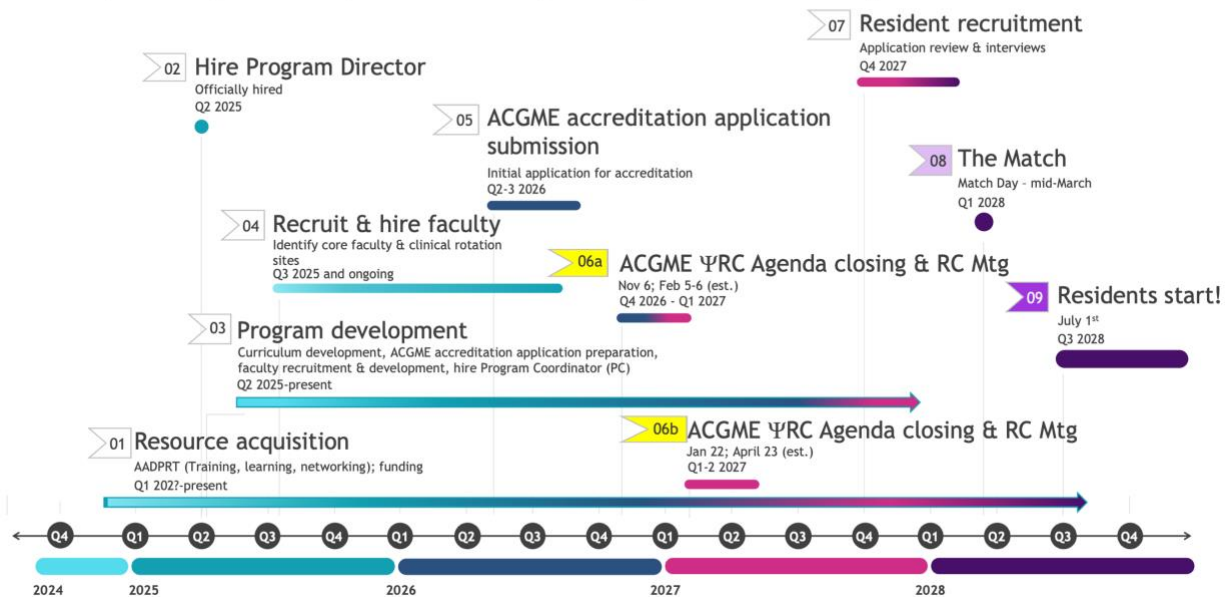


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### Sample Psychiatry Residency Project Roadmap



When considering starting a new program, it is important to look at the resources needed. While securing funding (discussed in the next section) is essential, it is important to look beyond funding to the ability of an institution to offer required learning experiences either within the institution or in partnership with local institutions. We recommend starting by closely examining the ACGME psychiatry program requirements (along with the ACGME institutional requirements for institutions without ACGME accreditation). From these requirements, a list of needed services, infrastructure, faculty, and staff can be generated and a gap analysis performed. Creating a draft schedule for the program as well as a draft didactic schedule will help to “right size” the program in terms of numbers of residents as well as financial resources that will be required. Institutions that lack access to someone knowledgeable about the ACGME accreditation process may wish to hire a consultant to assist them.

It is important to think about developing a scholarly culture early in program development. As the program is planned and potential faculty members are included in the planning process, thinking about creating both a scholarly culture on rotations as well as having faculty begin to



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plan to deliver didactics is important. Psychiatry residency requires didactics that are rotation-specific, which means that individual classes of residents must be taught at least some material class by class which can seem like a large volume when compared to a family medicine or internal medicine residency program where it is more unusual to split residents by class. Planning to teach at least some didactics with case-based learning as well as pairing residents with faculty members for presentation can take some of the load off of faculty members, especially faculty who are unused to preparing didactics.

Other considerations in the initial planning stage include looking at the possibility of partnering with rural hospitals, Veterans Affairs Medical Centers, federally qualified health centers and/or other entities that may allow the program to access federal or state funding. If a program has faculty who are subspecialty boarded, considering adding subspecialty fellowships from the beginning can be a smart financial decision especially if you are eligible for the CMS funding that comes from being a new hospital that has not had these positions in the past. Likewise, this may deter graduates from leaving your local area to pursue subspecialty training and then potentially not return to the area to practice.

### **FUNDING**

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Sources of potential funding for new GME positions differ from state-to-state and institution-to-institution. This list is not all-inclusive, but a starting point to explore in a program or fellowship's specific context.

#### **Local/community sources of funding**

- a. Hospitals – over-the-cap funding
- b. Community Mental Health organizations – specific rotations or tracks
- c. Foundations – specific needs identified, i.e., start-up funding, underserved areas or populations.

#### **State sources of funding.**

- a. Medicaid funding – State/Federal match program
- b. State funding of GME positions – mechanisms differ state-to-state. Strategies to explore include partnerships with state policy advocacy partners, state mental health leadership, local and state APA chapters.



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### **Federal sources of funding**

- a. Medicare funding – current priorities are rural, new programs in shortage subspecialties (psychiatry) and addiction.
- b. Veteran’s affairs (VA) and Military funding – institutions affiliated with VA and Military programs can request additional stipends/support.
- c. Health Resources and Services Administration (HRSA)
  - a. Teaching Health Center GME (THCGME) programs – prioritizes service to rural and underserved areas – [bhw.hrsa.gov/grants/medicine/THCGME](http://bhw.hrsa.gov/grants/medicine/THCGME).
    - i. Awarded to outpatient settings like FQHCs and rural health centers. Requires the institution to partner with hospitals to provide inpatient rotations.
    - ii. Funding can be more unpredictable than CMS.
    - iii. It has historically offered start-up grants (pending budgets), separate from ongoing operational funding.
    - iv. Must be based in outpatient clinic setting (as opposed to hospital-based program), and other opaque exclusionary criteria.
  - b. Addiction Medicine Fellowship (AMF) Program – new program for addiction fellowship training in underserved, community-based settings – [hrsa.gov/grants/find-funding/hrsa-20-013](http://hrsa.gov/grants/find-funding/hrsa-20-013) -- currently closed but may open again in the future.

#### **2019 AADPRT survey information on funding sources**

The majority of new or expanded program positions nationally as of 2019 have come from: 1) local institutions, 2) health care systems, 3) state funding, 4) federal funding such as Medicare, Medicaid, VA, and 5) Philanthropy or grants

### **CLINICAL INFRASTRUCTURE FOR TRACK CREATION/PROGRAM EXPANSION/NEW PROGRAMS**

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Creating new residency/fellowship positions, either within an existing program or a new program requires consideration of the clinical training experiences. Questions to consider:

- a. For an expansion, how will training additional residents influence current resident training?



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- b. If an expansion, is the expansion focused on specific types of training, such as a rural, public sector or community? If this is the case, consider forming a separate track of the program. This may also be used when creating a second site for a program in a different geographic area though some institutions prefer to have multiple separate programs.
- c. Are there types of clinical experiences that should/must be added?
  - 1) Does this require partnership with local sites (community mental health centers, forensic facilities, child psychiatry inpatient units, etc.?)
  - 2) Does this require transformation of an existing service to be faculty/resident run rather than run by non-physician staff such as nurse practitioners or physician assistants?
- d. Will bringing in residents require significant capital expenditure or adaptation of facilities to provide required spaces needed for a quality training environment? Some of the answers to these questions are linked to funding sources, as above, which will guide the next steps.
- e. Who will be the faculty for the program and how will these people receive faculty development to be ready to serve as faculty members?
  - 1) Do current staff physicians wish to serve as faculty members? If so, are they ABPN certified?
  - 2) Who is missing who might either need to serve in a different clinical role or be hired?
  - 3) Is there the possibility of partnering with a nearby medical school to gain assistance with faculty development, library access and other resources not locally available?
  - 4) How will these faculty members be compensated for teaching and supervising residents?
- f. What will be special about this program in terms of specific offerings such as telepsychiatry, integrated care, collaborative care, interventional psychiatry, etc.? How can you exploit the strengths that your institution already has?

### **EDUCATIONAL INFRASTRUCTURE**

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Creating new residency/fellowship positions, either within an existing program or a new program requires consideration of the educational resources, including institutional support, faculty recruitment, retention and development, curriculum development and administrative support.



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- a. Institutional support – conversations with leaders (GME, Chairs, etc.) within your institution should focus on value, services and unmet needs.
- b. Faculty – issues for faculty include buy-in, recruitment/retention of excellent faculty, development opportunities and ongoing support, resources/protected time for education, competitive salaries.
- c. Curriculum – Track or subspecialty curriculum development (this can be a particularly heavy lift for new programs; identify collaborators and resources early in the process)
- d. Administration – Training of existing staff or additional hiring

### **RECRUITMENT AND RETENTION OF TRAINEES**

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New or expanded programs will want to attract applicants by promoting and distinguishing themselves. Developing a mission statement and collaborative goals that showcase the strengths of the institution(s) involved in the program will help with this.

### **SPECIAL CONSIDERATIONS FOR RURAL TRACK DEVELOPMENT**

While developing a rural track within a larger psychiatric residency presents some unique challenges, developing a full 4-year program in a rural area can be *quite challenging* due to lack of availability of ACGME required rotations and supervising faculty.

Location: there are several options to consider when developing a rural track. One option is having residents spend all 4 years in a rural area. This option requires sending residents out to larger cities and academic centers for more specialized rotations. Alternatively, programs may choose to have the residents spend their first two years in an academic institution completing required inpatient, Consultation Liaison and subspecialty rotations, followed by 2 years in a rural area to focus on outpatient training. This may be a good way to start a program in a rural area, even if the eventual plan is to have the rural program be freestanding with all rotations available, in order to allow for resources to develop as the program grows.

Sending residents into the rural area to do internal medicine or inpatient psychiatry for 1-2 months during their first 2 years of training can help them get acquainted with the community, hospital systems, and other physicians in the area. This can help the resident become familiar with the area and start to create a support system for when they relocate between years 2 and 3.



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When developing rotations in rural areas, consider whether:

- a. The patient population is broad enough that residents will receive excellent training across the spectrum of psychiatric disorders.
- b. There are faculty members available to supervise.
- c. Funding is available to support resident time. Developing a partnership with a local hospital, health care organization or university (if present) can help substantially with quality rotations and supervision. There are also some opportunities for unique rotations that might be available in a rural area, such as Indian Health Services, which will add an uncommon feature to the program.

Supervision can also be a challenge in rural areas. The use of tele-supervision or other remote platforms, such as ECHO, can be utilized in the first several years as the program is being established and faculty recruited. Partnerships with other psychiatry residency programs in the region and faculty available remotely within the state can be helpful for didactics, psychotherapy supervision, and/or telepsychiatry rotations. Partnering with in-state psychoanalytic institutes and psychology graduate programs can also be a short or even a long-term solution to psychotherapy supervision needs.

Other special considerations:

- 1) housing during required rural rotations in years 1 and 2 if there will be different locations for the first two years than the second two years of the program.
- 2) location of program leadership (in the academic center or in rural area)
- 3) malpractice coverage if in a different state
- 4) medical student training/teaching
- 5) call duties
- 6) incentivized opportunities
- 7) Health insurance coverage (will it be different outside main academic center if the residents' employer changes?)

Curriculum and didactics can also be a challenge in a new rural track/program. Identify collaborators and resources early. One benefit of having a rural track associated with a larger program is that didactics can be telecast to residents in the rural track. As faculty involvement in the track grows, some lectures, more specific to rural healthcare can be given by local faculty. Senior residents can also teach some topics to junior residents with supervision.



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### **AVAILABLE RESOURCES**

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- GME consultants within or outside of your institution
- **AADPRT** – annual meeting, Virtual Training Office, mentorship program, new program caucus, community program caucus, rural program caucus and more!
- **AAMC** webinars, faculty development seminars, WIMS, ELAM and more
- **The American Psychiatric Association has many learning and support resources available on their website as well as at the annual meeting.**
- **The Association for Academic Psychiatry (AAP)** – especially the Master Educator Program but also the annual meeting which is focused on faculty development.
- **ACGME - Developing Faculty Competencies in Assessment Course and Learn at ACGME**
- **MedEdPortal** – a repository of medical education curricula
- **National Neuroscience Curriculum Initiative (NNCI)** – for neuroscience curricula
- Local medical schools - faculty development (often offers free library access and faculty development in exchange for offering clinical teaching to medical students)
- Journals related to education in Academic Medicine
  - o Academic Psychiatry
  - o Academic Medicine
  - o Journal of Graduate Medical Education (also a podcast)

### **CONSULTANTS**

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