Program Directors Forum 2016

Update in PM Fellowship Education

ACADEMY OF PSYCHOSOMATIC MEDICINE

Psychiatrists Providing Collaborative Care for Physical and Mental Health

APM 2016

Disclosure: Paul Desan, MD, PhD
Madeleine Becker, MD

With respect to the following presentation, there has been no relevant (direct or indirect) financial relationship between the party listed above (and/or spouse/partner) and any for-profit company in the past 24 months which could be considered a conflict of interest.

Agenda

Paul Desan, MD, PhD, Chair, Education Committee

Madeleine Becker, MD, Fellowship Education Subcommittee

1. Update on PM Fellowship Programs
2. Update on PM Match and new Match policies
3. Update on possible upcoming Program Requirements
4. Program Director's Guide
5. Program Directory Survey
6. Encouraging recruitment
7. Other topics…

1. Update on PM Programs

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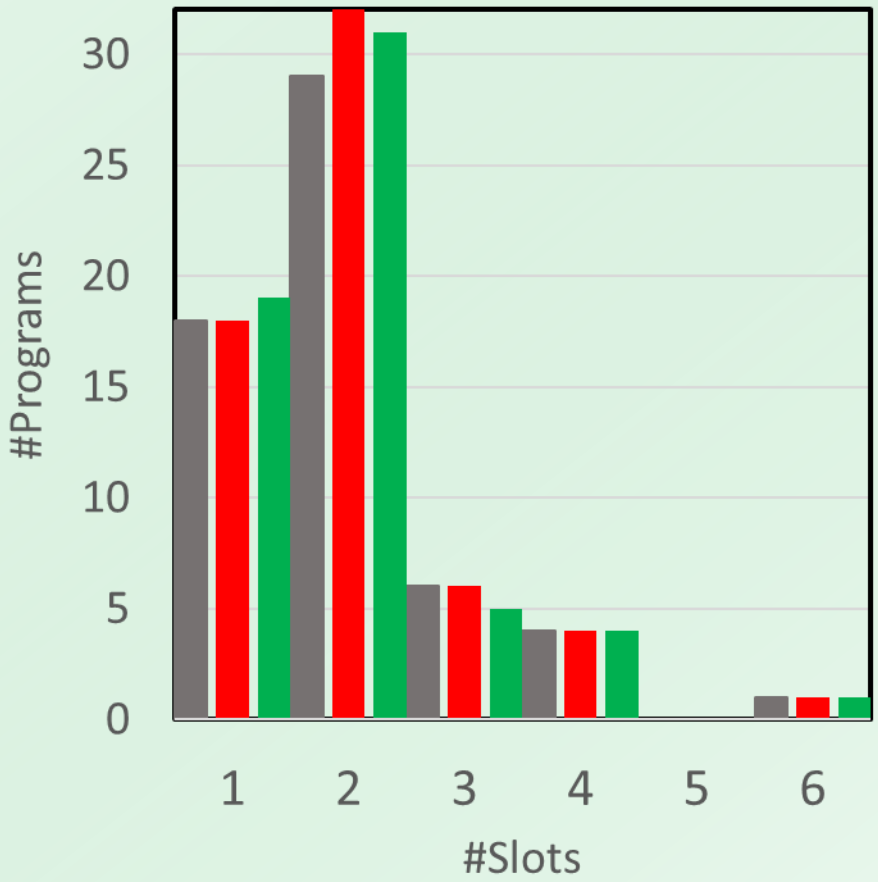
PM Fellowships on APM website ~~2014~~ ~~2015~~ 2016

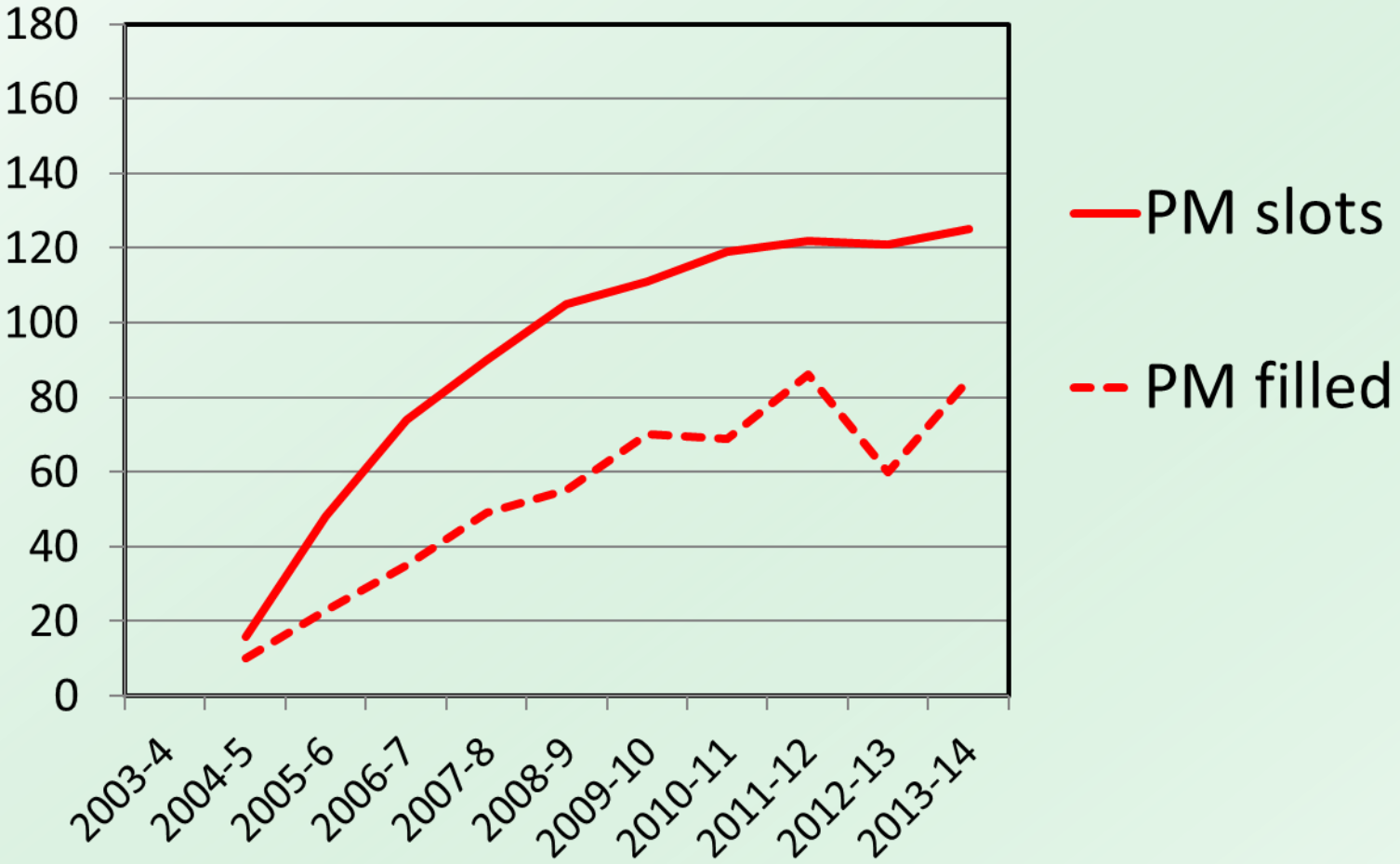
- ~~58~~ ~~61~~ **61** programs listed*
- ~~26~~ **27** states
- ~~116~~ ~~122~~ **119** slots
- ~~32~~ **31**% in NYC and adjacent counties)
- Most programs have 2 slots

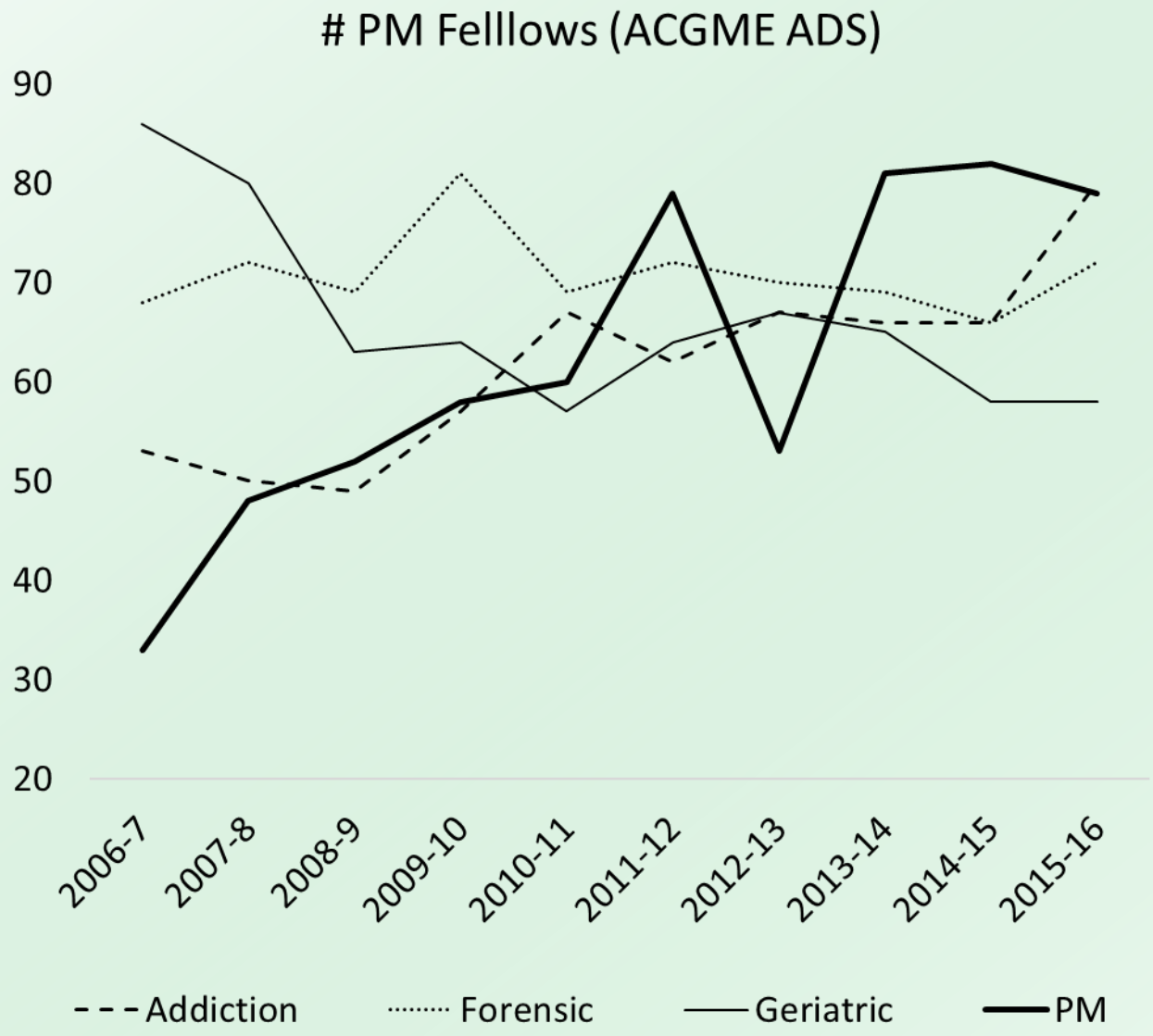
** not all active*

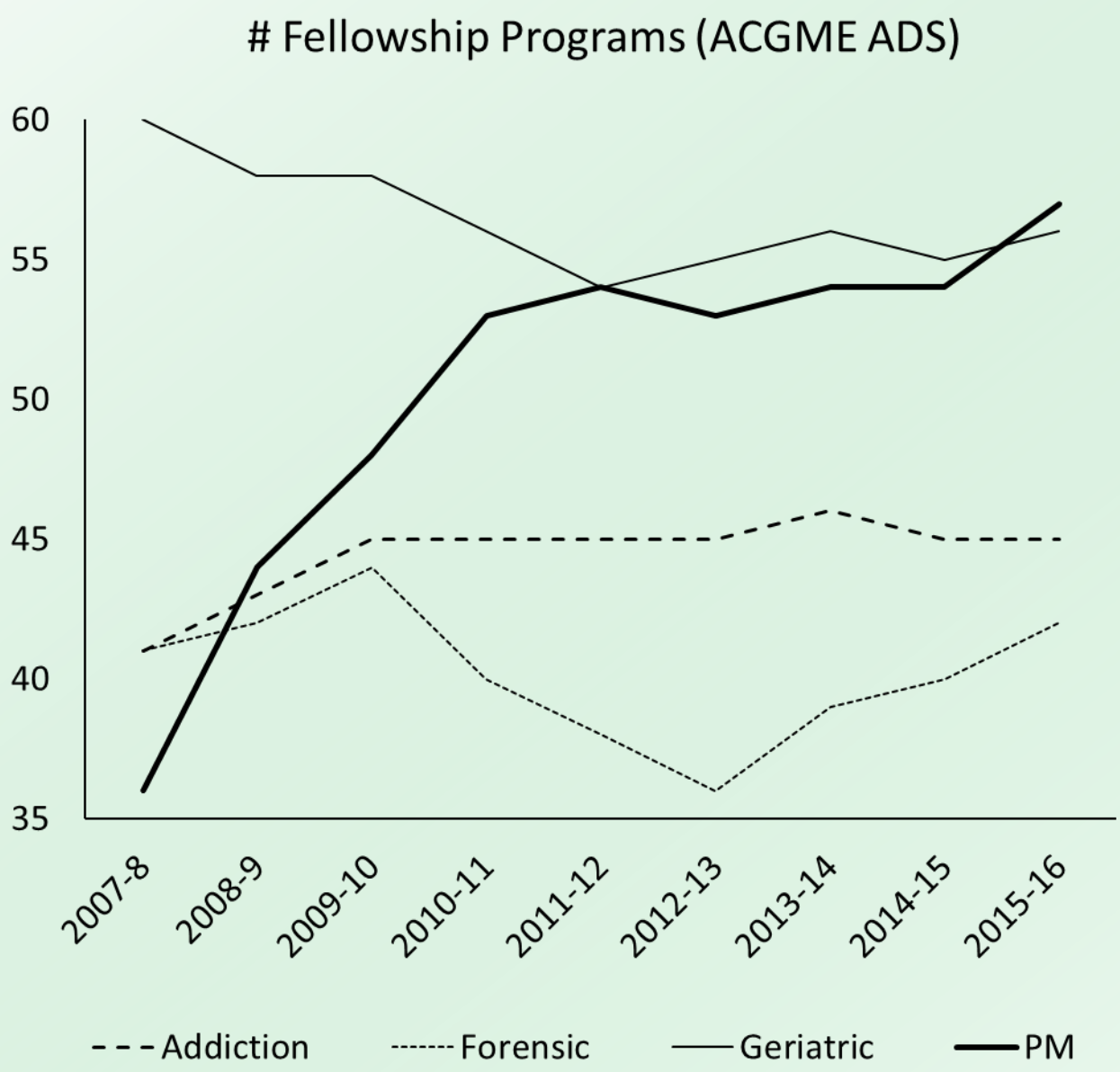


State	Programs	Positions
NY	14	37
MA	4	10
CA	6	9
OH	3	6
PA	3	6
CT	2	5
MD	3	5
VA	2	5
TX	2	4
MN	2	3
WA	2	3

PLEASE UPDATE YOUR LISTING!


180
160
140
120
100
80
60
40
20
0
2003-4
2004-5
2005-6
2006-7
2007-8
2008-9
2009-10
2010-11
2011-12
2012-13
2013-14
PM slots
PM filled


PM Felllows (ACGME ADS)
90
80
70
60
50
40
30
20
2006-7
2007-8
2008-9
2009-10
2010-11
2011-12
2012-13
2013-14
2014-15
2015-16
Addiction
Forensic
Geriatric
PM


Fellowship Programs (ACGME ADS)
60
55
50
45
40
35
2007-8
2008-9
2009-10
2010-11
2011-12
2012-13
2013-14
2014-15
2015-16
Addiction
Forensic
Geriatric
PM

2. Update on PM Match and new policies

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Match in US graduate medical education

1940s: due to need for residents, hospitals begin signing residents earlier and earlier, offering “exploding matches” with 48-72 hour deadlines

1950s: NRMP Match established at demand of residents

1995: Match discovered to be using “hospital proposal” system, which favors hospitals

1997: Match algorithm switched to “resident proposal”

2012: Nobel prize in Economics for match algorithms

2013: Match introduced in Psychosomatic Medicine

Psychosomatic Medicine Match

	2014	2015	2016
Number of positions:	95	93	101
Number of applicants:	73	68	80
Number matched:	66	64	73
Positions filled:	*69%*	*69%*	*72%*
Choices:			
First choice	74%	65%	72%
Second choice	14%	12%	12%
Third choice	3%	10.%	5%
> 3rd choice	0%	7%	1%
Other specialty	1%	0%	1%
Unmatched	8%	6%	8%

Psychosomatic Medicine Match

	2014	2015	2016
US allopathic:	68%	56%	59%
US osteopathic:	9%	5%	8%
Canadian:	2%	3%	3%
US international:	12%	14%	11%
Non-US international:	9%	22%	19%

Survey of fellows - November, 2014

The Match gives all applicants an opportunity to interview at all the programs they wish to visit and consider.

Agree: 90%

The Match should be continued as continued as the means for applying to Psychosomatic Medicine fellowships.

Agree: 82%

The Match

NRMP: National Resident Matching Program

- **November 9th**: Rank order list opens
- **November 30th**: Quota change deadline
- **December 14th**: Rank order list deadline
- **January 4th**: Match Day!

The Match

The purpose of the Specialties Matching Service (SMS) is to provide a uniform time for both applicants and programs to make their selections **without pressure**. All participants in the SMS shall conduct their affairs in an ethical and professionally responsible manner and shall respect the right of applicants to **freely investigate program options prior to submission of a final rank order list.**

Match Communication Code of Conduct

- One of the purposes of the *SMS* ***is to allow both applicants and programs to make selection decisions on a uniform schedule and without coercion or undue or unwarranted pressure.***

- ***Both applicants and programs may express their interest in each other; however, they shall not solicit verbal or written statements implying a commitment.***

Match Communication Code of Conduct

- Program directors shall **instruct all interviewers about compliance with** Match policies and the need to ensure that all applicant interviews are conducted in an atmosphere that is safe, respectful, and nonjudgmental.

- **Program directors shall assume responsibility for the actions of the entire interview team.**

Match Communication Code of Conduct

D**uring the interview and matching processes**, it is a breach of this Agreement for:

- a program to ask applicants **the names, specialties, geographic locations, or other identifying information about programs to which they have or may apply**
- asking illegal or coercive questions; about **age, gender, religion, sexual orientation, and family status**, PDs shall ensure that communication with applicants remains focused on the applicant's **goodness of fit** within their programs
- a program to request applicants to **reveal ranking preferences**

- http://www.nrmp.org/code-of-conduct/

Match Communication Code of Conduct

- **PDs should not require second visits or visiting rotations,** and shall respect the logistical and financial burden many applicants face in pursuing multiple interactions with programs and shall not require them or imply that second visits are used in determining applicant placement on a rank order list.
- **Discouraging unnecessary post-interview communication.** Program directors shall not solicit or require post-interview communication from applicants, nor shall program directors engage in post-interview communication that is disingenuous for the purpose of influencing applicants' ranking preferences.

- http://www.nrmp.org/code-of-conduct/

Match Communication Code of Conduct

- **It is a violation for a program and an applicant in the *SMS to make any verbal or written contract for appointment to a concurrent year fellowship position prior to the release of the List of Unfilled Programs.***

3. Update on possible upcoming Program Requirements

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ACGME Common Program Requirements

Proposed Changes/Revisions

- Patient safety
- Physician well-being
- Clinical experience
- Education hours

Patient Safety

- **Culture of safety:** the Program, faculty and residents/fellows must actively participate in pt safety systems and culture
- Formal educational activities that promote pt safety related goals in a well coordinated manner,
- All residents must receive training in how to disclose pt safety events to pts and families.
- Residents and faculty should receive specialty-specific data on quality metrics and benchmarks related to their pt populations.

Supervision

- Programs must define/communicate a structured chain of responsibility and accountability as it relates to the supervision of all patient care.

- PDs must evaluate each residents abilities based on specific criteria, guided by the **Milestones** (replacing, "~~specific national standards based criteria~~").

Physician well-being

- Self care is a component of professionalism.
- Policies and programs that encourage optimal resident and faculty well being…
- Residents must be given the opportunity to attend medical, mental health and dental appts, including those scheduled during their working hours.

Physician well-being

- Institution must educate faculty and residents in identification of symptoms of burn out, depression and substance abuse, and means to assist those who experience them
- Provide access to appropriate tools for self-screening
- Provide access to confidential affordable mental health counseling and treatment.

“Clinical experience and education” in place of “duty hours”

- Review committee can grant rotation specific exceptions for up to 10% or a max of 88 clinical and educational work hrs based on *sound educational rationale*.

- **Mandatory time free of clinical work and education**: The Program must provide residents with educational opportunities as well as reasonable opportunities for rest and personal well-being

4. Program Directors Guide

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Psychiatrists Providing Collaborative Care for Physical and Mental Health

Fellowship Education Subcommittee

Madeleine Becker MD, chair

Sejal Shah MD vice chair

Daniel Elswick MD

Mark Bradley MD

Christine Finn MD

Robert Joseph MD

Garrett Key MD

Terry Rabinowitz MD, DDS

Lisa Rosenthal MD

Shamin Nejad MD

Jorge Sotelo MD,

Marie Tobin MD

Roger McRoberts III MD

Program Directors Guide

ACGME requirements

- One year fellowship program requirements
- Psychosomatic Medicine Fellowship requirements

- 4 pages
- Includes bare-bones schedule
- Sample checklist for incoming/outgoing fellows

Program Directors Guide

- Available for PD on the Academy website.
- Available here in paper form.
- Take one.
- Use it,

  give us feedback,

  keep it simple.

5. Program Director Survey: Spring, 2016

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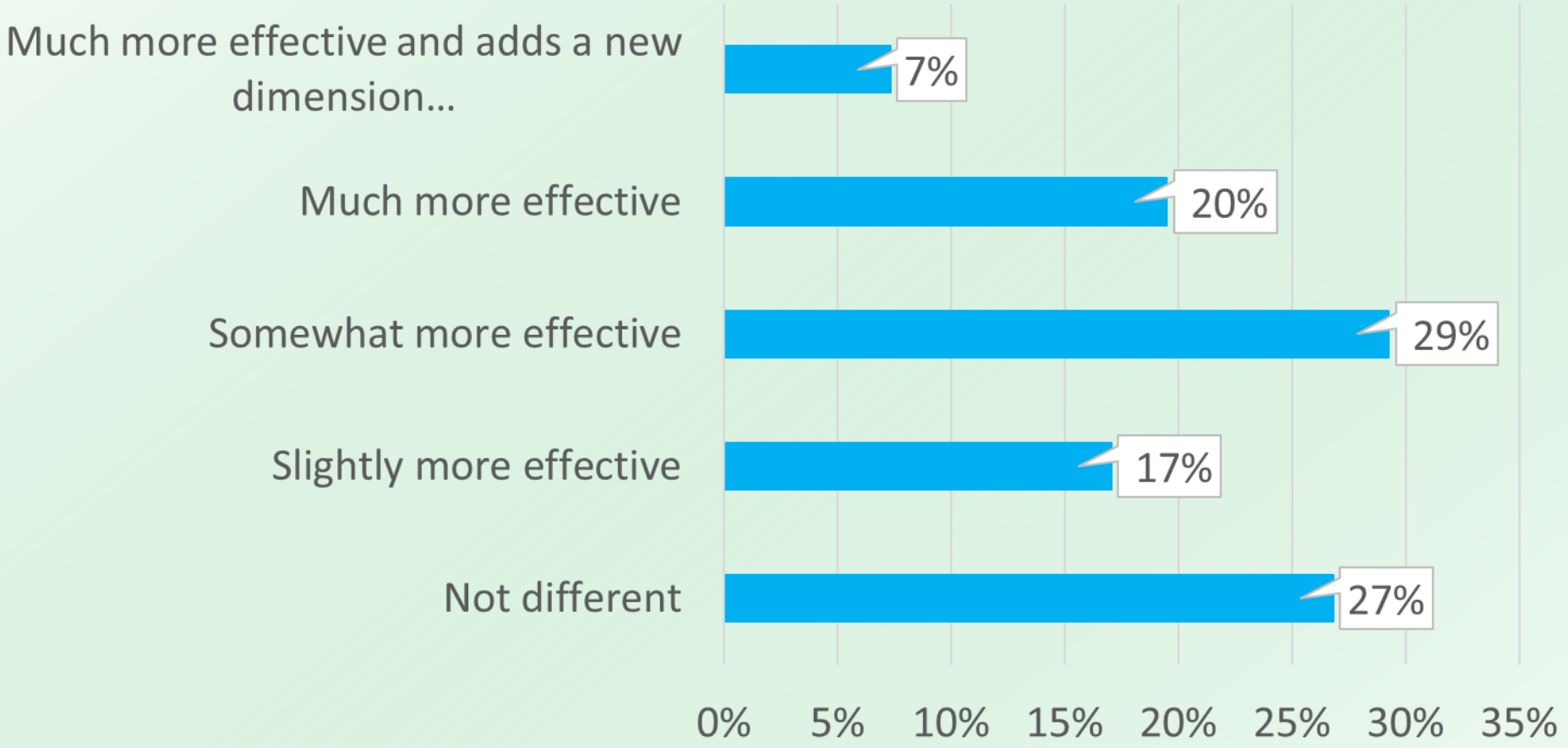
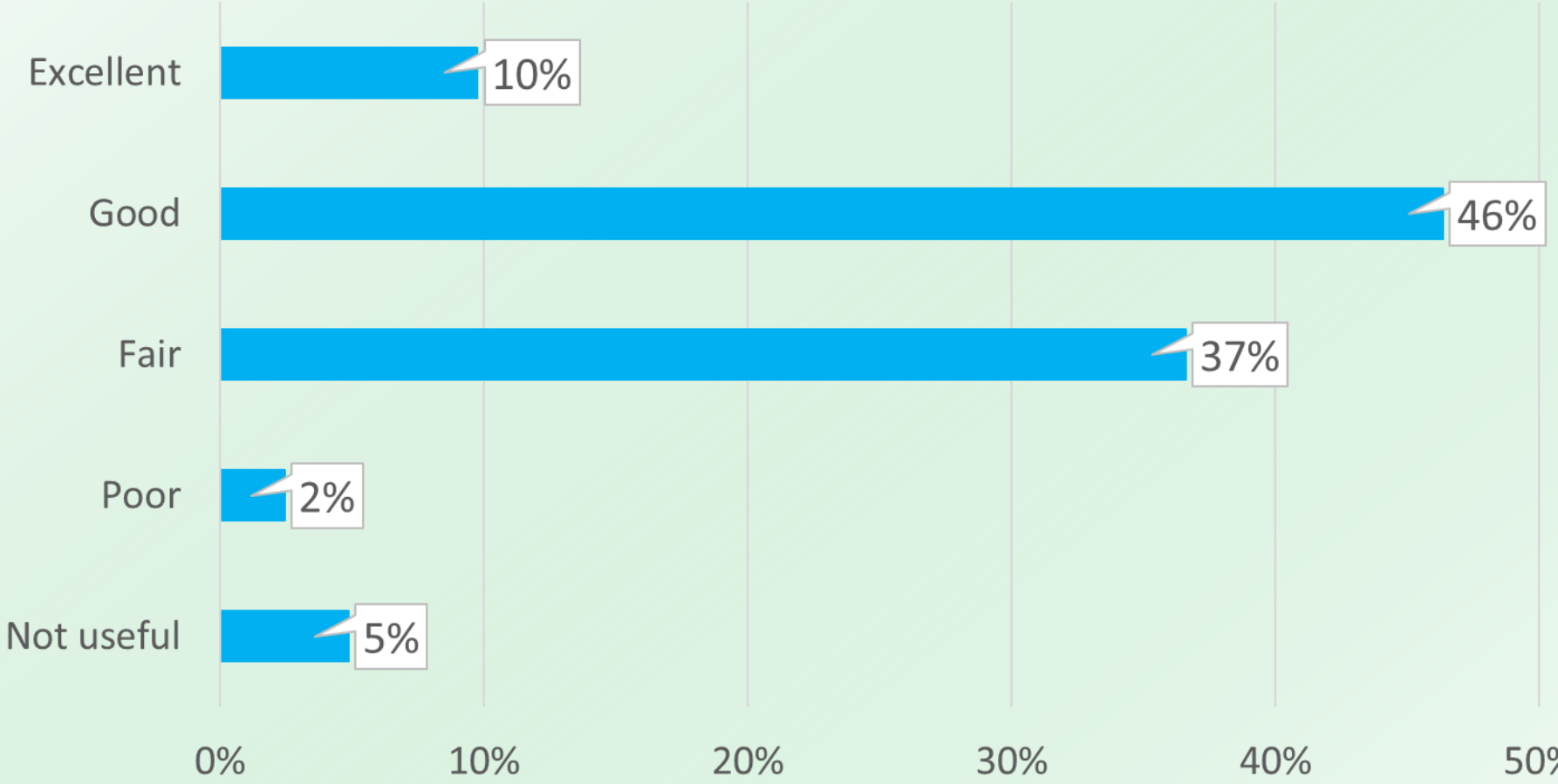
Please rate the usefulness of the Clinical Competency Committee (compared to the process of evaluation without the CCC) (n = 41)



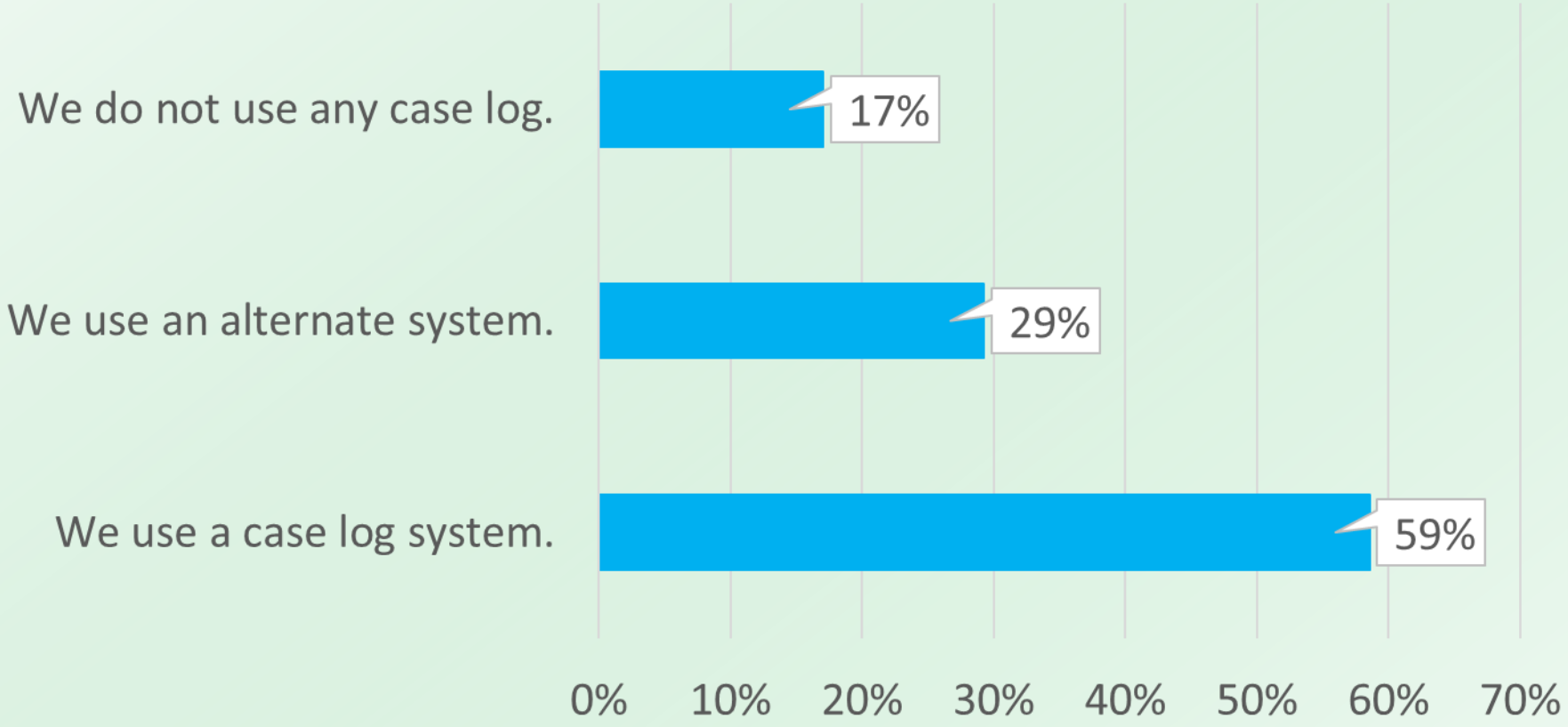
How would you rate the Psychosomatic Medicine Milestones in reflecting fellow performance throughout training? (n = 41)



Comments on Milestones

- Too many
- PC1 covers too much territory *(note that this is split in the APM Overall Assessment)*
- SBP1 to 4 could be one item
- Professionalism: multiple comments, eg, delete Prof2, split Prof1 into A and B
- No assessment of psychodynamic skills
- PC2 is not covered in some programs
- Much of what is evaluated is not specific to PM

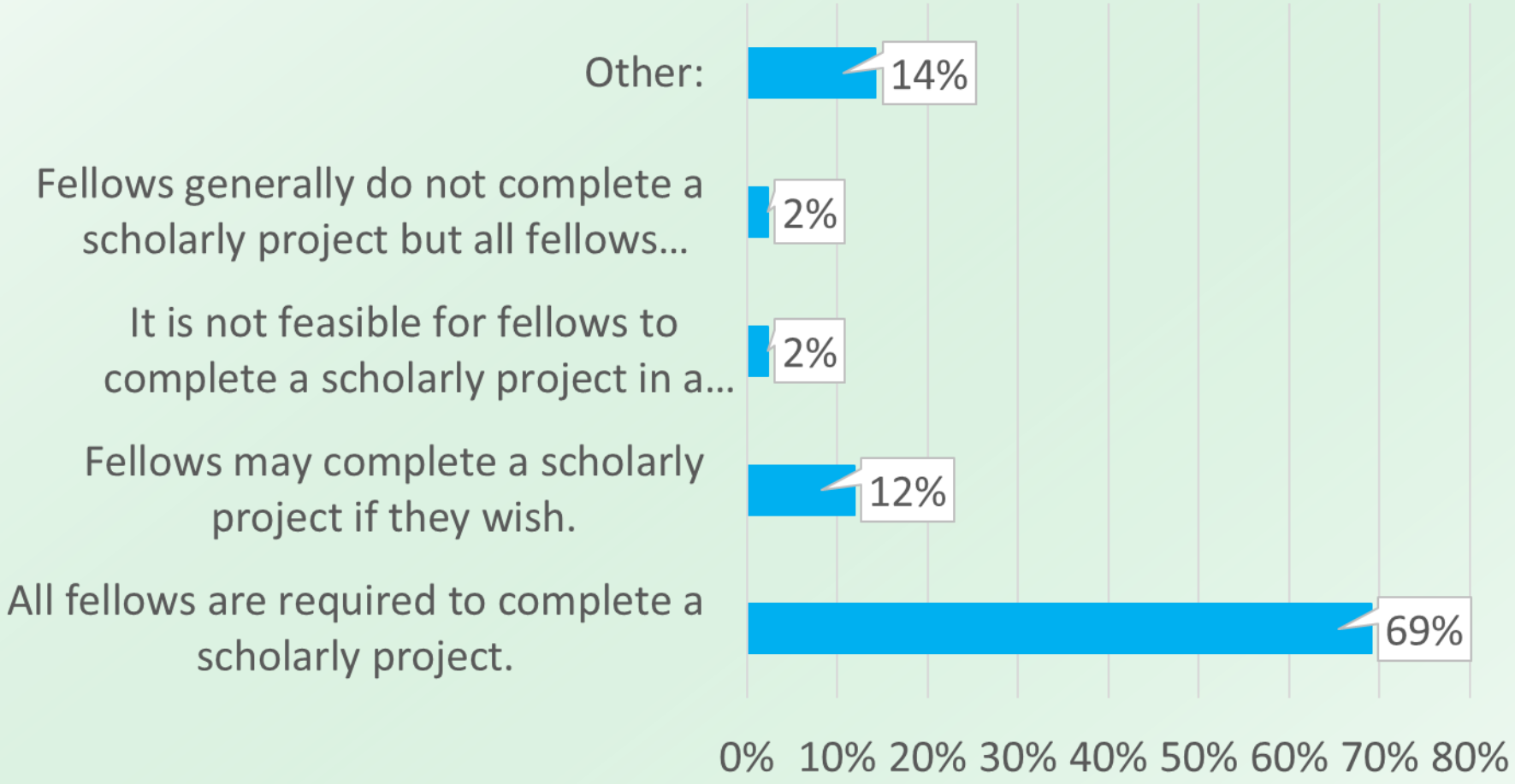
The ACGME requires fellows complete a case log, a "Detail" requirement, which means it may be met in alternative ways. How do you meet this requirement?(n = 41)



Alternatives to Case Logs -

- Logs derived from EMR
- Logs derived from billing system
- Logs derived from consult service database
- Fellows make portfolio of cases
- Fellows track type of cases

The ACGME requires that fellows "participate in developing new knowledge or evaluating research findings," and the ACGME asks about "scholarly projects" completed by fellows. How do you meet this requirement? (N = 42)



APM Fellowship Evaluation: Overall

"Basic" reflects simple or limited knowledge in PM with need for direct or indirect supervision. "Intermediate" indicates knowledge of standard PM diagnoses and interventions, as a well-trained resident might have at completion of psychiatry residency. "Advanced" represents competence in handling common consultation situations without supervision, a developing level of specialist knowledge. "Expert" requires fluency in handling complex, difficult, or unusual situations in PM. "Leadership" represents contribution to the advancement of PM (an aspirational goal in fellowship training).

Consultative & Integrative Patient Care

	____Basic____		_Intermediate_		__Advanced__		___Expert___		_Leadership_	
Question clarification & data collection	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Patient interview	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Diagnostic & therapeutic formulation	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Communication with team	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Integrative care role (if applicable)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Comment:

Knowledge of Psychosomatic Medicine

Rating Levels

- Assessment scale uses levels **1 to 5,** with intermediate ratings 1.5, 2.5, 3.5, 4.5
- rating levels related to skill level.
- levels are based on the language of the Milestones.
- It is expected that trainees will rate at a **lower level at the start of training and progress** gradually to higher levels.
- Scale should be distinguished from rating systems that are based on levels from “poor” to “excellent”.

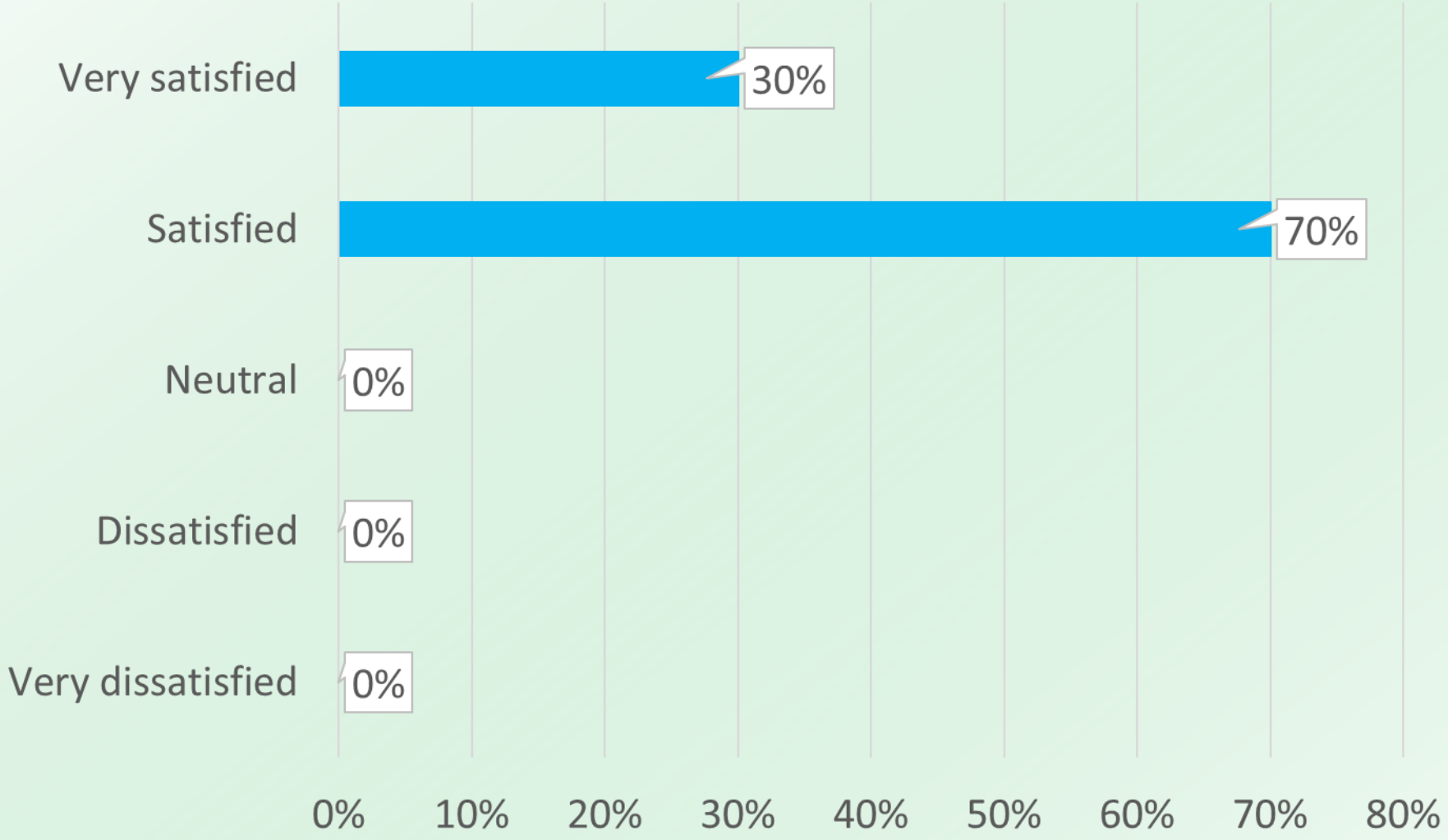
Milestone Levels

- **1."Basic”** : **elementary knowledge or skill in PM.** : simple or limited knowledge and need for direct or indirect supervision.
- **2.“Intermediate” knowledge of standard PM diagnoses and interventions :** level of skill that a well-trained and competent resident might have at completion of a general psychiatry residency.
- **3."Advanced” competence in handling common consultation situations without supervision:** skills and knowledge beyond that expected of a general psychiatrist, one who is developing the specialized skills of PM. A fellow in PM training would be expected to achieve this level at some point during the fellowship year.
- **4."Expert” fluency in handling complex cases** : difficult, or unusual situations in PM: more advanced level of knowledge and skill. fellow might be able to attain this level of skill in a number of domains by the end of a fellowship training year.

  Level 4, however, should not be regarded as a graduation requirement.
- **5.“Leadership”** represents contribution to the advancement of PM, refers to accomplishments as the generation or dissemination of new information or the organization of care systems.

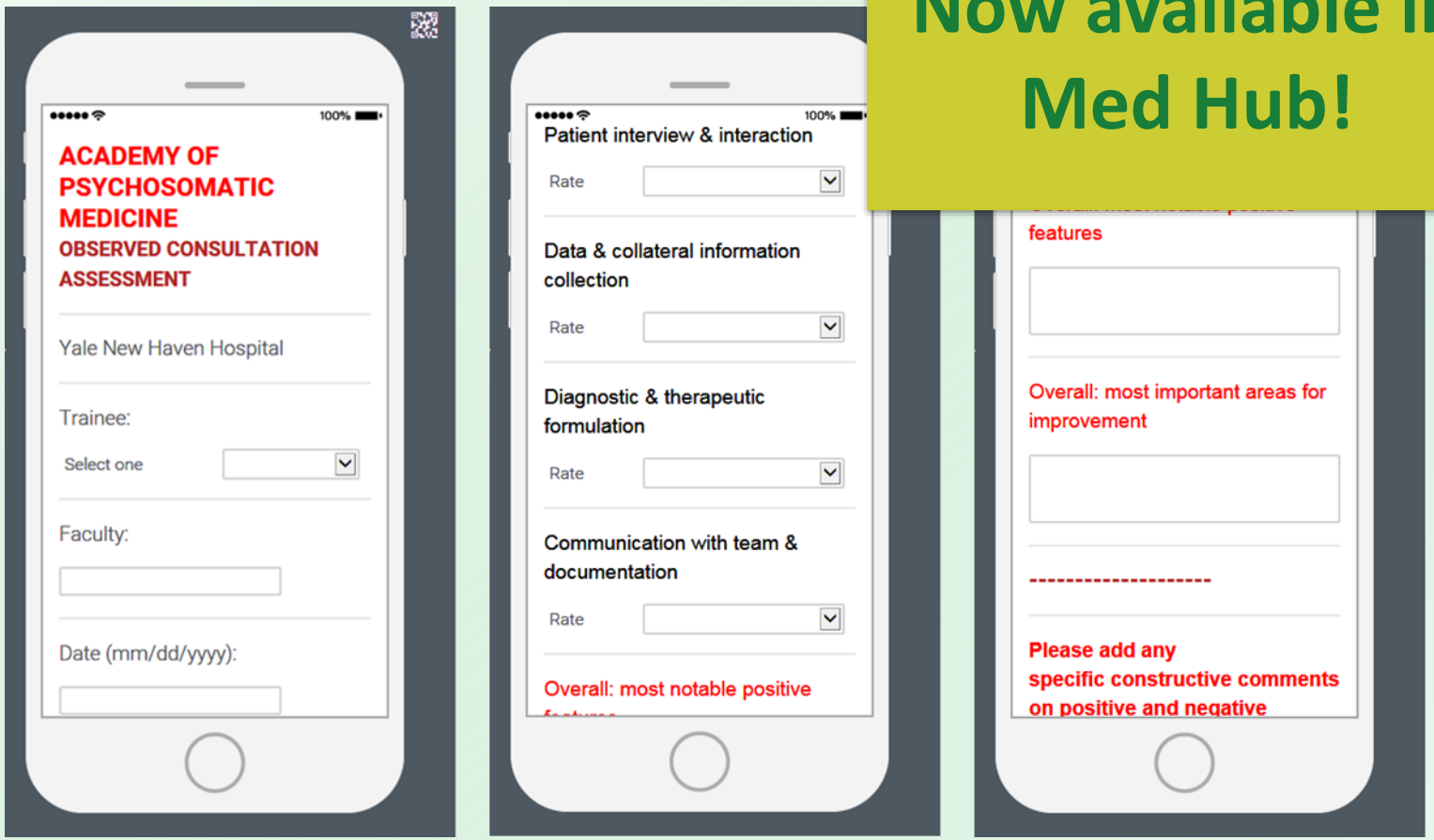
  Level 5 should be considered an aspirational goal in PM training, likely seldom achieved.

What was your experience with the APM Fellowship Assessment: Overall form? (N = 20 who had used)

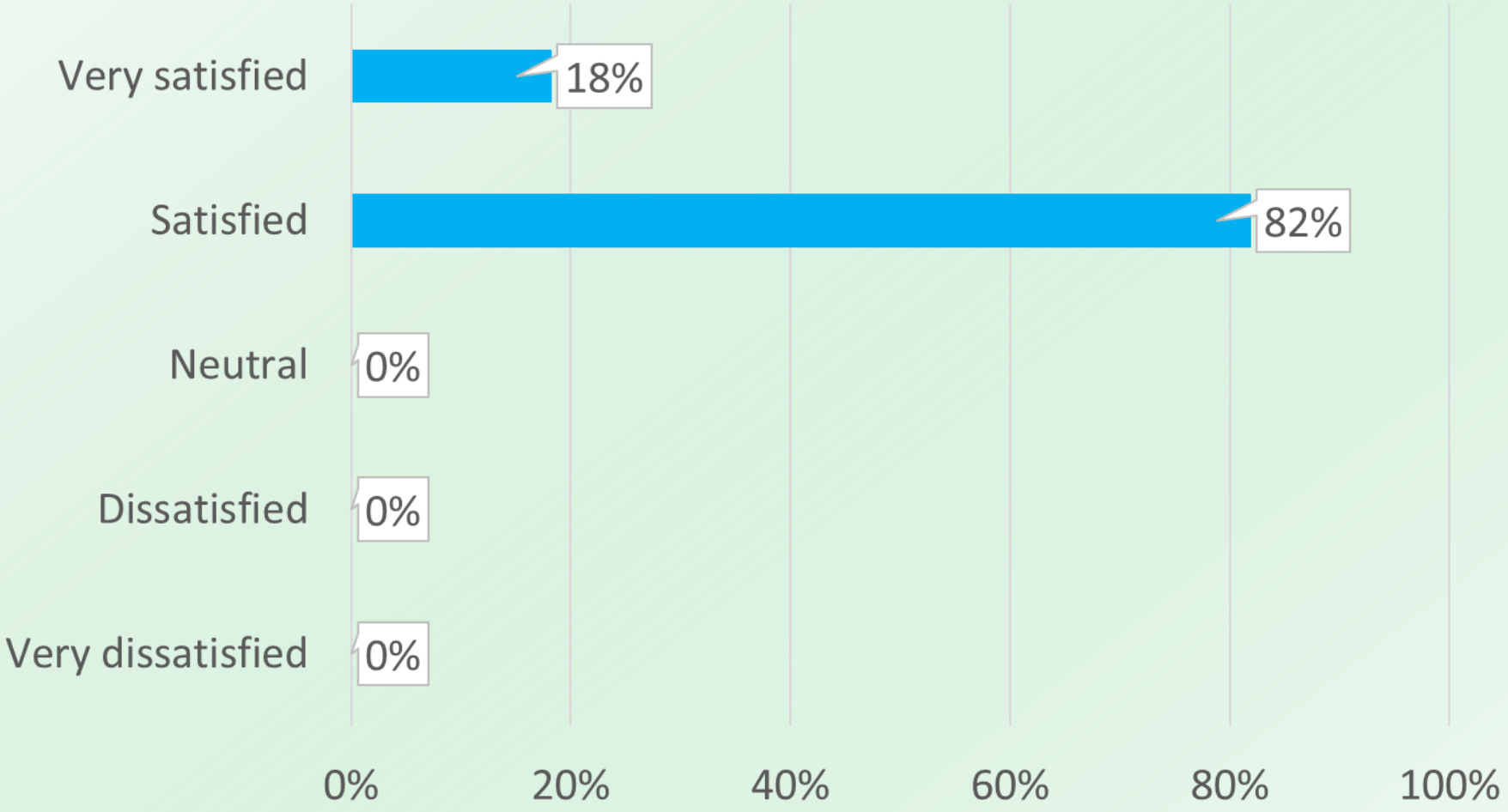


APM Observed Consultation Assessment: cell phone version

Now available in Med Hub!



What was your experience with the APM Fellowship Assessment: Observed Consultation form? (N = 11 who had used)

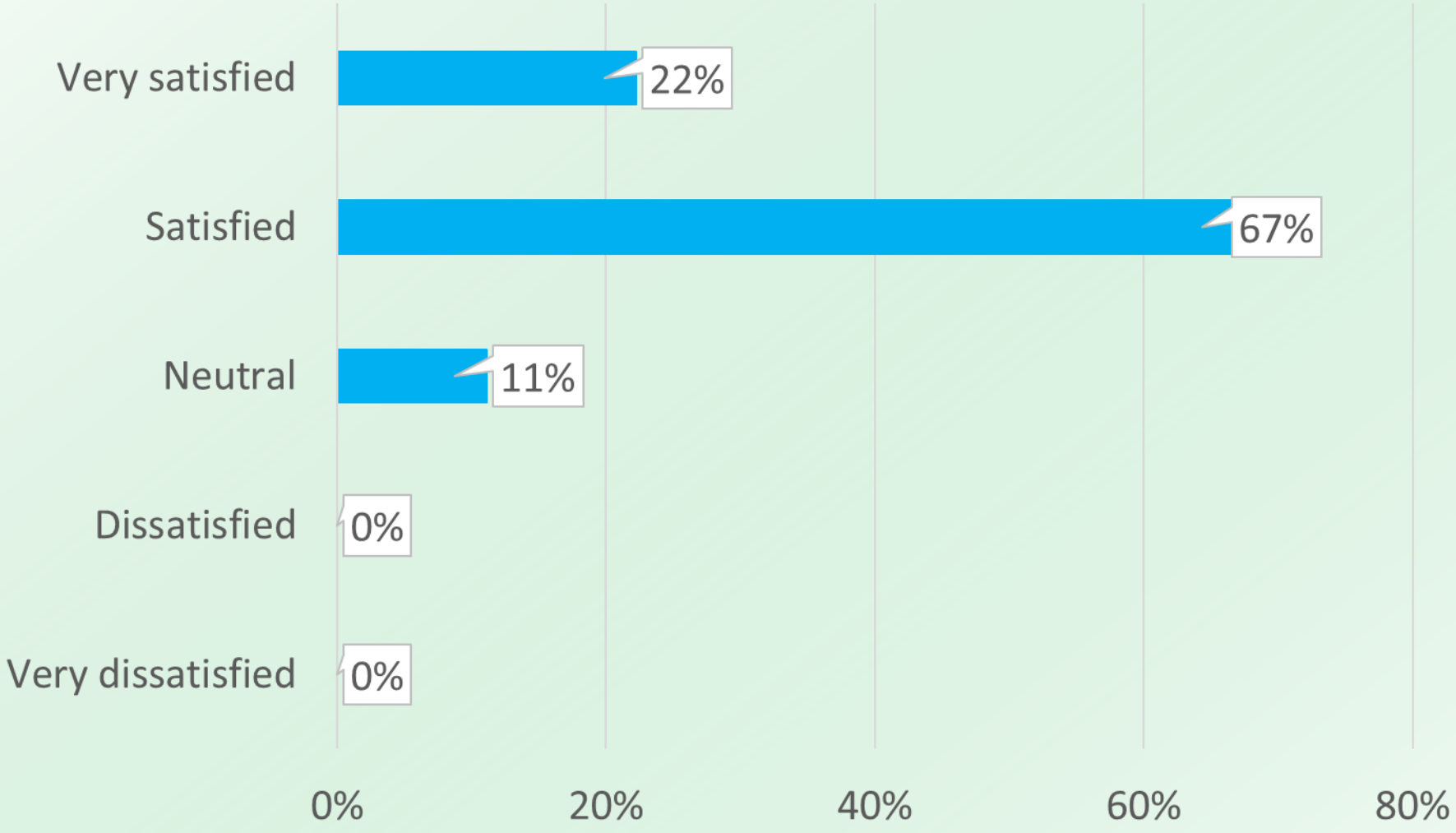


APM Fellowship Evaluation: 360° Assessment

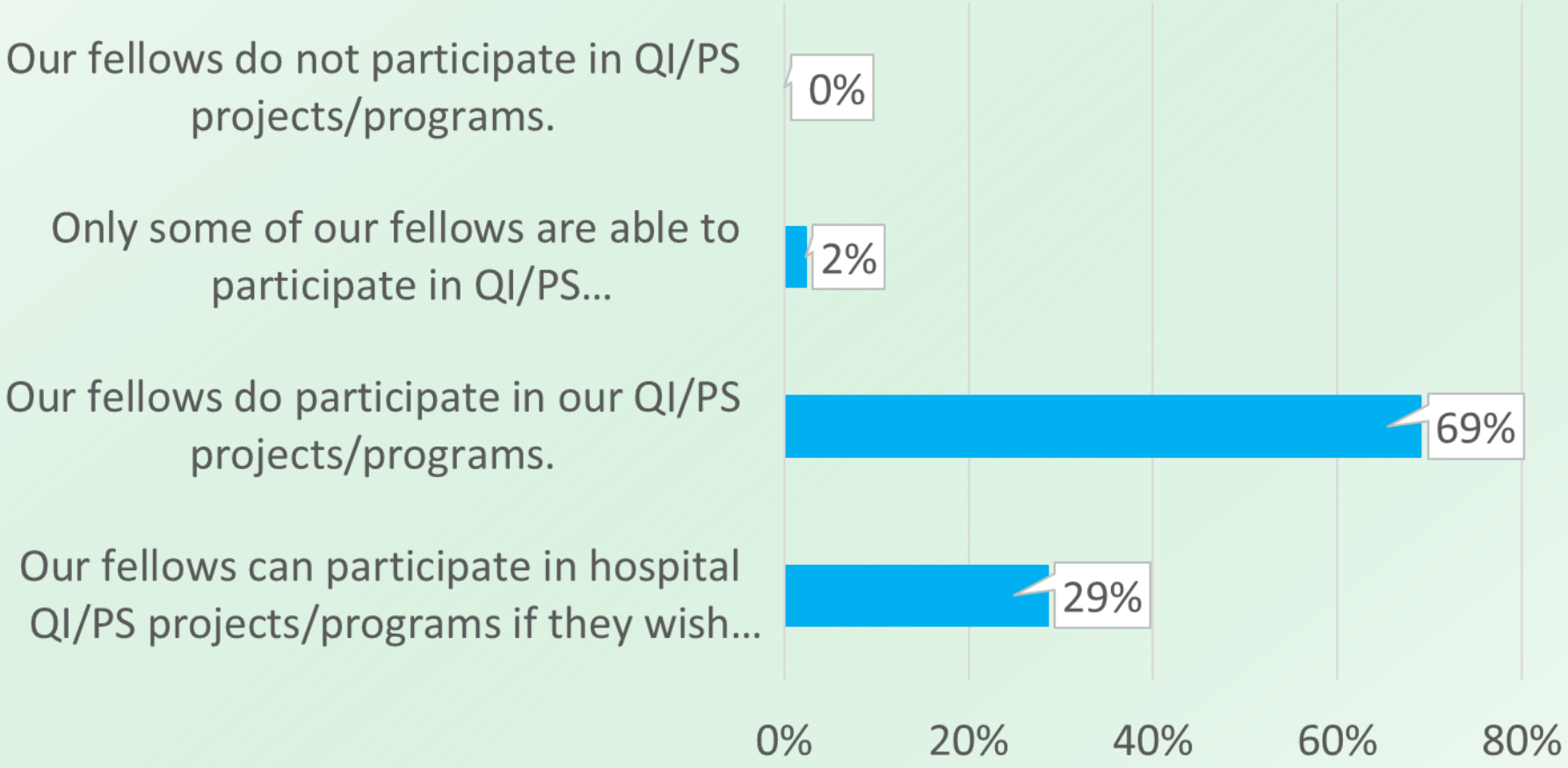
	Area for Improvement (requires comment)	Good Performance	Outstanding (requires comment)	N/A
Patient care	☐	☐	☐	☐
Interaction with consult team	☐	☐	☐	☐
Interaction with other medical professionals	☐	☐	☐	☐
Responsibility and timeliness	☐	☐	☐	☐
Responsiveness to feedback	☐	☐	☐	☐

Comment:

What was your experience with the APM Fellowship Assessment: 360 degree form? (N = 9 who had used)



The ACGME requires fellows "are integrated and actively participate in interdisciplinary clinical quality improvement and patient safety programs." How do you meet this requirement? (N = 42)



QI/PS projects: studies of -

- patient/staff safety
- hospital acquired guardianship
- MDT of Chronic pain patients, uncontrolled diabetic patients, morbidly obese patients
- proactive consultations, integrated care outcomes
- hospital acquired guardianship of patients in the VA
- chart reviews
- effectiveness of identification of postpartum depression
- measuring consultee satisfaction, liaison development
- 5HT syndrome risk in patients with neuroendocrine tumors on antidepressants
- reviewing psychiatry consults for suicidal ideation

QI/PS projects: changing system -

- improving ED to consult service communication
- redesign of consult referral process
- hand off formalizing
- revision of EMR consult note template
- improve documentation of firearm access in patients with SI
- improving screening for depression in dialysis unit
- improving outpatient follow-up post-inpatient C/L
- improving documentation of C/L notes
- improving handling issues such as SI or sitter use

QI/PS projects: participation in -

- Disruptive Behavior Committee
- supervising behavioral care managers
- ethics committee
- bioethics committee
- monthly multidisciplinary QI case conference
- hospital committees
- participation in root cause analyses

QI/PS projects: education -

- educating about optimal treatment of opioid withdrawal on CL
- educating about the use of Social Media sites in psychiatry
- educating families re delirium
- educating residents re capacity intervention
- providing training in hand-offs
- generating consensus guidelines on challenging clinical issues
- writing presentation guides
- creating orientation or policy documents

As a Program Director, what do you see as the main issues facing PM fellowship education?

- Recruitment (including into less established programs), n = 10
- Time, n = 8: *reliance on fellows for service, inadequate time for mentoring, didactics, and academic work, one year not long enough, too much time on required training and paperwork, balancing reimbursement and fellow autonomy*
- Need for teaching resources, n = 4: *APM-developed slide sets and online didactics, videotaped standardized cases, neuroscience teaching resources*
- Methods for knowledge testing, n = 3
- Availability of jobs with balanced inpatient/outpatient role, n = 1
- Enough boarded attending staff to meet ACGME criteria, n = 1
- Providing QI/Patient Safety experiences, n = 1

How can the APM best help you with these issues? (11 comments)

- Visibility at medical student and resident level
- Attract medical students and residents to Annual Meeting
- APM-developed resources for teaching, including teaching CLER, QI
- Guidance about meeting program requirements
- Decrease program requirements
- Productivity standards for attending staff to use in negotiation with departmental leadership

Please provide your suggestions as to how the APM can best increase recruitment of trainees to fellowship training in PM. (12 comments)

- Outreach at medical student and resident level, teach CL early in residency, emphasize integrative and collaborative and co-localized models as future of medicine, increase APM participation in ADPRT, increase medical student and resident participation in Annual Meetings including travel support, increase medical student CL experience, n= 11
- Not certain this is a necessary goal, n = 1

6. Encouraging recruitment

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Survey of fellows
September-October, 2015

2. Which of the following experiences were most instrumental in developing your interest in the field of Psychosomatic Medicine (PM)?

Medical school clerkship	18%
Psychiatry residency	76%
After residency experience	4%
Other	2%

3. Why did you choose to do a fellowship in PM?

Allowed me to work at the interface of psychiatry and medicine	92%
Preparation for career as clinician in this area	78%
Improve opportunity for academic job	51%
Preparation for career as educator in this area	49%
Improve employment opportunities	48%
Further clinical training in general psychiatry	38%
Preparation for career as researcher in this area	11%
As an international medical graduate, desired further training in US medical system	8%
Occupation while significant other completed other training/job	4%

5. What kind of career interests you most?

Inpatient consultation in an academic medical center	74%
Outpatient consultation in a medical setting	53%
Consultation in a specific specialty (transplant, women's clinics, etc)	49%
Mixed practice with both consultative & non-consultative roles	41%
Inpatient consultation in a community medical center	33%
Private practice	24%
Outpatient psychiatric practice	22%
Emergency room psychiatric practice	21%
Telepsychiatry practice	13%
Inpatient psychiatric unit practice	10%
Other	5%

7. How important do you believe loan repayment obligations are in discouraging residents from pursing fellowship training?

Very important: would dissuade many applicants	24%
Important factor	49%
Minor factor	20%
Not at all important: would not affect decisions from most applicants	7%

8. How important was desire for a career in an academic center in influencing you to pursue fellowship training?

Very important factor	34%
Important factor	44%
Minor factor	13%
Not a factor	9%

10. If you are aware of other residents who considered Psychosomatic Medicine but chose not to pursue fellowship training, what do you believe are their primary reasons for not pursuing this Fellowship training? Please specify

Themes	#
Money	42
Not needed for job	6
Tired of being in training	2

Replies also refer to fellowship workload, role similar to resident, limited to inpatient consultation …

11. Do you believe that “Psychosomatic Medicine” is an appropriate and accurate name to describe your subspecialty?

Yes	34%
No	66%

12. What name would you prefer for the subspecialty? (Rank 1st, 2nd, and 3rd)

	First	Total
Consultation-liaison (CL) psychiatry	34%	77%
Medical psychiatry	23%	35%
Psychosomatic Medicine	15%	37%
Consultation psychiatry	*9%*	*41%*
Medical consultation psychiatry	4%	29%
Medical-surgical psychiatry	3%	16%
Integrated psychiatry	3%	20%
General hospital psychiatry	3%	10%
Psychiatry of the medically ill	3%	23%
Other	1%	1%
Hospital psychiatry	0%	8%

13. How often do you need to clarify with colleagues in other specialties the meaning of the label "Psychosomatic Medicine"?

Very often	65%
Often	19%
Sometimes	10%
Rarely	5%
Almost never	1%

14. Please share any thoughts you have on how to increase resident interest in Psychosomatic Medicine as a subspecialty.

Themes	#
Increase residency exposure	13
Exposure to other subspecialties	6
Increase/demonstrate employability	5
Increase salaries	4
Fast track options	3
Rename subspecialty	2

7. Additional topics…

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Thank you!

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