Graduate Medical Education in Psychiatry

From Basic Processes to True Innovation

Matthew Macaluso
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From MM, LJH, JMK, and DSC:

To our trainees, the future leaders of our field. Our work is dedicated to the next generation of clinical psychiatrists, psychiatric researchers, and educators, who will continue to advance the field and advocate for patients.

From MM:

To my wife Katharine and children Matthew Jr (Matty) and William. You are the most important people in my life and the inspiration for everything that I do.

To my mentor and dear friend Sheldon Preskorn, who taught me important lessons about academic medicine and life. Your teachings made me a better person and professional.

From LJH:

To my husband, Chad, for his constant support and affirmation. You make me a better physician and human being. Thanks, as well, to all of those who have served as professional mentors in my journey. They are too numerous to name, but I thank you all for your support and wisdom.

From JMK:

To my wife, Sylvia, for her humor, encouragement, and support. To my children, Sebastian and Rémi, for their curiosity and interest. And, to my mother, Karen, and father, David, who are my greatest mentors.

From DSC:

To my husband Mark for his unfailing love and support over all these years. And thank you to the many trainees, colleagues, and mentors who have taught me so much and who have made being a program director and a psychiatric educator such a joy.

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Introduction

1

Matthew Macaluso, L. Joy Houston, J. Mark Kinzie, and Deborah S. Cowley

The graduate medical education (GME) offerings of any hospital, academic department, or medical school are arguably one of the most important functions of each entity. GME not only produces the next generation of board-certified physicians but also contributes education, clinical care, advocacy for patients and the profession, research, and scholarship to the communities each program resides within. This book aims to provide background, best practices, and innovations for GME programs in psychiatry. The chapter authors are leaders in psychiatry GME. The authors are experienced program directors, and many have been involved at the level of national professional organizations and societies related to GME. The book editors have a combined total of more than 80 years of experience in academic psychiatry. The book is intended for leaders in academic and non-academic GME settings interested in developing, managing, or improving new or existing psychiatry GME programs. The book also has value for trainees and those interested in general psychiatric residency, sub-specialty fellowships, or academic psychiatry. The book additionally should appeal to non-psychiatrists (including non-psychiatric physicians or non-physician clinicians) teaching in psychiatric GME programs and non-physician administrators in any setting where medical education or GME is being offered or considered.

Administering a GME program is a complex task that involves meeting large numbers of requirements, managing educational and employment issues, and ensuring appropriate systems are in place, including academic- and healthcare-related systems. While there is much written on organizing, managing, and innovating psychiatry residency programs in journal articles, there is not a single reference book that compiles standard and best practices on this topic for programs, trainees, and others. To our knowledge, this book is the first of its kind to compile this content into a single, published resource in psychiatry. The chapters focus on key areas of GME program management and innovation, including meeting accreditation requirements, clinical and didactic curricula, assessment and evaluation, resident and faculty wellness, managing resident and faculty performance issues, recruitment, preparing

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residents for fellowship, research, and scholarly activity in psychiatry GME programs, rural training programs, and faculty development.

We aim to cover the core areas of day-to-day program development, program management, and program evaluation while providing pearls from established programs. This includes the vital topic of program accreditation, reviewed by Drs. Boland and Sampang. They have experience at the Residency Review Committee (RRC) level, a component of the Accreditation Council for Graduate Medical Education (ACGME). Program accreditation ensures the quality of programs and that they meet criteria set by national accrediting bodies to provide quality training and graduate physicians eligible for board certification in the specialty. A challenge for all programs is serving as the resident or fellow's employer while providing necessary education and training at the same time. Then, on top of creating proper clinical and educational programs, programs must simultaneously create an environment that lends itself to wellness and the development of habits of lifelong learning. Using example vignettes, Dr. Anzia's chapter will help us understand how to create a safe and stimulating program to promote professional and personal development.

Dr. Adams and colleagues add discussion on creating a diverse, equitable, and inclusive environment for GME training, which is vital for creating a workforce that mirrors our patients and communities and for ensuring the participation of people of different backgrounds and skill sets. Dr. Kovach and collaborators further this discussion by helping us understand the best practices for residency recruitment, while Dr. Oakman's group discusses advocacy, including advocating for issues related to social justice. Dr. Khan's group deepens this discussion by helping us understand the needs of international medical graduates, whose role in American medicine is essential and contributes to its strength and diversity.

The book also provides background on developing curricula in specific areas, including psychopharmacology, psychotherapy, research, quality improvement, and professionalism. Dr. DeJong's chapter builds on the discussion from many sections of the book by clarifying the developmental stages of professionalism and demonstrating the impact of professionalism on improving patient care. In addition, the chapter includes a discussion on harnessing frontiers of clinical innovation to teach professionalism.

The book is rounded out with a review of program evaluation, including how to manage concerns with the performance of both residents and faculty and how to negotiate for needed change and resources. Next, Dr. Young reviews the literature on developing a competency-based assessment system. Competency-based medical education continues the desire to certify physicians based on measurable training outcomes, rather than training inputs such as time in training, which has been a significant paradigm shift in the decade leading up to this book's publication. The book also reviews how to globally manage program change, with examples from Dr. Sudak and colleagues. Program change may be managed in a strategic and planned way or may occur due to a crisis such as economic, social, or public health crises, all of which are discussed in this book.

Because of its critical importance in many areas, developing the next generation of psychiatrists being the most important, GME in psychiatry must be developed with the community's needs, key partners, and trainees in mind. In addition, it is critical to thoughtfully maintain and continually adapt a GME program to ensure that it continues to optimally meet its goals. This includes staying up to date on best practices, creatively leveraging resources, and maintaining awareness of new challenges and threats. We hope this book will be a guide throughout all stages of this process.

Starting a New Program

2

Ann Cunningham, Areef Kassam, Tanya Keeble, and Bill Sanders

Overview

Nearly three times the number of categorical psychiatry programs were newly accredited in the five academic years between 2016 and 2021 than in the prior 5-year period, as shown in Table 2.1 [1]. Growth in categorical psychiatry residency development reflects the trend in numbers of medical students applying to psychiatry residency.

Sidney Weissman, MD, clinical professor of Psychiatry at Northwestern University Feinberg School of Medicine, analyzed the Match data between 2011 and 2021 and writes "the total number of psychiatric positions in the 'Match' has risen from 1,097 in 2011 to 1,907 in 2021. The total number of senior allopathic medical school graduates selecting psychiatry has nearly doubled from 640 (4.1%) of 15,588 in 2011 students to 1,205 (6.5%) of 18,435 in 2021. A similar increase has been seen in osteopathic medical school graduates" [2]. The increase in numbers of medical students choosing psychiatry residency between 2020 and 2021 was greater than that of all other specialties. Only three psychiatry positions in the 2020 National Resident Match Program (NRMP) went unfilled [3]. Psychiatry is becoming a highly desirable and competitive specialty.

Table 2.1 Growth in new psychiatry residency programs

Academic year	Number of new programs	Academic year	Number# of new programs
AY 11–12	1	AY 16–17	19
AY 12–13	2	AY 17–18	22
AY 13–14	5	AY 18–19	9
AY 14–15	5	AY 19–20	13
AY 15–16	15	AY 20–21	18
Total AY 11–15	28	Total AY 16–21	81

This chapter provides a practical overview intended to help those in the early planning stages of psychiatry residency and/or fellowship development, those programs with initial accreditation or in the early stages of an existing program, and those who are considering track development.

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Why Create a New Residency Program?

Establishing a new graduate medical education (GME) program is a noteworthy endeavor and a major undertaking. When thinking of developing a program, it is important to discuss needs, strategy, and commitment with key potential partners. Key institutional partners are identified in conjunction with your Designated Institutional Official (DIO), but these individuals may include your DIO, department chair, chief executive officer (CEO), and chief financial officer (CFO). Involving partners from the broader community such as civic leaders, other hospital system leaders, local and regional medical association leaders, and leaders from non-psychiatry departments (e.g., neurology, internal medicine, and pediatrics) is critical at an early stage. These collaborators can provide testimony about mental health shortages, advocate for psychiatric service needs in their specialty area, and secure potential funding partnerships. They may also contribute future rotation sites to the new program.

In the initial consideration of the development of the program, there are important questions to consider. Some of these questions include the following:

1. *What gap is being addressed by starting a residency program?* Most new programs develop secondary to regional psychiatry shortages. Development of a residency program attracts psychiatrists who are interested in education, research, quality improvement (QI), and other scholarly activities, enhancing the overall quality of the psychiatric care for an entire community. Some GME programs develop as sites to address the need for regional medical student core clerkships.
2. *Is there longitudinal financial support for the establishment of a residency program?* Establishing a five-year pro forma can help to concretely project costs and determine whether the program will be sustainable. The initial startup budget should include salary costs for individuals planning the program and costs for residency office space (for the residents, faculty, coordinator, and program director), meeting space for didactic education, audiovisual equipment, library facility, and call rooms.
3. *Are there board-certified psychiatrists who are passionate about teaching and the development of the program?* The hospital's medical staff needs to be engaged and supportive of program initiation. Identifying core faculty members for the development of the program and clinical faculty members for teaching and supervision is imperative. These program trailblazers will have the challenge (and joy!) of creating the foundation of the program. This team collaboration and commitment are essential for the success of the program.
4. *Are there core rotation components available for a residency program? If not, what partnerships are available to complete these requirements?* It is important to review the Accreditation Council for Graduate Medical Education (ACGME) requirements to ensure that required clinical and other educational experiences will be met within the institution or with partnerships in the community. For example, core requirements for a general psychiatry residency program currently include inpatient, outpatient, consultation/liaison, emergency, child and adolescent, geriatric, community, forensic, and addiction psychiatry, as well as neurology and primary care. There needs to be robust training for supportive, psychodynamic, and cognitive behavioral psychotherapies and combined psychotherapy and medication management to enable competence prior to graduation. If ancillary sites are utilized for rotation requirements, Program Letters of Agreement (PLAs) must be in place and submitted to the ACGME with the application for initial accreditation of the program.
5. *Is the community able to support ACGME requirements for scholarly activity or will this need significant focus prior to program development?* Development of a program and faculty scholarly culture can be challenging for

new programs, especially those in community settings. Identifying gaps prior to the formal application for accreditation enables the sponsor to proactively identify the types of scholarly activities that align with the mission of the institution and the clinical environment. Faculty working in a clinical setting may not have significant interest in traditional research, writing, or grant writing. They may be much better suited to quality or patient safety (PS) initiatives, as these activities already exist in most institutional clinical environments. Doing a full assessment of participation of potential faculty in professional organizations, committees, research, quality improvement and patient safety (QIPS), medical student education that involves curriculum development, or those who have an expertise in implementation may help identify those who can be of most help in shifting the culture toward scholarship.

6. *Will be there be community versus academic sponsorship?* There may be a local medical school interested in a relationship with the program that could range from full sponsorship/accreditation to affiliation. The benefits and costs of such a relationship must be weighed by the institution given the unique local circumstances. Clear benefits of medical school accreditation and sponsorship include applicant recruitment of those medical students highly invested in an academic-sponsored residency environment. Other benefits include state-sponsored GME funding that in many states must flow through state organizations and not to private sponsors. Other benefits include an existing scholarly culture and faculty who are invested in demonstrating scholarship as it is tied to their academic advancement. The downsides of academic sponsorship include hierarchical rigidity in developing a resident site that may be quite remote from and have significantly different local and regional needs from the sponsoring academic site. Though scholarly activity may be robust, it may not be of the kind you want to emphasize in your program, especially if your desire is to train advanced clinicians rather than to develop research psychiatrists. Aligning departmental priorities with an academic sponsor may be challenging if your site is rural and serves a different population from that seen in the academic environment.
7. *Are your faculty and institution ready to adapt and support a positive clinical learning environment?* Medical residency training culture has shifted significantly over time, and physicians trained in years past may have an outdated view of the clinical learning environment and the role of residency education. There are now ACGME expectations surrounding limits on duty hours, faculty modeling of professionalism, graded levels of resident supervision and autonomy, the need for education as a primary emphasis rather than service, resident and faculty engagement in safety and quality initiatives, and the requirement to support the well-being of our residents and faculty.

Residency Track Development

Increasingly, large academic medical centers are reaching out to rural or underserved communities to address workforce shortages. Having psychiatry residents rotate at remote sites for a brief elective rotation is unsuccessful in encouraging those residents to practice at the site postgraduation. However, developing a specific training track is much more successful in retaining those graduates into practice within the underserved community [4]. Several programs have expertise in rural, public health, or underserved track development (see Table 2.2). Determining whether to create a track or a stand-alone rural residency program will be important from the outset. Track programs have unique Electronic Residency Application Service (ERAS) identification numbers from the main program and are typically structured to allow for core rotations not available at the track site to be completed in the first 2 years of training before the resident moves to

Table 2.2 Examples of psychiatry residency track programs

Psychiatry rural/underserved track	Website
University of Washington	https://depts.washington.edu/psychres/tracks.shtml
University of Texas Southwestern	https://www.utsouthwestern.edu/education/medical-school/departments/psychiatry/education-and-training/residency-program/rpmh-track.html
Michigan State University	https://psychiatry.msu.edu/adult-residency/adult-rural.html
University of Wisconsin public health track	https://www.psychiatry.wisc.edu/education-training/residency/tracks/#public-health-track

the track site for the senior training years focused on the particular educational emphasis important for that location.

Funding Models

Understanding GME funding is essential for developing and maintaining a sustainable program. Residency program funding across specialties has some common sources and unique opportunities. Additionally, psychiatry programs in particular have some funding advantages and unique challenges compared with other specialties. The development of a new program provides specific opportunities for funding and risks of common mistakes that can affect future funding. Furthermore, established psychiatry residency training programs may have opportunities to develop new revenue streams such as clinical reimbursements and research funding. The growing focus on and importance of mental healthcare fortunately have also created some uncommon opportunities for funding a psychiatry residency training program.

The more common sources of GME funding include the federal government (Medicare), state government (Medicaid), Health Resources and Services Administration (HRSA), Department of Defense (DOD), Department of Veterans Affairs (VA), hospital systems, healthcare organizations, health insurance companies, residency clinic revenue, and other private sector funding. It is common and recommended for residency training programs to use various combinations of funding sources. Government funding through the Centers for Medicare and Medicaid Services (CMS) is the most common and consistent source of funding. It is imperative to understand the rules of CMS funding when developing a new program. For example, the rules for developing a residency program funding cap through CMS will affect the funding of the program for many years. Each funding mechanism has its own unique set of rules and regulations. Understanding these rules and regulations will help each individual program determine whether the funding is worth the requirements involved.

GME funding through CMS starts the day the residents begin their training [5]. Thus, revenue from CMS starts to become available July 1st of the inaugural year of the residency program. It is recommended to secure funding for developing the program through grants as no CMS funds will be available until the official start of the program. Startup costs to consider include program director time, costs of initial resident recruitment, application fees (e.g., accreditation application fee), residency administrator salary, updating facilities (e.g., call rooms), and time of the director of graduate medical education or DIO (administrative support for program development). CMS funding is determined by calculating the amount of time residents spend training within the residency program's internal sites. CMS will fund new residency programs in hospitals that have never had a graduate medical education department. Hospitals that had received GME funding in the past and/or have a current GME residency program will not be eligible for new GME funding. CMS determines the funding by calculating a funding "cap." The cap is calculated at the end of the fifth year of the new program [6]. In Table 2.3 below, we demonstrate the equation for cap building along with an example:

The cap will be calculated using the largest residency class within the first 5 years of the resi-

Table 2.3 Funding "cap" calculation

Largest class in the last 5 years	× amount of time spent internal sites	× years of training
Example		
10 Residents	× 90% internal sites	× 4 years for psychiatry
Equation	*10 × 0.9 × 4 =*	*36 Residents*

Table 2.4 DGME payment calculation

DGME payment	=	Total approved DGME amount (adjusted rolling average FTE count × per resident amount)	×	Medicare patient load (Medicare inpatient days % total inpatient days)

dency program's existence. That number is then multiplied by the amount of time the residents spend training within the teaching hospital or sites the training program can claim (i.e., sites without graduate medical education funding). Finally, the number is then multiplied by the number of years of the training program (4 for psychiatry residency training). To maximize the cap, it is important to have the residents train within the teaching hospital or sites so the program can claim as much funding as possible. This time would include having resident lectures on site at the teaching hospital.

GME funding is dispersed to the sponsoring hospitals and is divided into direct and indirect funding [7]. Direct GME funding is supplied to the sponsoring hospital by CMS to pay the direct expenses of residency training (resident and faculty salary & benefits, certain administrative and overhead costs). Direct GME funding for a program is calculated by multiplying weighted resident count times per resident amount times Medicare bed-day ratio (see Table 2.4). The Medicare bed-day ratio is the ratio of the hospital's Medicare inpatient days to total inpatient days. This helps to approximate Medicare's share of training costs. The weighted resident count is a 5-year rolling average of the hospital's weighted number of full-time equivalent residents in an accredited program. This weighted average is a combination of residents in their initial residency training program (counted as 1.0 FTE) and residents training outside their initial program appointment (e.g., residents doing a second residency or subspecialty fellows; counted as 0.5 FTE). The initial per resident amount is a dollar amount calculated by claimable expenses for residents during the initial year of the program divided by the number of residents in the inaugural class. This number is compared to regional averages given per resident. The lesser of the two is the number used by CMS as the per resident amount. It is recommended to spend the appropriate amount of money developing the program so that the cost is above the regional average. This strategy would ensure the program is receiving the highest funding rate possible.

Indirect medical education (IME) funding is defined as an adjustment to the teaching hospitals' prospective payment system (PPS) inpatient rates to defray additional costs of care to patients that are associated with funding training programs [6]. IME becomes part of hospital revenue, not medical education funds. However, often this funding is used by hospital systems to support medical education. Typical CMS funding is approximately one-third direct GME and two-thirds indirect GME. CMS also uses a disproportionate share adjustment for some hospitals. Disproportionate share hospitals serve a significantly disproportionate number of low-income patients and receive payments from the CMS to cover the costs of providing care to uninsured patients.

GME can also be supported by state funding through Medicaid. Many states provide support for graduate medical education through managed care contracts and fee for service. A common funding mechanism is a per resident stipend to the teaching hospital. Commonly, state-funded and state-run community mental health centers (CMHCs) are opportunities for psychiatry residency program training. CMHCs will typically cover the cost of the overhead, while residents spend time providing valuable care to a vulnerable patient population. States can also leverage Medicaid funding for innovative training programs such as rural and urban track programs.

HRSA grants are available to support the development of behavioral health training programs mainly focusing on rural and inner-city

healthcare development. HRSA grants typically focus on primary care training; however, behavioral healthcare training is considered within the Teaching Health Center Graduate Medical Education Program. These federally qualified health centers (FQHCs) can provide excellent training environments while covering overhead costs and allowing the residency program to claim the residents' time on their cost report.

The Department of Veteran Affairs (VA) is a common training site for residents. The VA provides funded GME positions for thousands of residents across the country. VA training allows residents to provide meaningful care to veterans but typically does not offer the diversity of patients and training environments to provide a complete residency experience. Therefore, many VA programs affiliate with academic programs. The VA can provide a unique funding opportunity for established residency training programs that are over their "cap." The VA will support the direct costs and overhead of residents who spend time training in the VA when programs are over their "cap." The VA, however, will retain the IME funding. Therefore, this opportunity would be less beneficial for programs that are under their cap number. In this case, it would be preferable for the training program to retain all the funding (both direct and indirect).

The Department of Defense (DOD) also supports many ACGME training programs. These training programs are focused mainly on three branches of the military, namely, the Army, Navy, and Air Force.

Private insurance companies occasionally provide additional funding for graduate medical education programs. It is advisable to meet with insurance companies and negotiate reimbursement rates and contracts. Residency training programs can provide increased access to high-quality patient care and justify enhanced reimbursement. There is typically a shortage of psychiatric providers in communities, and residency programs that have an outpatient clinic can negotiate favorable rates to help support the expense of medical education. Many psychiatry residencies have reported the development of funding opportunities through collaborative/integrated care and telepsychiatry, especially to rural areas.

Philanthropy can also be an important resource for supporting the development of a psychiatry GME program. It is common to explore philanthropy and grants to cover startup costs. Private and public donors can support many opportunities in graduate medical education such as the development of clinics, updating facilities, purchasing electronics, external rotations, international rotations, and endowed chair positions. Consulting with your organization's foundation or administrative leaders can provide information regarding donor and philanthropic opportunities.

"Right Sizing" Your Program

When developing a training program, it is important to have a vision and a best-guess end goal in mind for what the program would like to accomplish. A solid understanding of the strengths and weaknesses of an organization can help guide the size of the program. The number of residents in the program might vary depending on the training environment. An organization with a 200-bed psychiatric inpatient unit with 20 psychiatrists will have different resources and opportunities compared to a program with a 20-bed inpatient psychiatric unit and 2 psychiatrists. An organization with a large outpatient or multiple outpatient clinics with 40 psychiatrists will likewise have different opportunities compared with a program with 4 outpatient psychiatrists. Also, residency programs that have more intensive overnight call schedules may require more residents to maintain resident wellness by dividing call responsibilities among a larger pool of residents. Programs that have a limited number of supervisors may not be able to support a larger number of residents.

To balance financial sustainability with appropriate supervision, outpatient residency clinics typically require faculty to resident ratios that vary between 1:3 and 1:5, depending on the residents' level of training. Another consideration will be how many residents may fast track into a fellowship program, thereby losing senior-level residents. If the psychiatry program has a child and adolescent fellowship program, it will be important to consider attrition of residents into the fellowship. The development of a psychiatry residency training

program will initially require significant resources and energy; however, once fully developed, the program can provide significant benefits and resources to an organization. It will be important to carefully consider what will be the ideal balance of service and education to maintain a safe and quality educational environment that supports resident and faculty wellness [8].

When considering the application for initial accreditation of the program, the ACGME will evaluate the scope of resources available to educate residents and meet the Common Program Requirements (CPRs). The ACGME typically approves programs and positions if there is demonstration of a safe academic environment with adequate faculty, facilities, and resources. Furthermore, the ACGME is motivated to increase residency training opportunities given the increased need for physicians and the significant increase in the number of graduating medical students. The ACGME is responsible for approving the number of GME slots available, but they do not determine funding for those positions. It is recommended to request as many positions as necessary as the program is not required to fill all positions. When starting a new program, it might be determined that a smaller class is required for a couple of years while the foundation and structure of the program are being developed, before growing the class size to that accredited by the ACGME.

Rightsizing a residency program can provide a great benefit to residents, faculty, the organization, and the community. A residency program that is built beyond its resources will struggle to provide adequate education and supervision, and this will negatively affect patient quality and safety. A program that has too few residents could put added pressure on the residents to cover clinical responsibilities, thereby affecting resident wellness.

Mission and Vision of Your Program

When starting a new program, it is imperative to develop a mission and vision with subsequent detailed aims. The defined mission and vision will be a guiding compass for faculty recruitment, resident recruitment, curriculum, and the development of the program. The aims provide a roadmap for sustaining and advancing your program. The mission, vision, and aims help to define what kind of graduates you intend to produce and for what kind of settings and roles. They also help to differentiate the program from other programs in the same specialty. The mission and vision will continue to serve as the shared focus for the direction and growth of the program.

A mission statement focuses on your program's core purpose, focus, and aims in the current state (here and now). To be relevant, the program's mission statement needs to be an extension of your department or division and sponsoring institution's mission. An effective mission statement is succinct, outcome oriented, and specific to your program. As an example, the mission statement for the ACGME [9] reads as follows:

> The mission of the ACGME is to improve healthcare and population health by assessing and enhancing the quality of resident and fellow physicians' education through advancements in accreditation and education.

A vision statement is aspirational and articulates how the program hopes to evolve over time (future). The vision statement should be rooted in the mission of your program. Here is the opportunity to think big about future goals—dare to be bold. The vision statement should be inspiring and uplifting and broad and inclusive and embody core ideology. As an example, the ACGME's vision statement [9] is as follows:

> We envision a healthcare system in which the Quadruple Aim* has been realized. We aspire to advance a transformed system of graduate medical education with global reach that is:
>
> - Competency-based with customized professional development and identity formation for all physicians.
> - Led by inspirational faculty role models overseeing supervised, humanistic, clinical educational experiences.

- Immersed in evidence-based, data-driven, clinical learning and care environments defined by excellence in clinical care, safety, cost-effectiveness, professionalism, and diversity, equity, and inclusion.
- Located in healthcare delivery systems equitably meeting local and regional community needs; and,
- Graduating residents and fellows who strive for continuous mastery and altruistic professionalism throughout their careers, placing the needs of patients and their communities first.

Once the mission and vision statements have been created, it is important to develop aims. The ACGME WebAds© system requires aims, both for a new program application and as part of subsequent annual reviews for an established program. The ACGME requests that programs provide aims (e.g., goals and objectives) that are guided by the mission statement. The program aims should describe what the program intends to achieve in accordance with the Common Program Requirements. Aims should be consistent with the overall mission of the sponsoring institution, the needs of the community and graduates it serves, and the distinctive capabilities of its graduates (e.g., leadership, research, public health). The aims should be defined and reviewed as part of the annual self-improvement process discussed by the Program Evaluation Committee (PEC) and articulated in the annual program evaluation. Aims may change over time in response to factors such as advances in the field, new training opportunities, or new demands on physician workforce. Three to five discrete aims should be clearly identified with defined SMART goals (i.e., goals that are specific [who and what], measurable [measurement that gives feedback on progress], achievable [based on institutional or regional resources], relevant [to the community setting in which the program is located], and time limited [realistically identified time frame for completion]).

When defining the mission, vision, and aims for the program, it is important to include input from key faculty and program, departmental, and institutional leadership. Creating a faculty development session to draft the mission, vision, and aims is a great team building activity and creates solidarity around a guiding compass for the direction of your program in the current and future states.

As part of such a faculty development event, breakout sessions to examine the key questions listed below are an excellent strategy for promoting engagement, dialogue, and inclusion of multiple perspectives:

Who are we?
What basic needs do we have?
What structures need to be in place to meet these needs?
What are our guiding principles?
How should we respond to our key collaborators or partners?
What makes us unique?

Once these questions have been discussed, breakout groups can draft the mission statement, vision statement, and aims, which can then be shared, edited, and combined within the larger group. These statements can then be vetted by key partners within your institution (typically Designated Institutional Official (DIO), department chair) for approval. This process fosters engagement of faculty and key leadership in the foundational elements of mission, vision, and aims for the intentional and strategic development of a new program.

Useful Mission and Value Resources:

https://www.acgme.org/Portals/0/PDFs/SelfStudy/SSAimsIPLK.pdf
https://www.acgme.org/About-Us/Overview/Mission-Vision-and-Values/
https://www.hrsa.gov/sites/default/files/advisorycommittees/cogme/COGME%20Meetings/2016/20160407-hrsa-carter.pdf

Successful Collaboration Within Your Sponsoring Organization

Strategic placement of residents in your sponsoring institution's GME residency programs and clinical services increases the likelihood that you will be considered critical to the operations and mission of the organization, which, in turn, enhances long-term residency sustainability. Programs that have achieved success in this area include those that have implemented brand-new paradigms of care or services that have not previously existed. These include integrated care models in the primary care setting, hospital-based addiction consultation, and rural telepsychiatry.

In developing services that align with the hospital mission and strategic priorities, you are often partnering with productivity-based non-teaching departments and clinical services in a community-based psychiatry setting. You can embed strong evidence-based rotations and residents who can then be easily hired into the organization following graduation. Identifying an unmet service need is helpful in creating a niche area that has not previously been addressed. This also has the added advantage of involving partnering across specialties (e.g., primary care, hospital medicine, surgery). Collaboration with those departments creates further goodwill, visibility, and advocacy.

Example

At one community-based psychiatry residency, there had previously been no embedded primary care behavioral health. The developing psychiatry residency program identified this gap and partnered not only across the GME Internal Medicine and Family Medicine programs but also into the organization's primary care environment to implement and expand collaborative care over the next 5 years. At the same time, Medicaid expansion in the state required integrated behavioral health in the primary care setting. This enabled the psychiatry residency program to harness additional funding to expand faculty positions to supervise residency rotations providing consultation to these primary care sites.

Creation of new rotations or services that train psychiatry residents in an interprofessional setting is another way to demonstrate value to the sponsoring organization. Interprofessional rotations including psychiatry residents, social work students, pharmacy students, and psychiatric advanced practice nursing (APRN) students are educationally valuable for psychiatry residents, provide much-needed clinical placements for other learners, and help the sponsoring organization to recruit well-trained professionals from a variety of highly sought-after disciplines.

Collaboration with other GME programs such as family medicine, internal medicine, or pediatrics can benefit all programs involved. Examples of this are training primary care residents in consultation psychiatry by embedding them on the primary psychiatry consultation liaison service for a required residency rotation or training family medicine residents in collaborative care during residency. These residents often take hospitalist or ambulatory positions at the organization and can advocate for continued access to those models of care, bringing value to the psychiatry residency program that trained them.

Development of strategic GME or sponsoring institution partnerships across common program required areas such as quality improvement (QI), patient safety (PS), and well-being, which enable mutually beneficial work to be done.

Example

One program with success in this area developed a new telepsychiatry service to a rural part of the state and at the same time created a quality improvement project based on that work. The QI project involved residency and non-residency partners, won an institutional quality improvement award, and generated significant scholarly activity for all members of the team, who went on to create posters, present workshops, and speak nationally about this project. Most importantly, the project enabled access to specialty mental healthcare for a rural underserved population.

Community Relationship Development

Developing and growing community relationships can significantly improve the quality of a psychiatry residency training program. A psychiatry program can also transform behavioral health throughout a community. Residents can improve access to care throughout the community during training by providing direct patient care. In addition, residents may practice in the community after graduation, further improving access to behavioral healthcare over time. The Association for American Medical Education (AAMC) data show that 54.2% of all residents remain in the state where they train [10]. Further, providing residents with multiple experiences in the community improves the likelihood they will remain to practice in a variety of settings they have developed familiarity and comfort with during training.

There are often several known, as well as unknown, private and public programs in a community that can help support a residency. It is useful for residency program leaders to contact as many medical and behavioral health organizations as possible to learn about all the opportunities available for training residents. Some external organizations will be able to provide unique medical and behavioral health training experiences such as maternal mental health, neuropsychology clinics, mental health courts, autism spectrum disorder programs, and collaborative care. Such organizations may be willing and able to provide resources such as volunteer faculty and funding to help support the residency training program. Fostering relationships with community partners can be one of the most enjoyable activities for program leaders. Developing these relationships and experiences diversifies and enhances the quality of the residency training experience.

Partnering with other organizations and utilizing volunteer faculty can provide the added benefit of relieving some of the burden on the program's core faculty. Faculty often balance clinical work with non-reimbursed teaching. Supervising and teaching residents are an enjoyable experience if faculty have reasonable time commitments. Faculty can experience a sense of burnout and lack of appreciation if they are overly burdened with resident training activities, especially uncompensated expectations. Residents learn new and innovative processes, procedures, and techniques while rotating at external sites, which can help foster quality improvement within the organization that sponsors the residency training program. Residents also provide great advertisement for the external organizations within their home institution. External organizations will often value having the opportunity to recruit residents that rotate through their facility. Psychiatrists and other clinicians in the community often value and find meaning in teaching. The benefits of program–community relationships provide a quid pro quo relationship with community partners. They help community partners recruit psychiatrists, improve community psychiatrist morale, and improve access to behavioral healthcare. In return, they help add more teaching faculty for the residency training program, provide unique training opportunities, and improve the quality of the training program.

Residents learn a lot by spending time at multiple organizations. They are exposed to multiple practice styles, electronic medical records, and unique specialty clinics. Residents have an opportunity to learn which type of hospitals, clinics, and specialties they enjoy the most. Spending time in the community prepares residents for the flexibility necessary to be successful in the current medical environment. External rotations often expose psychiatry residents to practice styles and settings with varying patient acuities, patient volumes, clinical responsibility, and productivity requirements. These experiences can help improve the resident's understanding of the pace of clinical psychiatry after residency.

While external rotations can be great experiences, it is important to monitor external sites regularly. Providers at external sites will need an orientation to the rules and regulations for supervising residents, rotation goals and objectives, and program expectations. It is recommended that regular meetings take place with leadership

and supervisors at the external rotations to enable bidirectional feedback and response to areas for improvement. It is also valuable to invite external volunteer faculty to residency activities such as case conferences, journal clubs, and grand rounds. It is recommended to limit the distance a resident needs to travel for external training experiences. Some external rotation experiences are extremely valuable or necessary and worth the travel time. The residency program can consider easing the burden of travel with a stipend for travel expenses, building travel time into the schedule, creating virtual experiences to minimize travel, and arranging for lodging at the rotation site.

Development of community relationships can also help with recruitment of medical students to the residency training program. Medical students interested in psychiatry value a diverse and comprehensive training program, with a focus on evidence-based care. The varied training locations and educational experiences can further help residents discern which area of psychiatry they will want to practice. Thoughtful planning of external rotations can provide job opportunities for residents without impacting the residency program faculty recruitment needs.

Faculty Recruitment and Retention

Nearly 76% of residency directors and 69% of fellowship directors report challenges in recruiting and/or retaining teaching faculty [11]. Modifiable challenges are centered around noncompetitive pay compared to the private sector, increased total (clinical, educational, administrative, and scholarly activity) workload in academic settings relative to practice in the community where workload demands often only involve clinical care, chronic short staffing leading to a vicious cycle of difficult recruitment and retention, and uncompensated teaching time [11].

In determining the best faculty salary model in a new program, it is critical to understand common GME compensation models [12].

1. *100% Salary Model*

This model is one in which faculty receive a fixed salary with a retirement and benefit package and no or small additional financial incentives. This model is common at many large academic medical centers where salary is tied to academic rank. In academic settings, salaries are generally lower, but retirement and benefits can be substantial. Ways to compensate for salary gaps relative to community practice include dedicated administrative time, faculty development funds, using an educational value unit (EVU) system to recognize and reward teaching, reduced clinical relative value unit (RVU) expectations, and providing protected time for scholarship. Departments can also develop specific faculty pathways, such as faculty scientist, clinician educator, and salaried clinician pathways with distinct expectations for performance and promotion and mentorship and career development support.

2. *Salary Plus Incentive (Hybrid) Model*

This model has a base salary with additional income available for components that are "on top" of the minimum job requirements for program faculty. The benefits of this model are that it allows for job role choice and allows faculty to augment the base salary in a flexible manner. This model financially incentivizes certain ACGME Common Program Requirement (CPR) behaviors, enables faculty to focus on areas of work that are most satisfying to them, and allows them to receive additional compensation for work that directly benefits the program. This model is more common in community-based residency environments, where a shift to an academic culture may need to be cultivated over time, by financially reinforcing ACGME educational and scholarly job functions that go above and beyond those typically encountered in community clinical positions.

The following are two examples of salary plus incentive models from recently developed successful community programs.

New Community Program #1

- *Base salary*
  - Fifty percent Medical Group Management Association (MGMA) median *"psychiatry faculty" salary*/50% MGMA *median "general psychiatry"* salary
  - Past 3-year rolling average data used to create median salary for the upcoming year to account for salary variations that may include salary decreases in some specialty areas
- *Teaching tier*
  - Time in teaching position model where salary increases by the number of years of residency and/or medical student educational experience
  - Tier 1, 0–2 years; tier 2, 3–6 years; tier 3, 7+ years
- *Quality and service incentives*
  - Aligned with the Accreditation Council for Graduate Medical Education (ACGME) faculty Common Program Requirements (CPRs) for faculty and program scholarly activity expectations
- *Additional call pay*
  - $/24 shift on weekend and official holidays
- *Transparency and equity*
  - No gender differences, no fellowship-based differences, no hospital versus ambulatory setting differences
- *Program director/associate program director stipend* to recognize and compensate for leadership responsibilities

New Community Program #2

- *Base salary*
  - Independent salary data review occurs annually to keep up with psychiatry salary trends and community salaries
- *Productivity above base* salary
  - productivity incentivized above base productivity expectations
- *Quality bonus*
  - Incentivizes ACGME CPR behaviors
- *Compensation (a la carte)* for additional educational activities that benefit the program
  - For example, creation and facilitation of seminars, on-call responsibilities, scholarly activity participation, resident supervision, educational program leadership, committee participation/leadership, residency recruitment (interviewing)

Table 2.5 common GME compensation(base salary chosen entirely for simplicity of calculation)

Tier definition	Assistant 0–2 years	Associate 3–7 years	Full 7+ years
% Above median	Median	105% of median	110% of median
Base	200	210	220
Quality & service (10% median salary at all levels)	20	20	20
Compensation	220	230	240
Call/year	10	10	10
Total compensation	230k	240k	250k
Increase from current	%	%	%

An example of salaries and salary composition for faculty members at different ranks in a hybrid model is shown in Table 2.5.

3. *Pure Productivity*

This model is a structure typical in most private or community employers across the country. Income is determined by work relative value units (RVUs), net charges, or net revenues. This structure creates a competitive environment with less predictable income and less dedicated time for teaching. Patient volumes can fluctuate significantly, and the emphasis is on clinical service

and typically needs to meet all patient care needs in the organization. This model leads to high clinical service experience for residents but may have the disadvantage of a lower emphasis on education with reduced faculty time spent teaching.

Multiple salary resources exist that can help with data collection when setting salaries and determining the model that works best for your program and employer (see Table 2.6).

Table 2.6 Salary information resources

Resource	Pros	Cons
MGMA	Most comprehensive, gold standard	Expensive to obtain report
AAMC	Best for academic departments	Not a good private practice measure
Merritt Hawkins	Based on Internet posted jobs	A lot of data to decipher
Medscape	Surprisingly accurate	Survey of members. Generalizability to educational setting may be limited
Salary.com	Largely based on online postings, provides information on large numbers of specialties	Source lacks context or explanation
Doximity	Geographically strong, based on physician self-report	Self-reports can be misleading
Medical Economics Annual Report	Physician-led information	Low number of participants
US Bureau of Labor and Statistics	Large number of federal jobs	Salary is low compared to national averages
Graduating Residents	Current year salary data for first jobs	Not as accurate for more mature positions/faculty depending on structure
Job Fairs	Real-time information from a live person	Information often censored to impress candidates
New Hires	Current year salary data	May conflate information to enhance competing offers

In a 2018 survey of 722 American Association of Directors of Psychiatric Residency Training (AADPRT) members, the top 3 identified needs of GME teaching faculty were more protected time (48%), teaching skills workshops (38%), and mentorship (16%) [13].

Several residency programs have addressed the challenge of faculty mentoring and retention in creative ways. The following are two examples, one from a major academic program with new track development and the other in a new small community program.

Example #1: Large Academic Program With a New Regional Track

This program has the challenge of being part of a large, multi-site academic department and has a new community-based regional track geographically distant from the core program.

At the core site, this program had developed several programs to enhance faculty mentoring and retention. These included a mentoring and career development program, in which each faculty member is assigned a mentor and meets with that mentor at least every 6 months to assess progress and set goals toward promotion using a templated individual development plan (IDP).The mentoring program offers information, support, and career development guidance.

The program developed site-based groups to support career development for junior faculty. These include a successful peer mentoring group available to clinician educator faculty, with a regular cadence of meetings and food provided by department. Each meeting includes member check-in, discussion of any career-related topic, support, feedback, advice from peers in the meeting, setting action plans, and accountability [14].

The program also worked to foster a sense of community for teaching faculty, including annual teaching retreats.

With the development of the new track, the program needed to consider ways to foster community and faculty development at a distant site, as well as a feeling of connection with the core program. Faculty of the new regional track were invited to participate in the annual teaching retreat in person or virtually. The program director collaborated with the regional track director to design and deliver specific faculty development sessions for regional track faculty before any track residents started at the regional site. These sessions were designed for faculty new to residency education. Faculty from the core program, including the associate program directors, participated in teaching these sessions and met with regional track faculty. The program director also negotiated teaching time for regional track faculty as part of the track development process, ensured that they had clinical faculty appointments, and oriented them to the program, department, and resources of the sponsoring institution that they could take advantage of (e.g., library resources, online grand rounds). Based on a needs assessment of the regional track faculty, the program director and regional track director made a plan for ongoing faculty peer mentoring groups at the regional site, focused on the needs of track faculty, and ongoing collaboration and sharing of teaching and supervision approaches between core site and regional faculty.

Example #2: New Non-academic Medical Center Accredited Community-Based Program

This program developed its faculty structure as it began initial recruitment into the program. Most faculty come directly from residency or fellowship training.

Initial program development of faculty positions included protected time for the work of administration, rotation, and seminar implementation and teaching. All faculty have the opportunity to receive a 0.6 full-time equivalent (FTE) clinical position with 0.4 FTE administrative and teaching time. Faculty who prefer higher clinical education care responsibilities over administration can choose a higher clinical FTE with less administrative FTE. This allows flexibility in job roles, enhancing job satisfaction and faculty retention.

Every new faculty receives weekly program director mentorship for the first year post hire. This enhances early career support, enables faculty to select administrative and leadership interests based on identified program needs, and allows the program director to work with faculty to set goals and then track progress. After year 1, faculty move to a biweekly and then monthly mentorship model. A benefit of this model is that the program director and faculty develop a collaborative relationship, enhancing whole faculty team functioning, since time is also spent discussing family, stressors, well-being, and outside interests.

This program intentionally worked on development of a culture of trust and teamwork through biannual retreats, biweekly all-faculty administrative meetings, biweekly peer-led faculty development, and, in the initial stages of faculty build, recruitment dinners to meet new faculty candidates.

Utilization of the Institute of Healthcare Improvement (IHI) open school faculty development courses in quality improvement and patient safety has led to robust individual and programmatic knowledge and skill set in this scholarly activity and led to collaborations across GME departments and interprofessional collaboration at the home hospital institution. Following Shanafelt's research, it has been found that

providing faculty with at least one day per week on an activity that is personally meaningful reduced burnout by half [15], and this program has encouraged and supported faculty in critical curricular or rotation development of particular interest to them. Examples have included integrated behavioral health, telepsychiatry, low threshold addictions, transplant, addiction consultation services, and psychotherapy seminars and rotations.

Working with physician recruitment is an often-overlooked area essential for strong recruitment of energetic and good fit faculty. Tips for success include relationship building with your recruitment department and specific personnel assigned to recruitment of your faculty positions. Involving and including recruitment partners in residency program strategic planning can be very helpful in enabling them to market your positions effectively and be invested in program success. Involving recruitment proactively in physician contract negotiation and salary adjustment can be helpful.

ACGME Application

Developing an ACGME application submission for accreditation of a new program is an investment of time, energy, and thought. However, there are many tools and resources available to make this process more efficient, less complicated, and more effective. Membership in American Association of Directors of Psychiatric Residency Training (AADPRT) and Association of Academic Psychiatry (AAP) can assist greatly with mentorship by experienced program directors/faculty, access to resources for the creation of the application (such as the AADPRT Virtual Training Office), and networking opportunities with other program directors and faculty who have recently undergone new application submission. These organizations are very collaborative and willing to share resources, tools, and support to assist with the development of the program and application.

Generally, approximately 1 year is needed for preparation of the application, site visit completion, and the accreditation decision. The ACGME Psychiatry Review Committee (RC) announces the next Review Committee agenda closing and meeting dates. Of note, the application submission, scheduling of the site visit, and site visit completion must occur prior to being placed on the Review Committee agenda. Submitting the application at least 3 months prior to the agenda closing date is generally recommended. The Psychiatry RC staff members can be contacted for a recommended timeline of submission to allow for any delays in application reviews and scheduling (such as holidays). It is strongly recommended to contact them for confirmation of the application timeline so that you know when you can aim for recruitment of residents for the program.

When initiating an application for accreditation of a new program, it is essential to review the ACGME instructions. These outline information to be submitted in WebADS® that is common to all applications, such as program director and program coordinator information, rotation site details, faculty member information, and information regarding expected duty hours and overall evaluation methods of the program. There are separate PDF uploads for a variety of documents, such as policies, goals for the program, Program Letters of Agreement, evaluations, and a block diagram of rotations. Additionally, the program-specific application is required and can be downloaded from the ACGME Psychiatry RC website. Reviewing all of the necessary items for completion from the onset of application development will help to develop a strategy for completion and ensure all necessary elements are addressed.

The ACGME Psychiatry RC requirements and frequently asked questions (FAQs) on their website are an absolute MUST for a thorough, detailed review [16]. Pay close attention to the words “must” and “should” to ensure compliance with the requirements. The program director needs to ensure that all of the ACGME requirements are met within the program, demonstrated