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Health Issue Brief

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Addressing California's Psychiatrist Shortage Through Graduate Medical Education Expansion

Psychiatrist shortage in California: A problem of supply, distribution, and diversity

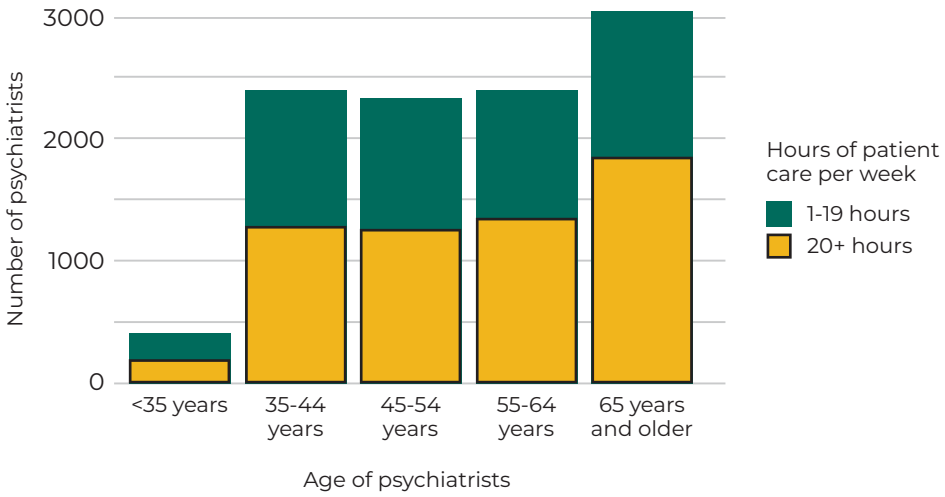
Demand for behavioral health care in California has grown substantially in recent years for multiple reasons, including increased awareness, decreased stigma, overall population growth, and increased prevalence of behavioral health issues during the COVID-19 pandemic. Despite efforts to increase the supply of behavioral health care providers, demand still significantly exceeds supply. The California Future Health Workforce Commission highlighted the behavioral health workforce as one of its three key focus areas in need of immediate attention. (CFHWC 2019).

Psychiatrists are essential members of the behavioral health workforce because of their unique role as licensed physicians who can address behavioral health issues across the spectrum of severity.

Psychiatrists are essential members of the behavioral health workforce because of their unique role as licensed physicians who can address behavioral health issues across the spectrum of severity Their treatment plans can include engaging patients in psychotherapy, prescribing medications, caring for people who are seriously mentally ill, admitting patients to the hospital and issuing confinement orders when necessary. The current supply of psychiatrists in California is insufficient to meet the needs of the population. By 2028, California will need about 6,515 psychiatrists to maintain current access and utilization (Coffman 2020). Yet, as of 2020, only 4,666 psychiatrists were providing patient care at least 20 hours a week in California. This gap is projected to widen, with nearly a quarter of the current workforce already eligible for retirement.

In addition, the existing workforce might be insufficiently prepared to address the specific patient populations requiring psychiatric services. Recent research suggests that a shortage of youth-serving psychiatrists across the United States is driving undertreatment, despite about half of psychiatric disorders beginning before age 14 and three-quarters by the age of 24 (Brenner et al. 2017; Ilango et al. 2020). Children and youth have unique complexities and challenges related to diagnosis and management of behavioral health conditions including co-morbid attention disorders, developmental delays, age restrictions on medications, consent for treatment, engaging parents, caregivers, social services, and schools. Lack of adequate treatment affects children's educational, social, and emotional development, creating problems that can multiply as they grow. Older adults likely are also underserved because of an increased demand for geriatric psychiatry services, although the availability of geriatric-focused psychiatrists has been insufficiently assessed (Brenner et al. 2017). Behavioral health diagnoses and management can be particularly challenging in older adults due to medical and cognitive comorbidities and polypharmacy.

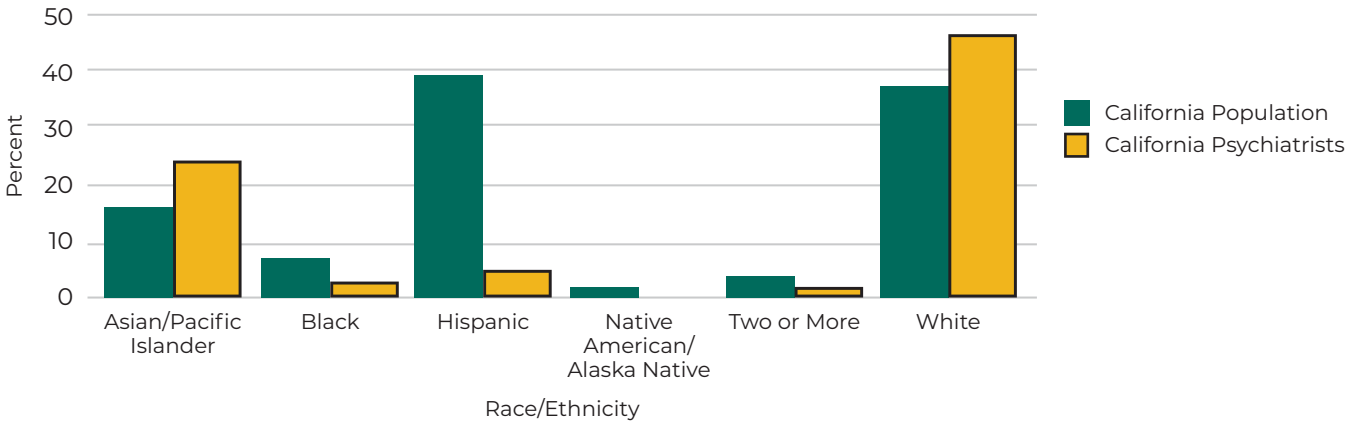
Psychiatrists providing patient care in California, by age



In California, costal and urban areas have higher supplies of psychiatrists per capita than inland and rural areas. Some small counties have no psychiatrists (Coffman 2020). Nationally, rural and low-income communities experience the greatest unmet mental health needs (Thomas et al. 2009). California's population is moving away from rural regions and toward suburban and urban regions, which could perpetuate a cycle of underservice in rural and remote regions (Johnson et al. 2022).

Despite growing evidence that racial and ethnic concordance between physicians and patients contributes to positive health outcomes (Roberts et al. 2014), the racial and ethnic distribution of California's psychiatric workforce differs substantially from its population (Coffman 2020). White and Asian or Pacific Islander psychiatrists are overrepresented compared with California's general population. Psychiatrists who are Black, Hispanic, Native American and Alaska Native, and

Race and ethnicity of California's psychiatric workforce compared with the state's general population



Source: California Medical Board Data 2020 and Census Bureau QuickFacts 2021.

two or more races are underrepresented, which has important health implications for California's increasingly diverse communities.

Expanding psychiatry graduate medical education in California: An essential part of the solution

The largest influx of new psychiatrists working in California comes from training new doctors, the last stage of which is residency training, an apprenticeship-like program also referred to as graduate medical education (GME). Medical school graduates apply to residency programs in which they receive supervised and specialty-specific on-the-job training before they can be licensed by the state and begin working independently. General psychiatry residency is a four-year program, with opportunities for subspecialization through additional years of fellowship training in focused areas such as child and adolescent psychiatry, forensic psychiatry, and addiction medicine.

Admission to psychiatry residency has become extremely competitive in recent years, and there are more medical school graduates applying than available residency training positions. ◢

In parallel with recent shifts in behavioral health among the public—including increased behavioral health awareness, decreased stigma, and increased morbidity during the COVID-19 pandemic—newly minted physicians are increasingly interested in pursuing psychiatry as a specialty. Therefore, admission to psychiatry residency has become extremely competitive in recent years, and there are more medical school graduates applying than available residency training positions This has created a bottleneck in training of the psychiatric workforce in California and across the United States. Sub-specialty fellowships are not as popular, however, possibly because of the increased training time, low salaries during fellowship, or the lack of income differential for those who subspecialize compared with those who don't.

Underrepresentation of Black, Hispanic, and Indigenous people among psychiatrists is largely due to underrepresentation among people admitted to medical school. Efforts to increase demographic representation within residency programs, and ultimately the psychiatric workforce, must begin with medical school admissions.

To increase the number of psychiatrists in California, more psychiatry residency positions must be created. Although there has been some recent progress in this area, much more is needed. In 2011, there were 20 residency programs admitting 123 physicians for psychiatry or combined psychiatry training (for example, combined training in psychiatry and family medicine). Over the past decade, 1 program closed and 14 new programs were established, so that in 2021, 33 residency programs admitted 196 physicians for psychiatry or combined psychiatry training. This represents a 70 percent increase in the number of psychiatry residency programs with a 35 percent increase in the number of physicians being trained annually. Much of the increase in psychiatry positions over the past decade occurred because of private hospitals launching new psychiatry programs. In 2011, 73 percent of psychiatry residencies were in public hospitals, sponsored by the public health system or, more commonly, the University of California Medical Centers. By 2021, despite the increase in training among all systems, 66 percent of psychiatry residencies were located in public hospitals and 34 percent in private hospitals. Despite these increases, there is still a large deficit of practicing psychiatrists in the state. Furthermore, this deficit is expected to grow as the population increases and a large part of the current psychiatric workforce retires, necessitating a continued drive to produce new psychiatrists.

Most of California's psychiatry residency programs are in the Greater Bay Area or in the metropolitan areas of Southern California (Coffman 2020). When psychiatrists train in major cities, most find their initial employment in nearby urban centers (Brenner et al. 2017). Because of the recent launch

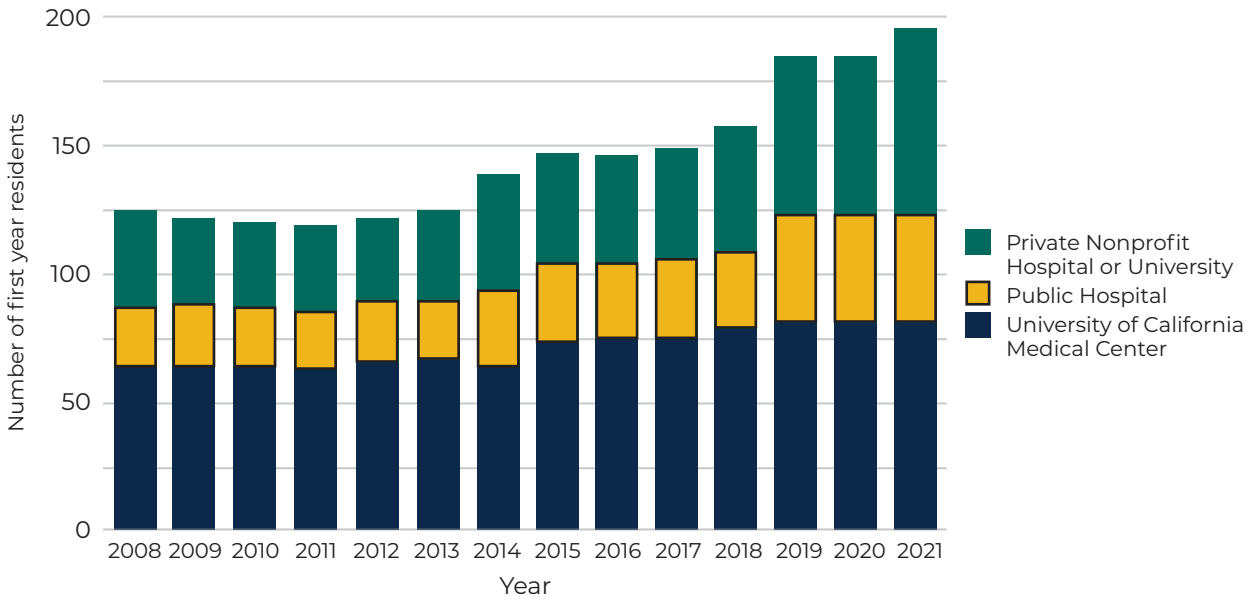
of new GME programs among private hospitals, however, psychiatry residency programs have become more evenly distributed across geographic regions of California. Although there still aren't any training programs north of the greater Sacramento area, the Central Valley and southern regions of the state both increased the number of psychiatry residents trained locally. This is important because research has shown that physicians tend to practice relatively close to where they finish their residency training (Fagan et al. 2015). By increasing training opportunities into more geographically diverse areas, graduates are more likely to remain in those areas and ultimately provide more access to care in these underserved areas.

Expanding psychiatry GME in California: Challenges and opportunities

There are two ways to increase the number of psychiatry residents training in California: establish new psychiatry programs, and expand the number of positions offered at existing psychiatry programs. Each approach has its benefits and challenges and both require substantial investment. Increasing residency positions in any specialty requires funding. Psychiatry is often perceived as a department that loses hospital revenue while some specialties, such as orthopedics, can offset training costs through revenue-generating procedures. However, hospitals that successfully launch new psychiatry programs describe substantial indirect financial benefits. For example, hospitals creating new residency programs note that recruitment of psychiatrists becomes relatively easy and less expensive. Other benefits can include reduced emergency room visits and shorter hospital stays, improved management of chronic disease or withdrawal, and lower costs associated with damages or staff paid time off because of disruptive or aggressive patients.

Launching new psychiatry residency programs in hospitals that have never sponsored GME of any kind allows for an influx of federal Medicare GME funds to help sustain the program over time. However, establishing new psychiatry programs in GME-naïve settings is an enormous effort requiring substantial start-up funding, dedicated leadership,

Number of first-year psychiatry residents by program ownership



Source: National Resident Matching Program Data, California 2008 to 2021.

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development of didactic curriculum, establishment of clinical rotations – which often require external partnerships – and a major shift in organizational culture. Perhaps the biggest obstacles are finding an experienced program director willing to champion a new program, and recruitment of qualified faculty from a field that is already experiencing a severe shortage.

Expanding the number of psychiatry training positions in well-established residency programs across the state is a quicker and simpler route to GME expansion. Some established programs can fund this expansion out of their operating budget or through community benefit funds or philanthropic donations. Other hospitals require substantial ongoing financial support. California's two major state sources of residency training funds, the Song-Brown program and CalMedForce, do not fund psychiatry residencies. Currently, the statue authorizing the Song-Brown program does not permit the funding of psychiatry residencies and would require new legislative authority. CalMedForce allows for funding of shortage specialties but is also mandated to fund five core specialties (emergency medicine, family medicine, internal medicine, obstetrics & gynecology, and pediatrics). Funding of additional specialties would require additional funding or reduce the amount available for existing programs. California does have one grant program, the Psychiatric Education and Expansion Program (PECE), that can be used to increase the size of existing psychiatry residencies and/or fellowships or offset costs associated with creating a new residency program.

Beyond the financial obstacles, programs interested in expanding must ensure they have the capacity to properly train the larger number of residents. This means recruiting more faculty to maintain an adequate faculty-to-resident ratio; identifying and, as necessary, partnering to provide the appropriate number and breadth of training experiences; and obtaining or building sufficient space for resident call rooms and workstations. Compared with other medical specialties, psychiatry residency programs require a greater number of resources dedicated to the didactic curriculum and to resident supervision.

Expanding psychiatry GME in California: Looking ahead

California is experiencing a shortage of psychiatrists, which is expected to worsen over time. The shortage is especially severe for certain geographic regions, such as rural areas of the state, and for certain populations, such as children and adolescents and geriatric patients. Additionally, the current psychiatric workforce differs significantly from the population it serves.

Though there are several strategies to alleviate the shortage, this report focuses on one critical mechanism to increase the number of psychiatrists in the state: expanding GME capacity. The number of California psychiatry residencies has increased in recent years; nonetheless, there is a need for further GME expansion both to meet the growing demand for mental health care and to replace an aging workforce. There is also a need for increased advocacy, not just for general psychiatry residencies but also for fellowships in child and adolescent psychiatry or geriatric psychiatry. As policymakers consider ways to support expansion of psychiatry GME, they should consider the stark disparities in provider supply in rural vs. urban areas; the need for increased training of psychiatric subspecialists; and the demand for a psychiatry workforce that more closely resembles the racial and ethnic diversity of its patient population.

The following case studies include examples of how two institutions in the state have addressed these challenges. Key takeaways include:

- Beginning a new residency program is challenging and requires the full support of organizational leadership.
- Due to the shortage of psychiatrists, recruiting qualified program leaders and faculty is difficult and time-consuming.

- Most hospitals don't have the resources within their institution to meet all of the accreditation requirements. Partnerships with other organizations for clinical rotations are often necessary.
- Clear communication between departments and between partnering organizations is a hallmark of success.
- Long-term funding is required to sustain the program over time.

Case studies of newly established psychiatry GME programs in California

Highlight: New Psychiatry Residency Program at Charles R. Drew University College of Medicine

Organizational overview

Charles R. Drew University (CDU) College of Medicine in South Los Angeles (LA) is federally-designated and federally-funded as an Historically Black Graduate Institution under Title IIIB. Founded in 1966 to increase access to care in the South LA area following the Watts Rebellion of 1965, CDU prides itself on its commitment to addressing the needs of the underserved, with educational activities primarily focused on guiding students and residents to navigate issues related to health disparities (CDU n.d[a], n.d[b]). South LA has a population of about 1,050,000 people, with more than 70 percent of the community identifying as Black/African American or Hispanic/Latinx. In addition, more than half of the residents in South LA primarily speak Spanish at home, and the median household income was $33,661 in 2017 (Los Angeles Department of City Planning 2019). With South LA's demographics in mind, CDU serves as the sponsoring institution for three Accreditation Council of Graduate Medical Education–accredited residency programs focused on health equity: family medicine; psychiatry; and, most recently, internal medicine.

Reasons for pursuing a psychiatry GME program

CDU had a history of providing GME through a partnership with nearby Martin Luther King Jr./ Drew Medical Center and served as the training site for several residency programs, including psychiatry. But with the closure of the Martin Luther King Jr./ Drew Medical Center in 2007, CDU was forced to end its GME program, leaving South LA with no residency programs. This eliminated opportunities for new physicians to gain first-hand experience working with the traditionally underserved community of South LA, forcing the physicians to train in other communities and reducing the likelihood of them practicing in South LA upon completing their residencies. This compounded existing access and quality of care issues in the area.

Several years later, staying true to its original mission to improve access to care in South LA, CDU decided to restart its GME program to help tackle the severe workforce shortages in that area and broadly in California. After some organizational strategizing and reorganizing, CDU hired a new dean in 2016 to lead these efforts, and the administration began work to have the College of Medicine re-accredited as a sponsoring institution.

CDU's administration was well aware of the hesitancy of minority communities to acknowledge mental health as a legitimate health need because of cultural beliefs, historical mistreatment by the health care system, and a lack of access to high quality mental health care. In addition, the LA County Department of Mental Health (DMH) had a vested interest in and excess funding available for developing and strengthening the psychiatric workforce in LA through California's 2004 Mental Health Services Act. Identifying these as opportunities for CDU to make a difference, CDU's administration partnered with DMH and prioritized starting a psychiatry GME program and a family medicine program over programs for other specialties. The school then hired a GME expert and worked directly with DMH to organize the details of the psychiatry program, such as where residents would train and what the curriculum would look like, and drafted a proposal for funding to DMH. In 2017, DMH awarded funding to CDU to start the residency program in psychiatry, and, in 2018, the psychiatry residency program welcomed five residents, establishing its first residency class on track to graduate in summer 2022.

Because CDU is an educational institution without clinical teaching sites, the school had to partner with clinical entities in the area where residents could complete rotations for their training. The primary teaching site for the psychiatry program is Kedren Community Health Center, a community clinic that offers primary care services along with inpatient and outpatient behavioral health care. Residents complete rotations primarily at Kedren during the first two years of their postgraduate training. During the final two years of the program, through CDU's other partnerships, residents can complete rotations at DMH, the VA (Veterans Affairs) Long Beach Healthcare System, Rancho Los Amigos National Rehabilitation Center, or a few other clinical sites in the LA area.

Funding for the psychiatry GME program

Initial start-up funding for CDU's psychiatry GME program came almost entirely from LA County Department of Health Services (DHS), which was approved by the Los Angeles County Board of Supervisors when it voted to spend $800,000 to launch the psychiatry and family medicine residency programs. Based on DMH's mission to meet the mental health needs of residents in LA county and CDU's residents primarily training at county facilities, DMH felt that it was appropriate to assume the funding for psychiatry resident and faculty positions. Today, CDU's main source of psychiatry residency funding comes from DMH, and, every year, CDU negotiates the program funding budget with the county, accounting for factors such as general cost-of-living increases and inflation. The psychiatry program receives additional funding through the VA. The VA reimburses DMH for CDU psychiatry residents' salaries and benefits when residents receive training through rotations at the VA.

Challenges with launching the psychiatry GME program

Although DMH ultimately funded the psychiatry GME program, CDU emphasized that obtaining funding was a major challenge to starting its GME program. Initially, when the school decided to restart the psychiatry program, making the business case to potential funders to justify the relevance and benefits of a psychiatry GME program was difficult. CDU attempted to find long-term and stable funding to sustain the program over time, but feedback from some potential funders, such as community-based philanthropic organizations, indicated that donors were not able or willing to support the program because they desired a return on investment that was immediate and profitable. These expectations were unrealistic for a new psychiatry GME program, especially in an historically underserved community such as South L.A. But because of increased awareness of the mental health crisis during the COVID-19 pandemic, identifying funders became easier for mental health programs and services across the country. For CDU, identifying funding is no longer an issue because of their partnership with DMH. Because county funding is subject to the priorities of the government and taxpayers, however, there are limits that make it difficult for CDU to do everything that it wants to do in its program. Therefore, CDU has to be creative and efficient to make the best use of the funds available.

Another ongoing challenge for the psychiatry GME program is recruiting and retaining faculty willing to serve at an academic institution, particularly one located in an urban underserved area. The shortage of psychiatrists, not only in California but across the country, makes hiring psychiatrists difficult. Many psychiatrists do not have the desire or the qualifications to teach, and those who do must be willing to accept a lower salary than they'd earn in private practice. Academic institutions increase the administrative and bureaucratic burden on psychiatrists who might prefer to see patients in a private setting. All of these challenges are compounded for CDU because of its location in the under-resourced community of South LA.

The lack of resources in South LA presents additional challenges for recruiting and retaining faculty that other psychiatry GME programs might not face. Because of systemic racism and a lack of economic investment in South LA, CDU says that the visual evidence of poverty is something that potential recruits cannot ignore. Many of

the buildings are dilapidated, and there are fewer businesses and community amenities in the area. By contrast, schools and clinical sites located in West LA have immediate access to the beach, diverse restaurants, and other businesses that contribute to the comfort and beauty of that community. These differences between South and West LA are important factors that potential faculty members often consider before accepting a job offer, as physical environment could affect the level of happiness or satisfaction that they feel in a job. In short, CDU is aware that people tend to gravitate toward beautiful and exciting environments, which South LA is not able to offer. Thus, without the environmental incentives that West LA touts, CDU explained that potential hires must truly be committed to teaching in South LA. Serving in the area requires a deep connection to their inner compassion and to the mission of the school, which can be a personal sacrifice that is too great for some, further decreasing the pool of available psychiatrists to hire.

Along similar lines, as a school located in an under-resourced area, CDU is committed to addressing the societal and systemic barriers that perpetuate the cycle of mental health disparities. One of these barriers is social and cultural attitudes toward mental health care and education that hinders access to well-trained psychiatrists. Traditional biases related to mental illness include the perception that people suffering from mental illness are weak and frightening and that doctors that treat them are not real physicians. From CDU's perspective, however, these and other negative attitudes toward mental illness have decreased with younger generations, whose values often center on human rights and justice. As such, many medical students and residents are looking for programs that offer more than just clinical experiences. To address this, CDU crafted a psychiatry program that includes exposure to policy, advocacy, and community-based research to provide a more comprehensive training experience for residents that aligns with their values. Even so, CDU maintains that broader societal attitudes have not shifted enough to catalyze the system-level changes necessary to increase investments in psychiatric and mental health training, which ultimately limits the resources available to expand and broaden the scope of psychiatry training programs.

CDU explained that navigating the gap between the goals of the educational system and the health care system for residents continues to be an ongoing challenge. As an academic institution, CDU's primary mission is to train young physicians and help develop their skills. In contrast, the goals of the health care system are often focused on recruiting, retaining residents after they've completed training, or placing residents so they fulfill the needs of the system at that time. This misalignment results in challenges with residents providing the high quality patient-centered care that they are trained to provide. For example, time constraints on how long residents should spend with patients are not conducive to ensuring that patients receive the attention that they need and that residents meet their educational objectives. These time constraints are often in place because of the reimbursement mechanisms that health plans use to pay psychiatrists. CDU recognizes that this is a system-level issue that perpetuates limited access to care, but until these policies are reformed, the school advocates on its residents' behalf to ensure that the residents have clinical experiences that align with their educational training.

Successes of the psychiatry GME program

CDU's first residency class will graduate in summer 2022, so it is too early to measure all program outcomes. CDU has added six residents in each year following its program's start, however, bringing the total to 23 residents in the four-year program. Other early successes of the psychiatry program include hiring faculty that have been a great fit, recruiting residents who are diverse and passionate about CDU's mission, and successfully bringing the program into operation.

Despite the shortage of psychiatrists across the country and the lack of incentives to work in South LA, CDU's administration highlighted that it had been able to hire and retain high quality psychiatrists who have the passion and are willing to dedicate the time required to teaching residents.

Moreover, its faculty have embraced teaching all along the spectrum by training medical students from CDU's College of Medicine that are doing their core clerkship in psychiatry and bringing in physician assistant students from CDU's College of Science and Health to work with psychiatry residents. CDU's administration also boasts its success recruiting diverse residents who are compassionate and dedicated to serving in a traditionally underserved and under resourced environment. Likewise, they believe that they have created a welcoming program for their residents by hiring faculty who reflect the racial and ethnic demographics of the community and establishing partnerships that allow residents to complete rotations in various settings.

Finally, given the newness of CDU's psychiatry program, the administration is very excited about the foundation that it laid for the future. By creating manuals for program operations, forums for residents to share honest feedback, and systems to implement changes based on resident feedback, CDU has brought about and managed its psychiatry GME program in such a way to ensure its continued existence and success.

Future plans

CDU is in the process of expanding its psychiatry GME program by developing a two-year Child and Adolescent Psychiatry Fellowship. The impetus for this fellowship is the philosophy of CDU and the psychiatry GME program staff that mental illness often begins in childhood, with adverse childhood experiences frequently prevailing in underserved communities, contributing to the disparities that exists in mental health outcomes. The faculty believe addressing mental illness during childhood and throughout the lifespan, with consideration of the social and structural determinants of health, is critical. With this fellowship, CDU intends to continue its mission to train physicians to provide patient-centered culturally sensitive care that addresses the needs of vulnerable children and adolescents in South LA and plays a role in preventing and mitigating the onset of mental illness in adulthood.

Highlight: New Psychiatry Residency Programs at Kaiser Permanente Northern California

Organizational overview

Kaiser Permanente, headquartered in Oakland, California, is one of the dominant health care systems in the state. As an integrated health plan and delivery system, Kaiser includes the Kaiser Foundation health plan, a network of hospitals, and a network of physicians that belong to the Permanente Medical Group. Over the past several years, Kaiser has actively pursued new GME programs in different specialties in Northern California.

Because of the substantial shortage of psychiatrists locally and nationally, Kaiser launched psychiatry resident programs in Oakland and San Jose in 2019, with the goal of increasing the number of psychiatrists within Kaiser and in the community as a whole. The Oakland and San Jose residency programs enrolled their first class of residents in July 2019. Each location has six residents per cohort, and, in summer 2022, both locations will have their first cohorts entering their fourth year of residency. In addition, Kaiser has plans to add another psychiatry residency program in the Greater Sacramento region in the near future.

This case study focuses on the Kaiser Oakland psychiatry residency program.

Reasons for pursuing GME

Several years before launching its psychiatry residency programs, the Kaiser Foundation Hospitals and The Permanente Medical Group recognized that there was a major shortage of psychiatrists within Kaiser and in the broader community. Facing challenges with recruiting psychiatrists to serve their patients and the communities they serve, Kaiser Regional GME began planning to start a residency program to train new psychiatrists and, ultimately, retain some of them within the network and contribute new psychiatrists to serve at other health systems in the community. As part of the goal of adding to the workforce in psychiatry, Kaiser Oakland's program has sought

to increase the racial and ethnic diversity of the workforce. Since the program began, it has made efforts to enroll residents from diverse backgrounds with the goal of graduating new psychiatrists who are more representative of the demographics of Oakland and the surrounding communities.

Funding

The costs of starting a psychiatry residency program are substantial. For example, according to Kaiser executives, the costs of providing all resident salaries and benefits, funding non-payroll costs, and hiring a program coordinator are about $4 million per year for the full four-year psychiatry program of 24 residents. Other costs include creating office space for teaching physicians and other new personnel and the costs associated with supporting research and teaching time. Kaiser Foundation Hospital/Health Plan funds the resident salaries, benefits, and non-payroll costs. The Permanente Medical Group provides salaries for the program directors and faculty. Because Kaiser decided to invest financial resources into the psychiatry residency program as part of its GME strategy, obtaining start-up funding was not a major hurdle.

Start-up process

The program director emphasized the importance of grounding the program in strong values from the outset, including collaboration and feasibility, respect and equality across levels, support for staff and residents, and feedback and continuous quality improvement.

At the outset, Kaiser leadership intentionally designed the program through a collaborative process with ample stakeholder engagement. For example, the program director spoke about the importance of making sure the psychiatry department's leadership and medical center leadership are aware of plans and developments and, if necessary, seeking their buy-in, approval, and specific requests before starting any process. The program director also described intentional engagement when setting up rotations. For instance, in seeking to start a new rotation, the program director and assistant program director would meet with the head of that particular clinical service and provide a brief overview of the residency program. Then they would engage the leaders of the clinical service in an open dialogue about what their clinical services look like, their level of interest in collaborating, and whether they felt it was feasible and a good fit for both parties. If there was mutual interest, they would then have several subsequent meetings and engage other key stakeholders, such the attending supervisors or the leaders of the department or institution. The program director would seek input from staff members who would be involved in key aspects of the rotation.

The program director and assistant program director have engaged stakeholders in other ways on an ongoing basis. For example, they seek feedback from residents about potential novel rotations to understand how they would be received and experienced by residents. They also continue to cultivate their relationships with the residents and attendings by obtaining verbal and anonymous written feedback to refine the experience for residents, patients, and attendings. This iterative refinement process is ongoing.

Program leaders emphasized feasibility as an important part of designing the program. For this reason, they sought to develop the program with a manageable number of residency slots and set realistic goals for the program. They temporarily discontinued fourth-year visiting medical student rotations in their department because they knew they would not have the attending capacity to continue this while starting a new residency training program. They hope to have the capacity to resume medical school rotations in the near future.

Program leaders said that creating the didactic curriculum has been one of the more challenging components of developing a new psychiatry residency program. Because of the substantial work involved in designing the curriculum, program leaders created a specific role for this task, appointing a director in charge of overseeing the development of the didactics. This director of didactics began the process of creating didactics by researching the curriculum of other psychiatry

residency programs, using resources from the American Association of Directors of Psychiatric Residency Training, and speaking with leaders of other residency program. As another strategy to help support didactic instruction, Kaiser Oakland leveraged the expertise of psychiatrists in the Kaiser Northern California network, recruiting psychiatrists from within Kaiser across the region to present on key topics. Staff who are passionate about particular topics provide direct instruction to residents. This strategy reflects the program leaders' philosophy that high quality instruction is best provided by physicians passionate about teaching and specific aspects of psychiatry. Kaiser Oakland has leveraged its large network of physicians across Northern California, recruiting staff from Santa Clara, San Francisco, Greater Southern Alameda area, the Diablo Valley service area, and Sacramento, to teach the didactics.

Challenges

The major challenges that Kaiser Oakland has faced in developing its psychiatry residency include (1) facilitating the major department operational and cultural change involved for the psychiatry department to become a teaching program, (2) recruiting psychiatry faculty with the requisite experience and interest in teaching and research, (3) developing the required psychiatry rotations, (4) constructing the didactic curriculum, and (5) obtaining clinical supervision for residents when they begin to have their own patient panels.

Kaiser Oakland's program directors identified one of the biggest challenges to setting up their psychiatry residency program as the cultural change inherent in moving from being a department solely focused on clinical care to becoming teaching organization, a process that takes several years. For example, existing physicians need to learn new skills to provide medical education and to conduct research because research activity is one of the Accreditation Council of Graduate Medical Education's residency program requirements. In addition, teaching requires the faculty as educators to generate learning objectives for residents on each educational experience and then create the educational experience (for example, teaching method) based on these learning objectives and, at the same time, maintain patient care and ensure residents' wellness is upheld. There is a constant tension for the clinical educator to prioritize residents' and patients' experiences in clinical encounters involving trainees.

Another part of the culture change involves hiring new faculty with the right skills, experience, and interests. Program leaders explained that this shift from having staff that are solely clinically focused to having a boarder focus on education and research along with clinical care has gradually become easier with each year of the program. In addition, they are optimistic that, as their residents graduate and some remain with Kaiser, the new psychiatrists will further embed the cultural change.

Recruiting such faculty was initially challenging for Kaiser. For example, there is a limited pool of psychiatrists to recruit given the provider shortages. In addition, Kaiser has some competition with academic institutions, such as University of California San Francisco, a prestigious and established institution with a great deal of research activity that is a very attractive option for psychiatrists with interest in teaching and research. In addition, within the pool of available psychiatrists, many are solely interested in providing clinical care rather than conducting research and teaching residents. Thus, the pool of interested faculty is limited. This challenge has lessened as the residency program matured, with program leaders explaining that the presence of the residency program has generated more interested applicants over the last couple of years.

Another major challenge for Kaiser Oakland has been developing inpatient psychiatry rotations. Because Kaiser Oakland does not have an inpatient psychiatry unit, executives at Kaiser have helped oversee the development of inpatient psychiatric rotations with non-Kaiser psychiatric facilities in the East Bay. For example, Kaiser Oakland's psychiatry residency program partners with Heritage Psychiatric Health Facility's inpatient unit for a four-month rotation for their first-year residents.

Second-year residents spend two months at the Kaiser Fremont inpatient facility and participate in emergency psychiatric care rotations at John George Psychiatric Hospital in Alameda County.

One of the major foundations of developing the psychiatry residency is creating the didactics. Program leaders described some challenging aspects of developing psychiatry didactics that differ from those of other specialties. For example, because psychiatry residencies are four years rather than three, as is the case for many other specialties, the quantity of didactic curriculum is larger. A compounding challenge is that psychiatry residencies need to teach curricula sequentially, with each cohort going through each year of curriculum in a prescribed order. As a result, within psychiatry residencies, program leaders and faculty members prepare 12 to 16 hours of unique didactic content each week. By comparison, in internal medicine, the first, second, and third years can all go through the same didactics together, which reduces the burden of preparation and teaching. The particular aspects of psychiatry residencies create a fairly substantial and labor-intensive process, so leaders at Kaiser Oakland emphasized the need to devote substantial resources to developing the didactics.

Program leaders mentioned other aspects of psychiatry as a specialty that add to the challenge of developing didactics. For example, in medical school, there is less focus on mental health, psychiatry, and mental illness relative to physical health. Therefore, psychiatry residency programs must spend more time laying a foundation of knowledge on these topics. In addition, there are medical aspects and psychological components to psychiatry. Residents must learn both the medical background and therapeutic modalities, such as motivational interviewing, behavioral activation, problem-solving therapy, dialectical behavioral therapy, cognitive behavioral therapy, interpersonal psychotherapy, psychodynamic psychotherapy, and group psychotherapy.

The last aspect of psychiatry residencies that Kaiser Oakland leaders described as a challenge is the need to develop intensive clinical supervision for residents providing care. For example, in their third and fourth years, residents work as outpatient providers with their own patient panels, providing care under supervision for various types of therapy. Each third-year resident receives, weekly, one hour of psychodynamic psychotherapy supervision, one hour of cognitive behavioral therapy supervision, one hour of interpersonal psychotherapy supervision (six months of the year), and 30 minutes of group psychotherapy supervision. In addition, they receive roughly two hours a week of psychopharmacology supervision. Each fourth-year resident receives one hour of weekly psychodynamic psychotherapy supervision and roughly 30 to 60 minutes of psychopharmacology supervision. For Kaiser Oakland's residency program to make that happen, it had to recruit attendings and volunteer faculty to provide the supervision. The residency program relies on a combination of supervisors from within and outside of the department via volunteer community faculty. This strategy is not particular to Kaiser: using volunteer community faculty for psychotherapy supervision is an age-old tradition for psychiatry residency training programs. This is because most psychiatry departments cannot solely rely on their own faculty to provide this service given the size and scope of supervision in terms of the types of therapy modalities and the number of hours of supervision involved.

Facilitators

Leaders at Kaiser Oakland's program described a few organizational characteristics that have facilitated the development of the residency program. Certain aspects of Kaiser as an organization have aided recruitment of faculty positions for the GME program. For example, although there is a limited pool of available psychiatrists and competition with other location health systems, Kaiser offers competitive salaries and benefits. Another facilitator, according to program leaders, is that residents fit well into the existing workflows of Kaiser's psychiatry department. For instance, before launching the GME program, Kaiser already provided a range of psychiatric services that are essential aspects of resident training, including psychiatric consultative services for medical patients in the hospital and

at other Bay Area locations, psychiatric crisis services, geriatric psychiatry, and dementia care. The department was able to integrate residents into these existing services and did not have to build new services to provide GME.

Early successes

Although the residency program is relatively new, and it is too early for data on program outcomes, there are some early indicators of successes. For example, program leaders shared that over the past couple of years, they have received more than 900 applicants for six residency slots, indicating strong interest among medical school graduates in Kaiser Oakland's program. In addition, Kaiser Oakland has seen many new applicants for psychiatrist positions, and applicants have cited the residency program as a key reason for their interest. Thus, as Kaiser works to build the pipeline of psychiatrists to serve the community, it is already reaping some of the benefits of GME, with the residency program itself generating increased interest among the existing pool of psychiatrists.

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Appendix

Table A.1. Psychiatry residency programs in California, 2021

Residency Program Sponsor	County	Number of First Year Residents
University of California Medical Center		
University of California, Davis - Psychiatry	Sacramento	9
University of California, Davis - Medicine-Psychiatry	Sacramento	2
University of California, Davis - Psychiatry-Family Medicine	Sacramento	2
University of California, Irvine - Psychiatry	Orange	9
University of California, Riverside - Psychiatry	Riverside	8
University of California, San Diego - Psychiatry	San Diego	9
University of California, San Diego - Psychiatry/Research	San Diego	1
University of California, San Diego - Psychiatry/Community	San Diego	2
University of California, San Diego - Psychiatry-Family Medicine	San Diego	2
University of California, San Francisco - Psychiatry	San Francisco	16
University of California, San Francisco - Fresno - Psychiatry	Fresno	6
UCLA Semel Institute Neuroscience - Psychiatry	Los Angeles	12
UCLA Semel Institute Neuroscience - Psychiatry/Research	Los Angeles	2
UCLA Semel Institute Neuroscience - Psychiatry/Harbor, NPI, WLAVA	Los Angeles	1
Other Public Hospital		
Arrowhead Regional Medical Center - Psychiatry	San Bernardino	6
Harbor - UCLA Medical Center - Psychiatry	Los Angeles	7
Kaweah Delta Health Care District - Psychiatry	Tulare	6
Kern Medical Center - Psychiatry	Kern	6
Olive View - UCLA - Psychiatry	Los Angeles	7
San Mateo Behavioral Health - Psychiatry	San Mateo	4
VA Greater LA Health System - Psychiatry/UCLA/SFVP	Los Angeles	6
Private Hospital or University		
California Pacific Medical Center - Psychiatry	San Francisco	4
Cedars Sinai Medical Center - Psychiatry	Los Angeles	
Charles Drew University - Psychiatry	Los Angeles	6
Community Memorial Health System	Ventura	4
Kaiser Permanente - Fontana - Psychiatry	San Bernardino	5
Kaiser Permanente - Oakland - Psychiatry	Alameda	6
Kaiser Permanente -San Jose - Psychiatry	Santa Clara	5
Loma Linda - Psychiatry	San Bernardino	9

Residency Program Sponsor	County	Number of First Year Residents
Loma Linda - Psychiatry, Child Track	San Bernardino	2
Riverside University Health System	Riverside	6
Stanford University -Psychiatry	San Mateo	12
Stanford University - Psychiatry, Research Track	San Mateo	1
University of Southern California - Psychiatry	Los Angeles	12