PERSONAL STATEMENT EXAMPLE #1

CLINICAL TRACK ASSISTANT PROFESSOR

TO

CLINICAL TRACK ASSOCIATE PROFESSOR

CT Asst → Assoc

Personal Statement on Scholarship

Clinical research is vital in improving resident training as well as patient care and surgical outcomes. Throughout my time as an assistant professor at the University of Iowa, I have worked hard to maintain a balance between academic scholarship and clinical practice. As part of my scholarship activities, I have mentored multiple residents as well as medical students. Additionally, I have worked with numerous institutions and experts within the field to generate high-quality research publications. Despite being on the clinical track, my own perseverance and hard work has led me to be one of the most productive junior faculty in the department, amassing 31 peer-reviewed publications to date, 17 of which were mostly or entirely completed while at the University of Iowa (see CV and supporting papers).

The majority of my research has focused on technical aspects of laparoscopic surgery, novel approaches for laparoscopic surgery, and nephrolithiasis. With regard to minimally invasive surgery, I have participated extensively in publications on laparoendoscopic single site surgery (LESS). Most of this research is outcomes-based and seeks to determine potential benefits for LESS over standard laparoscopy with regard to perioperative outcomes. In addition to being part of a large consortium of experts that has contributed to the publication of multiple important works, my most important work revolved around evaluating the cosmetic benefits of single site surgery. Performing this study involved obtaining IRB approval, developing a novel cosmetic satisfaction survey, and administering this survey in a prospective fashion to 90 patients undergoing laparoscopic surgery. During the study, I had the opportunity to oversee two subsequent fellows at UTSW and work with them closely in the compilation, analysis, documentation, and presentation of our findings. I continue to work with other institutions to combine our cumulative LESS experience in order to further determine its role in minimally invasive surgery.

Another important project, which I developed during fellowship but continue to work on extensively since joining the UIHC, is evaluating the effect of various animal proteins on development of nephrolithiasis. The development of this study required over a year of dedicated effort. It is a prospective, diet-controlled inpatient study involving three separate dietary phases with various animal proteins, including chicken, fish, and beef. The results have been fascinating and have contributed greatly to our understanding of stone disease. While the results of this study have yet to be published secondary to delays from my mentor, the abstract, which won best poster at the 2011 AUA Annual meeting, has been cited in in multiple subsequent plenary sessions and presentations from other well-known endourologic faculty. My hope is that we will, finally, have this published this fall.

One of my key goals with regard to scholarship is to work with residents using a "ground up" approach, where they help with the development of a project, the implementation of that project, the collection of data, and the publication and presentation of that data. This approach creates far more academic interest than merely having residents complete a study that I designed and then "handed" to them. While this approach is substantially more involved for the residents, it is far more rewarding in the long run and those who have worked with me have greatly appreciated this approach. The first such study

involved a survey questionnaire regarding the role of current and future need for academic urologists in the United States that came about when trying to help two of our residents decide on their future career goals. This article has become more important over the last several years as staffing issues remain a concern for multiple specialties in the era of consolidated healthcare and new healthcare economics. Our work with the RENAL nephrometry scoring system was the first to report that the scoring system may predict risk of complications following kidney surgery. This project involved idea development and the oversight of two residents and a medical student who eventually entered a urologic residency. Over the last year this paper has become quite important, having been cited in 19 peer-reviewed publications during the 12 months since its publication.

Three of the other projects with which I have worked with residents have been particularly interesting and rewarding. In 2011, n and I were the first researchers to report on a potential role of antioxidants in the prevention of nephrolithiasis. The results, which were first presented as a podium presentation at the American Urological Association annual meeting, garnered a great deal of attention and, in addition to being published in a peer-reviewed journal, were reported on by the Associated Press and *U.S. News and World Report*. The results of this study then led to the development of a subsequent resident project evaluating the potential role of pomegranate extract in the prevention of kidney stones. This study, for which we applied for and received a ~$25,000 grant from POM Wonderful, combined both basic science work, allowing the resident to learn various extraction techniques and use of gel electrophoresis, as well as clinical work, greatly improving the resident's medical knowledge. We have recently completed accrual and are in the process of evaluating the data and preparing the manuscript. The abstract has been accepted for presentation at the World Congress of Urology taking place this fall in New Orleans. A separate area of interest has been evaluating the use of ureteral stent extraction strings following ureteroscopy. An initial retrospective review of our experience at Iowa was presented by at a national meeting and then subsequently published in a peer-reviewed journal. Following the results of that study, I worked with two of our residents to prepare a prospective randomized study, which is the only ongoing, resident-run prospective trial within the department. Although this study has required a great deal of time and effort, the results to date have been very enlightening, with our recent presentation at the 2013 AUA winning the "best poster" of its session, despite competing against multiple prospective studies.

One of my current main projects with regard to scholarship involves the opportunity to coauthor a chapter in *Campbell-Walsh Urology*, the "bible" of urology that is read and referenced by all urologists at some point in their career. The development of this chapter, which is titled "Percutaneous Ablation of Renal Cell Carcinoma," has already begun. I helped to develop the outline for the chapter and have written the first two sections. There is no doubt that this project will be a significant undertaking over the next year, but I am honored to be a part of such an important publication.

I continue to work with multiple institutions, residents, fellows, and medical students in the publication of cutting-edge urologic research. Current projects under way include radiation exposure during percutaneous ablation of kidney cancer, development and validation of a scoring system for predicting success and complications following percutaneous nephrolithotomy, decreasing the rate of transrectal

ultrasound-guided biopsy infection (see more details in "service" personal statement), and determining the learning curve for robotic-assisted laparoscopic surgery.

Personal Statement on Service

The service component of my appointment at the University of Iowa has come in the form of clinical service, quality improvement, intra- and inter-departmental committees, and involvement in national organizations (please see CV for full listing). Clinically, I have been very busy within the department. In fact, from a productivity standpoint, starting with my first full year on staff, I have consistently generated the highest RVU total in the department. However, productivity should not be measured solely in clinical and patient volume, but also in the development of multiple new services as well as the deployment of multiple quality improvement projects.

As the D   y for the Department of Urology, I have been happy to be involved with the rapidly shifting surgical nature of our specialty. In addition to overseeing the incorporation of new technology and helping to improve surgical efficiency in the programs we already offered, I helped to develop two new surgical services that were not performed prior to my arrival at UIHC. In 2009, I helped perform one of the first robotic-assisted laparoscopic partial nephrectomies (RAPN) in the state and the first one at UIHC. Since that time, I have worked diligently with the other surgeons within the department and with the OR administration and nursing staff to increase the number of partial nephrectomies to more than 50 a year, and climbing. Currently, we are performing the most RAPNs in the state and, in fact, this year RAPN at the University of Iowa easily surpassed open partial nephrectomy for the first time. Institution of this program has helped to improve patient outcomes substantially and further work in this area will hopefully make us a leader in the Midwest. Along similar lines, I also helped with the first several robotic cystectomies performed within the last several years. While these had previously been performed at UIHC, they were few and far between with questionable patient benefit. Since helping develop the technique here two years ago, we have continued to push forward with this service and I am currently stepping back to allow two of our more junior faculty to assume this program. Finally, with regard to new services and pushing the envelope laparoscopically, in 2010 I performed the first urologic single incision surgery (removing a kidney through a belly button) at the University of Iowa and one of the first single-site surgeries in the state. Since then, I have continued to improve this service and have even started offering robotic single incision surgery as an alternative to standard laparoscopy.

In addition to new laparoscopic services, I also helped develop a program at the University of Iowa for percutaneous renal ablation. Working closely with   , Director of Vascular & Interventional Radiology at UIHC, we developed a unique surgical protocol for radiofrequency ablation using CT guidance. Unlike many other centers, where these procedures are performed solely by a radiologist, our program here is unique in that we both collaborate on every case, allowing my expertise with treating kidney cancer to work synergistically with   expertise in interventional radiology. Together, we have performed approximately 20 percutaneous ablations with a 100% success rate when treating patients with malignancy. Amazingly, we have had very few complications, with all patients discharged within 24 hours of the procedure. We are continuing to refine our protocol with the hope that we can expand this service to more patients with kidney cancer. Additionally, we have recently

found that our protocol is one of the best in the country for limiting radiation exposure and work is under way to publish our technique and roll it out to other institutions, including some of the most high volume institutions in the world.

Another major component of my service role has been in the development and implementation of multiple quality improvement initiatives. One of my first initiatives was the development of a preoperative risk assessment tool for determining which patients should have sequential compression stockings placed for outpatient cases in the urology operating room. This tool (see included documentation under "service"), which was approved by all of the faculty within the department, allows us to determine which patients are at risk for venous thromboembolism, so that we are not over-utilizing resources yet at the same time are providing state of the art care for our patients. Since instituting this program 2 years ago, we have not had any patients, including those at very high risk, with a symptomatic thrombotic event. My second major quality improvement initiative was the development of a "preop checklist" for all cases performed in the urology operating room (see included documentation under "service"). The impetus for this checklist was that we, as a department, were often missing several aspects of the preoperative evaluation, which, in some cases, may have placed patients at risk. Additionally, it was clear that several residents were not appropriately prepared for surgical cases. The checklist, therefore, was developed to improve patient care as well as improve resident education. We now also use the checklist as a way to improve resident "hand-offs" as it facilitates transfer of the patient from the operating room to the care of the resident taking care of floor patients.

Perhaps my most significant quality improvement project to date was the development of a prostate biopsy protocol for prevention of infectious complications following prostate biopsy. Within the medical community there has been a recent emphasis on the morbidity of prostate cancer detection and treatment. One of the factors included in this emphasis is the increasing prevalence of bacterial-related complications following transrectal ultrasound-guided prostate biopsy (TRUS), likely secondary to increasing levels of bacterial antibiotic resistance. As a department, we (including the VA Medical Center) had never developed a standardized protocol for recording or preventing infections. To that end, in July of 2012, I began working on a plan to track infections and modify clinical protocols with a goal of improving patient care and decreasing our infectious complication rate to zero. Following an extensive literature review and an assessment of current clinical practices within the department, I worked with members of the infectious disease, pharmacology, and microbiology departments to develop a method for preventing infection within the confines of American Urological Society (AUA) and Surgical Care Improvement Project (SCIP) guidelines. The final comprehensive protocol involves a novel rectal screening swab technique to determine a patient's antibiotic resistance pattern, followed by appropriate antibiotics based on individual patient flora (see included documentation under "service"). In order to simplify antibiotic regimens, appropriate protocol-specific antibiotic dosing was created as part of an EPIC smart set. All residents, clinical faculty, and support faculty at both the University as well as the VA Medical Center were instructed on appropriate use of the protocol, which was instituted in the early fall of 2012. I am delighted to say that following an initial run-in period, we have had only one

biopsy-related infectious complication in an 11 month period, which encompasses over 350 biopsies at the VA and UIHC (expected rate of infection is 2-5%).

In addition to clinical service, I have also had the opportunity to serve on the departmental, collegiate, and national levels (see CV for full listing). Within the department I am the coordinator for surgical supplies for the urology operating room, a member of the clinical trials committee, director of robotics, and the director of visiting professorships as well as the annual Iowa Urologic Society meeting. Within the hospital, I have been a key member of the Minimally Invasive Robotic Surgery Group (MISRG) and have worked closely with other robotic surgeons from multiple departments to coordinate and improve our robotic surgery program. Within this committee, I have been involved with the purchase of new robotic equipment, the development of a robotic training center, and the allocation of robotic time. Additionally, I have used this committee to present our urologic robotic experience in order to help with cost containment and improve OR efficiency.

My largest service commitments, in terms of time, are my roles as Medical Director of 3 Roy Carver and as a member of the Hospital Credentialing Committee Surgical subpanel. In my role as Medical Director, it is my job to act as the physician coordinator and liaison for the busiest inpatient floor in the hospital, serving primarily orthopedics, urology, ophthalmology, and trauma. Along with one of the best nursing coordinators in the hospital, a, I work very closely with hospital administration to improve every parameter from patient satisfaction to length of stay. Over the last several years, we have been showing a dramatic improvement in all of these parameters and continue to work toward excellence. As of the most recent data, we currently rank as the third highest unit for patient satisfaction within the hospital and we have also been identified as one of the best units for length of stay. While we are above the hospital mean on almost every Press-Ganey category, I know that with further work and emphasis on patient care, we will continue to improve with each year. Our goal is to be the exemplary unit for all categories within the UIHC. As a member of the hospital Credentialing Committee, I vote twice a month on the suitability of practitioners to obtain credentialing for operating at UIHC and also help with the approval process for any definitional statements for departments that wish to change their credentialing process.

On a national level I serve as a reviewer of multiple journals, including the *Journal of Urology*, the primary publisher of urology research in the U.S., and the *Journal of Endourology*, the top periodical within my specialty, as well as several other smaller journals. I have acted as a speaker at the North Central Section (NCS) of the AUA and the World Congress of Endourology. This fall I will act as a moderator for one of the sessions at the NCS. As my clinical practice continues to gel over the next several years, my hope is to become more involved with my current service commitments and then to expand on a national and international level.

Personal Statement on Teaching

One of my great joys and the reason I joined an academic practice is teaching others about the wonders of medicine and, in particular, urologic disease. My involvement with teaching since joining the faculty at the University of Iowa has involved teaching of UI students and residents as well as residents from other institutions. Additionally, I have also been fortunate enough to teach faculty and community physicians both from the University of Iowa and from around the world.

I have been involved with the teaching of medical students in multiple environments. As a faculty member participating in the urologic curriculum for the Foundations of Clinical Practice (FCP), I have taught the "urinary tract obstruction" lecture for the last 3 years. During that time I received favorable reviews from those in attendance. I also have been involved as a Clinician Mentor for second-year medical students in FCP IV. I previously served in this role in 2011 and plan to participate again as a mentor in the winter of 2014. My previous evaluations from this course were excellent, with an average score of 4.75 out of 5. In addition to my involvement in FCP, I have mentored more than 70 students during their selective urology clerkship or advanced research clerkships, which have resulted in 3 peer-reviewed articles and 5 meeting abstracts. I have received very positive reinforcement from medical students for these teaching efforts and was rewarded with the Carver College of Medicine Medical Education Celebration Day Faculty Award in 2011. Outside of the College of Medicine, I have worked closely with the University of Iowa students and faculty in the schools of Business, Law and Engineering through my role as a faculty member in the Iowa Medical Innovation Group (IMIG), an innovative multi-specialty course designed to help teams of students from each school develop new medical products.

It has been a pleasure working with the urology residents over the last 4 years. When I first arrived I noted that there were multiple deficiencies in their education and since that time I have taken an active role in their education through the development of multiple courses, written guidance, and a urology-specific core curriculum. The most comprehensive course I have developed is the robotic surgery curriculum (see attached documents), using publically available information from the manufacturer as well as from other institutions. This course has since been utilized as a framework for development of similar curricula by other departments. The curriculum is designed in multiple phases by resident year, beginning with the Foundations of Laparoscopic Surgery course (FLS) offered by General Surgery, where residents learn basic laparoscopic skills. First-year urology residents (PGY-2) are brought to the robotic training center where they learn the various aspects of docking the robot and becoming familiar with the instrumentation. Prior to this "dry" laboratory portion, they complete an online practicum, going over the safety aspects of the robot as well as the various instrumentation. Following initial training, they are provided with a video library of various urologic procedures to begin learning the key steps of urologic robotic surgery. Included within this library are three videos I created myself, featuring condensed surgeries that include a voice-over describing the key portions of each case. Following the didactic, hands-on, and video sessions, residents are allowed to participate on a rotating schedule using the robotic simulator located in the main operating room. On average, each resident will utilize the robot in this setting 6-8 times per year. The development of this curriculum allows the residents to be

far better prepared when they reach their fifth year and have actual operative exposure to the robot. In that regard the course has been well received by both residents as well as faculty who utilize the robotic platform.

In addition to development of the robotic curriculum, one of my proudest teaching achievements over the last 4 years was overseeing the development of a pocket guide for urology (see attached documents). . The pocket guide is a simple reference manual that includes physician preferences (surgical protocols and post-operative care plans) as well as "high yield" urologic reference material that residents and faculty can always have at hand. A secondary goal of the pocket guide was for urology faculty to agree on various postoperative pathways in order to streamline and improve patient care. Development of the pocket guide involved compiling important reference material from each faculty member as well as from various texts, landmark papers and other sources, including making a list of all urologic surgical procedures and outlining the preferences of each faculty surgeon regarding management of their surgical patients. Resident input was valuable in adding information germane to the daily work of residents. The final product, a 75 page pocket-sized guide, has been a resounding success. It is currently used by all residents within the department as well as several faculty and Due to the popularity of the guidebook and resident word of mouth, we have also shared this guide book with other interested institutions.

I was recently named [illegible] for urology and have developed three recurring courses per year. The first course is typically taught during the summer months and involves the dry lab portion of the previously mentioned robotic curriculum. A second course, which occurs in the fall, is a porcine lab that teaches basic laparoscopic skills as well as more advanced techniques. Each resident is given the opportunity to perform surgery on a live animal, which is a valuable introduction to laparoscopic surgery. The third course, which occurs in the spring, is led by [illegible]n, in conjunction with myself, and involves the instruction of pelvic surgery on fresh human cadavers. The surgical skills curriculum is currently in its second year and I hope to add more courses over the coming years including percutaneous ablation and brachytherapy, as well as further improve the current courses. Additionally, I plan to further enhance the basic principles of laparoscopic and robotic surgery through my role as co-director of the minimally invasive surgery and oncology conference series.

In addition to teaching students and residents at the University, I have been involved with teaching activities for the Family Medicine Department, community urologists, and residents throughout the world. Through my role as director of the Iowa Urologic Society annual meeting I have arranged 3 successful Iowa Urologic meetings, at which I have given one to two talks per year in addition to creating the agenda and topics for each meeting. I have also participated in the Family Medicine conference series, giving a lecture on acute stone episodes. On a national and international level, I have participated as a hands-on instructor for the American Urological Association (AUA) annual meeting as well as the AUA basic science course, both highly sought-after positions typically led by more senior faculty. At the AUA I have taught courses on chronic scrotal pain, single incision laparoscopic surgery, and robotic single incision laparoscopic surgery. At the basic science course, which is attended by 75% of the urology residents in the United States, I have participated as one of the course directors for laparoscopic training involving both didactic lectures and a wet lab experience with a porcine animal lab.

PERSONAL STATEMENT EXAMPLE #2

CLINICAL TRACK ASSISTANT PROFESSOR

TO

CLINICAL TRACK ASSOCIATE PROFESSOR

CT - Asst → Assoc

Personal Statement on Professional Productivity and Scholarship

As a resident on consultation-liaison psychiatry, I met the patient that would become the perfect symbol of my academic career to date. Perfect not because she was perfectly compliant, on time, or responding well to treatment (she was none of these), but because she personified the difficulties faced by childbearing women with complex mental health needs. She had experienced depression through many pregnancies and during the postpartum. When we first met, she was pregnant and clearly depressed, yet she had received little treatment for her mood symptoms. Our patient-provider relationship lasted several years, as I followed her as a resident and then as a faculty member. She managed to attend most of her appointments, as they were co-located and co-scheduled with her obstetric visits in the clinic I would eventually co-develop with [redacted], now known as the Women's Wellness and Counseling Service (WWC). With encouragement from a visiting nurse, she took the antidepressant medications I recommended following the birth of her little girl and then several more children. Her depression and irritability were somewhat improved, but she continued to struggle with getting to appointments and accessing therapy. Her experience raises important questions that my career to date has focused on. What factors contributed to her difficulty in accessing mental health care during her childbearing years? What might be effective interventions that thoroughly address the biopsychosocial nature of her difficulties on both an individual and community level? My goal has been, and remains, to be a leader working at the interface of the fields of mental health and maternal health to improve the accessibility and acceptability of women's mental health care both at the individual and public health level.

My earliest years as an associate and then faculty member were devoted to addressing these questions through the research program I developed through collaboration with the Iowa Depression and Clinical Research Center (IDCRC) and under the mentorship of [redacted]. This was an incredibly rewarding period, in learning about the needs of pregnant women and new mothers, as well as fathers, from across the state of Iowa. Through independent and center research projects, as well as my studies that were awarded support by the K12 Mentored Clinical Research Scholarship at The University of Iowa, we began to answer some of these questions. Those lessons continue to have applications in IDCRC research collaborations, the clinical services we provide each day in the WWC, as well as my efforts in education and service.

One of my first projects focused on partners of postpartum women and assessed their emotional well-being in the postpartum. In addition to the original epidemiologic data, this project served as an excellent springboard for work by [redacted]D., during his graduate studies. I provided mentorship for the development and implementation of a follow-up study of fathers, mothers, and their toddlers and served on his research advisory committee. Data from these projects were presented internationally on two separate occasions, the second time in a symposium I coordinated on postpartum fathers for the biennial meeting of the Marcé Society. Our collaboration has been fruitful, not only in terms of publications, but in the ongoing educational and clinical applications for the WWC. Based on our projects stressing the importance of addressing partner mental health for their own well-being, as well their family members, all WWC trainees learn about postpartum depression in partners. I also

implemented our routine use of proxy-screening for partner depression in the WWC clinical intake questionnaire.

Screening for depression in perinatal women has become a strong area of focus and collaboration among public health, maternal health, and women's mental health practitioners, both at the national and state level. Starting in 2002, I pursued a longstanding interest in public health, enrolling in the Masters of Public Health program in the University of Iowa College of Public Health (UI-CPH), in the Department of Community and Behavioral Health. Both my coursework and practicum were focused on health promotion and program planning and evaluation, targeting the area of maternal mental health. Through a grant for an Academic Health Department, a partnership between UI-CPH and the Iowa Department of Public Health (IDPH), I conducted a formal mixed-methods evaluation of perinatal depression screening practices in the state of Iowa and developed "Best Practice Guidelines" published and used by the IDPH Bureau of Family Health. I was invited to present these findings and guidelines in a number of settings by IDPH and the UI-CPH. I have remained a frequent consultant and speaker on implementation of perinatal depression screening on the state level, including in my roles as the parental mental health consultant for IDPH's Iowa Perinatal Depression Project and, presently, for IDPH's Project LAUNCH, which is focused on healthy mental development in young children. As co-director of the WWC, I have played a leading role in implementing perinatal depression screening in our own institution, providing training and consultation for the Department of Obstetrics and Gynecology outpatient clinics and mother-baby units, as well as in other departments such as Pediatrics. These screening programs also serve as a critical source of clinical and research referrals for the WWC and IDCRC.

Each of these experiences dovetailed with my K12 research examining barriers to care and preferences for treatment for perinatal depression. The findings of this mixed-methods study have been presented in a number of settings, including scientific conferences, public health conferences, and as continuing education for the participating Title V funded maternal health agencies across Iowa. The primary findings from the formative work suggested that perinatal women needed the following in order to make perinatal depression care accessible and acceptable: 1) Enhanced education about perinatal depression and treatments for women and their providers. 2) Continued efforts to develop alternatives to traditional treatment options and settings. 3) Improved trust in their providers through education and collaboration between their primary providers and expert care. Each of these areas related in part to concerns about taking antidepressant medications while pregnant or breastfeeding. Preliminary findings were presented at the biennial Marcé Society conference. Work with my research assistant and ongoing collaborator, ..., on these data continues. Moreover, the findings directly impact the work that I and my WWC colleagues and trainees perform each day.

The capstone of my professional productivity and scholarship thus far, particularly in terms of contribution to the University of Iowa Hospitals and Clinics and College of Medicine, has been the development of the Women's Wellness and Counseling Service (WWC) and its fulfillment of the mission of clinical care and service, research, and education. During my first faculty years, as the sole dedicated mental health provider for perinatal women, I often found myself pulled toward a desire to help expand care for these patients. Likewise, I was drawn to teaching at the college and state level about this

important population, imparting the fundamental knowledge and skills relevant to their care. These interests led to my decision to switch in 2008 to a clinical track appointment. This focus has allowed for and I to work together to develop the most successful outpatient specialty clinic in the Department of Psychiatry. From seeking input from my patients in naming the service to the unique nature of providing on-site mental health in the Women's Health Center, the WWC has emphasized provision of high quality, accessible mental health care to perinatal women and other women with reproductive-related psychiatric concerns. The WWC is the clinical recruitment and treatment site for research studies affiliated with the IDCRC, including two NIH funded studies of treatments for perinatal depression. Through this connection, I am delighted to continue to participate in all phases of research, from study design to serving as a treatment provider.

From the earliest days, the WWC has responded to the growing needs of its patient population and their preferences. Clinically, we have expanded to our current staff of three psychiatrists, one Ph.D. psychologist, one L.I.S.W. therapist, and have as many as three general psychiatry residents and four psychology graduate students providing evaluation, pharmacologic treatments, and psychotherapy. My role in the development and expansion of the clinic has largely focused on three areas: 1) Supervision and support of clinical services, including serving as the administrative liaison between obstetrics and gynecology and psychiatry staff to coordinate all clinic logistic issues. I also developed an "on-call" system to respond to questions about perinatal psychopharmacology, as my WWC colleagues and I are identified as the "go to" consultants at the department and college level, and at the state level I have developed a web-based consultation service. I am presently evaluating the effectiveness of the web-based service in responding to state-wide requests for consultation. 2) Develop, maintain, and revise clinical initiatives. Through our clinical collaborations, the impact of the WWC is far-reaching. These include, the previously noted perinatal depression screening programs both at UIHC and statewide as well as my service as a liaison to the group prenatal care program "Centering Pregnancy," for which I supervised the development of an interactive education program on stress and depression in the perinatal period and participate regularly in its delivery. I have also supervised the development and revision of a clinical intake questionnaire for the WWC, focused on areas relevant to women's mental health, improving accessibility of services, and ensuring comprehensive care. I am currently facilitating its move to an electronic format which will enhance its clinical and, potentially, research utility. Each of these projects serves as an excellent clinical referral and research study recruitment opportunity. 3) Primary educational director. We have developed a popular education program in the WWC, drawing trainees from multiple health disciplines. I will discuss this further in the Statement on Teaching.

The future holds many opportunities to continue to build programming addressing maternal and women's mental health. My ongoing relationship with the Bureau of Family Health and its initiatives has been and remain an area for growth. Clinically, through connections built by Project LAUNCH and participation on its state council, I will be piloting a telehealth service for mothers of children receiving care through Iowa's Child Health Specialty Clinics. Adding clinical capacity through technology, in addition to the web-based consultation, is an exciting area for collaboration on a statewide basis. Through my involvement in Graduate Medication Education wellness programming, I plan to build support programming focused on the unique needs of female trainees. Currently, I teach trainees from

a wide range of departments about self-care, stress management, and burnout and provide clinical care for female residents and fellows in the WWC. Continued clinical and scholarly innovation in women's mental health and wellness will allow me to continue to improve the mental health and well-being of women, locally and statewide, with future national applications.

Statement on Teaching

My clinical teaching has largely been interwoven with my interest in training providers from a number of disciplines about women's mental health so that they are prepared to address the myriad needs of this special population. Two key concerns of perinatal women are: 1) knowing that their providers are well-educated about perinatal depression and its treatments and 2) trusting their providers have and will collaborate with perinatal mental health experts. While I provide teaching in the psychiatric medical student clerkship on a variety of topics, my primary focus has been on developing a psychiatry clerkship outpatient experience and a fourth year elective for students, each focused on women's mental health. These are highly reviewed experiences, attracting motivated students heading into the related fields of obstetrics/gynecology, pediatrics, family medicine, and internal medicine-women's health, as well as psychiatry. It is here that my preparation of providers, ready to deliver informed care for women, begins. During their respective experiences, medical students read classic and current literature on perinatal and women's mental health and evaluate new and return patients for perinatal and reproductive psychiatric concerns. For elective students, the readings are more advanced and clinical experiences include additional independence and exposure to the clinic population at the VA-Women's Clinic in Coralville, as well as participation in WWC educational activities. The elective has culminated in a required women's mental health presentation, setting the presentation standard for other psychiatry electives. Most recently, an individually arranged elective student, (, now an obstetrics and gynecology resident at University of Madison, developed her presentation into the first prize winning essay in the Robert D. Sparks essay contest. Supervising and editing the writing of "Sadness and Support: A Short History of Postpartum Depression" was one of the highlights of my 2013 teaching year. Previous students often stay connected to the service, training and teaching both as medical students and residents. participated in the clerkship and elective rotations and is now a resident in her second year of service with the WWC.)., a former elective student and now a combined family medicine-psychiatry resident, teaches in the elective, providing one-on-one guided reading and discussion on topics relevant to women's mental health and her dual training and will join the WWC clinic next year.

Importantly, my teaching life mirrors my clinical life. Just as I go on-site to the Women's Health Center to provide mental health care in the WWC, I have developed an interactive women's mental health lecture that I provide regularly for the obstetrics and gynecology medical student clerkship. This is an excellent example of modeling the significance of work done at the interface of medical specialties. More recently, this cross-department education of trainees has moved to the next level. In 2013, the first group of obstetrics and gynecology residents rotated with the WWC. They participated in our education activities, prepared a presentation, and evaluated patients, during which we all learned how beneficial it can be when a patient is able to collaborate with her women's mental health provider and women's health provider in the same room. I am excited about the potential that this training

experience has in developing expertly trained women's health providers who are capable of evaluating and treating women's mental health issues. The importance of addressing mental health for perinatal women and their care providers is also reinforced by the book chapter I wrote on mental health in pregnancy for Clinical Maternal-Fetal Medicine and my recent invitation to begin teaching in the maternal-fetal medicine fellowship training here at Iowa.

My general psychiatry resident teaching follows a similar pattern, as I am a significant contributor to the general teaching in the department, primarily in the adult outpatient psychiatry clinic and in the psychotherapy lecture series. Beyond this, I have focused on women's mental health teaching. I have had the opportunity to double the perinatal psychopharmacology instruction for our residents, as well as both coordinate and participate in the women's mental health lecture series for the general psychiatry residents. These lectures cover psychiatric treatment of the major psychiatric disorders in pregnancy and lactation, perinatal mood disorders and other reproductive related disorders, as well as other topics of importance to women's mental health, including outside guest lecturers on topics such as trauma. My teaching in the general adult clinic and in the psychotherapy curriculum offers opportunities to reinforce the lessons of preconception planning, risk-benefit discussions in perinatal care, and the importance of psychotherapy, specifically Interpersonal Psychotherapy, for a population at high risk for interpersonal or parent-child difficulties and often reluctant to take medications due to safety concerns. I have also had the opportunity to influence the training of residents here, and elsewhere, in writing the chapter on management of depression in pregnancy for Psychosomatic Medicine: An Introduction to Consultation-Liaison Psychiatry.

Teaching in the WWC has afforded me the tremendous opportunity to develop a group of future experts in women's mental health care. In the WWC, a major component of my role as co-director focuses on coordinating the women's mental health curriculum. With rotations ranging from six months to a full year, trainees in both psychiatry and psychology graduate programs participate in weekly combined psychotherapy-psychopharmacology case conferences, multidisciplinary education sessions focused on women's mental health and psychotherapy for women, as well as evaluating and treating patients with perinatal or reproductive mental health concerns on an ongoing basis. A number of trainees continue to provide care for their WWC patients in an optional continuity of care clinic in their final year of residency. In addition to providing more in-depth lectures on topics perinatal mental health, medications in pregnancy and lactation, alternative treatments such as exercise, access to care, and partners of postpartum women, I coordinate this year-long education series which covers wide-ranging women's mental health topics, as well as psychotherapy for women, which is taught largely by . Outside speakers are a common feature, again reinforcing the importance of working side-by-side with our maternal-child health partners. All WWC trainees and staff are required to lead case conference and education sessions throughout the year. Trainees are encouraged to teach and have the opportunity to teach medical students while rotating in the WWC. One former resident, now psychiatry faculty member, , worked with me to create a teaching module on perinatal depression for psychiatry clerkship students. Over time, the WWC has hosted a variety of other trainees, including a graduate student in social work, a physician assistant fellow, and nurse practitioner student. The broad importance of women's mental health is emphasized by the number of opportunities I have had

to teach students in other colleges and disciplines at the University of Iowa, including the College of Nursing and College of Public Health.

Beyond the University, I am a frequent speaker in community and continuing education settings. I have also produced education materials through my partnerships with IDPH targeted at both women and their providers, most notably in my contribution to the text for the Iowa Perinatal Depression Project's website (www.beyondtheblues.info) and a pocket guide "A Provider's Guide to Perinatal Depression," which was distributed to women's health providers across the state of Iowa. I have found it extremely rewarding when women have contacted me to seek help for previously untreated concerns and when providers have requested advice about treating their patients. These are a common outcome of my talks, webinars, podcasts, and other teaching venues on topics ranging from identifying and treating perinatal depression or caregiver depression to anxiety in women and premenstrual dysphoric disorder.

In sum, my teaching activities have largely focused on women's mental health and are closely linked with my clinical and research endeavors since residency. The audience for women's mental health is broad, including not only the women themselves, but also multiple service providers who may come in contact with this population, including therapists, social workers, family physicians, internists, pediatricians, and obstetrician-gynecologists, as well as public health practitioners. The overarching goal of my work is to improve the quality of training and the acceptability and accessibility of evidence-based care for perinatal women. Recently, I had the opportunity to join the newly-formed committee on education for the North American Society for Psychosocial Obstetrics and Gynecology (NASPOG). It is my intent to contribute to and learn from the work being done in the teaching of women's mental health across North America in the upcoming years of my career.

Statement on Service

Not unlike my clinical and educational endeavors, my service work is largely focused on contributing to the mental health and general well-being of women, as well as their families. Like many faculty members, I contribute to the University of Iowa Carver College of Medicine by interviewing potential medical students, participating in graduation ceremonies, volunteer teaching in the free mental health clinic, and serving on committees, having most recently agreed to serve on a special ethics committee. Two aspects of my service at the University of Iowa stand out as most rewarding and congruent with my goals of making significant contributions to the mental health and well-being of women. First, I have served on the Family Issues Charter Committee (FICC) since 2008. Given my exposure to the impact of stressors for family caregivers, I am uniquely positioned to contribute to this committee. Together with two other FICC members, I helped to synthesize information about family and maternity leave policies for graduate college students at other institutions, compared these with policies for students in the College of Liberal Arts, as well as from other colleges at Iowa, including the College of Medicine, and made recommendations that positively impacted the wording of and awareness of family leave policies for graduate students and time to dissertation completion. Second, I am currently involved in a project with FICC representative from and manager of Family Services at the University of Iowa, to collaborate on a web-based resource for new parents. We hope that this work will fit together with work being initiated by recent WWC trainee, .D., who will be, under my

supervision, reinstituting a support program for new mothers in the University community. Mentoring of students or trainees, like ; another primary area of university-based service. Over the past several years, I have had a number of opportunities to provide this type of mentorship for undergraduate students, psychology graduate students, medical students, and psychiatry residents. Notable outcomes include not only award-winning essay, teaching sessions, and 's teaching module, but also mentoring other students in women's mental health related projects including an evaluation of UIHC's perinatal depression screening program and consultation on a student research project investigating congenital heart issues in SSRI exposed infants. I am also particularly excited to have co-developed a "Women in Psychiatry" group with , which is dedicated to the personal and professional development of women trainees and faculty, focused on collegial support and education. Now in our earliest formative years, we have focused on readings, videos, and discussions related to a variety of topics including negotiation, leadership, and dealing with gender-specific sexual comments from patients or colleagues. This group has been very popular and, again, contributes to my over-arching goal of promoting the well-being of women.

Outside our institution, my educational seminars and community based talks all focus on the themes of perinatal or maternal mental health and well-being, including, for example, an upcoming talk for Johnson County National Alliance for the Mentally Ill (NAMI) on the impact of caregiver mental health on children. In keeping with my emphasis on women's mental health, I have served as an ad hoc reviewer for several different peer-reviewed journals, largely evaluating papers and brief submissions on topics related to either women's mental health or women's health more generally, especially on areas related to access to care. At the state level, I have been a team member for the maternal health and mental health chapters for Healthy Iowans 2010 and 2020, drafting matching goals for each with regard to maternal mental health. For the future, as noted in my Statement on Teaching, I have recently joined the education committee for NASPOG, and I believe that this service experience will serve as a further stepping stone to developing a national reputation on the accessibility and acceptability of mental health care for women. It is fantastically motivating and rewarding to be able to participate in so many different activities that will positively influence the wellness of women and their families, through direct care, education, and service.