There’s a Big Crack in Pediatric Training, and Children and Families are Falling Through It

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MARSHALL LAND, M.D.

Our objective: To convince you that
• Prevention, identification, and care of B/MH health problems in infants, children, adolescents, young adults, and their families is the responsibility of all pediatricians
• Residency and fellowship training should include development of competencies to address those problems
• Training pediatricians to address those problems is possible—but it will require important and difficult changes
• You are the "tipping point"

Why me?
• My roles with the two sponsoring organizations
  • American Board of Pediatrics
  • National Academy of Sciences, Engineering, and Medicine (NASEM) Forum
• My role as a developmental–behavioral pediatrician
• My role as a parent

• Disclosures: no financial disclosures or conflicts of interest

Why you?
Each one of you has been hand-picked because you are leaders.

Leaders care about complex problems and are willing to take on big, hairy, audacious goals.

Key questions for this meeting
• Is there a problem?
• Is it our responsibility?
• What can we do about it?
• What are our next steps?
Prevalence

- 13-20% of children in the U.S. experience a mental health disorder in any given year (IOM, 2009)
- 14 million children a year (CDC, 2013)
- This doesn’t include those children with risk factors or problems that don’t yet meet the definition of a disorder

So there’s a problem.
Can we do anything about it?
Strong and growing evidence base

- Screening tools
- Prevention programs: universal and at risk
- Behavioral interventions
- Psychosocial treatments
- Psychotropic medications

Screening tools

There are plenty of resources and evidence-based tools although there are implementation barriers.

Key questions for this meeting

- Is there a problem? YES
- Is it our responsibility?
- What can we do about it?
- What are our next steps?
WHO ARE THE CHILDREN WITH BEHAVIORAL AND MENTAL HEALTH NEEDS?

We can’t count on specialists . . .

Can families access B/MH care?

• Only 20% of children and adolescents meeting diagnostic criteria are accessing services
  • Why?
    • Stigma
    • Parents with personal problems
    • Rural residents
    • Minorities
    • Insurance
    • Grant-funded programs that focus on prevention or individuals with risk-factors

Primary care pediatricians reporting too few medical specialists

<table>
<thead>
<tr>
<th>Specialty</th>
<th>Total %</th>
<th>Non-rural %</th>
<th>Rural %</th>
<th>Pletcher et al, J Pediat, 2010</th>
</tr>
</thead>
<tbody>
<tr>
<td>Child/adolescent psychiatry</td>
<td>95.8</td>
<td>95.1</td>
<td>100.0*</td>
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</tr>
<tr>
<td>Developmental behavioral pediatrics</td>
<td>86.6</td>
<td>85.9</td>
<td>92</td>
<td></td>
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<tr>
<td>Pediatric dermatology</td>
<td>87.5</td>
<td>87.5</td>
<td>88.3</td>
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<tr>
<td>Pediatric rheumatology</td>
<td>68.2</td>
<td>67.3</td>
<td>74.0</td>
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<tr>
<td>Pediatric neurology</td>
<td>68.7</td>
<td>68.1</td>
<td>76.7</td>
<td></td>
</tr>
<tr>
<td>Adolescent health</td>
<td>64.2</td>
<td>64.2</td>
<td>64.9</td>
<td></td>
</tr>
<tr>
<td>Others</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pediatric cardiology</td>
<td>37.3</td>
<td>35.9</td>
<td>26.3*</td>
<td></td>
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<tr>
<td>Nephrology</td>
<td>5.5</td>
<td>4.9</td>
<td>13.2*</td>
<td></td>
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</tbody>
</table>

*indicates significant at p < 0.05

What about child and adolescent psychiatrists?

https://www.aacap.org/aacap/Advocacy/Federal_and_State_Initiatives/Workforce_Maps/State.aspx


https://www.americanboard.org/pediatrics/
Workforce readiness: Barriers to mental health care

Horwitz et al., Academic Pediatrics, 2015

Why primary care pediatricians

• First resource parents often go to
  • Trusting, long relationships
  • Less stigma than mental health
  • Increasingly comfortable with a chronic care model
  • Mental health increasingly “mainstream pediatrics”

Why subspecialty pediatricians

• First resource parents of children with chronic conditions often go to
  • Trusting, long relationships
  • Less stigma than mental health
  • Increasingly comfortable with a chronic care model
  • Mental health increasingly “mainstream pediatrics”

Key questions for this meeting

• Is there a problem? YES
• Is it our responsibility? YES
• What can we do about it?
• What are our next steps?

Why you?

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Leaders care about complex problems and are willing to take on big, hairy, audacious goals.

You tube: The doctor said

https://www.youtube.com/watch?v=p3g9dIA001s
We will need to change expectations

- Trainees and faculty
  - Providing B/MH care is the expected responsibility—of trainees and faculty, whether primary or subspecialty care
- Educators
  - Competence in behavioral and mental health care is critical
- Administrators
  - Resources are identified (eg, training, time, people)
- Funders
  - B/MH is prioritized in training

Disincentives for children’s B/MH health

- Faculty not skilled in this area
- Cross-departmental/cross-disciplinary clinics complex
- Funding, time
- Competitive health care markets are narrowly focused on short-term high cost patients who aren’t children
  - Small proportion of overall health expenditures
  - Investments show benefits after long horizons not short-term
- Cross-sector coordination and financing often necessary
  - Not a strong focus on prevention
  - Care focused on the individual patient and not the family

You represent the stakeholders who can help to move us forward

- Parents/patients
- Trainees
- The pediatric training community
- The pediatric B/MH training community
- Federal organizations that fund training or support B/MH care
- Others: Thought leaders, foundations

What do you bring to this meeting?

- Integrated co-occurring pediatric/child psychiatry/child psychology training into program
- Engaged non-pediatrician B/MH faculty formally involved in training
- Embedded B/MH clinicians in general pediatrics, continuity clinic
- Developed novel models of training
  - Common behavioral problems clinic
  - Longitudinal rotations
  - On-line interactive B/MH curriculum
- Two-day “boot camp” program with support calls
- Positive Parenting Program training for residents
- Participated in child/adolescent psychiatric consultation through state models
- Hosted maternal and child health collaborative office rounds
- Developed/provided in evidence based tools eg, motivational interviewing, cognitive behavioral therapy, help seeking
- Set up a collaborative learning community for program directors
- Prioritized B/MH as a critical initiative
- Advocated for B/MH for children and families

Your hopes for this meeting

- Create community of change agents and build momentum
- Engage families and patients
- Find promising practices
  - Curricula, telehealth, co-management models, longitudinal rotations, subspecialty fellows training, faculty preparedness, assessment tools, ACES and social determinants of health
- Develop an action plan
  - Leadership development
  - Support of QI projects on B/MH training for 3-5 years
  - Payer support
  - Workforce development

We need training programs to acknowledge, respect, and seize the opportunity to address the burden of B/MH problems for families.
Why you?

Each one of you has been hand-picked because you are leaders.

We are asking you to imagine, network, learn from each other, and commit to making a change in the next 6 months.

Resources

- Centers for Disease Control and Prevention, Mental health among children — United States, 2005-2011, http://www.cdc.gov/mmwr/preview/mmwrhtml/su6202a1.htm

Photos

Boy
https://static.pexels.com/photos/256658/pexels-photo-256658.jpeg

Curly haired boy
https://static.pexels.com/photos/784028/pexels-photo-784028.jpeg

Boy on Bus
https://static.pexels.com/photos/918806/pexels-photo-918806.jpeg

Anxiety girl

Baby in hospital

Child behind fence
https://static.pexels.com/photos/350614/pexels-photo-350614.jpeg

Drugs
https://www.pexels.com/search/teen%20doing%20drugs/

Child in park
Preparing Future Pediatricians to Meet the Behavioral and Mental Health Needs of Children

Where are we now?
Where do we want to be?
How do we get there?

Goals
- Compare stated goals of pediatric care to current capacity to meet those goals
- Understand the current structure that determines pediatric training and the barriers and possibilities presented by the way it is supported financially.
- Envision the future.

ACGME Program Requirements for Residency Training in Pediatrics:

“Pediatrics encompasses the study and practice of physical and mental health promotion, disease prevention, diagnosis, care, and treatment of infants, children, adolescents and young adults during health and all stages of illness.”

American Board of Pediatrics

Vision: The “North Star” for the ABP is and will remain the improvement of health outcomes for children, adolescents, and young adults.

Guiding Principles: The ABP sets standards for key elements of accredited training based on health needs of populations served, recognizing the value added by the interdependence of the relationship between certification and accreditation. [my emphasis]
Previous calls for action by pediatricians:

1978: Future of Pediatric Education Task Force Report called for residency programs to provide more training in behavioral, developmental, and adolescent issues, to improve physicians’ skills in working with other health professionals.

2000: FOPE II, Pediatric Generalists of the Future Workgroup Report: “Extra training in children’s mental health must be provided, particularly with respect to the initial assessment, diagnosis, and treatment of common childhood psychiatric conditions and the use of pharmacotherapy and other modalities.”

How are we doing?
Residency Training in Mental Health Care

- 2014 survey; 99 program directors (51%) response
- 8% required MH rotation; 87% incorporated MH training in other rotations
- 64% of PDs reported resident had knowledge of ADHD diagnosis; 57% treatment
- Less than 50% reported resident knowledge/skill was very good/excellent in
  - Principles of behavior change
  - Evidence-based psychosocial interventions
  - Psychopharmacologic interventions
  - Treatment of depression


AAP Periodic Survey, 2013

- 65% of the 512 pediatricians surveyed indicated they lacked training in the treatment of children and adolescents with mental health problems
- 40% lack confidence to recognize MH problems
- >50% lack confidence to treat MH problems
- 44% not interested in treating, managing, or co-managing child mental health problems


Program Directors: What could you do to insure that trainees would be incompetent in B/MH care?

- Do not acknowledge, screen, or assess for B/MH problem
- Focus on documentation and productivity
- Minimize the importance of behavioral and mental health—“That’s not our problem.”
- Focus only on physical health issues in settings like the PICU and ED
- Assign residents disproportionately to rotations in ICUs and emergency departments
- Sito B/MH care by location; use separate medical records for physical and B/MH care, and manage B/MH issues exclusively in psychiatry clinics
- Prioritize block rotations rather than longitudinal experiences
- Eliminate or minimize the importance of adolescent medicine and developmental/behavioral rotations

Graduating Residents and Common Childhood Mental Health Problems (CCMPs, n=107)

<table>
<thead>
<tr>
<th>Attitudes on Competencies</th>
<th>Percent Endorsing Agree/Strongly Agree</th>
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<tbody>
<tr>
<td># going into primary care</td>
<td>Competent in the identification of CCMPs</td>
</tr>
<tr>
<td></td>
<td>Competent in the management of CCMPs</td>
</tr>
<tr>
<td></td>
<td>Competent in the referral and co-management of CCMPs</td>
</tr>
<tr>
<td># going into subspecialty care</td>
<td>Competent in the identification of CCMPs</td>
</tr>
<tr>
<td></td>
<td>Competent in the management of CCMPs</td>
</tr>
<tr>
<td></td>
<td>Competent in the referral and co-management of CCMPs</td>
</tr>
</tbody>
</table>

My training program is committed to ensuring graduating residents can address CCMPs | 84% |
Perception of Graduating Residents’ Comfort Level (n=102)

<table>
<thead>
<tr>
<th>Mental Health Competency</th>
<th>Percent Endorsing Somewhat/Very Comfortable</th>
</tr>
</thead>
<tbody>
<tr>
<td>Providing anticipatory guidance around common behavioral health problems (e.g., social-emotional difficulties, discipline)</td>
<td>78%</td>
</tr>
<tr>
<td>Eliciting parent/patient concerns in an empathetic manner</td>
<td>86%</td>
</tr>
<tr>
<td>Managing behavioral problems (e.g., social-emotional difficulties, disciplinary issues)</td>
<td>54%</td>
</tr>
<tr>
<td>Using evidence-based tools like motivational interviewing to encourage engagement in treatment</td>
<td>39%</td>
</tr>
<tr>
<td>Identifying ADHD</td>
<td>89%</td>
</tr>
<tr>
<td>Treating depression and/or anxiety with medications</td>
<td>23%</td>
</tr>
</tbody>
</table>

Mental Health
What are Possible Roles of the ACGME Requirements & ABP Credentialing?

Ann Burke MD
Chair, ABP Board of Directors
Program Director, Wright State University
Boonshoft SOM

Suzanne Woods MD
Executive Vice President, ABP
Credentialing and Initial Certification

Disclosures
Ann Burke, MD
• None
• Member of the Pediatric Review Committee at the ACGME

Suzanne Woods, MD
• None
• Former Chair of the Pediatric Review Committee at the ACGME

ACGME & ABP

Accreditation Council for Graduate Medical Education (ACGME)

• Certifies individual pediatricians
• Sets the standards residents must meet during training to be admitted to the initial certification examination and for fellows to be admitted to the subspecialty certifying examination
• Works closely with ACGME to ensure that requirements for program accreditation & standards for certification of individuals are aligned

American Board of Pediatrics (ABP)

• Develops the accreditation requirements for training programs
• Evaluates programs through site visits and data collection

ACGME: Possible Tools

1. Graduating resident survey?
   “Recognize and assist in the management of common behavioral/mental health problems”
2. Competency based requirements that emphasize mental health?
3. Mandated rotation?
4. Mental health EPA as a requirement?

ACGME

• Flexibility vs prescriptive details
• Outcomes vs process
• Create change: examples
  • Developmental behavioral rotation
  • Section VI wellness
ABP Credentialing and Initial Certification

- Set standards - applicants must complete training in an ACGME accredited program
- All information submitted: applicant + program director
- Successful completion of 6 competencies on final evaluation
- Successful completion of examination

ABP Credentialing and Initial Certification

- Encourage emphasis on Mental Health
- Modify the blueprint of the certifying exam to include more mental health questions
- Promote EPAs and Competencies
- Educate Program Directors

ABP

Entrustable Professional Activities

#9 Assess and manage patients with common behavior/mental health problems

Challenge: No data on level of entrustable acceptable for credentialing
Consideration: Collection of information – pilot
Needs: Community education, implementation info

EPA’s

STAY TUNED…

Graduate Medical Education Funding: Does it currently limit what we can do in behavioral and mental health training?

Michael Artman, MD
Senior Vice President, Pediatrician-in-Chief
Chair, Department of Pediatrics
University of Missouri-Kansas City and Kansas University Medical Center

GME Funding: Does it currently limit what we can do in behavioral and mental health training?

Short Answer: No (sort of)
**GME Funding: How is it structured now?**

- **1965**: Medicare and Medicaid Act began federal funding
  - Intended as a short-term solution for physician shortages
  - Driven by Medicare: Free-standing children's hospitals excluded
- **Two major components**: Direct and Indirect
  - **Direct GME (DME)**: calculates a per-resident allocation
  - **Indirect GME (IME)**: calculation based on resident-to-bed ratio; attempts to account for higher indirect patient costs incurred by Academic Medical Centers
  - Both capped at 1996 levels by Balanced Budget Act of 1997

**CHGME Payment Methodology**

- Mirrors the model for Medicare GME funding
  - 1/3 DME and 2/3 IME
  - Zero-sum game: total amount set; share to each hospital applying for funds allocated annually, according to the following straightforward formulas

\[
DME_{PAYi} = \frac{Z_{DME} \cdot X \cdot (WFTE_{1996\text{cap}} + WFTE_{\text{current}}) \cdot (LRS \cdot W_{Ii} + N_{LRS})}{X \cdot \sum_{\text{i=1}} \left( WFTE_{1996\text{cap}} + WFTE_{\text{current}} \right) \cdot (LRS \cdot W_{Ii} + N_{LRS})}
\]

\[
IME_{PAYi} = \frac{Z_{IME} \cdot NoDi \cdot CMIi \cdot (LRS \cdot W_{Ii} + N_{LRS}) \cdot ADJUSTi}{\sum_{\text{i=1}} NoDi \cdot CMIi \cdot (LRS \cdot W_{Ii} + N_{LRS}) \cdot ADJUSTi}
\]

**GME Funding: Current Problems**

- **Not enough $$**: hospitals cover the shortfall
- **Insufficient transparency and accountability**
- **Free Standing Children’s Hospitals excluded from Medicare DME and IME federal funding program**
  - Children’s Hospital Graduate Medical Education (CHGME) program requires annual appropriation; 2018 target $315M
  - Per resident, only 45% of Medicare $ for training adult specialists
  - CHGME recipient hospitals (less than 1% of nation’s hospitals) train 49% of all pediatricians and 57% of all pediatric specialists

**GME Funding: Does it currently limit what we can do in behavioral and mental health training?**

Short Answer: No (sort of)

- **Sort of**: funding is fixed and in jeopardy; no new dollars for behavioral and mental health training
- **No**: GME funding does not determine educational program requirements during residency training

**GME Funding: Current Problems**

- **Cap on funded slots**: locks in current funding distribution regardless of workforce needs (geography and specialty)
- **Children’s Hospital Association survey of workforce needs**
  - Percent of Hospitals reporting vacancies:
    - #1: Child and Adolescent Psychiatry: 47%
    - #2: Developmental Pediatrics: 47%
  - Top-Ranked shortages that affect ability to deliver care:
    - #1: Developmental Pediatrics
    - #2: Child and Adolescent Psychiatry
Who Determines the Educational Content and Requirements for Residency Education?

- The Accreditation Council for Graduate Medical Education (ACGME)
  - "Independent, not-for-profit, physician-led organization that sets and monitors the professional educational standards essential in preparing physicians to deliver safe, high-quality medical care to all Americans."
- ACGME Program Requirements for Graduate Medical Education in Pediatrics
  - 40 page playbook that guides every pediatric training program

Implications for Next Steps

- "Who" is the ACGME
- American Board of Medical Specialties (ABMS)
- American Hospital Association (AHA)
- American Medical Association (AMA)
- Association of American Medical Colleges (AAMC)
- Council of Medical Specialty Societies (CMSS)
- American Osteopathic Association (AOA)
- American Association of Colleges of Osteopathic Medicine (AACOM)

Summary of GME Funding

- Funding for pediatric graduate medical education is complicated and disproportionately low
- Future funding is uncertain (but not likely to increase)
- Importantly, federal GME funding does not determine educational content and program requirements
- Changes in pediatric residency training program requirements for behavioral and mental health must be implemented by the ACGME

Implications for Next Steps

- "How" do we change training program requirements?
  ACGME Bylaws: "Each Review Committee shall prepare specialty Program Requirements for the specialty Program over which it has cognizance. The specialty Program Requirements shall be approved by the respective Review Committees after review and comment by their Review Committee appointing organizations, and then submitted for approval by the Board of Directors."

Say What?
Envision the future for families:

"What we needed most was the physician recognition of patient/family mental health needs as part of our routine patient experience in the exam room. Then, after receiving that ‘life raft’, it would be nice to know how to get on board with tools, experts and other safe ways to help our child (and ourselves). It’s not a one time conversation, but one that ebbs and flows over and through transition, ages and life changes. It should be normal, empathetic and compassionate."

From the mother of a child with type 1 diabetes mellitus

Call to Action:

“Pediatricians have responded to crises in child health care in the past. We again have an opportunity to define ourselves in relation to the needs of America’s children. If we do not now ensure that graduates of our training programs are prepared to meet those needs, they will continue to be unmet, and the relevance of pediatric care to the health of children will be significantly diminished.”


If only…

Terry Stancin, PhD, ABPP
MetroHealth Medical Center & Case Western Reserve University
Cleveland, OH

If only … this is what pediatric health care looked like

- Care delivered by pediatricians & behavioral health providers (BHPs) working together in teams
- In all pediatric settings: primary care, specialty care, ED, inpatient units, critical care units

If only ....

- For any pediatric patient, the right BHPs available to collaborate in care
- Care made use of most current technologies to measure/monitor outcomes & to ensure efficiency
- Services were financially sustainable
Imagine pediatric training

- Faculty: interprofessional teams of peds + BHPs
- BHPs embedded in all training experiences

If only ... e.g., Inpatient rounds

- Instead of current typical rounds
- Team rounds led by Peds & BHP faculty discuss each patient with peds & BHP trainees
- Morning report presentations by peds & BHP trainees

MetroHealth Integrated Care Model

If only ... e.g., Continuity Clinic

- Team consists of peds residents & BHP trainees
- Cross discipline precepting provided by Peds & BHP faculty
- Warm-handoffs, shared decision-making, care coordination, same day & follow up BHP appts seamlessly occur
- Telehealth child psychiatry consultations

Highlights of Interprofessional Training: MetroHealth Model

- BHP trainees
  - Psychology graduate students, APA interns, postdoctoral fellows
  - Social work students, psychiatric APN students
- Shared didactics & clinics
  - Pediatric residents + psychology trainees
  - Psychology trainees clinical time divided
  - Primary care, specialty care, inpatient consults
- Cross-discipline teaching
  - Psychology & child psychiatry mentors of peds residents
  - Pediatric mentors for psychology trainees
- Simulated interprofessional team training
- Psychopharm consultation training
  - For peds + psychology trainees
- Sustainable clinical model
  - Most behavioral health services are billable
What will it take to get there?

- Dedicated “change makers”
- To champion shift in models of pediatric care delivery & training
- Pediatric and BH leaders
- Commitment
- To create culture where developmental, BH, social factors are foundation for all pediatrics, including specialties
- To bring resources necessary to support new culture
- Recognition & support for training needs of BHPs
- Workforce shortages

CHANGE starts with YOU

Payment for integrated care
ABP/NASEM Stakeholder meeting: Preparing Future Pediatricians to Meet the Behavioral and Mental Health Needs of Children
April 6, 2018

Katherine Hobbs Knutson, MD MPH
Adjunct Assistant Professor, Duke University School of Medicine
Department of Psychiatry
Chief Medical Officer, Alliance Behavioral Healthcare

Challenges for payment for integrated care

- Practicing integrated care in a fee-for-service payment environment is almost impossible.
- Prohibitions on “same day billing” for physical and behavioral health services continue in many states.
- We haven’t achieved true parity in terms of service delivery and payment in most states.
- Behavioral health carve-outs complicate billing, especially for physical health providers.

Promising solutions for paying for integrated care

- Capitated payments and value based purchasing arrangements

National examples of payment systems supporting integrated care for youth

- Health Homes
  - Purpose: Integrated physical, behavioral health, and community-based support services for individuals with 2+ chronic conditions.
  - Components of Health Homes:
    - Care management and coordination, including coordination across treatment settings
    - Individual and family supports
    - Referral to community support services
    - Incorporation of Information Technology (IT) into health services

Figure 1: Payment Reforms That Move Away from Fee-for-Service

National examples of payment systems supporting integrated care for youth

- Montefiore Health System: Creating capitation out of fee-for-service
  - At-risk Integrated provider association (IPA) between physicians and the hospital.
  - Robust care management services.
  - Collocated behavioral health and primary care services.
  - Demonstrated improvements in efficiency and health outcomes.

### Evidence for pediatric integrated/collaborative care

#### Four selected randomized trials

<table>
<thead>
<tr>
<th>Study</th>
<th>Population</th>
<th>Intervention</th>
<th>Comparator</th>
<th>Outcome measures</th>
</tr>
</thead>
<tbody>
<tr>
<td>DOCC, Children’s Hospital of Pittsburgh, Road,</td>
<td>352 children ages 8-17yrs</td>
<td>Triple Depression: Case manager provided psychoeducation and treatment planning, CBT (two 45 min sessions over 6 months), psychoeducation</td>
<td>Control: Primary care intervention</td>
<td>Clinical improvement: 81% vs 49%, Quality of life: 10% vs 3%, Satisfaction with care: 97% vs 67%</td>
</tr>
<tr>
<td>University of Washington, Seattle,</td>
<td>132 children ages 8-17yrs</td>
<td>Depression: Primary care intervention</td>
<td>Control: Usual care</td>
<td>Clinical improvement: 76% vs 56%, Quality of life: 12% vs 6%, Satisfaction with care: 90% vs 75%</td>
</tr>
<tr>
<td>UHC, University of California, Los Angeles,</td>
<td>123 children ages 8-17yrs</td>
<td>Depression: Case manager provided psychoeducation and CBT (two 45 min sessions over 6 months), psychoeducation</td>
<td>Control: Usual care</td>
<td>Clinical improvement: 76% vs 56%, Quality of life: 12% vs 6%, Satisfaction with care: 90% vs 75%</td>
</tr>
<tr>
<td>Boston Medical Center,</td>
<td>120 children ages 8-17yrs</td>
<td>Triple ADHD: Case manager provided psychoeducation and motivational interviewing to address ambivalence toward medications, stepped care based on PHQ-15, psychoeducation</td>
<td>Control: Primary care intervention</td>
<td>Clinical improvement: 76% vs 56%, Quality of life: 12% vs 6%, Satisfaction with care: 90% vs 75%</td>
</tr>
</tbody>
</table>

#### Selected outcomes

<table>
<thead>
<tr>
<th>Study</th>
<th>Clinical improvement</th>
<th>Quality of life improvement</th>
<th>Increased health service use</th>
<th>Satisfaction with care</th>
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<tr>
<td>DOCC, Children’s Hospital of Pittsburgh, Road,</td>
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<tr>
<td>Boston Medical Center,</td>
<td>✓</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
</tr>
</tbody>
</table>

*NA = Not applicable, ✓ = Statistically significant (p<0.05), √ = Not assessed

Capitation to support clinical services provided during training and education

- Training programs can develop integrated behavioral health and primary care clinics.
- Incorporate both pediatrics and psychiatry trainees.
- Key components: Team visits, team huddles, care management support.
- Easier to accomplish within capitated payment arrangements, but not impossible in fee-for-service.

Summary

- Payment for integrated care almost completely requires capitated payments, as opposed to fee-for-service.
- Payment for integrated care has been successful nationally.
- Capitation payment arrangements for integrated care may also support training programs.
THE MENTAL HEALTH EPA: HOW WILL IT HELP DEFINE THE PEDIATRICIAN OF 2025?

Kenya McNeal-Trice, MD
Residency Program Director, University of North Carolina
and
Michael Barone, MD
Vice President of Licensure Programs, National Board of Medical Examiners

ENTRUSTABLE PROFESSIONAL ACTIVITY

- The entrustable professional activity (EPA) concept allows faculty to make competency-based decisions on the level of supervision required by trainees.
- Competency-based education targets standardized levels of proficiency to guarantee that all learners have a sufficient level of proficiency at the completion of training.
- These frameworks must translate to the world of medical practice.
- EPAs were conceived to facilitate this translation, addressing the concern that competency frameworks would otherwise be too theoretical to be useful for training and assessment in daily practice.

-Olle ten Cate, Journal of Graduate Medical Education

GENERAL PEDIATRICS EPA CURRICULAR WORKGROUP

- Marsha Anderson – Children’s Hospital Colorado
- Mike Barone – Vice Pres., National Board of Medical Examiners
- Ann Burke – Dayton Children’s Hospital
- Sharon Calaman – St. Christopher’s Hospital for Children
- Anna Kuo – Peachtree Park Pediatrics, Atlanta, GA
- Jerry Larrabee – University of Vermont Children’s Hospital
- Kenya McNeal-Trice – North Carolina Children’s Hospital
- Sue Poynter – Cincinnati Children’s Hospital Medical Center

DEVELOPMENT OF EPA 9

- EPA Writing Group
- EPA 9 – Subgroup
  - Development of Draft
  - Review
  - Submit
  - Revise
  - Finalize

EPA 9
Assess and manage patients with common behavior/mental health problems.
EPA 9 SUMMARY

- **Rationale:** Pediatric care must assess behavioral wellness and address prevention as well as anticipate, identify, and manage behavioral and mental health needs, recognizing when consultation is needed.
- **Scope:** Assessment, diagnostic criteria, screening instruments, pharmacotherapy.
- Generally within the scope to recognize, evaluate, and initiate treatment: Common behavioral issues—bedtime refusal, tantrums, delayed toilet training; ADD, depression, anxiety, autism; normal adolescent dev issues/conflict, and substance abuse.
- Referrals as needed and awareness of mental health resources in community.

PEDIATRIC MENTAL HEALTH CRISIS

- 2001-2011: Childhood disability due to mental health conditions increased by 20.9%.
- 1 in 13 high school students attempts suicide.
- Lifetime prevalence among 18 year olds:
  - Depression 18.6%
  - Specific phobia 19.9%
  - OCD 12.6%
  - ADHD 8.1%

WHAT ARE THE MOST PRESSING ISSUES YOU ARE FACING AS A RESIDENCY PROGRAM DIRECTOR?

1. Preparing residents to treat mental healthcare conditions
2. Incentivizing faculty for educational activities
3. Resident and Faculty well-being

SURVEY OF PEDIATRIC PROGRAM DIRECTORS

- **Preparedness to diagnose and manage mental health issues:**
  - Not at all: 7
  - At all: 93

What are the biggest barriers to mental health training in your program?

- Lack of faculty expertise: 59%
- Insufficient patient exposure: 34%
- Residents do not prioritize mental health as a concern: 27%
- Lack of resources: 24%
- Lack of availability of mental health professionals: 17%
Pediatrician of 2025

A day in the life of a pediatric clinic / educator

PGY-1

Adolescent Health Maintenance Visit
15 yr female
• Before visit:
  – Preceptor provides information / resources on Screening, Brief Intervention, Referral to Treatment (SBIRT)
• Screening:
  – In the past year, on how many days have you had more than a few sips of beer, wine, or any drink containing alcohol?
  – “If your friends drink, how many drinks do they usually drink on an occasion?”
• Referral:
  – Substance Abuse Counseling
  – Co-management sought with substance abuse counselor

PGY-2

Diabetes Mellitus; non-adherence
15 yr male
• Before visit:
  – Resident had training in Motivational Interviewing (MI) with standardized patients / feedback from faculty in clinic
• Principles of MI in practice
  – Assesses patients’ interest in change
• Faculty Observation in Clinic
• Follow up:
  – Resident seeks permission to speak to child’s coach
  – One month follow-up visit scheduled
  – Feedback provided from faculty

PGY-3

Well child visit
7 yr Hispanic female- new to practice
• Screening:
  – Before visit- parent raises concern of school problems
  – Pre-visit PSC-17 requested of the parents (Spanish)
• Visit:
  – PSC-17 corroborates history and child’s interaction
  – Many family stressors noted
  – Normal lesion!
  – Common actions approach
  – M.A.R.P.
• Follow up:
  – Reports to preceptor
  – Make aware of community, senior resources
  – One-month follow-up visit
  – Additional scales for AD/HD requested

Pediatrician / Teacher / Faculty Member
Office visit - later this week
27 mo male “Behavior Problems”
• Screening:
  – Routine Developmental Screening (completed at 18mos [no referral])
  – Patient missed 24 month visit
• Pre-Visit: (guided by MH EPA)
  – Complete CK at on-line course
  – (MOC-2 credit)
• Visit:
  – History and Physical
  – M-CHAT-R administered/ scored
  – Referral
  – Local Developmental Services
• Follow-up arranged
The Future: Meeting the Needs of Children

John C. Duby, MD, FAAP, CPE
Professor and Chair, Department of Pediatrics
Wright State University Boonshoft School of Medicine
Vice President of Academic Affairs and Community Health
Dayton Children’s Hospital

If we are successful and effective in changing what and how we teach, what would a pediatric visit look like in 2025?

Mental Health is Mainstream Pediatrics!

The Future of Pediatric Practice

Promoting Social Emotional Development
• An office culture that welcomes mental health discussions
• Group Well Visits
• Universal positive parenting supports

Fostering Resilience

Universal Screening and Management
• Screening
  - Social Determinants of Health
  - Adverse Childhood Experiences: 2 generation
  - Postnatal Depression and Anxiety
  - Developmental and Social-Emotional Status
  - Adolescent Depression and Substance Use
• Management: Mild to Moderate
  - Disruptive Behavior
  - ADHD
  - Anxiety
  - Depression
  - Learning and Developmental differences
  - Trauma

Pediatric Medical Home
Early Brain and Child Development
Community Connections
Chronic Condition Management

New CDC Report on Children’s Mental Health

Dayton Children’s Hospital
Collaborative Practice
- Embedded Behavioral health
  - Trauma Informed Care
  - Child Parent Psychotherapy
  - SBIRT
- Social work
- Community health workers
- Care Coordination

Buffering Stress
- Relationships
- Meditation
- Exercise
- Sleep
- Nutrition
- Mental Health

Technology
- Pediatric Telemedicine

Policy Recommendations
- All benefit plans should include coverage and payment for mental health services including those provided by pediatricians.
- Truly establish parity between medical services and mental health services
- Eliminate mental health carve-out models
- Expand and align provider networks

Policy Recommendations
- Support integrated models of care within the family and patient-centered medical home
- Pay primary care clinicians for the mental health services they provide
- Provide payment for peer-to-peer consultation, non-face to face care, team-delivered care and team meetings
- Make a long-term commitment to home visiting programs for at risk families

What can you do to make this happen?

Mental Health is Mainstream Pediatrics!
There’s a Big Crack in Pediatric Training. What Can and Should We Do About It?

LAUREL K LESLIE, MD, MPH
AMERICAN BOARD OF PEDIATRICS

Is there a problem? YES

Is it our responsibility? YES

What can we do about it?

What are our next steps?

Key questions for this meeting

Tomorrow’s agenda

• Panel
• Brainstorming breakout groups
• Round robin
• Lunch with abstracts
• Commitment to change breakout groups
• Commitment to change “fishbowl” conversations
• Finalize your commitment to change before your departure

Tonight’s “to do”

• Take a look at the questions for your brainstorming group and the other groups in your agenda book
• Remember: bring your name badge back tomorrow-you will need it!
• But, also . . .

Imagine training as you hope to see it . . .

• Extended periods of longitudinal, ambulatory care
• Partnering with B/MH provider in a subspecialty clinic
• Spending time with B/MH provider in the PICU, NICU, or ER
• Young adult patients, parents, and trainees co-designing curriculum
• B/MH has a standard item in the patient history
• Including B/MH in resident surveys and assessment
• Trainees seek feedback on their skills managing children with B/MH issues
• Resident assignments and experience reconsidered in light of child health needs
• 8.6% have asthma
• 20% of children have a diagnosable behavioral/mental health disorder

Commitment to change

• Each organization is begin asked to commit to implementing one change strategy over the next 6 months
• To help you plan for that change strategy, we are using some tools provided by the IHI’s course “Leadership and Organizing for Change”
• You can find the IHI framework and worksheet
  • In your agenda book
  • On your tables
  • In your email
Imagine a motivating vision...

And develop your personalized, compelling narrative of why now, what, for whom, and how.

Examples of theories of change

- Build awareness
- Develop a toolkit
- Provide training in skills
- Employ technology
- Advocate/influence policy
- Create social movements
- Mandate a change

Identify your...

- Measureable aim that we can accomplish in the next 6 months

Think about people

Who are we organizing?
With whom should we build relationships?
Lay out your tactics and timeline

Why these tactics and not others?
1. Will it influence the outcome you’re hoping to achieve?
2. Will it use your resources effectively?
3. Will it create organizational capacity?
4. Will it develop leadership?

Your commitment to change statement

“I am organizing (WHO — leadership & constituency) at (WHERE) to do (WHAT — measurable aim) by (HOW — tactics) because (WHY — motivating vision) by (WHEN — timeline).”

We are organizing parents, patients, trainees, leaders in pediatric residency training (program directors and department chairs), pediatric organizations, regulators, and funders to make an improvement in the B/MH training of pediatric residents by implementing one change strategy of their choice within six months of attending the ABP/NASEM meeting because we want to improve residents’ comfort level and competencies in B/MH with the ultimate goal to improve outcomes for children and families.

IHI framework for organizing for change

• Motivating vision and narrative
• Theory of change
• Measureable aim
• People
• Assets
• Tactics and timeline

But we can’t do it without you and your organizations.

We are guilty of many errors and many faults,
But our worst crime is abandoning the children,
Neglecting the fountain of life.
Many of the things we need can wait,
The child cannot wait.
Right now is the time his bones are being formed,
His blood is being made,
And his senses are being developed.
To him we cannot answer ‘tomorrow’,
His name is Today.

Gabriela Mistral, 1945, first Latin American author to win Nobel Prize in literature
Maternal and Child Health Bureau
Preparing Future Pediatricians to Meet the Behavioral and Mental Health Needs of Children

National Academies of Sciences, Engineering, and Medicine
and American Board of Pediatrics
2018 Stakeholder Meeting
April 6, 2018

Laura Kavanagh, MPP
Maternal Child Health Bureau (MCHB)
Health Resources and Services Administration (HRSA)

Presentation Agenda

• Overview of Maternal and Child Health Bureau (MCHB)
• Describe MCHB Efforts to Support Pediatricians to address the Behavioral and Mental Health Needs of Children
  • Workforce/Training Programs
  • Bright Futures
  • Opportunities/Emerging Issues

Maternal and Child Health Bureau

Mission:
Improve the health of America’s mothers, children, and families.

MCHB Workforce Development Programs

• Developmental-Behavioral Pediatrics (DBP)
• Leadership Education in Neurodevelopmental and Related Disabilities (LEND)
• Leadership Education in Adolescent Health (LEAH)
• Collaborative Office Rounds (COR)

Collaborative Office Rounds Program

• To foster joint pediatric-child psychiatry continuing education in psychosocial development aspects of child health
• Uses a grand rounds approach to train pediatricians in mental and behavioral health
• 2017 internal evaluation indicated:
  • model of joint pediatric-child psychiatry communication, education, and collaboration is improving the professional competence of participants
  • impact on the community by increasing collaboration and networking to improve access to behavioral health care for children.
Reaching Pediatricians through Interdisciplinary Training

In FY 2015, MCHB trained 750 pediatricians through these interdisciplinary programs

<table>
<thead>
<tr>
<th>Program</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>LEND</td>
<td>407</td>
</tr>
<tr>
<td>LEAH</td>
<td>228</td>
</tr>
<tr>
<td>DBP</td>
<td>115</td>
</tr>
</tbody>
</table>

Reach of DBP and COR Programs

<table>
<thead>
<tr>
<th>Type of Trainee</th>
<th>Number of Trainees</th>
</tr>
</thead>
<tbody>
<tr>
<td>Long-Term Trainees (&gt;300 hours training)</td>
<td>50</td>
</tr>
<tr>
<td>Medium-Term Trainees (41-299 hours training)</td>
<td>441</td>
</tr>
<tr>
<td>Short-Term Trainees (0-40 hours training)</td>
<td>2,454</td>
</tr>
<tr>
<td>Continuing Education Participants</td>
<td>30,063</td>
</tr>
</tbody>
</table>

Bright Futures Guidelines for Health Supervision

- To improve health outcomes for the nation's infants, children, and adolescents by increasing the quality of primary and preventive care with age-specific, evidence-driven clinical guidelines.
- Provide technical assistance to three key audiences:
  - Health care professionals
  - State maternal and child health programs
  - Families

Bright Futures: Tools and Academic Training

- Integrate Bright Futures into professional preparation and academic training programs for primary care clinicians
- Develop innovative strategies and tools

Bright Futures: Continuing Education Training

- Develop continuing education training
- Provide educational tools
- Use technological innovations
- Training on best practices for:
  - Effective psychosocial/behavioral screening, referral, and care coordination
  - Mental health and the misuse of opioids

Bright Futures Reach to Academic Training Programs and Practitioners

<table>
<thead>
<tr>
<th>Discipline</th>
<th>Number of Academic Training Programs</th>
<th>Number of Practicing Practitioners</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pediatrics</td>
<td>207</td>
<td>91,915</td>
</tr>
<tr>
<td>Family Practice</td>
<td>583</td>
<td>70,989</td>
</tr>
<tr>
<td>Nurse Practitioners</td>
<td>350</td>
<td>106,073</td>
</tr>
<tr>
<td>Physician Assistants</td>
<td>229</td>
<td>70,383</td>
</tr>
</tbody>
</table>
Future Opportunities/Emerging Issues

- Innovative Models of Expanding Access to Care
  - Telehealth, teleconsultation, tele-training
  - Team-based/interdisciplinary Care
- New Approaches
  - Two-generation approaches to systems and care
- Emerging Issues
  - Opioid epidemic

Contact Information

Laura Kavanagh, MPP
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Maternal and Child Health Bureau (MCHB)
Health Resources and Services Administration (HRSA)
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Phone: 
Web: mchb.hrsa.gov

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There’s a Big Crack in Pediatric Training; We’re Going to Do Something About It!

LAUREL K LESLIE, MD, MPH

AMERICAN BOARD OF PEDIATRICS

There’s a Big Crack in Pediatric Training; We’re Going to Do Something About It!

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AMERICAN BOARD OF PEDIATRICS

Key questions for this meeting

• Is there a problem? YES
• Is it our responsibility? YES
• What can we do about it? WE GOT IDEAS!
• What are our next steps?

Commitment to Change Breakout

• What does the commitment to change include?
  “I am organizing (WHO — leadership & constituency) at (WHERE) to do (WHAT — measurable aim) by (HOW — tactics) because (WHY — motivating vision) by (WHEN — timeline).”
  • Can be done
    • On paper (handouts at your table) or
    • Electronic (in your email)
  • We expect a commitment to change from each of you

IHI Framework as a living document

• IHI Framework
  • Motivating vision and narrative
  • Theory of change
  • People
  • Assets
  • Measureable aim
  • Tactics and timeline

Your commitment to change

• During the break,
  • If paper, take a picture and send it to us at abpfoundation@abpeds.org
  • If electronic, email us at abpfoundation@abpeds.org

Next steps

• Use the IHI framework as a working tool over time
  • We are sending you a summary pdf to help you work through this document over time after the meeting
  • We will also send you the abstracts in case you want to reach out to others
  • We will contact you every 2 months to “check in”
  • We will survey you at 6 months to track
    • Steps made
    • Challenges encountered
    • Lessons learned
Email us at abpfoundation@abpeds.org

There’s a big crack and we’re doing something about it!

MARSHALL “BUZZ” LAND, MD
LAUREL K LESLIE, MD, MPH
AMERICAN BOARD OF PEDIATRICS

If you haven’t yet, email us at abpfoundation@abpeds.org

Some commitments prior to this meeting
- NASEM-ABP will follow up with you about your commitments to change
- ABP will host a quarterly virtual meeting with designees from pediatric organizations to create synergies
- APPD has started a B/MH learning community
- AAP has a policy statement coming out that addresses both primary care and subspecialty pediatricians

Wrapping up
- You should have received an email from abpfoundation@abpeds.org
- It includes a very brief evaluation
- Provide feedback to our funders
- Let us know what 1 next step you would like to see leadership groups in pediatrics or at NASEM embrace to help support you

Thank you.