



Entrustable Professional Activities

EPA 4 for Developmental-Behavioral Pediatrics

EPA 4: Recognize and Longitudinally Manage Behavioral Variations, Problems, and Disorders in Typically Developing Children and Children with Developmental Disorders

Supervision Scale for This EPA

1. Trusted to observe only
2. Trusted to execute with direct supervision and coaching
3. Trusted to execute with indirect supervision for most simple cases and some complex cases
4. Trusted to execute with indirect supervision but may require discussion at critical portions of management for a few complex cases
5. Trusted to execute without supervision

Description of the Activity

Developmental-behavioral pediatricians (DBPs) are referred patients (with and without associated developmental problems) due to concerns about their behavior. Behavioral problems occur across a spectrum from variation to problem to disorder, and DBP physicians are responsible for behavioral diagnoses and providing both behavioral and psychopharmacologic management. DBP physicians also need to be confident in differentiating those problems most appropriately cared for by DBP physicians from those that require referral to other mental health specialists.

The specific functions which define this EPA include:

1. Describing the spectrum of behavioral concerns and risk factors for behavioral problems in both children with typical development and developmental disorders
2. Providing behavioral consultations for children with typical development and developmental disorders presenting with behavioral variations and problems
3. Identifying and managing behavioral disorders in children and adolescents with both typical development and developmental disorders

Judicious Mapping to Domains of Competence

- Patient Care
- Medical Knowledge
- Practice-Based Learning and Improvement
- Interpersonal and Communication Skills
- Professionalism
- Systems-Based Practice
- Personal and Professional Development



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Competencies Within Each Domain Critical to Entrustment Decisions

PC 4:	Interviewing families
PC 6:	Using optimal clinical judgment
PC 7:	Developing management plans
PC 9:	Counseling patients and families
MK 1:	Demonstrating knowledge
ICS 3:	Communicating with health professionals
ICS 5:	Consultative role
SBP 2:	Coordinating care

Context for the EPA

Rationale: DBPs are referred patients due to concerns about their behavior. Behavioral diagnoses are primarily clinical diagnoses, and laboratory workup is rarely contributory to the diagnostic process. Thus, DBPs must develop expertise in identification and management of behavioral variations, problems, and disorders in both typically developing children and children with developmental disorders.

Scope of Practice: Behavioral concerns are ubiquitous in general pediatric practice, and primary pediatric health care providers rely on DBP physicians for medically based behavioral consultation. DBP physicians must be expert in differentiating behavioral variations, problems, and disorders. Given the overwhelming prevalence of behavioral concerns in children, DBPs need to be able to provide consultative services for referring physicians for behavioral variations/problems and to identify and longitudinally manage behavioral disorders, particularly behavioral disorders that occur in children/adolescents with associated developmental disorders. While DBPs must be competent in evaluating patients and making diagnoses independently, they also must be competent in working as a member of an interprofessional diagnostic team that may include psychologists, special educators, social workers, and other allied health personnel. Particularly given that there are approximately ten times as many board-certified child psychiatrists (approximately 8,000) as board-certified DBPs (755), DBPs also require expertise in differentiating those patients with behavioral disorders who they should manage from those that should be referred to (or co-managed with) other medical (child psychiatrists, pediatric sleep medicine specialists) and nonmedical (psychologists) specialists.

Curricular Components That Support the Functions of the EPA

1. Describing the spectrum of behavioral concerns and risk factors for behavioral problems
 - Traces the spectrum of behavioral concerns from behavioral variation to problem to disorder
 - Explains the critical role between a child's underlying developmental abilities and the demands and expectations placed upon them in interpreting presenting behavioral concerns
 - Identifies neurobiological risk factors for behavioral problems
 - Identifies adverse childhood events and psychosocial influences that constitute risk factors for behavioral problems
 - Identifies resiliency factors to promote and community resources to address adverse childhood events/psychosocial risk



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- Defines the roles of temperament, adaptive styles, “goodness of fit,” attachment, autonomy, and family, social, and cultural background in influencing behavior
2. Providing behavioral consultations for patients presenting with behavioral variations and problems
- Performs psychosocial screening, using standardized psychosocial screening tests and home and parent risk assessment tools
 - Performs behavioral screening, using standardized behavioral screening tests
 - Analyzes the antecedents and consequences of presenting behaviors before initiating behavior management recommendations and follows up on targeted outcomes for the interventions recommended
 - Describes the basic principles of behavior management (consistency in behavior management strategies across providers and environments, positive reinforcement of desired behaviors, ignoring minor transgressions, labeling the act not the child, establishing routines, modeling, progressive expectations, choices, natural consequences, logical consequences, time-out, contingency charts, rewards/punishment)
 - Provides anticipatory guidance for and counsels families in the management of common behavioral variations and problems, including:
 - Crying/colic
 - Problems with feeding, sleep, toileting (including enuresis/encopresis)
 - Variations in development of gender identity
 - Aggressive-resistant behavior (negativism, noncompliance, defiance, temper tantrums, breath-holding spells, hitting/biting, sibling rivalry, bullying)
 - Overdependent/withdrawing behavior (demanding behavior, separation upset, clinging, whining, excessive fearfulness)
 - Habits (head banging, thumb sucking, nail biting, teeth grinding, masturbation)
 - Adaptation to general health problems and their treatments
 - Somatic symptoms
 - Experimentation with alcohol, drugs
 - Identifies evidence-based interventions for parents to address problem behaviors (Parent-Child Interaction Therapy; Positive Parenting Program (Triple P); The Wonder Years)
3. Identifying and managing behavioral disorders in children and adolescents
- Identifies and manages behavioral disorders in infants, children, and adolescents with and without associated developmental problems, including:
 - Attachment disorders
 - Post-traumatic stress disorder
 - Selective mutism
 - Attention-deficit/hyperactivity disorder
 - Oppositional defiant disorder
 - Conduct disorder
 - Anxiety
 - Obsessive-compulsive disorder
 - Depression/mood disorders



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- Sleep disorders
 - Elimination disorders (enuresis, encopresis)
 - Stereotypic movements/self-injury
 - Tourette syndrome
 - Substance use disorders
 - Eating disorders
- Identifies school-based services mandated by federal law to address behavioral concerns (Individualized Education Program for Emotional/Behavioral Disorder) or to provide accommodations (Section 504 Plan) at school
 - Identifies community-based services to address behavioral concerns
 - Identifies evidence-based behavioral interventions for children/adolescents with behavioral disorders (Applied Behavior Analysis; Cognitive-Behavioral Therapy).
 - Counsels families about the large number of nonevidence-based interventions proposed for treatment of behavioral disorders
 - Identifies indications for use of psychotropic medications for behavioral disorders, including:
 - Hyperactivity/disruptive behavior
 - Aggression/self-injury
 - Anxiety/mood disorders
 - Difficulty with transitions/compulsive behavior
 - Sleep problems
 - Longitudinally monitors dose and side effects of psychotropic medications
 - Differentiates behavioral problems that are most appropriately managed by DBP physicians from those that require referral to other mental health professionals
 - Recognizes children and adolescents with suicidal behavior and makes emergent referrals to child psychiatry or other mental health services as needed

Problems that can be referred back to primary care physicians:

- Given the prevalence of behavioral variations, problems, and disorders in the general pediatric population, the limited number of board-certified DBP's, and the long waiting lists for developmental-behavioral consultation, DBP's must be competent in providing comprehensive consultative services for primary care physicians and must also be confident in referring patients back to their primary care physicians, co-managing patients as necessary. Problems that generally can be referred back to primary care include:
 - Behavior variations and problems in children with typical development
 - Mild sleep disorders
 - Enuresis
 - Encopresis
 - ADHD without significant comorbidity

Problems that **generally** require referral/interprofessional co-management:

- Given the prevalence of pediatric behavioral/mental health disorders, DBPs often collaborate with other subspecialists, including child psychiatrists, child psychologists, and pediatric sleep medicine specialists.



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DBPs may co-manage patients with these professionals, particularly those patients with behavioral disorders who also have associated developmental disorders. Given the significantly larger number of board-certified psychologists, board-certified child psychiatrists, and board-certified sleep medicine specialists relative to the number of board-certified DBPs, many patients with the problems listed below may need to be managed primarily by these child professional resources. The list of problems that generally require referral depends greatly on the context in which one practices. Those DBPs practicing in areas where access to these subspecialists is difficult will likely provide more of the care and may do so with telephone advice from a trusted subspecialist as needed. Problems that generally require referral include:

- Moderate to severe psychiatric disorders including psychosis, substance use disorders, eating disorders, and suicidal ideation
- Moderate to severe sleep disorders

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Curricular Components Authors

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