

APPD Spring 2018

Program Director Grassroots Forum

Moderators:
Jen DiPace, MD
Vasu Bhavaraju, MD
Suzanne Wright, MD

**Log onto Poll
Everywhere:**

**Text PCHMEDED
to 22333**

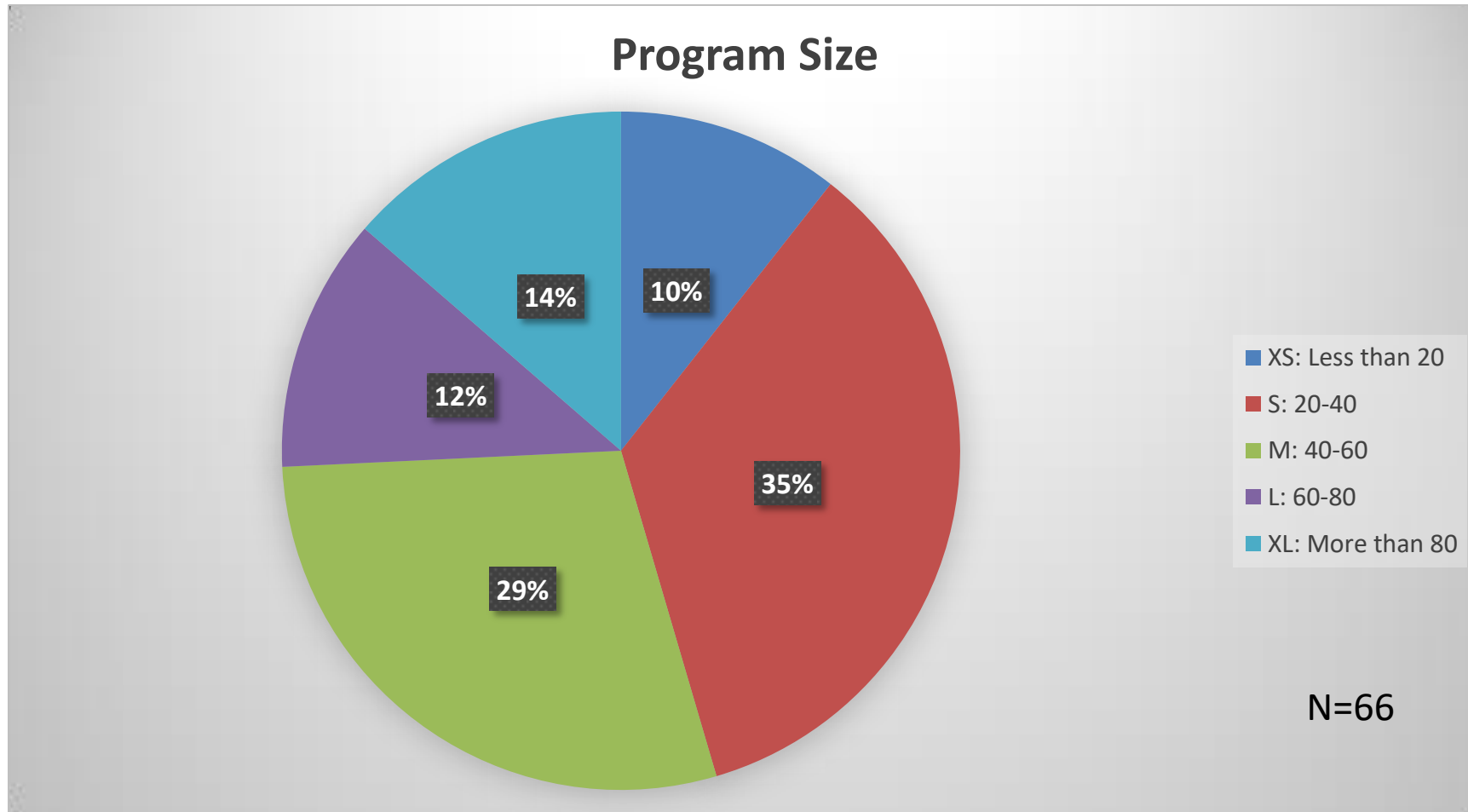


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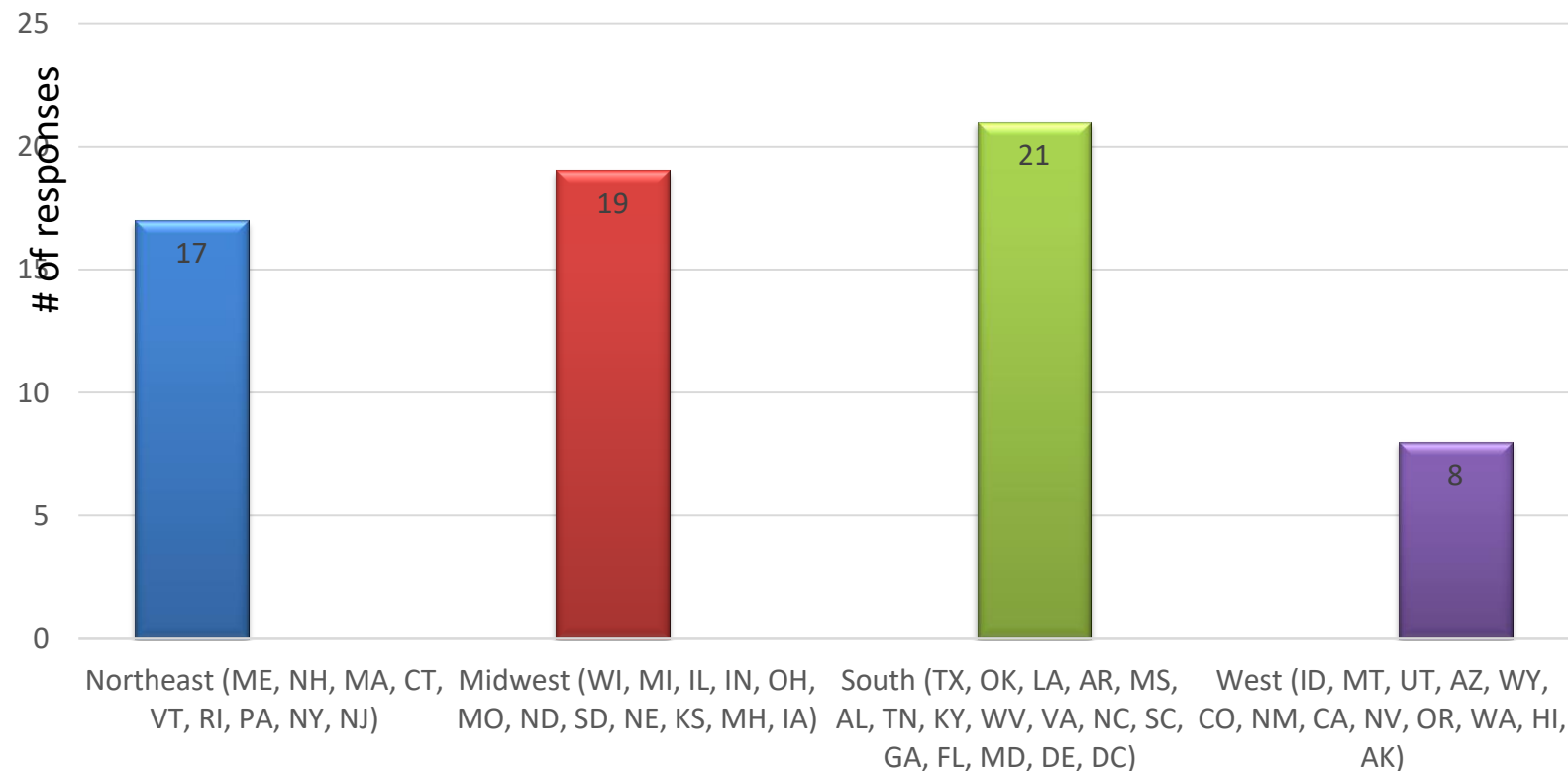


Demographics



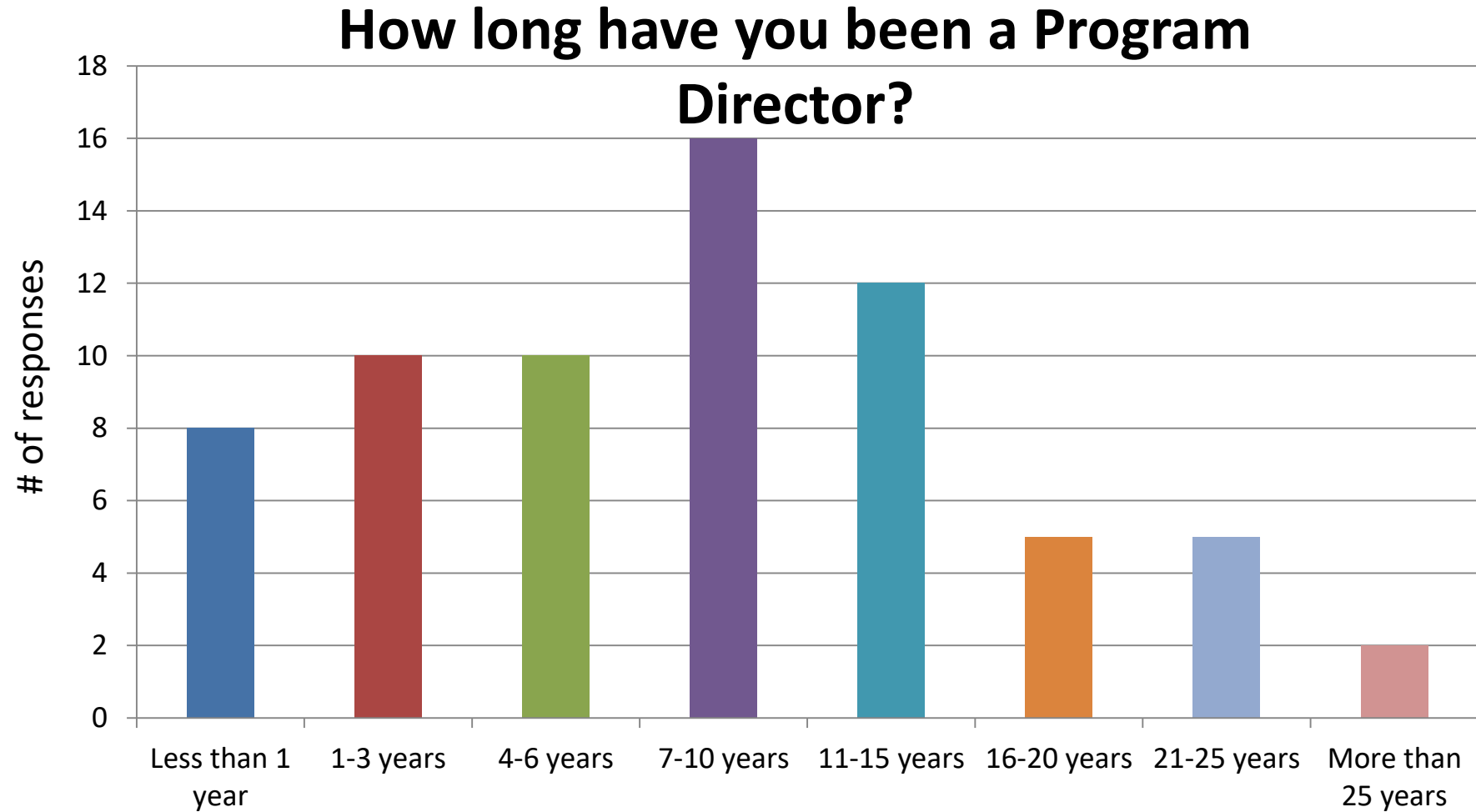
Demographics

In what region of the country is your program?



N=66

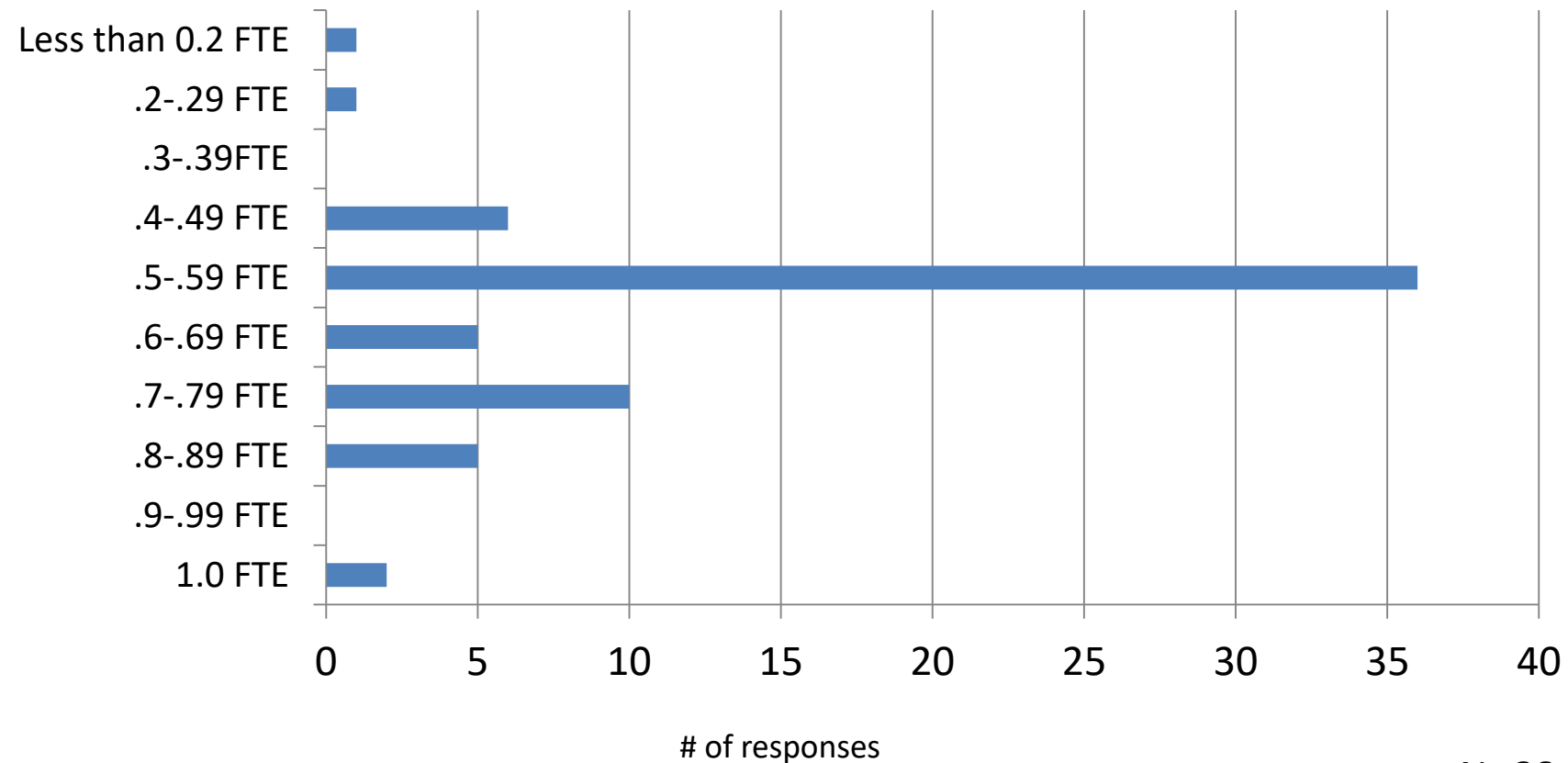
Demographics



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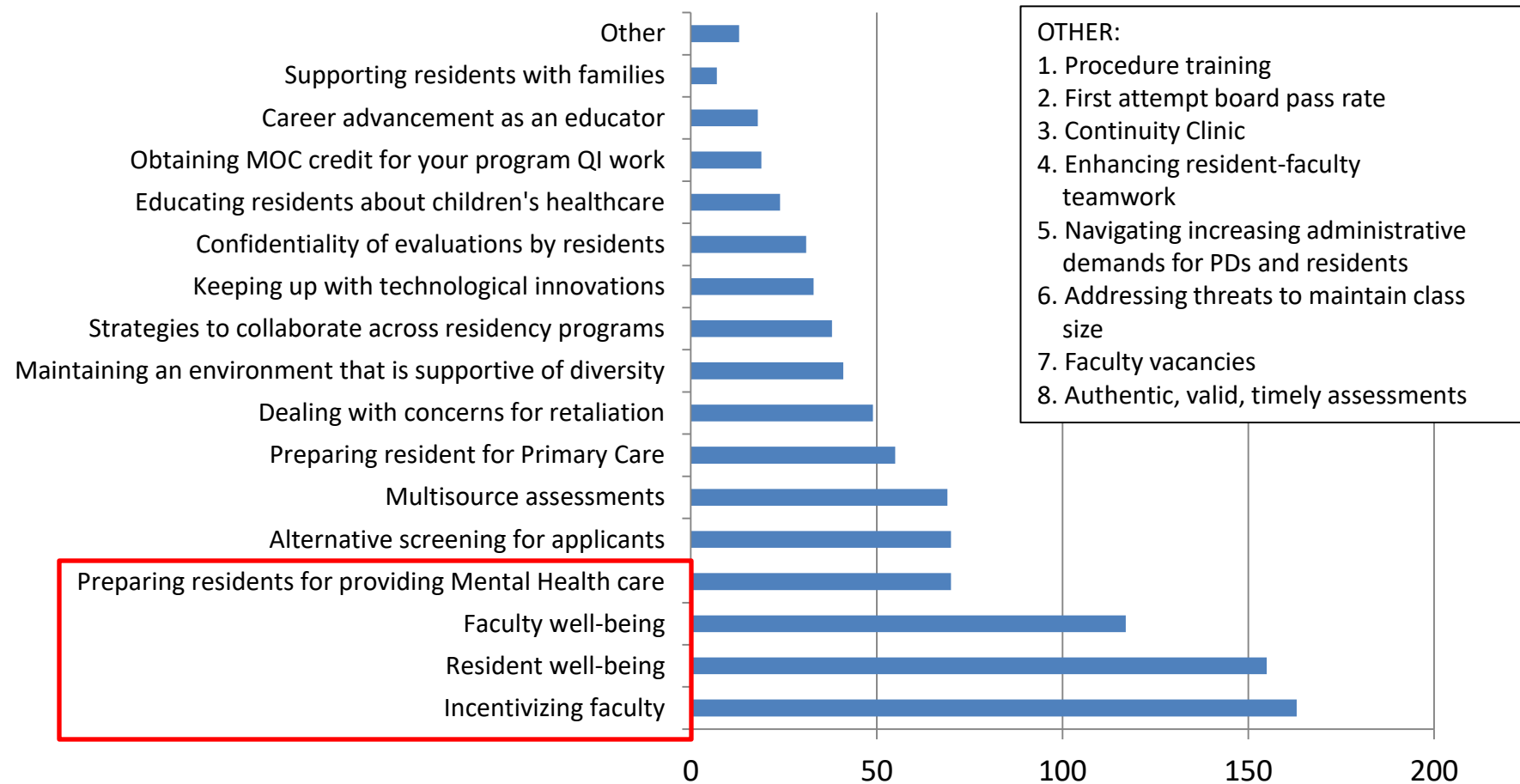
Demographics

What is the amount of protected time you have for your role as PD?



N=66

What are the most pressing issues you are facing as a PD?



N=66

What are the most pressing issues you are facing as a PD?

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

Preparing Trainees to Address Mental Health Needs of Children

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%

How well do we prepare our graduates?

- AAP survey of primary care and specialist physicians
 - 65% lacked training in the treatment of mental health problems
 - 40% lacked confidence in recognizing the problem
- Resident survey (2010)
 - Less than half of residents rated their competence in this area as good to excellent
 - 28% reported that vacation time was permitted during dev/beh rotation

Horwitz SM, Storfer-Isser A, Kerker BD, et al. Barriers to the Identification and Management of Psychosocial Problems: Changes From 2004 to 2013. Acad Pediatr. 2015;15(6):613–620

Horwitz SM, Caspary G, Storfer-Isser A, et al. Is developmental and behavioral pediatrics training related to perceived responsibility for treating mental health problems? Acad Pediatr. 2010;10(4):252–259

How well do we prepare our graduates?

- Program director survey (2014)
 - Majority of programs did not emphasize mental health training
 - Majority of PDs were unaware of AAP mental health competencies

ACGME Requirements

- At least 1 faculty member who is certified in dev/behavior
- Complete 1 month or 200 hour experience in dev/beh peds

Proposed Solutions

- Robust behavioral and mental health curriculum
 - AAP mental health competencies and curriculum
- Tools to assess entrustment for unsupervised practice
- Appropriate training environments
- Faculty development for pediatrician faculty
- Collaboration with non-pediatrician clinicians

About

Advocacy and Policy

Education

Key Resources

Working with Families

Collaborative Projects

Implementing Mental
Health Priorities in
Practice

Mental Health Initiatives

-A +A

Residency Curriculum

To support continuity clinic preceptors in training residents to address mental health issues in their patients, the AAP Mental Health Leadership Work Group (MHLWG) has developed a set of teaching materials on brief interventions and managing mild to moderate anxiety. The MHLWG hopes this is just the beginning of a larger set of materials that will help address other common mental health issues in the primary care setting.



Preceptors are welcome to tailor the materials and presentations accordingly. While the information in the presentations is comprehensive, preceptors can select what to highlight if time is limited.

Module 1 - Brief Intervention

Utilize evidence-based approaches to engage patients and families in managing mental health concerns

Module 2 - Anxiety

Recognize and provide initial management for children and youth with mild to moderate anxiety in the primary care setting

[Acknowledgements](#) | [Implementation of the Curriculum](#)

Collaborative Office Rounds

Emily Borman-Shoap, MD
University of Minnesota

Pediatric Residency Education and the Behavioral and Mental Health Crisis: A Call to Action

Julia A. McMillan, Marshall Land Jr, Laurel K. Leslie

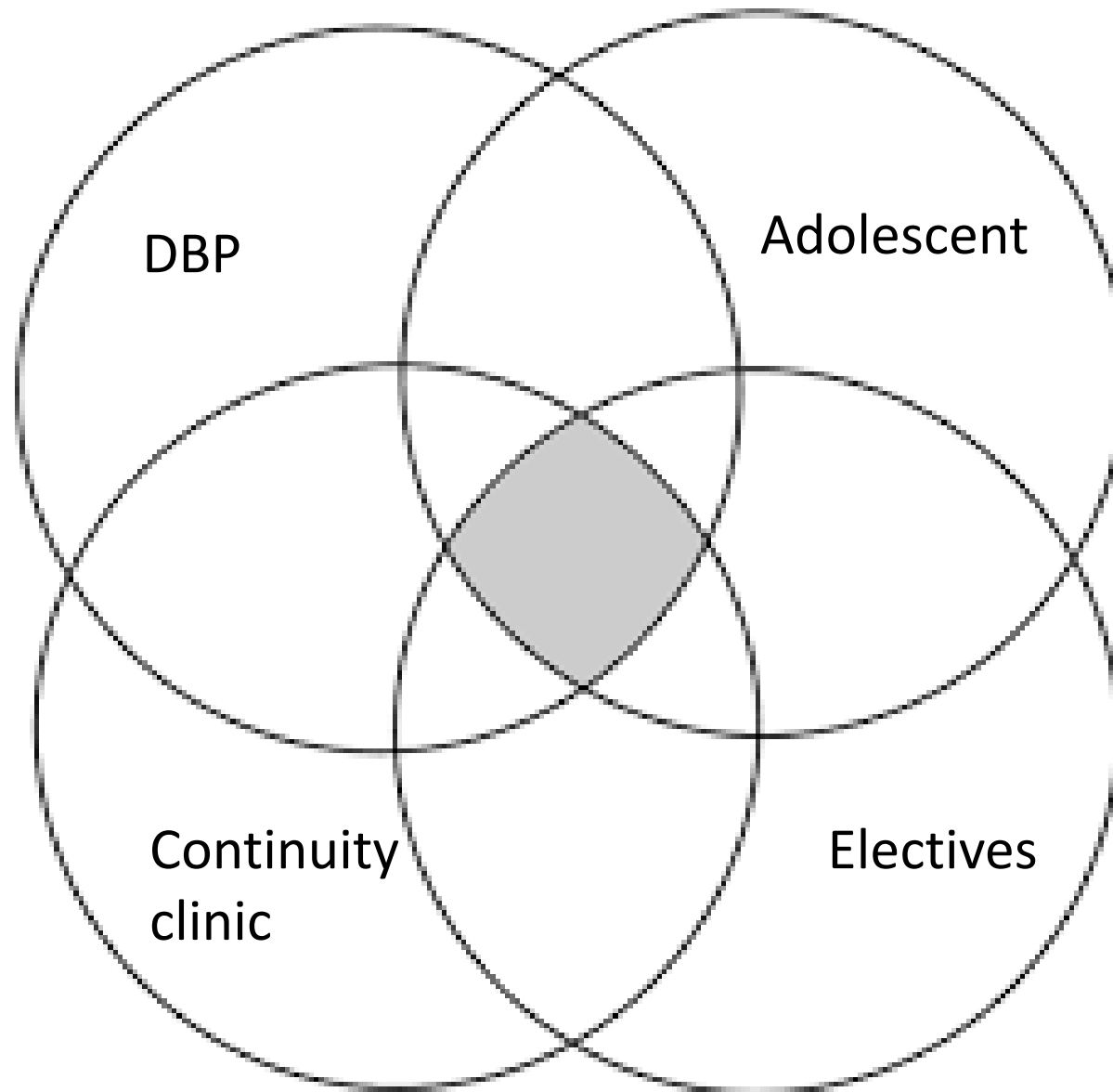
Closing the Gap: Improving Access to Mental Health Care Through Enhanced Training in Residency

Gauri R. Raval, MD, MPH,^{a,b,c} Stephanie K. Doupnik, MD^{d,e,f}



Grassroots Coalition with Interest in Pediatric Mental Health Training





Collaborative Office Rounds

Adapted a model already in place at faculty level

Residents present a challenging mental health case from continuity clinic, conference occurs approx once every 6 weeks

Attendees:

- Residents
- Developmental Behavioral
- Psychology
- Psychiatry
- Dental Residents and Faculty
- Continuity Clinic Preceptors
- Hospitalists
- Social Workers

12 year old with cutting and suicidal ideation

4 year with anxiety

8 year old blind, developmentally delayed

6 year old ADHD eval

5 year old with persistent speech delays

I am now aware of rights of homeless patients re: school system and will let them know. I also feel that I absorbed some of the perspective of the mental health team that joined our presentation - less concrete but I think of their words often in my daily practice.



Helped discern where to begin in the medical system for dealing with complex behavioral issues. Team approaches are necessary.





SF 2659/HF 3223
(Sen. Clausen/Rep. Baker)



Peds residents at MN Ped Day 2018
got to advocate for their own
education and ultimately better care
for Minnesota children.

DISCUSSION: WHAT CAN WE DO TO BETTER PREPARE
OUR RESIDENTS FOR PROVIDING MENTAL HEALTH
CARE?

Solutions from the Forum

- Multidisciplinary clinics to address mental health issues
- Mental health education should be a part of all, not just deferred to Development or Adolescent
- Engage stakeholders (including legislators) to get support/funding
- Train social workers to perform cognitive and behavioral testing
- Have evaluation clinics that residents rotate through on a longitudinal basis

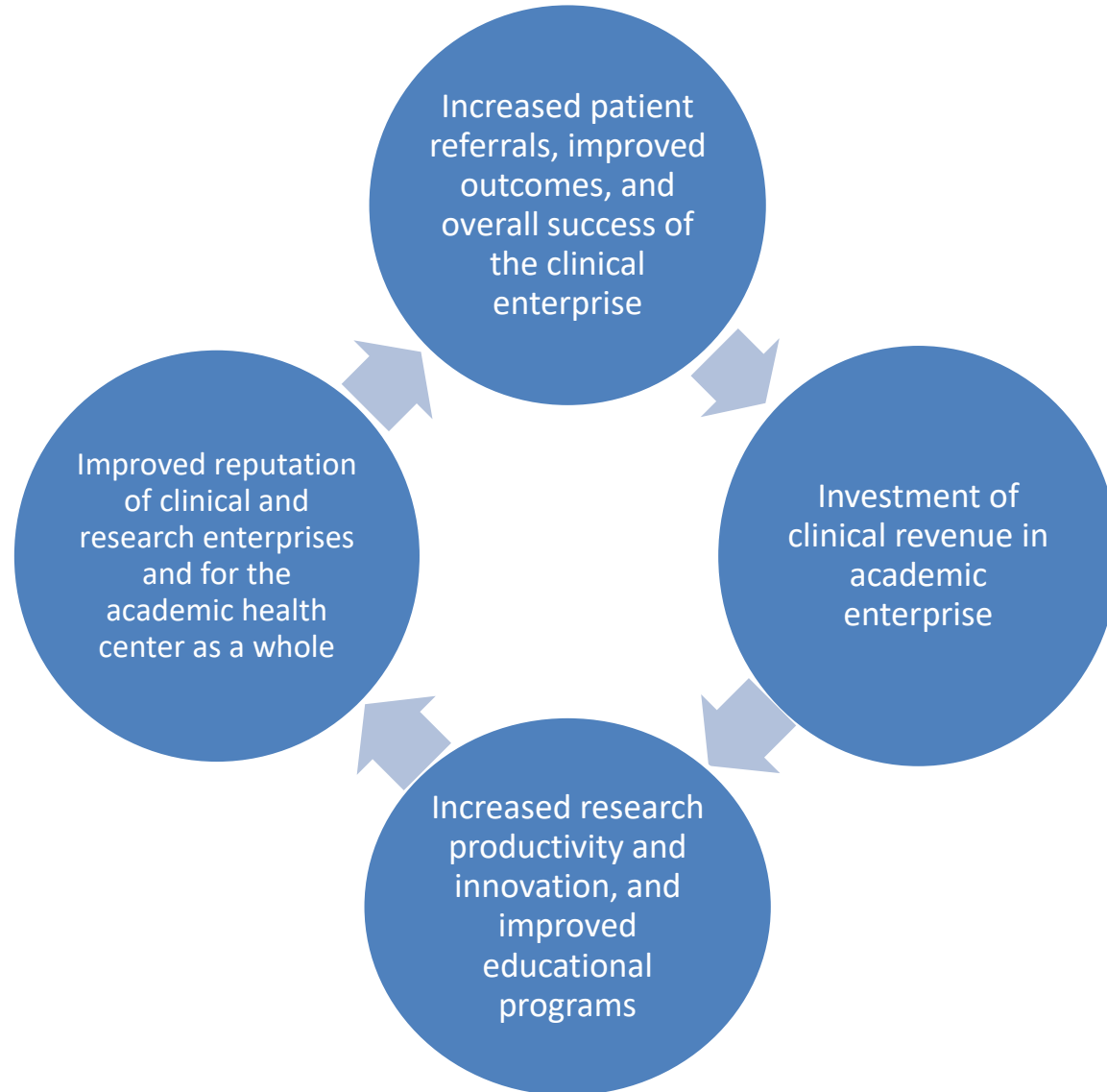
Incentivizing Faculty for
Educational Endeavors:
What Can Program Directors do
to Drive the Process?

The Faculty Role: from the ACGME

- Devote sufficient time to the educational program to fulfill their supervisory and teaching responsibilities
- Administer and maintain an educational environment conducive to educating residents in each of the ACGME competency areas
- Establish and maintain an environment of inquiry and scholarship with an active research component
- Oversee educational units and individualized curricula
- Participate in faculty development
- Serve on the CCC and PEC
- Assess residents and serve as advisors

The Faculty Role: From Academic Institutions

*The Virtuous Circle:
Clinical Care
Research
Education*



Barriers to Effective Faculty Engagement

Mission-Based Budgeting: the allocation of resources based on core-mission-related priorities

Clinical Excellence, Research, Education

Education...

- Often seen as voluntary rather than required
- Challenging to monitor and assign value to
- Does not have the same revenue stream as research and patient care
- Educational scholarship may not be as respected as traditional scholarship
- Physician recruitment rarely emphasizes educational skills

Sample Models of Faculty Incentives

- Teaching as a recognized expectation: Educational time or stipend distributed equally amongst teaching faculty
- Educational Value Units: Points awarded per activity performed (clinical and non-clinical) with weighted compensation
- Faculty Track System: RVU reduction based on additional educational or scholarly responsibilities
- Professional Requirements: MOC Part 4 credit for mentoring learner QI projects, CME hours for preparing/presenting a didactic lecture
- “Time Bank”: Performing additional educational tasks earns credits toward work or home-related services (i.e. cleaning service, prepared meals, grant-writer)

One Program's Experience

- Phoenix Children's Hospital: Community hospital-University affiliated
- Prior to 2017: "Educational stipend" for clinical teaching was proportioned annually amongst the teaching faculty based on numbers of resident learners rotating through each division
- As number of faculty and number of learners grew exponentially, stipend did not change

One Program's Experience

- In 2015, our DIO assembled institutional PDs/APDs to create a “Teaching Activities Report” (TAR) to document the number of FTEs faculty spent on educational activities compared to the number of FTEs with formal educational roles/protected time
- TAR, historical data, and current trends presented to administration – goal to offer protected time for faculty based on a tiered system of educational involvement plus a continued baseline stipend for all teaching faculty
- Ask for two things, you may get one...

One Program's Experience

- Educational stipend was increased with a mechanism to grow proportionally with increasing numbers of learners
- “Teaching” now includes clinical and non-clinical educational activities (i.e. advisors, research mentors, rotation directors) for all levels of learners (students, residents, and fellows)
- Faculty log activities; monitoring is by division chiefs
- Each activity has a weighted value that translates to a financial bonus

Discussion: What can program
directors do to impact faculty
incentives at their home institution?

Solutions from the Forum

- “Honor Roll” for teaching faculty that get nominated for an award. Have them provide mentorship/faculty development to others
- PDs should have a seat at the table at all institutional discussions about educational incentives
- Don’t count too many educational “widgets” - that can get cumbersome to track and reward
- Consider “criterion-based rewards” that any faculty can attain if they put in the effort
- Water bottles for faculty that are identified as “top educators”

Resident & Faculty Well-Being

Resident & Faculty Well-being

ACGME Common Requirements

“Programs and Institutions must emphasize the need to prioritize well-being of residents and faculty”

In our efforts to promote resident well being, have we inadvertently increased the risk of fatigue and burnout among our faculty?

Impact on Faculty

How have the ACGME requirements to protect resident's from excess fatigue impacted your **faculty**?

Response from the forum:

- Many PDs believe faculty burnout /morale suffered while trying to improve life for residents.
- Many strategies employed to help residents have not been employed for faculty. This may lead to resentment.
- Need to focus on both faculty and residents.

Resident and Faculty Well-being

ACGME Common Requirements

Programs and Institutions must

- Evaluate the **safety** of residents and faculty in the learning and working environment
- Provide attention to and education in resident and faculty **burnout, depression, and substance abuse** in themselves and others

Resident and Faculty Well-being

ACGME Common Requirements

Programs and Institutions must

- Establish policies & programs supporting optimal resident and faculty well-being

Resident Resiliency Team

Taylor McLain and Nicole Dyess

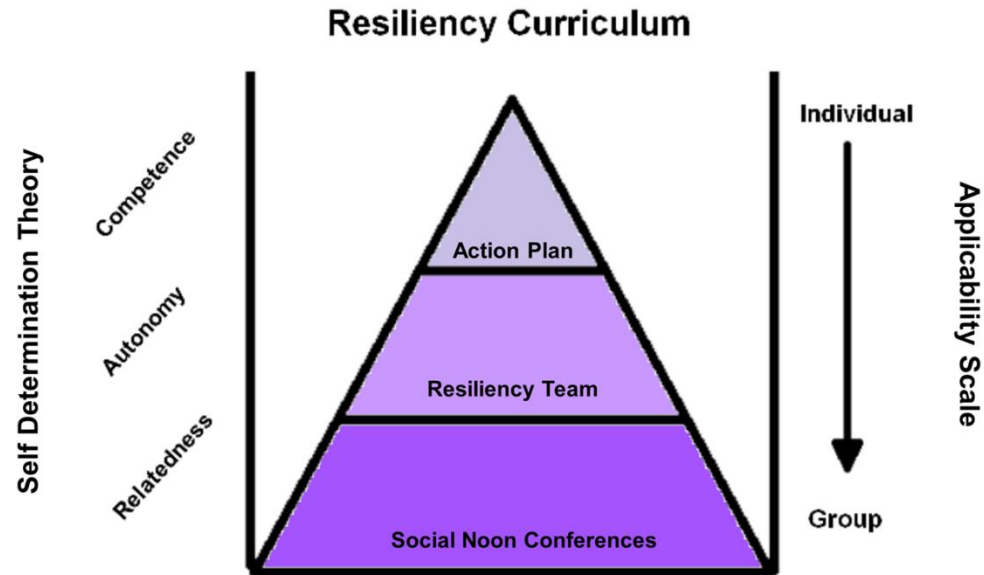
Rising Chief Residents 2018-2019

Baylor College of Medicine

Texas Children's Hospital

Houston, TX

Who are we?



- “It takes a village.”
- Thirty rising PGY-2 and PGY-3 residents interested in mental health and wellness
- Part of a three-tiered program for resiliency within the Pediatric residency program

What do we do?

-
- Create and support a culture of resiliency and awareness of resident mental health
 - Newsletter
 - Weekly running club
 - Monthly socials
 - Provide a 24/7 resident call system
 - Addresses burnout and depression
 - Debriefing
 - Check-in on “high burnout” rotations
 - Support each other!
 - Discuss ways in which to improve burnout from a structural standpoint

Resident Involvement and Future Directions

- Uniform involvement throughout all resident classes
- Zero to three pages per block received
- Seven to eighty-five residents per social
- Future Goals
 - Scheduled weekly check-ins
 - Grow and improve through system-based changes
 - Diversifying outcome measurements
 - Passing the torch



DISCUSSION: WHAT CAN PROGRAMS DO TO
ADDRESS BOTH FACULTY AND RESIDENT
WELL-BEING?

Solutions from the Forum

- Faculty-Resident resiliency team
- Invite faculty to resident wellness activities
- Use “Life Values Inventory”
- Divide classes into societies or houses with a monthly touch base with an assigned Chief; House Cup for Wellness
- Teach senior residents how to lead a debrief
- Preschedule half-days off throughout the year for healthcare appointments

Solutions from the Forum

- Engage chaplains, social workers, and palliative care team
- Share with upper administrators your resident wellness initiatives so they can be applied to faculty
- Creative scheduling (i.e. X+Y clinic)
- Resident's What's App group to share info

Comments About New Common Program Requirements

Common Program Requirements (CPR): Revision Sections I-V

- Review of the CPR initiated in Fall 2015
 - Phase 1 – Section VI implemented July 2017
 - Phase 2 – developed 2 sets of requirements (core and fellowship)
- Proposed effective date July 1, 2019
- Call for comments due March 22, 2018

Comments?

I.C. – The program must engage in practices that focus on mission-driven ongoing, systematic recruitment and retention of a DIVERSE workforce.

- *Task force (TF) thought this was necessary to address the current lack of diversity in the profession.*
- *TF anticipates no impact on patient care or on resources.*

Comments?

II.B.2.e – Faculty members must at least annually pursue formal faculty development to enhance their skills:

- as educators
- in QI and patient safety
- in fostering their own and residents' well being
- in patient care based on their PBLI efforts

- *TF estimated that there may be some additional cost for programs to develop programs for faculty*

Comments?

V.a.1.b - Longitudinal experiences, such as continuity clinic, must be evaluated at least every three months and at completion.

Comments?

V.C.4.b &f – Aggregate pass rate of program graduates taking the board exam for the first time must be above the 5 %tile (over 3 yrs).

- Any program whose graduates have achieved an 80% pass rate over 3 years will have met the requirement
 - *TF rationale is that setting a single standard for pass rate across specialties is not supportable. By using a %tile rank, the performance of the lower 5% of programs can be identified and set on a track of reform.*
- V.C.4.g – Programs must report to ACGME through ADS board passage rate annually for the cohort of residents who graduated in the past 7 years

Comments?

- IV.D.1 – The program must demonstrate evidence of scholarly activities consistent with its mission and aims.
- Faculty scholarly activity must have efforts in at least 3 of the following:
 - Research in basic science, education, translational science, patient care
 - Peer reviewed grants
 - QI or patient safety initiatives
 - Systematic review, meta-analysis, review articles, etc
 - Creation of curricula, evaluation tools, didactics
 - Contribution to professional committees
 - Innovations in education

Comments?

I.D.2.c – The program must ensure clean and private facilities for lactation that have refrigeration and are in close proximity to residents' clinical work.

– *TF – Mirrors institutional requirements. Additional resources may be required for some.*

Comments?

II.A.4.a – The program director must be a role model of professionalism.

- *TF – residents must be able to see the PD as an exemplar of professionalism, high-quality patient care, educational excellence, and a scholarly approach to work.*

Summary of Proposed Changes

- Creating a diverse workforce
- Enhanced faculty development
- Q3 month evaluation of continuity clinic/longitudinal experiences
- Aggregate first time board pass rate of programs above 5th percentile
- Faculty scholarly activity composite
- Lactation facilities
- PD as a role model of professionalism

THANK YOU!