Innovative Curricula for Pediatric Teaching Residents/Fellows
Behavioral and Mental Health

APPD 2019 Annual Spring Meeting
Introductions
Ann E. Burke, MD
  - Dayton Children’s Hospital, Wright State University Boonshoft School of Medicine

Elizabeth Chawla, MD
  - Medstar Georgetown University Hospital, Georgetown University School of Medicine

Jennifer DiPace, MD
  - New York Presbyterian Hospital (Cornell Campus) Komansky Children’s Hospital, Weill Cornell Medicine

Kenya McNeal-Trice, MD
  - North Carolina Children’s Hospital, University of North Carolina School of Medicine

Heather McPhillips, MD
  - Seattle Children’s Hospital, University of Washington School of Medicine

Keith Ponitz, MD
  - University Hospital Case Medical Center/Rainbow Babies, Case Western Reserve University

Sue Poynter, MD
  - Cincinnati Children’s Hospital Medical Center, University of Cincinnati College of Medicine

Joseph Zenel, MD
  - Sanford Children’s Hospital, University of South Dakota School of Medicine
Getting to Know You

Keith Ponitz, MD

University Hospital Case Medical Center/Rainbow Babies, Case Western Reserve University
Objectives

- Review and discuss the content of the ABP EPA #9
- Introduce innovative curricula to enhance the exposure and clinical training in the areas of behavioral and mental health
- Provide resources for development of curricula within training programs to improve clinical training and competencies in behavioral and mental health
- Discuss effective assessment tools for evaluating competency in behavioral and mental health diagnosis and treatment
Entrustable Professional Activity

Kenya McNeal-Trice, MD
University of North Carolina School of Medicine
Assess and manage patients with common behavior/mental health problems.
• 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
• **Rationale:** Pediatricians 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
Training Curricula
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<tr>
<th>COORDINATED</th>
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<tbody>
<tr>
<td>KEY ELEMENT: COMMUNICATION</td>
<td>KEY ELEMENT: PHYSICAL PROXIMITY</td>
<td>KEY ELEMENT: PRACTICE CHANGE</td>
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<tr>
<td>LEVEL 1</td>
<td>LEVEL 2</td>
<td>LEVEL 3</td>
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<tr>
<td>Minimal Collaboration</td>
<td>Basic Collaboration at a Distance</td>
<td>Basic Collaboration Onsite</td>
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Behavioral health, primary care and other healthcare providers work:

**In separate facilities, where they:**

- Have separate systems
- Communicate about cases only rarely and under compelling circumstances
- Communicate, driven by provider need
- May never meet in person
- Have limited understanding of each other's roles

**In separate facilities, where they:**

- Have separate systems
- Communicate periodically about shared patients
- Communicate, driven by specific patient issues
- May meet as part of larger community
- Appreciate each other's roles as resources

**In same facility not necessarily same offices, where they:**

- Have separate systems
- Communicate regularly about shared patients, by phone or e-mail
- Collaborate, driven by need for each other's services and more reliable referral
- Meet occasionally to discuss cases due to close proximity
- Feel part of a larger yet non-formal team

**In same space within the same facility, where they:**

- Share some systems, like scheduling or medical records
- Communicate in person as needed
- Collaborate, driven by need for consultation and coordinated plans for difficult patients
- Have regular face-to-face interactions about some patients
- Have a basic understanding of roles and culture

**In same space within the same facility (some shared space), where they:**

- Actively seek system solutions together or develop work-arounds
- Communicate frequently in person
- Collaborate, driven by desire to be a member of the care team
- Have regular team meetings to discuss overall patient care and specific issues
- Have an in-depth understanding of roles and culture

**In same space within the same facility, sharing all practice space, where they:**

- Have resolved most or all system issues, functioning as one integrated system
- Communicate consistently at the system, team and individual levels
- Collaborate, driven by shared concept of team care
- Have formal and informal meetings to support integrated model of care
- Have roles and cultures that blur or blend
Co-Management as defined by AAP

“Collaborative and coordinated care that is conceptualized, planned, delivered, and evaluated by two or more health care providers, one being a PCP and the other a subspecialist”
INTEGRATED MENTAL HEALTH CLINIC MODEL

ELIZABETH CHAWLA, MD, FAAP
APD, Peds Residency Program
Georgetown University Hospital
PRIMARY CARE SETTING – IDEAL PLACE TO ADDRESS MENTAL HEALTH

- Ideal for early identification and intervention
  - Emerging behavior problems
  - Common MH Disorders → ADHD, depression, anxiety, substance use
- Trained in normal development
- Friendly to families
- Opportunity to engage patient and family without stigma
- Can provide counseling, guidance, care coordination
- Help to manage chronic illness (longitudinal care)
- Coordinated with child’s other health care
- Care can be multidirectional & holistic

Slide borrowed from Sean Pustilnik, MD
INTEGRATED MENTAL HEALTH CLINIC AT MEDSTAR GEORGETOWN PEDIATRICS

• First, Define Your Goals:
  ** Improve the education of future pediatricians around mental and behavioral health
  • Improve access to mental healthcare for our patients
  • Trial Reimbursement options
    • Make our model financially sustainable
    • Attainable for other pediatric practices (academic and private practice)
INTEGRATED MENTAL HEALTH CLINIC AT MEDSTAR GEORGETOWN PEDIATRICS

• Level 6 Integrated Model:
  – One day per week, embedded CAP [intermittently fellow(s) on other days]
  – CAP precepts during resident continuity clinic
  – Levels of collaboration:
    • Different Day Curbside Consult
      (Indirect Consultation)
    • In the moment Curbside Consult
      (Indirect Consultation)
    • Shared visit (Direct Consultation)
    • Full Consultation (warm handoff)
INTEGRATED MENTAL HEALTH CLINIC AT MEDSTAR GEORGETOWN PEDIATRICS

Routine Visit (Well-child or Sick)
- +/- Screening

Indirect Curbside Consultation
- Further targeted screening/assessment
- Brief office interventions
- Evidence-based medication use
- Referral to care if needed

Direct Consultation (CAP sees patient)
- Full Consult evaluation
- Warm Handoff (co-visit with PCP and CAP)

Training and Education
- 1x/month, 30 min
- During already established article review time

Common Factors Interventions
- 6 sessions, video based
- Engagement, empowering families, communication, resilience

Disorder Specific Assessment and Treatments
- ADHD
- Anxiety
- Depression/SI
INTEGRATED MENTAL HEALTH CLINIC AT MEDSTAR GEORGETOWN PEDIATRICS

- **Structured Educational component** – based on EPA 9
  - Common Factors Approach
  - Screening/Diagnosing
  - Basic In-Office Treatments
  - Medication Management (ADHD, Anxiety, Depression)
  - Suicidality
    - how to assess risk
    - emergent vs urgent referral options
Rainbow Babies and Children’s Hospital Mental Health Program/Track

Keith Ponitz, M.D.
Residency Program Director
Disclosures

• I have nothing to declare
• I have no relevant financial disclosures
Program Curriculum

- Clinical
- Traditional didactic sessions
- BMW Lectures and Modules - http://ohioaap.org/BMWeLearning
- Interdisciplinary lectures with pediatric and psychiatry residents
- Mental Health Journal Club
- Scholarly Activity and QI projects within mental health arena
- Director of the Program – 10% FTE
Rainbow Mental Health Clinical Program

- Based on Asthma Model
- Building Blocks Strategy
- Rainbow Ambulatory Practice (Continuity Clinic)
  - Mental Health Embedded
- Outpatient Psychiatry Elective and Longitudinal Experience
- Developmental Behavior Pediatrics Rotation and Elective
- Inpatient Psychiatry Consultative Service Elective
- Inpatient Psychiatry Unit Elective
- Inpatient Hospital Units
- Director of the Program
The Buddy System

Program Leaders:
Cori Green
Janet Chen
Mental Health Training in Pediatrics

Coordinated Care
Current referral system

Co-located
Peds and MH deliver care in the same practice location, although care is often still siloed.

Integrated
Peds and MH professionals work together in same space. One treatment team.

Slide adapted from Joy Himmel
Key Components of the Buddy System

• Development of an informal consultative model
• Pairing with buddy for shadowing experiences in primary care and psychiatry clinic
• Bidirectional transfer of patients between pediatrics and psychiatry
• Collaborative teaching sessions presenting a case to both pediatricians and psychiatrists
• Developing relationships between learners
Introductions: Pair/Share or Buddy Pairing

When/how/why did you decide to be a pediatrician or CAP?

What do you think is one major cultural difference between psych and peds?

What is one thing you want to get out of a closer relationship with psych/peds?
Collaborative Relationships:
“What’s in it for the pediatric resident?”

• Access to care issues
• Education support around Mental Health Competencies
• Longitudinal follow-up of referred patients
Collaborative Relationships:
“What’s in it for the CAP fellow?”

• A network of peer colleagues
• Curbside consultation around pediatric issues
• Extending professional role into the community (1 pediatrician said “the one patient I contact you about, gives me tools for the next 15 patients…”)
• Co-management is likely better care
• These contacts can be fun and rewarding
Stakeholder Alignment

Heather McPhillips, MD, MPH
Residency Program Director
Professor, Pediatrics
University of Washington and Seattle Children’s Hospital
National issue: Disconnect between what we know we need to do and what we are doing about it

- Comprehensive reports in pediatric education have emphasized the need to enhance residency training in behavioral, developmental and adolescent issues for the past 40 years (FOPE 1, FOPE 2, ABP Foundation)
- Most recent AAP periodic survey (2013)
  - 65% of pediatricians indicated they lacked training in treatment of children with mental health problems
  - 40% reported they lacked confidence in their ability to recognize problems
  - >50% lacked confidence in their ability to treat mental health problems.
  - 44% indicated they were not interested in treating, managing, or co-managing child mental health problems.
Potential contributors to lack of training despite recognized importance for 40+ years

- GME funding for pediatric residency programs is predominantly through hospitals = inpatient workforce
- 4 week block rotations are potentially difficult to allow for gaining competency in behavioral and mental health problems
- Little emphasis on importance during inpatient rotations and/or reliance on consultants (psychiatry, adolescent) where residents spend most of their time.
Steps to Gaining Stakeholder Involvement

Create a sense of urgency—this will not be difficult!

We committed to have a one day planning and prioritizing session with stakeholders.

• Our leadership team developed a short list of “key attendees”
  • DBP, Adolescent, General Peds faculty.
  • Chose a date >3 months in advance (so clinic schedules, etc. could be changed)
  • Asked “key” stakeholders to generate list of stakeholders
  • Considered other key components (diversity, community, interprofessional)
  • Ended up with over 40 attendees including residents, fellows, faculty, community PCPs, hospitalists, specialists, social work, psychology, psychiatry
Our Goal: Day long Stakeholder Meeting to Identify Priorities, Innovations

• Ideal state visioning
• SOON analysis (strengths, opportunities, obstacles, next steps)
• Priority areas (core curriculum, individualized pathway or track, faculty development, longitudinal integrated experience)
• Design ideas (getting more granular)
• Votes on next steps—what to start first
Work Groups

- Longitudinal Curriculum
- Integrated Clinic Model
- Behavioral Health 101
- Mental Health Track
- Faculty Development/Engagement
Report Out

Joseph Zenel, MD
Sanford Children’s Hospital
University of South Dakota School of Medicine
Brainstorm Assessment Tools

Elizabeth Chawla, MD
Medstar Georgetown University Hospital
Georgetown University School of Medicine
Assessing Resident Competency

Assessing EPA #9
Assessing Resident Competency on EPA #9 – one example

• Senior Resident OSCE
  • PGY3’s in last month of residency
  • Goals:
    • Model for evaluation of Communication Skills (non-traditional use of standardized patients)
    • General assessment of our residents’ clinical skills around communication and BMH → individual assessment
    • Gather some preliminary info about IMHC → curriculum assessment

• 10/11 residents: 2 in IMHC, 8 in standard CC clinic
• 4 cases:
  • My baby needs a cardiologist – general communication skills
  • Tommy the terror – separation anxiety + behavioral issues
  • School Sucks – ADHD
  • Sam Silencio – depression w/ SI
OCSE 3: “School Sucks”
OSCE #2: Tommy the Terror
Faculty Evaluation

Resident Learner: ________________________________

Date: ________________________________________

Faculty Evaluator: ______________________________

Please check the appropriate box for each item below. "Partially" means emerging = 1 point, "Yes" means mastery = 2 points.

**Medical Knowledge**

- Recognizes symptoms of anxiety in the history and asks further questions to support or rule out the diagnosis
- Recognizes level of impairment based on history and/or score on the SCARED Screener

**Patient Care**

- Is able to take an age-appropriate psychosocial history
- Uses a validated Screener to help with diagnosis (mentions the SCARED Screener, uses the Screener)
- Knows how to score and interpret the Screener
- Able to formulate a management plan for diagnosis condition based on understanding of level of impairment
- Is able to provide condition-specific psycho-education to the parent/Explains the diagnosis in away the patient can understand (e.g., how anxiety contributes to his behavior)
- Explains the management plan in a way the patient can understand (e.g., importance of both healthy parenting strategies and addressing underlying anxiety)
- Uses simple language and avoids medical jargon
- Encourages the patient to ask questions and check for understanding
- Provides in-office counseling about healthy parenting discipline strategies
- Provides appropriate psychotherapy for anxiety to the patient/parent (e.g., belly breathing, blowing bubbles, exposure therapy, contingency planning, etc.)
- Includes the patient/parent in choices and works toward shared decision-making

**Interpersonal Communication Skills/Professionalism**

- Asks open-ended questions, gives parent time and space to answer
- Asks for clarification when necessary, summarizes and checks for understanding
- Avoids interrogating the patient/parent
- Demonstrates active listening using both verbal ("OK? I see") and non-verbal techniques (open posture, eye contact, nodding, etc.)
- Explicitly asks patient/parent's beliefs, feelings, concerns about the illness/problem (e.g., "What do you think is going on?")
- Validates parent's feelings/concerns ("you seem upset", or "I understand this is very stressful")
- Asks about the events/circumstances that might affect the parent's beliefs about the problem
- Demonstrates sensitivity to health beliefs/fears/concerns
- Recognizes their own emotion in the situation and keeps it under control in front of patient
- Avoids talking down to the patient/parent (e.g., "That's not what is going on here")
## Patient Care

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<thead>
<tr>
<th></th>
<th>YES</th>
<th>Partially</th>
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<tr>
<td>I was able to explain the management plan in a way the parent could understand</td>
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<td>I felt comfortable explaining the management plan in a way the parent could understand</td>
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<td>I was able to provide in-office age-appropriate psychotherapy for ADD to the patient (ex. creating routines, visual aids, limiting distractions, sitting in the front of class, breaking tasks into steps, etc)</td>
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<td>I was able to prescribe stimulant medication: appropriate medication, appropriate starting dose</td>
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<td>I was able to discuss side effects of the medication and answer questions about medication</td>
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<td>I knew how to create an appropriate plan for follow up and monitoring/titration of the medication</td>
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<td>I included the patient/parent in choices and worked towards shared decision-making</td>
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[Total Score: ________________________]
Preliminary Results

- OSCE 1: 81.50%
- OSCE 2: 93%
- OSCE 3: 81.50%
- OSCE 4: 78.50%

Standard: 89%
IMHC: 67% 64% 61.60%

Bars represent Standard (blue) and IMHC (purple) performance across OSCEs 1 to 4.
Group Discussion
Wrap-up

Ann E. Burke, MD
Dayton Children’s Hospital
Wright State University Boonshoft School of Medicine
Resources
Welcome

Pediatricians are, and will continue to be, an important first resource for parents who are worried about their child’s behavioral problems.

HIPAA Privacy Rule and Provider to Provider Communication

Learn more about the HIPAA Privacy Rule.
AAP MENTAL HEALTH CURRICULUM

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

Developmental, Behavioral, Psychosocial, Screening, and Assessment Forms

The following Bright Futures Tool and Resource Kit materials are available for download for review and reference purposes only. For any other use, to make multiple copies of specific items, or to incorporate forms into an Electronic Medical Record System, please contact institutions@aap.org.

Maternal Depression Screening
Patient Health Questionnaire-2 (PHQ-2) | Instructions
Patient Health Questionnaire-9 (PHQ-9) | Instructions (translated versions available here)
Edinburgh Postnatal Depression Scale: Permission required for use.
Contact the Royal College of Psychiatrists at permissions@rcpsych.ac.uk to request permission to use.
Rights and Permissions Manager: Lucy Alexander.

Parent and Family Assessment
Safe Environment for Every Kid (SEEK) Parent Questionnaire (PQ)
This brief evidence-based questionnaire screens for prevalent psychosocial problems:

Web page with tools for MH in primary care
(Algorithms, lists of Screening tools)

The Roadmap Project

Resources You Can Use

- A Website where you can learn more about Roadmap and download all of our resources: https://www.ambp.org/foundation/roadmap
- A Change Package with tools and strategies.
- Four Example Conversations to help clinicians introduce support for emotional health and depression screening for young children, young teens, and all ages.
- A Video to hear why families and clinicians are partnering with the Roadmap Project: https://youtu.be/n3j82_12TDw

Background and Aim

Living with a chronic pediatric condition is challenging, and can cause stress, altered coping, and lasting impacts on child and family emotional health. Emotional health support often lags physical care. The prevalence of behavioral and mental health conditions in children, adolescents, and young adults is significant.

The Roadmap Project aims to increase the resilience and emotional health of pediatric patients with chronic conditions and their families by:
- Raising awareness among patients and families to normalize or validate stress and promote self-care,
- Among clinical teams to address these issues and provide support, and
- Providing resources and connections for clinicians and families.

- Maintenance of Certification (MOC) Part II module with background of topic, overview of Roadmap key points, and post-review self-assessment.
- MOC Part IV with suggested metrics that could be used in run charts to track change over time.
- Curriculum outline and template(s) with associated slide deck for use in teaching sessions.
- Development of suggested staging to aid in implementation.

Funded by the American Board of Pediatrics Foundation, the Roadmap Project aims to increase the resilience and emotional and mental health of children with chronic conditions and their families. Contact questions to the Roadmap Project Team: solis4f@chime.org
Integrating Mental Health and Pediatric Primary Care