Section V
CONCLUSIONS

“Your dream isn't big enough if it doesn't scare you.”
(Matthias Schmelz)

In April 2012, the members of the Back to Project Future (BPF) Steering Committee began their work by reflecting on this quotation. From the beginning, the BPF Steering Committee has challenged itself and the BPF subgroups to think big, lean forward, and “cast a wide net” to capture the important ideas and translate them into “Goals, Recommendations, and Action steps” in BPF’s Plan for the Coming Decade. This section includes important takeaway points from the report and the Steering Committee’s consensus selection of the priority recommendations for implementation in 2013-2015.

Takeaway Points

The richness and density of the complete BPF report is important and necessary for future study and consideration by AACAP leadership, members, and staff. The Steering Committee encourages readers to carefully consider the full report. However, the following takeaway points are offered by the Steering Committee as a way to summarize and focus several key themes that are addressed throughout the report:

- (Affordable Care Act) The ACA is here and its implementation and roll-out means major changes to CAP practice, role and payment over the next 5-10 years.
- (Training and Practice) CAP training and practice will need to change and incorporate new technology (e.g., e-health, telepsychiatry) and changes in healthcare delivery.
- (CAPs Role) CAPs must continue to be the diagnosticians and treatment coordinators for the most complex and severe cases.
- (CAP Shortages) In order to be relevant in the evolving healthcare system, CAPs need to extend their “reach” by using newer technology (e.g., telepsychiatry) and collaboration/consultation with other healthcare providers and child-serving systems of care.
- (Lifelong Learning) AACAP must offer relevant education to students and members throughout their careers. AACAP’s continuing medical education and maintenance of certification programs must be adapted and tailored to the coming changes that are facing AACAP members.
- (Advocacy) AACAP and its members must expand advocacy efforts at all levels (local, state, and federal) to promote quality psychiatric care for children, adolescents, and families and to increase funding for graduate medical education and research.
- (Member Needs) As the “professional home” for CAPs, AACAP must remain committed to providing its members all the support and assistance needed to manage the significant changes anticipated in role, training, and practice during the coming decade.

Priority Recommendations & Action Steps for 2013-2015

During the comprehensive review and final editing of the report, the BPF Steering Committee was challenged and encouraged by the BPF honorary editors (Cohen and Enzer) and several BPF distinguished consultants to prioritize selected recommendations and action steps. The BPF Leadership Group and Steering Committee developed
a process to identify a manageable number of “recommendations with action steps” that should be targeted for implementation during the first two years of the coming decade.

The following seven “Recommendations” with their respective “Action steps” were prioritized for implementation during the first two years by a consensus of the BPF Steering Committee:

*** (2013-2015 Priority) Recommendation 1.1– AACAP will support the integration of evidenced-based treatments and advances in both neurobiology and psychosocial sciences into members’ practices.

*Action step 1.1.1* – Create an AACAP Task Force (e.g., representatives from *JAACAP*, AACAP Program Committee, AACAP Quality Issues Committee, senior clinicians) focused on establishing a working relationship between child and adolescent psychiatry (CAP) researchers and practitioners to facilitate the translation of science advances into clinical practice

*Action step 1.1.2* – Create a Web-based portal for members on evidence-based practices and translational research.

*Action step 1.1.3* – Ensure that all AACAP *Clinical Practice Guidelines* (formerly AACAP *Practice Parameters*) are updated and revised in accord with Institute of Medicine (IOM) standards.

*Action step 1.1.4* – Consider broadening the membership of the AACAP Program Committee to include more CAPs in clinical practice, and also consider establishing an advisory group to the *JAACAP* editors composed of CAPs in clinical practice.

*Action step 1.1.5* – Ensure adequate representation of psychosocial sciences and treatments at AACAP’s Annual Meeting and continuing medical education (CME) programs.

*** (2013-2015 Priority) Recommendation 1.6 – AACAP will promote the creation of outcomes-based data on the efficacy and effectiveness of psychiatric treatments for children and adolescent.

*Action step 1.6.1* – Develop, implement, and maintain an information center/clearinghouse on psychiatric treatment outcomes that covers the spectrum of care (e.g., psychotherapy, psychopharmacology, environmental interventions, consultation):

- Provide data searchable by various criteria (e.g., patient age, disorder)
- Collaborate with clinicians to obtain information on clinical practices and results (e.g., solicit information on certain types of therapy based on certain criteria; provide incentives for contributors’ participation)
- Collaborate with researchers to design collection practices/criteria, analyze data, summarize conclusions
- Provide outcomes data with treatment recommendations

*Action step 1.6.2* - Promote the education of CAPs to use evidence supported treatment interventions, participate in the collection of data, and develop models to monitor and systematize clinical practice:

- Verbal and written educational material (e.g., meeting, web, journal) for members
- Training for members throughout the lifespan
- Training the trainers (e.g., program directors)
- Ongoing educational requirement for membership
- Educational programs on using Performance in Practice (PIP) modules and other quality assurance monitoring

*** (2013-2015 Priority) Recommendation 3.3 - CAPs need to be familiar and able to work in evolving models of healthcare delivery systems including the Accountable Care Organization (ACO) and medical home models.

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**Action step 3.3.1** – In the short term AACAP will need to actively educate its members about the impact of healthcare reform (e.g., annual meeting presentations, *AACAP News* and *JAACAP* articles, and webinars developed by the various AACAP components).

**Action step 3.3.2** – AACAP needs to inform and support its members by developing educational materials related to innovations in efficient mental healthcare delivery.

**2013–2015 Priority** Recommendation 4.5 – CAPs and AACAP should support collaboration with primary care physicians and pediatric subspecialty physicians by establishing stronger relationships in training and clinical practice.

**Action step 4.5.1** – CAPs should work with primary care and pediatric subspecialty physicians to clearly define their respective roles in patient and family mental health care coordination.

**Action step 4.5.2** – AACAP should encourage CAP training programs to increase training in collaboration with primary care and examine new models of education (e.g., primary care pediatric practice rotations).

**Action step 4.5.3** – AACAP should advocate that CAP function as a subspecialty of both pediatrics and psychiatry when considering policy and system planning.

**2013–2015 Priority** Recommendation 6.1 - Develop and disseminate a clear, broad-based research agenda that covers the breadth of CAP disorders, with particular emphasis on those disorders that are the most common, have the greatest morbidity and mortality, are in areas where prior research provides the most promising opportunities, and have the greatest public health and societal costs, especially those occurring in understudied or underserved populations.

**Action step 6.1.1** – Develop and implement an approach to guide the prioritization of research agendas, explicitly communicate the rationale, and integrate transparent mechanisms for refining priorities in response to scientific advances. This process should include members who are representative of the AACAP membership and include opportunities for all members to provide comments (i.e., email updates and surveys).

**Action step 6.1.2** – Develop a transparent process to develop and maintain a current list of research priorities that is responsive to all of AACAP's membership. The process to develop and maintain this prioritized list would be inclusive of the full range of AACAP members.

Possible research studies and priority areas:

1. Treatment approaches targeting the progression of psychiatric disorders to more severe forms or disorders (e.g., Do antipsychotics given very early prevent progression of psychotic disorders? Does treatment of anxiety prevent progression to Major Depression?)

2. Usefulness of specific biomarkers and other risk factors in predicting disease course and optimizing individualized treatment.

3. Treatment approaches in severely refractory cases. Research in adults and in neurological conditions uses relatively invasive methods that act directly on brain circuitry. Clearly, some of these treatments will not be appropriate for children for many years. Others may be appropriate but only for children who are treatment refractory. Work is needed to define the situations where such invasive treatments are justified, and research needs to evaluate their efficacy.

4. Development of quality improvement interventions using emerging technologies to more rapidly disseminate and sustain evidence based practices in community-based settings.

5. Development and demonstration of effectiveness of short-term/brief psychotherapy modules addressing specific symptoms and problems that may be combined in optimum ways for our patients.
(6) Psychotherapy dissemination and effectiveness research.

(7) The impact of the new DSM-5. Research will be needed to understand the impact of the changes in DSM-5 diagnostic categories, especially in the area of autism and the carving out of Disruptive Mood Dysregulation Disorder from Bipolar Disorder.

**Action step 6.1.3** – Disseminate AACAP’s prioritized list of research opportunities to all members, the National Institute of Health, other governmental agencies, Congress, clinical and research training programs, allied professional organizations, and others to build a consensus of support.

**Action step 6.1.4** – Promote collaboration between AACAP and other stakeholders (e.g., consumer organizations, other professional organizations) to jointly advocate for more funding and targeted research in priority areas.

*** (2013-2015 Priority) **Recommendation 7.1** – AACAP will provide leadership by advocating for the unique role of CAPs and expanded funding to target the critical CAP workforce shortage and maldistribution.

**Action step 7.1.1** – AACAP will partner with appropriate national organizations, regulatory agencies, and key stakeholders to obtain and maintain funding for key roles and functions of child psychiatry. Examples include but are not limited to GME funding, undergraduate medical education funding, and funding to support practitioner activities.

**Action step 7.1.2** – Advocate with HRSA and SAMSHA to promote and support CAPs loan repayment and work in federally qualified health centers (FQHCs) in underserved areas.

**Action step 7.1.3** – AACAP will support expansion and development of primary care consultation models to target CAP maldistribution (e.g., Massachusetts Child Psychiatry Access Project).

**Action step 7.1.4** – AACAP will advocate to remove the cap on the number of GME positions or allow exceptions for shortage specialties including child and adolescent psychiatry.

**Action step 7.1.5** – AACAP will advocate for developing incentives for medical students to pursue careers in child and adolescent psychiatry (e.g., differential payments from Medicare and Medicaid).

**Action step 7.1.6** – AACAP will establish a clearinghouse for loan repayment and funding methods to address the shortage and maldistribution of CAPs. AACAP will explore possible funding for CAPs through National Health Service Corps and also develop a loan repayment model for states to target CAP practice in rural areas.

**Action step 7.1.7** – AACAP will advocate for credits and/or funding for providing CAP training experiences in non-traditional GME sites (e.g., schools, correctional facilities, or community settings).

**Action step 7.1.8** – AACAP will advocate for incentives for medical colleges to offer innovative GME training programs in CAP (e.g., integrated programs, post pediatric portal programs).

**Action step 7.1.9** – AACAP will advocate for states to classify CAP as a primary care specialty in order for general psychiatry residents to extend J-1 Visa waivers into CAP training.

*** (2013-2015 Priority) **Recommendation 8.5** - Promote innovative models for training and practice that include e-health (e.g., telepsychiatry, Internet, communication technologies) and multidisciplinary collaboration that expands the reach of CAPs to underserved areas.

**Action step 8.5.1** – Develop a curricular needs assessment and gather innovative training models for medical student and CAP residents regarding telepsychiatry.
**Action step 8.5.2** – Develop a curricular needs assessment and gather innovative training models for medical students and CAP residents regarding multi-disciplinary collaboration.

**Action step 8.5.3** – Develop web based multidisciplinary case conferences with edited content and commentary for CAP trainees and practitioners.

Bottom line – The time is NOW for AACAP leadership, members, and staff to study the “roadmap” presented in this report and make the decision to begin the “journey” into the coming decade.