

*AMERICAN ACADEMY OF CHILD AND
ADOLESCENT PSYCHIATRY*

STRATEGIC PLAN

November 1, 2002

A CALL TO ACTION:

*CHILDREN NEED OUR
HELP!*

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Introduction

Numerous national studies and Presidential Commissions have repeatedly substantiated the magnitude of emotional, behavioral and developmental problems in the nation's children, adolescents and their families. Consistently, 16-20% of the population of children and adolescents has some disturbance and 4-7% suffer significant functional impairment. The Report of the Surgeon General's Conference on Children's Mental Health (2001) stated, "The burden of suffering by children with mental health needs and their families has created a health crisis in this country. Growing numbers of children are suffering needlessly because their emotional, behavioral and developmental needs are not being met by the very institutions and systems that were created to take care of them."

There are approximately 6300 child and adolescent psychiatrists in the US and over 15 million children and adolescents who are in need of the special expertise of a child and adolescent psychiatrist. Many psychiatry residency positions go unfilled each year, and the proportion of physicians seeking specialty training in child and adolescent psychiatry is not increasing to meet the projected need.

- The National Center for Health Work Force Information and Analysis of the Bureau of Health Professions reports that the demand for child and adolescent services will increase by 100% between 1995 and 2020. However, it projected the increase of child and adolescent psychiatrists to be only 30%.

For the sake of our Nation's children and their families, these projections need to be reversed. The AACAP's Strategic Plan, *A Call to Action: Children Need Our Help*, aggressively addresses the workforce crisis.

Charge

The American Academy of Child and Adolescent Psychiatry's primary priority over the next 10 years is to increase recruitment to Child and Adolescent Psychiatry by 10% per year starting in 2004.

Three Strategic Initiatives for Building the Future

EXECUTIVE SUMMARY:

Initiative I- Attraction: Get the data, tell the story

- 1. Data Acquisition**
- 2. ListServ/Website Support**
- 3. Mentoring (Residents and Medical Students)**
- 4. Public Image**

Initiative II- Expansion: Multiple portals of entry

- 1. Increase Triple Board Programs**
- 2. Promote Integrated Training Tracks**
- 3. Explore CAP Only Training**

Initiative III- Support: Access and Advocacy

- 1. Appropriate, Fair, Incentives**
- 2. Workforce Advocacy Coalition**
- 3. Children's Hospital's Access**

STRATEGY I: ATTRACTION --- MEDICAL STUDENTS, RESIDENTS, PRACTICING PHYSICIANS

There are four components to Strategy I:

A. DATA ACQUISITION:

A number of data sets need to be gathered, integrated and maintained on an ongoing basis. Some of the data come from the AMA, ACGME, AAMC, NRMP, APA and from CAP and general psychiatry training sites. Other data do not now exist and need to be obtained via specific efforts (e.g., surveys, a series of focus groups, telephone calls to program directors, etc). A set of reports (AACAP Recruitment Reports) needs to be generated annually and made available to the field. Without data, recruitment efforts are guided by past experiences; our history to date suggests the need for new strategies. As a data model, it is important to review the American Academy of Pediatrics' "Future of Pediatric Education" (FOPE) study.

Some of the immediate data that need to be gathered address the following questions:

- Do minority recruitment programs work?
- Do we lose $\frac{3}{4}$ of the general residents who plan on CAP training? Why?
- How many and which general psychiatry training programs do not have child programs?
- How many medical schools place > 8% of their graduates into psychiatry? Which ones? Why?
- How many general psychiatry programs place > 30 % of their general residents into CAP? Which ones? Why?
- How many unfilled CAP resident slots are there annually? Where are they located?
- Which programs support early child training in the general psychiatry program? Which programs support "integrated" training?
- What are the variables that differentiate successful programs from unsuccessful programs? (fill vs. not fill; match vs. not using the match; fill 100% from within vs. fill from outside).

RECOMMENDATIONS:

1. Establish an AACAP Database Committee
2. Rename the AACAP Office of Research and Training to Office of Research and Education. Assign a full time staff member to manage data acquisition and Listserv/website support (cf. below)
3. Produce annual recruitment report
4. Network with Center for Mental Health Services, IOM, and NIH CAP Workforce Group to develop an annual recruitment profile (report card) for the field

5. Develop Dean's/Chair's Awards to recognize outstanding or lagging medical schools/psychiatry departments.

LEAD PERSONS: Trish Brown (AACAP), T. Anders, WJ Kim, D. Norris (SCWFI).

B. LISTSERV/WEB SITE SUPPORT:

Training directors, potential CAP trainees and medical students increasingly use the internet. AACAP efforts should facilitate communication and access to information. There is a need for effective support of recruitment initiatives via ListServ and website communication. Listservs should be developed for medical students receiving subscriptions, travel grants, other awards and for those who serve as monitors at annual meetings, for general residents in the same categories, and for CAP residents. There should also be Listservs for CAP Training Directors and other components of the Academy. The AACAP student/trainee web page should have an email response function for those interested in obtaining more information about CAP training and opportunities. The interested party need only click to send an email and receive a packet of information. The AACAP website should also be linked with medical student sites.

RECOMMENDATIONS:

1. Establish an AACAP Website Oversight Committee
2. Charge the AACAP Office of Research and Education to develop and maintain the Listservs and website links.
3. Encourage Training Directors and Components to use and promote Listservs.

LEAD PERSONS: Brad Cady (AACAP), Amy Ursano and Henrietta Leonard (SCWFI), newly appointed Committee Chair.

C. MENTORING:

Medical students and general psychiatry residents need to have relationships with local ROCAP members, sponsorship at annual meetings, summer clinical electives, and individualized preceptorships. Current programs have been successful (e.g. the Spurlock and Comer awards) but they are limited to minority medical students. The importance of developing ongoing, one-on-one relationships with the "right" kind of enthusiastic and charismatic mentor is considered key to enhanced recruitment.

- A summer clinical experience for interested medical students, of any ethnicity should be established with funding from the NIMH or the Research Work Group.
- A more intensive program for trainees who attend annual meetings should be developed (akin to the Laughlin model).

- Institutes and Workshops for Teaching Teachers/Mentors should be developed.

RECOMMENDATIONS:

1. The Assembly should establish a Committee on Mentoring to develop a regional program of mentoring medical students and general psychiatry residents.
2. The Assembly should establish Mentoring Awards.
3. The Committee on Training should develop Institutes or workshops on Teaching and Mentoring excellence.

LEAD PERSONS: WJ Kim, R. Hendren (SCWFI). Sandra Sexon (Assembly). Jeff Newcorn (Committee on Training)

D. PUBLIC RELATIONS AND IMAGE

Medical students report that both ignorance of CAP practice and stigmatizing, stereotypic images of CAPs are common at medical schools; they serve to discourage consideration of CAP as a career choice. In general, lack of visibility of CAP faculty means there are few positive images to counterbalance the negative. Specific areas need to be addressed:

- 1) Change perceptions of the profession.
 - How do CAPs spend their days?
 - What are the challenges and exciting areas of the field?
 - Quality of life for CAPs.
 - Focus groups, what do medical students/general psychiatry residents want?, Obstacles?
- 2) Enhance the National Image of AACAP
 1. AACAP as the primary political force for CAP
 2. AACAP speaks for its membership
 3. AACAP as an active member of the consortium of children's agencies

RECOMMENDATIONS:

1. Support a marketing PR study (2002-2003).
2. Re-charge an existing AACAP committee to address this issue.
3. Send publications such as the Developmentor and Facts for Families to every entering medical student.

LEAD PERSONS: Maureen McDermott (AACAP). D. Norris, L. Tenunfeld (SCWFI).

STRATEGY II: EXPANSION --- MULTIPLE PORTALS TO TRAINING. Increase the total number of CAP trainees by supporting a variety of training venues that appeal to those who have a primary interest in children

A. THE TRIPLE BOARD PROGRAMS:

The TB programs have a proven track record of attracting highly qualified medical students. There have been problems in implementing new programs, but new programs will increase the workforce. There is currently a lack of any formal support for TB programs and no accreditation by ABMS like for other sub-specialties. Accreditation has been loosely monitored by ABPN. Re-certification in all 3 boards poses a potential problem. Resistance for new programs continues to come from Pediatrics and Psychiatry Chairs. Data are needed to understand more about program difficulties.

- Complete the currently funded (Abrahamson Fund) project to study the impact and outcome of the Triple Board programs and determine the impediments to program expansion?
- Select appropriate sites and increase TB programs over the next 5 years starting in 2004.
 - 9 programs in 2002
 - 10 programs in 2004 (+2 CAP/yr in 2009)
 - 11 programs in 2005 (+4 CAP/yr in 2010)
 - 12 programs in 2006 (+6 CAP/yr in 2011)
 - 13 programs in 2007 (+8 CAP/yr in 2012)
 - 14 programs in 2008 (+10 CAP/yr in 2013)

This provides 10 new practicing CAPs per year by 2013.

RECOMMENDATIONS:

1. Charge H. Leonard to complete Abrahamson Triple Board Study.
2. Charge the Committee on Liaison with Primary Care to establish an AACAP Triple Board sub-committee for support of TB programs with sufficient funding to support annual program retreats.
3. Establish Foundation matching support for new TB pediatric slots. Funding: \$80,000/slot x 2 yrs = \$320,000/program for first 2 pediatric yrs. To support the first 5 years of each program (25 program years *in toto*), the cost approximates \$8.0 million.

LEAD PERSONS: H. Leonard (Abrahamson Fund), F. Wren/R. Martini (Committee on Liaison with Primary Care) J. O'Brien/A. Ursano (SCWFI)

B. INTEGRATED TRAINING:

Medical students with a known interest in children will be more attracted to integrated programs than programs that defer child training until adult training is completed.

- What are the regulatory and political impediments to integrated tracks?

- Review current integrated programs
- Select appropriate pilot sites for augmentation of new integrated curricula
 - 5- & 6-year curricula for academic and clinical child/adolescent psychiatrists.
 - CAP training before general psychiatry training, with or without significant integration. This portal may be most suitable for pediatricians/family physicians that wish to change careers.
 - 54-month “experimental” pilot program (integrated) that would require RRC approval (6 months shorter than current requirements).

RECOMMENDATIONS:

1. Charge the Taskforce on Training and Education to develop model curricula for several of the integrated pathways.
2. Develop business plans and marketing programs to insure success
3. Select and coordinate 5-10 pilot programs (perhaps using Telepsychiatry)
4. Establish funding (Incentive support for Training Director of \$10,000/year X 5 years/ program = \$50,000/program = \$500,000.)

LEAD PERSONS: J. Leckman (Task Force on Training and Education), T. Anders, WJ Kim, S. Weissman (SCWFI).

A. CAP ONLY PROGRAM:

Some students who now choose pediatrics, and some practicing pediatricians/family practitioners may well be interested in a CAP only program. This program would require 4 years of training (PG-I in Pediatrics/child Neurology, PG-II & III in CAP, and PG IV as an elective (adults, families or CAP specialization). CAP only training would result in eligibility for certification by one board only (CAP). The CAP only program requires much preparatory work, both conceptually and politically.

RECOMMENDATIONS:

1. Begin to plan strategies for this program but in terms of activating it, put it on the back burner.

LEAD PERSONS: J. Leckman (Task Force on Training and Education), T. Anders, Sid Weissman (SCWFI).

STRATEGY III: SUPPORT-- IMPROVE ACCESS; INCREASE TRAINING FUNDS

A. APPROPRIATE, FAIR, INCENTIVES----IMPROVE REIMBURSEMENT RATES FOR CHILDREN'S SERVICES:

- Reimbursement rates that do not adequately reflect the more time consuming and complex work with children and their families act effectively as negative incentives, making the field less attractive, concurrently reducing available academic time (i.e. visibility and teaching involvement) of child psychiatry faculty. Comparable code-based reimbursements for child and adult services result in lower per-hour earnings for CAPs, whether they are in practice or supporting part of an academic salary.
- There are new reimbursement schedules for CAPs in Massachusetts, pioneered by Magellan. These models address the inherent inequities in traditional reimbursement. They need to be monitored to determine if they, in fact, increase access to CAPs as intended and need to be exported to all states.
- The Kennedy Bill provides loan forgiveness for CAP training. The Domenici Bill authorizes the secretary of DHHS to provide full GME funding to shortage specialties such as child psychiatry programs. Both bills require full AACAP support.
- All CAP training programs need to know how to obtain State Health and Mental Health Department funds, with federal matching dollars, for Medicaid appropriate mental health services. For example, some administrative codes for CAP activities are paid by State Health Departments, but not by Mental Health Departments.
- There are regional differences and special expertise is required to be successful.

RECOMMENDATIONS:

1. Charge the Committee on Health Care Access and Economics to develop a plan to improve reimbursement rates and generate the data to support the advocacy needed to implement such a plan.
2. Publish the data regarding reimbursement strategies on the AACAP website.
3. Assist ROCAPs to lobby for child-specific rates.

LEAD PERSONS: Mary Crosby (AACAP), Sandra Sexon (Assembly) M. Houston, D. Berland, N. Winter/M. Chenvin (Committee Chairs), G. Fritz, D. Norris (SCWFI).

B. CHILDREN'S HOSPITALS ACCESS:

The "rump" group (ACOPOCH) of CAP Directors in Children's Hospitals agreed to consolidate with the Committee on the Physically Ill Child to reduce redundancy and increase the likelihood of accomplishing goals. Unique opportunities for CAP programs in Children's Hospitals need to be exploited.

RECOMMENDATIONS:

1. Charge the Committee on the Physically Ill Child to develop a strategy whereby Children's Hospital psychiatry programs can pursue new windfall money for resident support
2. Develop information manuals and support services to enhance programs in Children's Hospitals.

LEAD PERSON: G. Fritz (SCWFI); M. Wamboldt (Committee on the Physically Ill Child)

C. LEGISLATIVE ADVOCACY

AACAP as an organization, and all of its members, trainees and ROCAPs need to become more active on behalf of CAP training specifically.

RECOMMENDATIONS:

1. Develop active liaisons with allied professional organizations and develop an active lobbying strategy (cf. above)
2. Charge Assembly to establish a Workforce Advocacy Committee that will develop strategies to get sponsors for the Kennedy and Domenici bills.

LEAD PERSON: M. Crosby (AACAP), S. Sexon (Assembly), R. Hendren, D. Norris, G. Fritz (SCWFI)

ADDITIONAL IDEAS FOR FUNDING

- AACAP Innovative Training Grants(a.k.a. Institutional Training Grants)
 - Triple Board support
 - Integrated Program support
 - 1 Year of training for Pediatricians
 - Integrated CAP/Child Neurology tracks
- AACAP Master Teacher Programs (a.k.a. Career Teacher Grants)