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AMERICAN ASSOCIATION OF DIRECTORS OF CHILD AND ADOLESCENT PSYCHIATRY

Spring 2018

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American Association of Directors of Child and Adolescent Psychiatry

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PRESIDENT'S COLUMN

Victor Fornari, MD
AADCAP President

Dear AADCAP Members:

53rd Annual Meeting of AADCAP in Washington, DC

The 53rd Annual Meeting of AADCAP was a very productive and informative meeting. I would like to thank everyone who attended for their interest and participation. I would particularly like to thank our many outstanding presenters. Special thanks to Earl Magee for his tireless efforts and efficient attention to details that allow the Annual Meeting to run smoothly. Being in Washington, DC during the peak of the cherry blossom season was a particular delight for those who had the opportunity to tour our magnificent Capital City. All presentations received have been uploaded to the meeting's webpage. *View photo highlights!*

New Division Directors' Roundtable

The meeting offered an opportunity for new child division directors to once again participate in the New Division Director's Roundtable. Nearly twenty child division directors were present, including ten new child division directors, accompanied by returning directors. This opportunity has been available for the past 15 years under the leadership of Marty Drell who began this with Allan Josephson. I joined Marty for the past eight years. A wide range of topics were covered in order to prepare new division directors for challenges they may expect and offered each member who attended an opportunity to discuss his/her particular division. Issues discussed include: budgets, academic mission, training challenges, resident and faculty recruitment concerns, mentoring, developing an academic division; managing unprofessional behavior in faculty, as well as a variety of issues relevant to each of our roles. Each year we learn new information from each other.

Business Meeting

Welcoming remarks by outgoing President John Diamond opened the meeting followed by the Business Meeting where we heard reports from AADCAP, AACAP, JAACAP, APA and AADPRT. John Diamond presented John Pruett with an award in recognition of his two years of service to the organization as Secretary/Treasurer. AACAP President Karen Dineen Wagner discussed her Presidential Initiative of Depression Screening in Children and Adolescents. Doug Novins, *JAACAP* Editor-in-Chief, reviewed the current *Orange Journal* and informed us of updates including a call for children's artwork for the *Journal* cover. APA Deputy Director Ranna Parekh welcomed us and discussed the move of the APA Headquarters to Washington, DC. Sandra Sexson offered a report on behalf of Sandra DeJong, Immediate Past President of AADPRT, regarding training and recruitment.

Administration Symposium

The Administration Symposium, organized by Co-Chairs Robert Chayer and Felicity Adams, provided a rich opportunity to hear from three Department of Psychiatry Chairmen. Their presentation entitled, *Recruiting and Retaining an Excellent CAP Faculty: A Chair's Perspective*, was informative. Steve Cuffe, Chair, Department of Psychiatry and Program Director, Psychiatry Residency, University of Florida College of Medicine in Jacksonville, Florida, described his experience as a child & adolescent psychiatrist building a new department of psychiatry, a new training program, a new child division and now a new child fellowship. Timothy Soundy, Psychiatry Chair, described his experience at the University of South Dakota Sanford School of Medicine. Tim reported on how he can retain faculty by incentivizing them for their various roles within the department. Finally, guest speaker Jon Lehrmann, MD, Department of Psychiatry and Behavioral Medicine Chairman, University of Wisconsin at Milwaukee, reported on the relationship between the Division of Child & Adolescent Psychiatry and the Department of Psychiatry in Milwaukee.

Clinical Symposium
The Clinical Committee, organized by Co-Chairs Matthew Biel & Michael Sorter, introduced David Axelson from Nationwide Children's Hospital in Columbus, Ohio, who presented an impressive narrative of the development of clinical services there in his talk entitled: *Addressing the Demand for Pediatric Mental Health Services: A Systems of Care Approach*. David described the funding opportunities when philanthropy invests in this mission.

Program Consultations
For the second year, the meeting included a formal consultation opportunity for division directors to ask questions of the entire group. The discussion was led by Marty Drell, Tami Benton and myself. We reviewed issues related to recruitment, the Child Match; Generational issues with Millennial Trainees and Colleagues, as well as a variety of other topics. The format allowed for a lively discussion and participation from all who attended. Below is the Summary Report from that session.

Research Symposium
The Research Symposium, organized by Co-Chairs Judith Crowell & Charlie Zeanah, presented, *Developing a Patient Centered, Pragmatic Trial,* by guest speaker Lisa Settles, PhD from Tulane University. Lisa described the history of the Patient Centered Oriented Research Institute (PCORI) and the application process for funding. A discussion of pragmatic trials as an opportunity for future clinical research was discussed.

ABPN Update
Larry Faulkner President & CEO of ABPN, presented an update of ABPN with information about the new procedures for Maintenance of Certification (MOC).

AADCAP Banquet Dinner
All who attended the Annual Meeting were invited to join for the dinner in a collegial and festive social evening.

Committee Meetings
The Administration, Clinical Services, Research, and Training and Education Committees met for one hour to discuss possible suggestions for the next year's meeting. With a presidential theme of Early Identification of Youth at Risk, each committee reviewed ways in which they might present a topic and speaker(s) for the next meeting to support this initiative. The committee chairs will continue to discuss these issues during the monthly conference calls in order to develop the program for April 2019 in Deer Valley, Utah.

NIMH Funding Report
Guest speaker Christopher Sarampote, PhD, Director of Research Training and Career Development (DDTR) at the National Institute of Mental Health (NIMH), reviewed funding opportunities for research.

Training & Education Symposium
Co-Chairs Lee Ascherman & Sandra Sexson introduced the Training & Education Symposium. Jim Hudziak presented: *Training the Next Generation of CAPS in the Science of Building Healthy Brains*. John Walkup served as a discussant. The presentation offered an innovative look at the way mental health services are being delivered in Vermont in order to support brain development. Health life style coupled with music lessons, meditation, yoga, mindfulness and care for the entire family were described. The challenges of adapting this to large urban settings were reviewed.

Emeritus Committee (New Committee)
Under the leadership of Jim Harris, a new committee has been created to create an important role for the emeriti members to mentor junior division directors as well as to facilitate development

for AADCAP. Jim has graciously agreed to chair this new committee and will participate in the monthly conference calls together with the Executive Committee. We are grateful to Jim for leading this new initiative.

Closing Remarks
I presented John Diamond with an award for his two years of service as President of AADCAP. I described my goal of my Presidential Initiative to be education about Early Identification of Youth at Risk for mental health problems. Karen's AACAP Presidential Initiative of Depression Screening addresses the importance of screening to identify cases for treatment. The AACAP Legislative Conference followed AADCAP's Annual Meeting, and many division directors participated on Capitol Hill the following day.

AADCAP PROGRAM CONSULTATIONS

53rd Annual Meeting: Saturday, April 7, 2018
The Mayflower Hotel

Summary Report

MODERATORS


Marty Drell, MD


Victor Fornari, MD


Tami Benton, MD

SUBMISSIONS

QUESTION:
With CAP shortage, we are considering qualified nurse practitioners as autonomous attendings in our outpatient, inpatient & day treatment centers. Although state law allows independent practice, we are thinking of making collaboration mandatory. Thoughts? *(Currently 23 states allow NP practice autonomy.)*

RESPONSE:
We have Child & Adolescent Psychiatry NP's in a variety of clinical settings: the Child & Adolescent Outpatient Department; the Adolescent Inpatient Unit and the Eating Disorders Day Program. They work on a Team and do see their own cases. It is working well in our setting, provided there is clinical supervision and oversight.

QUESTION:
Do most CAP Division Directors manage their own budgets? *(Southeast region)*

RESPONSE:
The Child Division Director has access to certain elements of the budget, but, not control of the Budget, generally, controlled by the Chairman. I have input into outpatient visit targets; inpatient case-loads; input into cost of living or merit raises (offering recommendations to the Chairman); discussion about salary rectification issues.

QUESTION:

What is an optimal set up for psychotherapy supervision of child fellows by a psychologist in the clinic? How would billing for such a clinic work with commercial insurance? Medicaid? *(Southeast region)*

Medicaid and most payers require that trainees be supervised by same discipline supervisors for billing purposes. Unfortunately, this can become a barrier to cross disciplinary supervision due to productivity expectations. Optimally, we should be able to benefit from the expertise available in our own divisions, including the psychotherapy expertise of our psychology and social work colleagues. There are a few options that folks are using to address this problem that might be helpful.

1. Develop an RVU metric for teaching that credits the psychotherapy supervisors. This can be factored into their clinical RVU efforts, as most programs require multiple activities for promotion and compensation.
2. Establish a fee for service trainee practice. The reduced rates will attract families, and the guidelines are based upon your departmental practices as opposed to payers.
3. Do joint supervision with a psychiatrist/psychology duo and bill at the higher rate for the psychiatrist for time for time based codes. Not as practical, but for junior faculty, it has the added benefit of learning a new skill. For example, many of our junior folks are interested in learning PCIT, so they will sit in with the psychologist and the trainee. That way you split the RVU for productivity reasons, but bill at the higher rate.

QUESTION:

Many programs did not match this year. There seems to be significant variation in practices across departments. What are your recommendations regarding the match for child psychiatry fellowship programs? Should we all stick fully to the match, or is it OK to sign some candidates outside the match? *(Midwest region)*

RESPONSE:

Few of the new program directors remember what it was like before the match for child and adolescent psychiatry. Believe me, it was worse.

In my case, while doing an elective in child psychiatry at Boston Children's in my junior year of medical school, I was told I needed to apply for my general psychiatry residency. I assured the person telling me this that couldn't possibly be true, as I was a junior in medical school. "I haven't even signed up for my internship." The person clarified that I was wrong and that it was indeed time to apply for my general psychiatry if I wanted to be in a Boston program. He explained that there had been an ongoing competition between two of the local Harvard programs that led to these programs taking candidates earlier and earlier, which, in turn, impacted the other Boston programs. I was confused, but my informant was correct. If I would have applied a year later when I thought I should, I would have been out of luck.

I ended up doing child psychiatry first at the Boston Children's/Judge Baker Guidance Center Program. While there in my first year, I applied for my general residency. Again I found there was no standardization. I ended up being pressured to agree to the Cambridge Hospital Program before I was able to attend my scheduled interviews at MGH and Beth Israel. Although I really liked the Cambridge Program, I felt cheated and that the way things were done was not fair.

I was not alone in my feelings, and through the AADPRT Child Caucus, was able to change things. The Child Caucus discussed standardizing the recruitment process and implementing "The Match" as two related but separate issues.

As far as the recruitment process, it was agreed that recruitment should begin July 1st of the year before fellows would begin their fellowships. This was implemented to standardize the process and to take care of the programs that started more than a year ahead of time. The original plan included a "gentlemen's agreement' (n.b., there were few women Training Directors at the time), which is now called the "gentle person's agreement" that programs could recruit before the agreed upon July 1st date one year before residency would begin. This allowed for programs to take "in-house" and other valued applicants. The agreement made it clear that after July 1st, all programs should go through a standardized process. Shortly before these discussions, general psychiatry had gone to "The Match." It seemed logical and expeditious to use the "Match" to further standardize applications for child psychiatry.

Using the Match included the demands by the company that 70% of all child and adolescent psychiatry programs sign up and pay. This was the early to mid-80 and the agreement was signed off on by the majority of the Training Directors at the time. The process was overseen by Gene Beresin, MD, who was the first Chair of the Child Caucus and myself as second Chair. Although the original "July 1st" agreement has remained the same since then, the issue of the Match remained continuously and contentiously on the Child Caucus agendas since. There were numerous reasons for this. The difficulties involved:

1. That it proved difficult in the beginning to get 70% of the programs to be involved in the Match. The subsequent Caucus meetings involved clarifying the process and begging programs to join. This took time, as many of the smaller programs who filled internally and had small numbers of applicants were not eager to pay for a Match program that they felt they didn't need. Why pay the costs to set up a program that would not be advantageous and "add value" to their programs?

2. The sense in many people's minds that the Match would favor the larger programs.

3. The sense (that never made sense to me) that the computer algorithm favored the applicants over the programs. Many Training Directors felt that that was ok. This reflected the reality that there were differences from the start as to whether the Match was more for the applicants or for the programs. As a "confused" past applicant, I was in the group that felt that the Match would help the applicants. In reality, I felt that the Match would be good for both the applicants and the programs, making the Match a win-win situation. Others disagreed!

4. The main reason as I remember it was that there were Training Directors who were not "gentlemen" and violated the spirit and letter of the agreement. Altruism is difficult when one fears your program won't fill and people will "blame you" when it doesn't.

After a few years of explaining and cajoling, the Child Caucus reached 70% level demanded by the Match. Despite this success, there remained a sizable minority that didn't sign up. These programs were free to not follow the rules or just to follow the ones that they felt in their best interest. This minority block seemed to include smaller programs and/or those with traditional recruitment challenges.

Each year there were infractions to the rules (n.b., people cheated!). This incensed many members of the Child Caucus, especially those that felt they didn't fill because of the infractions of other child and adolescent Training Directors and the "Match."

These infractions continued year and year and stimulated (like the movie "Groundhogs Day") repetitive passionate discussions. Early on, the Child Caucus, with Sandra Sexson taking the lead, set up a system to call in infractions. This seemed a good idea, but there was little the

Child Caucus could do to address the complaints other than by shaming people or threatening to "snitch" to the program's department heads. This "call in" system never had any teeth and proved ineffective. This in turn, assured that there continued to be future infractions.

As usual, these issues were on the agenda for this years' AADPRT Child Caucus with Lisa Cullins handling it with more aplomb and less irritation than usual. She even created a survey dealing with what she referred to as an "All In" policy for the Match. I wrongly thought that this referred to the goal of having all child and adolescent psychiatry programs in the Match. This was wishful thinking on my part. In reality, the "All In" policy referred only to those programs in the Match and advocated for these programs to be "all in" the Match if they chose to be in the Match in the first place. It did not deal with the minority who chose not to be in the Match altogether. The survey showed that many Caucus members agreed to this in principle, but a consensus was not reached. There were some new potential solutions brought to bear. My favorite being that ERAS should only be used by those in the Match who remain "All In" the Match. I was left unclear how this would be implemented and monitored. There was the usual call for gathering more information on this and other questions, but no major decisions were made which guarantees that this will be an agenda item again next year. I smiled as people asked whether the process should favor the applicants who remain confused about the process or the programs. People remarked that having everyone "all in" would reduce this confusion. I had my usual déjà vu feeling.

Recruitment: The Real Issue

The fact that only half the programs filled in the Match this year complicated the Match discussion, as the Match was implicated once again as contributory. It was noted that we should await future data concerning whether the unfilled programs actually will end up filling their slots.

I strongly believe that there are more important issues at play then the Match, and that the real problem is a general recruitment problem that we have faced for years. A short list as to why would include:

1. That child psychiatry deals with populations of children and their caregivers, which many shy away from.
2. That it requires extra training which is costly (n.b., 60K for a fellows stipend vs. 200K plus for a first year graduates contract).
3. That people have amassed large training debts that they want to deal with.
4. That stigma remains alive and well!
5. That we are still low on the MD specialty pay scale despite seemingly working harder.
6. That our field is in transition and that we are changing the definitions of who we are and what we do.
7. Funding issues for the increased number of stipends due to several new child training programs.
8. Specific circumstances in some of the unfilled programs regarding location, competitions with other programs in their areas, work load, perceptions of quality, etc.
9. Generational issues.

The questions of recruitment have also been continual throughout the years (n.b., another Groundhogs Day phenomenon), along with the interrelated topic of a child and adolescent psychiatry shortage.

QUESTION:

Could you please provide some guidance on how to best incorporate midlevel clinicians such as NPs into the clinical services and educational programs? *(Midwest)*

RESPONSE #1:

A child & adolescent psychiatry NP serves as the Program Coordinator of our Eating Disorders Day Program. This role lends itself nicely given the medical and psychiatric issues of this population. A child & adolescent psychiatry NP in the outpatient clinic works well. Victor Fornari, MD

RESPONSE #2:

We use NP's on every clinical service as peer clinicians. They work alongside trainees, and expand clinical care for patients in the inpatient and outpatient setting. They work "incident to" a group of billing attendings. In that role, they seen patients along with trainees and other attending's in the clinic.

As they gain expertise and don't rotate off of services, they begin to teach the residents and fellows, about specific subspecialty areas. For example, a few of our NP's have expertise in addictions or eating disorders, and they provide that supervision for fellows. Other NP's have expertise in Autism and developmental disabilities, and are able to share that expertise with the fellows in a supervisor capacity.

We utilize NP's to teach certain topics to fellows. They are especially skilled in educating families about diagnosis and treatment, and are excellent family advocates. My experience is that they do this much better than we do.

We also integrate the APN trainees into the CAP curricula. They learn alongside the fellows. For our new APN's, we provide an "apprenticeship" of sorts in our specialty services. For example, we have them shadow an attending for a period of time, while picking up new cases under supervision so that we can build capacity in our areas of need.

2019 Annual Meeting

April 25-27, 2019

Deer Valley Resorts

Park City, UT

Click *these links to watch one-minute videos on Deer Valley Resort and enjoy:*

https://youtu.be/1eNgVS4_L40

https://youtu.be/mme1qaYbgxE