A Proposed Three Year Residency in Child & Adolescent Psychiatry (CAPS-3)

Jim Hudziak, MD

Vermont Center for Children, Youth, and Families

THIS PROPOSAL IS MEANT TO BE IN ADDITION TO EXISTING PROGRAMS. A PILOT PROGRAM TO BE TESTED, NOT A REPLACEMENT OF EXISTING WONDERFUL FELLOWSHIP, TRIPLE BOARD, AND PPPP PROGRAMS.

Disclosures

Source	Advisory Board	Research Support	Travel	Royalties
AACAP			X	
NIDA		X		
VCHIP		X		
Conrad Hilton Foundation		X		
Apple Corp		X		

Bonafides

- I love our field and want it to flourish
- Served on the ACGME RRC for 10 years
- Served on AAMC test writing team
- Worked with ABPN teams
- Understand ABMS process
- Director of Child Psychiatry Division for 26 years and have interviewed many or our medical students who initially indicated they wished to become CAP and then chose a different residency.

OUTLINE

- **RATIONALE**
- PROPOSAL
- Example of Proposed PROGRAM
- FELLOWSHIPS
- Conclusion

RATIONALE

- 30 year work force crisis.
  - 1976 GMENAC Report predicted severe shortage (see Health Policy and Education 3: 337-349, 1983). American College of Physicians concurred in 1980 in a typewritten report that might make for a nostalgic slide
  - Report of the Surgeon General 1999
  - Decades Into Crisis, Kids Still Suffer From Shortage of Psychiatrists
  - What we are doing is not working at reducing the shortage at a time of heightened need in the face of increasing burdens
- Others have made this decision successfully
  - Pediatrics
  - Family Medicine
  - Internal Medicine
  - Emergency Medicine
- Others (above and NP etc.) are treating more children with psychiatric illness with little or no training.
- AND AGAIN, WHAT WE ARE DOING IS NOT WORKING ON THE LESSONING THE WORKFORCE SHORTAGE

Steps

- Funding – embedded in Children's hospitals (DIO and Federal funds to end shortage)
- Designed to fast track work force issues
- Graduates would be board eligible for child psychiatry but not general psychiatry
- Invite Adult Psychiatry to test a similar pilot program

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CAPS-3 PROPOSAL

- A NOVEL PILOT PROGRAM – NOT TO REPLACE EXISTING WONDERFUL FELLOWSHIP, TRIPLE BOARD, PPPP PROGRAMS – THIS PROPOSAL IS IN ADDITION TO WHAT ALREADY EXISTS
- REBOOT-OUR PERCEPTIONS ABOUT WHAT IS NECESSARY (PEDS, IM, FM, ED)
- SPECIFICALLY I PROPOSE - 10 PILOT PROGRAMS WITH 5 RESIDENTS PER YEAR (THIS APPLICATION WILL BE DEVELOPED AND PRESENTED TO THE ACGME RRC AND ABMS)
- I PROPOSE THAT THESE PROGRAMS BE TESTED IN CHILDREN HOSPITALS – DESIGNED TO LEARN IN AN INTEGRATED CARE CONTEXT, DIMINISH ED, WAIT LIST AND CONSULTATION ISSUES

Proposal continued

- Would be board eligible for Child certification not adult (currently the ABPN allows CAPS to maintain Child certification without maintaining adult cert).
- Would mean two years less training, two years less of deferring loan payments from medical school, allows CAP to offer higher paying jobs for three year graduates than both pediatrics and family medicine.
- May impact on diversity and SES membership in the CAP community (in other words those who cant afford the extra two years of training can enter our field).
- Proposed Children's Hospital to also create an integrated buddy systems in which CAPS3 co-train pediatricians, thus improving their ability to DX and treat developmental psychopathology

Proposed CAPS-3 application

- Invite applications with 10 sites chosen (I propose embedding in Children's Hospitals) based on a number of criteria.
- 5 residents per year for three years (thus graduate upto 50 additional CAPS-3 each year)
- Pilot program to run 10 years (500 additional CAPS3 to add to current program graduates)
- Outcome and progress monitoring include:
  - Will the programs fill?
  - Medical students Boards 1 and 2 scores to compare and contrast
  - Performance on Child Boards
  - Diversity of CAPS3

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Possible Curriculum (Developed by David Rettew, MD at UVM)

First Year					
2 months	2 months	2 months	2 months	2 months	2 months
Peds (Inpt)	Peds (Outpt)	Pedi Neuro	Inpatient (Adult)	Inpatient (Child)	Inpatient (Adol)
Outpatient 10%, Didactics 10%					

Second Year			
2 months	2 months	2 months	6 months
Acute Care (Resid, Partial, IOP)	Acute Care (Resid, Partial, IOP)	Inpatient	INTEGRATED CARE Consult-Liaison (PRIMARY CARE,Inpt, ED, Outpt)
Outpatient - Continuous at 20% (often afternoons), Didactics 10%			

Third Year
Educational Experiences – Addiction, Forensic, Developmental – 20%
Outpatient – Continuous at 50% with at least half-day per week in community setting
Research and Scholarship – 20% time; Didactics 10%

A novel approach to traditional didactic learning

- Standardized learning modules developed over the period of applications
- Suites of Standardized Patients (allow individualized and multiple contacts tailored to the individual learner).
- Tele-teaching of core knowledge, skills, and attitudes.
- VR packages to test and improve interviewing, assessment, and treatment formulation.
- Outcome and assessment packages based on state of the art approaches to determine skill achievement.
- Shared across all 10 programs.

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Following Model of Internal Medicine - Fellowships

- 1-2 years fellowships in a variety of special emphasis settings
- 2 year Psychotherapy
- Forensic
- Psychopharmacology
- Research (in many disciplines)
- Autism
- Etc.

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Conclusions

- We need a new (and again additional) pathway to get into CAP Training
- We can view learning our knowledge base as achievable in the same fashion that Pediatrics, Family Medicine, Internal Medicine, and Emergency medicine acknowledge that their training can be achieved in three years.
- We will have to figure out obstacles about funding, go through the process of ACGME RRC, ABMS, ABPN but I believe it is achievable.
- We can propose this work as a pilot program that will run 5 years and have the potential to yield 500 new CAPS3 who may not have even applied to our traditional tracks.