# Supplemental Guide:

# Child and Adolescent Psychiatry Milestones

ACGME

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## Milestones Supplemental Guide

This document provides additional guidance and examples for the Child and Adolescent Psychiatry Milestones. This is not designed to indicate any specific requirements for each level, but to provide insight into the thinking of the Milestone Work Group.

Included in this document is the intent of each Milestone and examples of what a Clinical Competency Committee (CCC) might expect to be observed/assessed at each level. Also included are suggested assessment models and tools for each subcompetency, references, and other useful information.

Review this guide with the CCC and faculty members. As the program develops a shared mental model of the Milestones, consider creating an individualized guide (Supplemental Guide Template available) with institution/program-specific examples, assessment tools used by the program, and curricular components.

Additional tools and references, including the Milestones Guidebook, Clinical Competency Committee Guidebook, and Milestones Guidebook for Residents and Fellows, are available on the Resources page of the Milestones section of the ACGME website.

## Additional Notes

The ACGME does not expect formal, written evaluations of all milestones (each numbered item within a subcompetency table) every six months. For example, formal evaluations, documented observed encounters in inpatient and outpatient settings, and multisource evaluation should focus on those subcompetencies and milestones that are central to the resident's or fellow's development during that time period.

Progress through the Milestones will vary from learner to learner, depending on a variety of factors, including prior experience, education, and capacity to learn. Residents and fellows learn and demonstrate some skills in episodic or concentrated time periods (e.g., formal presentations, participation in quality improvement project, child/adolescent rotation scheduling, etc.). Milestones relevant to these activities can be evaluated at those times. The ACGME does not expect programs to organize their curricula to correspond year by year to the specialty- or subspecialty-specific Milestones.

For the purposes of evaluating a resident's progress in achieving Patient Care and Medical Knowledge Milestones, it is important that the evaluator(s) determine the resident's or fellow's knowledge and abilities, separate from the supervisor.

Implicit in milestone level evaluation of Patient Care and Medical Knowledge is the assumption that during the normal course of patient care activities and supervision, the evaluating faculty member and resident/fellow participate in a clinical discussion of the patient's care. During these reviews the learner should be prompted to present clinical thinking and decisions regarding the patient. This may include evidence for a prioritized differential diagnosis, a diagnostic work-up, or initiation, maintenance, or modification of the treatment plan, etc. In offering independent ideas, the resident/fellow demonstrates capacity for clinical reasoning and its application to patient care in real-time. As residents or fellows progress, their knowledge and skills should grow, allowing them to assume more responsibility and handle cases of greater complexity. They are afforded greater autonomy—within the bounds of the ACGME supervisory guidelines—in caring for patients. At Levels 1 and 2 of the Milestones, a resident's/fellow's knowledge and independent clinical reasoning will meet the needs of patients with lower acuity, complexity, and level of risk, whereas, at Level 4, residents/fellows are expected to independently demonstrate knowledge and reasoning skills in caring for patients of higher acuity, complexity, and risk. Thus, one would expect residents achieving Level 4 milestones to be more senior learners at an oversight level of supervision. In general, one would not expect beginning learners to achieve Level 4 milestones. Level 5 is for the rare resident/fellow who exceeds expectations on the specific subcompetencies. At all levels, it is important that learners ask for, listen to, and process the advice they receive from supervisors, consult the literature, and incorporate this supervisory input and evidence into their thinking.

| **Patient Care 1: Psychiatric Evaluation**<br>**Overall Intent:** To gather and organize findings from the patient interview; mental status and cognitive exams; targeted physical and neurological exams; data from collateral sources including information gathered from the medical record, family members, other providers; and laboratory and imaging results; to screen for risk, and integrate risk assessment into the patient evaluation | |
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| **Milestones** | **Examples** |
| **Level 1** *For adolescents, acquires accurate history and mental status examination findings, customized to the chief complaints* | ● Uses a standard outline to obtain thorough psychiatric and medical history and completes a mental status exams and basic developmental assessment<br>● Explains the limits of confidentiality to patient and family/guardian |
| *Collects relevant information from collateral sources* | ● Contacts parents/guardians, primary care providers, and school with appropriate consent |
| *Screens patients for risk of harm to self, to others, or by others* | ● Screens for self-harm, suicidal ideation, homicidal ideation, and aggression, including plan and intent<br>● Screens for physical and sexual abuse and neglect |
| **Level 2** *For adolescents, obtains information that is sensitive and not readily offered by the patient* | ● Collects a focused history, notes inconsistencies |
| *Selects appropriate laboratory and diagnostic tests, including standardized assessment tools* | ● Orders urine drug screen for patients with suspected substance use and orders lipid profile and HbA1c (i.e., blood glucose) tests for patients taking antipsychotics |
| *Engages in a basic risk assessment and basic safety planning for children and adolescents* | ● Asks patient about feelings of hopelessness, thoughts of self-harm or suicide, and what the patient would do if the patient had suicidal thoughts; uses standard suicide screens, such as the Columbia Suicide Severity Rating Scale. Assesses children not capable of providing this information (because of their developmental/cogntive stage) using nonverbal methods, by engaging collateral sources, and by assessing child-caregiver relationship |
| **Level 3** *Uses hypothesis-driven information-gathering to obtain a complete, accurate, and relevant history from child and adolescent patients and their family/caregivers* | ● Uses the evolving differential diagnosis and mental status findings to prioritize the interview questions, address new diagnostic possibilities, differentiate among diagnoses, and avoid premature closure |
| *Interprets collateral information, test results, and standardized assessment tools to determine necessary additional steps* | ● Orders complete blood count (CBC) and mononucleosis spot test (i.e., Monospot) for a depressed female adolescent |

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| *Incorporates risk and protective factors into the assessment of imminent, short-term, and long-term patient safety and the safety of others* | ● Asks adolescent patient's parents to leave the room for some part of the examination for inquiries about safety at home, risk factors, substance use, risky behavior, sexual history, and the relationship between substance use and hopeless thoughts or impulsive behaviors<br>● Identifies protective factors such as success in academics, music, theater, sports, jobs |
| **Level 4** *Efficiently acquires an accurate and relevant history and performs a targeted examination customized to the patient's developmental level, patient's family context, and complexity of the patient's clinical presentation*<br><br>*Evaluates the structure and functioning of the patient's family, including strengths, vulnerabilities, and cultural factors, as they pertain to the child/adolescent patient*<br><br>*Incorporates risk and protective factors into the assessment of complex patient and patient family presentations, including eliciting information not readily offered by the patient and utilizing standard risk assessments scales* | ● Notices uncommon findings from the history and from observation of mental status examination<br><br>● Identifies the level of the guardianship of the parents and other caregivers<br><br>● Assesses emotional tone, structure, and problem-solving capacity of identified patient's families<br><br>● Uses patient's strengths to develop rapport during the interview and facilitates more complete disclosure<br>● Explores the impact of social determinants of health on the patient's mental health during the interview |
| **Level 5** *Incorporates therapeutic interventions into the initial evaluation interview and collateral sources and creative use of both verbal and non-verbal evaluation techniques*<br><br>*Serves as a role model for risk assessment in all clinical settings* | ● Uses multiple skills to engage a non-forthcoming adolescent or a minimally verbal child with autism spectrum disorder<br><br>● Serves as a peer-consultant for patient or parent risk assessment by colleagues |
| Assessment Models or Tools | ● American Board of Psychiatry and Neurology Clinical Skills Examination (ABPN CSE)<br>● Case-based discussion<br>● Direct observation or retrospective video review<br>● Medical record (chart) review<br>● Simulation or standardized patients |
| Curriculum Mapping | ● |

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| Notes or Resources | ● This Milestone set refers to psychiatric evaluations in all clinical settings (e.g., emergency, inpatient, outpatient, consultation) and with patients throughout the pediatric lifespan<br>● Collateral includes information from family members, friends, caregivers, other providers, schools, past medical records<br>● Case presentation and documentation is included in the Interpersonal and Communication Skills milestones<br>● American Association of Directors of Psychiatric Residency Training. Virtual Training Office. https://www.aadprt.org/training-directors/virtual-training-office. Accessed 2019.<br>● SAMHSA National Suicide Prevention Lifeline. Columbia Suicide Severity Rating Scale Suicide-Risk-Assessment-C-SSRS-Lifeline-Version-2014.pdf (suicidepreventionlifeline.org). Accessed 2022<br>● Lempp T, de Lange D, Radeloff D, Bachmann C. The clinical examination of children, adolescents and their families. In Rey JM ed. *IACAPAP e-Textbook of Child and Adolescent Mental Health*. Geneva: International Association for Child and Adolescent Psychiatry and Allied Professions; 2012. https://iacapap.org/content/uploads/A.5-CLINICAL-EXAMINATION-072012.pdf; https://psychiatryonline.org/doi/book/10.1176/appi.books.9780890426760<br>● American Board of Psychiatry and Neurology (ABPN). APBN. Requirements for Clinical Skills Evaluation of Residents in Child and Adolescent Psychiatry. APBN; November 2017. https://www.abpn.com/wp-content/uploads/2015/04/CSE-CAP-2017.pdf |

| **Patient Care 2: Psychiatric Formulation and Differential Diagnosis**<br>**Overall Intent:** To organize and summarize findings and generate differential diagnosis; identify contributing factors and contextual features and create a formulation, and use the emotional responses of clinician and patient as diagnostic information | |
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| **Milestones** | **Examples** |
| **Level 1** *Organizes and accurately summarizes information obtained from the patient evaluation to develop a clinical impression* | ● Accurately reports evaluation data in a note and concludes that the child has symptoms consistent with attention deficit hyperactivity disorder (ADHD) |
| *Recognizes that biological, psychosocial, and developmental/life cycle factors play a role in a patient's presentation* | ● When asked, identifies biopsychosocial factors that could contribute to psychiatric presentations, such as in-utero exposures, substance use, trauma history, or food insecurity |
| *Recognizes that clinicians have emotional responses to patients* | ● Identifies one's own feelings of cheerfulness, sadness, anxiety, or anger when interviewing a child and family members |
| **Level 2** *Integrates and prioritizes information obtained from the patient, patient's caregivers, other health care practitioners; and education, welfare, and legal systems to develop a clinical impression* | ● For a child with impaired concentration and behavioral concerns, integrates information from caregivers, teachers, and the patient to appropriately develop and prioritize a differential diagnosis |
| *Identifies specific biological factors, including heredity, genomics, nutrition, sex, race, and substances, that play a role in a patient's presentation* | ● Accurately lists strong family history of ADHD, in-utero exposure to nicotine, very low birth weight, nutritional deficiencies, and male sex as risk factors that may contribute to ADHD in a particular child |
| *Recognizes that the clinician's emotional responses to patients may have diagnostic value* | ● Notices a pattern of feeling frustrated while interacting with a child with conduct disorder |
| **Level 3** *Incorporates the significance of a patient's and patient's family's adverse childhood experiences; patient's intersecting identities; and experiences into the clinical impression* | ● In a child with impaired concentration and behavioral concerns, prioritizes ADHD in the differential based on the school and caregiver data, but continues to explore the possibility of other neurodevelopmental disorders, cultural considerations, and differences in expectation based on sex |
| *Identifies specific psychosocial factors, including relationships, home environment, advancement opportunities, and social determinants of health that contribute to a patient's presentation* | ● Integrates contributing biopsychosocial factors and relates these factors to begin developing a formulation: in-utero exposure to smoking increases risk of concentration problems that can worsen with exposure to domestic violence, resulting in amygdala hyperactivity and impulsive aggression |

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| *Differentiates emotional responses that are related to the clinician's history and those that are induced by a patient* | ● Identifies own anger with a patient and considers the possibility that the patient has a disruptive behavior disorder diagnosis |
| **Level 4** *Reconciles information from different collateral sources, recognizing when information varies or conflicts, and integrates information into a comprehensive formulation*<br><br>*Identifies the role of psychological, cognitive, social, sexual, and moral developmental level in a patient's presentation*<br><br>*Attends to and appropriately uses feelings elicited in the patient and psychiatrist to develop a diagnostic picture* | • In developing a differential diagnosis for a child presenting with inattention and behavioral concerns, compares information reported on the Vanderbilt rating scales by parents and teachers; if there is a discrepancy, considers whether learning disorders, differences in behavioral expectations, and environment are affecting performance<br><br>● Identifies that a school-age child with untreated ADHD may have trouble navigating Erikson's stage of industry versus inferiority, resulting in low confidence in own academic abilities<br><br>● Identifies own feeling of helplessness with a patient may be related to projective identification with the parent who has low confidence in the treatment; uses own feeling of frustration with the child to empathize with the parent who has similar feelings |
| **Level 5** *Serves as a role model in the development of accurate and complete differential diagnoses and formulations*<br><br>*Serves as a role model to others for identifying how biological, psychosocial, and developmental/life cycle factors play a role in a patient's presentation*<br><br>*Consults to others when emotional responses are impeding treatment* | ● Becomes a case discussant and models the process of developing a differential diagnosis and formulation as part of a case conference or grand rounds |
| Assessment Models or Tools | ● Assessment of case conference presentations<br>● Case-based discussions<br>● Clinical skills evaluation with discussion<br>● Direct observation or retrospective video review<br>● Medical record (chart) review for assessments and formulations<br>● Simulation or standardized patient<br>● Written case formulations |
| Curriculum Mapping | ● |
| Notes or Resources | ● A psychiatric formulation is a theoretically based conceptualization of the patient's mental disorder(s). It provides an organized summary of those individual factors thought to contribute to the patient's unique psychopathology. This includes elements of possible etiology, as well as those that modify or influence presentation, such as risk and protective |

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| | factors. It is therefore distinct from a differential diagnosis that lists the possible diagnoses for a patient, or an assessment that summarizes the patient's signs and symptoms, as it seeks to understand the underlying mechanisms of the patient's unique problems by proposing a hypothesis as to the causes of mental disorders.<br>● Models of formulation include those based on either major theoretical system of the etiology of mental disorders, such as behavioral, biological, cognitive, cultural, psychological, psychoanalytic, sociological, or traumatic, or comprehensive frameworks of understanding, such as bio-psycho-social or predisposing, precipitating, perpetuating, and prognostic outlines. Models of formulation set forth a hypothesis about the unique features of a patient's illness that can serve to guide further evaluation or develop individualized treatment plans.<br>● American Psychiatric Association (APA). Cultural Formulation Interview. https://www.psychiatry.org/File%20Library/Psychiatrists/Practice/DSM/APA_DSM5_Cultural-Formulation-Interview.pdf.<br>● APA. Supplementary Modules to the Core Cultural Formulation Interview. https://www.psychiatry.org/File%20Library/Psychiatrists/Practice/DSM/APA_DSM5_Cultural-Formulation-Interview-Supplementary-Modules.pdf<br>● DSM-5® Outline for Cultural Formulation<br>● Henderson SW, A Martin. Case formulation and integration of information in child and adolescent mental health. In Rey JM ed. *IACAPAP e-Textbook of Child and Adolescent Mental Health*. Geneva: International Association for Child and Adolescent Psychiatry and Allied Professions; 2014. https://iacapap.org/content/uploads/A.10-CASE-FORMULATION-2014.pdf.<br>● Lewis- Fernández R, Aggarwal NK, Hinton L, Hinton DE, Kirmayer LJ. *DSM-5® Handbook on the Cultural Formulation Interview.* 1st ed. Arlington, VA: American Psychiatric Publishing; 2016.<br>● Ross DE. A method for developing a biopsychosocial formulation. *Journal of Child and Family Studies*. 2000;9(1):1-6. https://cchs.ua.edu/wp-content/cchsfiles/psych/BIOPYCHOSOCIAL.pdf. |

| **Patient Care 3: Treatment Planning and Management**<br>**Overall Intent:** To create a treatment plan, monitor and revise treatment when indicated, and incorporate the use of community resources | |
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| **Milestones** | **Examples** |
| **Level 1** *Identifies potential biopsychosocial treatment options* | ● On an emergency department rotation, presents a case of depressed 15-year-old patient who reports substance use, including using illegal substances with parents, and suicidal ideation to the supervising attending; Suggests an antidepressant and psychotherapy; requires discussion with the attending to identify the best labs to order such as CBC, thyroid-stimulating hormone, Monospot, and drug screen |
| *Recognizes that acuity and complexity affect level of care and treatment monitoring* | ● Recognizes the patient is not acutely unsafe or grossly functionally impaired and does not require hospitalization; discusses alternatives such as partial hospitalization/day treatment |
| *Gives examples of types of community resources* | ● Notes illegal substance use with parents and discusses with attending whether to file a report to Child Protective Services<br>● Suggests referral to group psychotherapy for patient and family therapy for patient and family |
| **Level 2** *Informs the patient/patient's family of the available evidence-based biopsychosocial treatments, recognizing that co-occurring conditions and side effects impact treatment* | For a five-year-old patient with separation anxiety disorder:<br>● Recognizes co-occurring conditions that may be present including mood disorders and subsequently and effectively communicates to the family first-line treatment options including appropriate first line psychotherapy (e.g., parent-child interaction therapy (PCIT), cognitive behavioral therapy (CBT)), as well as medication options if needed as an adjunctive |
| *Recommends the most appropriate level of care based on acuity and complexity, and monitors treatment adherence and response* | ● Appropriately recommends family-based treatments |
| *Coordinates care with community resources* | ● Coordinates care with patient's school, including the counselor and teacher<br>● Provides referral for patient and family to support groups |
| **Level 3** *Applies an understanding of psychiatric, substance use, neurologic, and medical co-occurring disorders in the management of common presentations* | ● For a 17-year-old patient with psychotic symptoms and daily marijuana use, assesses cultural attitudes and explanatory model the patient and family use to understand psychiatric symptoms; considers extended urine toxicology screening to assess for drugs of abuse, including opioids, cocaine, methamphetamines, and synthetic drugs; monitors the patient's body mass index (BMI), hemoglobin A1c, glucose, and lipids; coordinates care with the patient's primary care physician; considers alternative antipsychotic treatment when pre-diabetic conditions appear |

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| *In common presentations, considers family and sociocultural factors, recommends the most appropriate interventions/treatments, and adjusts as indicated*<br><br>*Incorporates support and advocacy services/groups in treatment planning* | ● Discusses the potential benefits and risks of medication options with the patient and family members, taking the patient's history and views into consideration in deciding on alternative treatment<br>● Discusses with the patient and family members the potential role for National Alliance on Mental Illness (NAMI) Family-to-Family Program<br>● Discusses with family referral for family support specialist, as well as therapeutic mentor for the patient<br>● Consider referral to an early psychosis clinic for comprehensive services<br>● Considers necessary educational accommodations via 504 plan and/or individualized education program (IEP) for patient to return to school when stable<br><br>● Refers patient to a clinic-based medication support group |
| **Level 4** *Develops individualized treatment plans for complex presentations; integrates multiple biopsychosocial modalities and input from other care practitioners in a comprehensive approach*<br><br>*In complex presentations, considers family and sociocultural factors, recommends the most appropriate interventions/treatment, and adjusts as indicated*<br><br>*Locates and connects patients to community resources in complex and difficult situations* | ● For an 11-year-old patient with a history of autism spectrum disorder, childhood neglect and physical abuse resulting in traumatic brain injury, referred for increasing aggression:<br>  ○ Obtains a longitudinal history of behaviors including self-harm, and safety assessment of home environment, including substance abuse in the home<br>  ○ Obtains neurological consultation to assist in assessing sequelae of the traumatic brain injury<br><br>● Evaluates risk and protective factors for suicide and harm to others; in planning treatment, considers neuropsychological testing, substance use treatment, cognitive remediation, cognitive behavioral therapy, and dialectical behavior therapy as potential interventions; considers pharmacologic treatments<br><br>● Referral to state agencies that serve patients with developmental disorders to assist with resources such as respite care<br>● Referral to local organizations (e.g., Child Mind Institute) for parent support |
| **Level 5** *Supervises treatment planning by other learners and multidisciplinary practitioners*<br><br>*Matches patient and family needs and preferences to specific local or virtual/online resources and advocates for the creation of resources when gaps are identified* | ● Facilitates discussions about treatment planning with clinical staff members at the local mental health center<br><br>● Works with the state Department of Mental Health to create standards for early onset psychosis programs across the area and with the state rehabilitation agency to create a new supported employment program |
| Assessment Models or Tools | ● Assessment of case conference presentations<br>● Case-based discussions<br>● Clinical skills examination |

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| | ● Direct observation or retrospective video review<br>● Medical record (chart) retrospective review/audit for assessments and formulations<br>● Written case formulations |
| Curriculum Mapping | ● |
| Notes or Resources | ● American Academy of Child and Adolescent Psychiatry (AACAP). Parameters, Updates, and Guidelines. Web page. https://www.aacap.org/AACAP/Resources_for_Primary_Care/Practice_Parameters_and_Resource_Centers/Practice_Parameters.aspx<br>● Dulkan MK. *Dulcan's Textbook of Child and Adolescent Psychiatry*. American Psychiatric Publishing, Inc.; 2009.<br>● Kaminer Y, Winters KC. *Clinical Manual of Youth Addictive Disorders*. American Psychiatric Publishing, Inc.; 2020. ISBN: 9781615372362<br>● National Institute on Drug Abuse (NIDA). Adolescent Substance Use. https://teens.drugabuse.gov/<br>● US Department of Health and Human Services. Local Organizations with Mental Health Expertise. https://www.mentalhealth.gov/talk/community-conversation/services. Updated January 20, 2021. |

| **Patient Care 4: Psychotherapy**<br>**Overall Intent:** To establish a therapeutic alliance, select and provide psychotherapies, and manage therapeutic process | |
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| **Milestones** | **Examples** |
| | ● *The following scenario is used for the examples in this subcompetency.*<br>Casey is an eight-year-old female who lives with her biological parents. She attends third grade and has always been a good student with many friends. Recently, she was diagnosed with a sore throat and tested positive for strep. Rather suddenly, Casey became extremely upset about sitting down in chairs because she was afraid of "boy germs." She refused to go to school, refused to eat, and she was unable to sleep. She became obsessed with wiping down surfaces because of contamination fears. There was no history suggestive of abuse and no evidence. She was referred for psychiatric evaluation. |
| **Level 1** *Demonstrates empathy, respect, and interest in both the identified patient and the patient's family/caregiving system* | ● Demonstrates empathy and respect for the child as well as her parents and recognizes how desperate they are feeling |
| *Develops familiarity with a range of therapeutic modalities for individual psychotherapy with children and adolescents* | ● Discusses with attending the evidence-based therapies for children with obsessive-compulsive disorder (OCD) |
| *Develops familiarity with a range of therapeutic modalities for multi-person psychotherapy, including dyadic, family, and group psychotherapies* | ● Discusses differential diagnosis and treatment options with parents |
| **Level 2** *Builds and maintains a therapeutic alliance with a patient and patient's family, and identifies potential boundary violations and crossings in a psychotherapeutic relationship* | ● If the child asks not to disclose information to parents, discusses with supervisor how to handle secrets |
| *Selects appropriate modality for individual psychotherapy, including the needs, goals, culture, and resources of the patient and the patient's family system* | ● Selects exposure and response prevention (ERP) as an individual psychotherapy modality for OCD, along with psychoeducation with parents on how they can support, at home, the therapy work she is doing in the individual and group therapy sessions |
| *Selects the appropriate modality for multi-person psychotherapy, including the needs, goals,* | ● Recommends group therapy using the Superflex model, meets with parents and daughter to establish comfort level and trust, then meets with both parents alone to review treatment plan |

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| *culture, and resources of the patient and the patient's family system* | |
| **Level 3** *Recognizes the value of family involvement while maintaining the ethical and legal limits on confidentiality of psychotherapy with a minor patient* | ● Establishes a therapeutic alliance with parents by discussing rationale for exposure therapy, possible relationship between strep infection and rapid onset of obsessive-compulsive symptoms, and importance of continued family involvement |
| *Creatively uses techniques from play and expressive therapies to facilitate individual psychotherapy* | ● Uses puppets, drawings, and non-verbal techniques to introduce CBT coping skills for anxiety, teaches puppet relaxation techniques that they practice together |
| *With supervision, manages complex interactions and therapeutic process in multi-person psychotherapy* | ● Meets with family to provide education about diagnosis and establish expectations.<br>● Provides "homework" assignments for patient and their caregivers/family based on CBT and exposure principles<br>● Anticipates the family's difficulty with implementing home plan |
| **Level 4** *Maintains a dual alliance with patients of all ages and their families, and maintains appropriate and culturally-informed boundaries and professional relationships* | ● Improves alliance with parents, establishes trust with patient and family, and reaches out to the school system to support the patient's return to class |
| *Provides individual psychotherapy from beginning to termination to youth at various developmental stages* | ● Seeks supervision when parents unable to stop accommodating child's anxiety<br>● In finishing course of psychotherapy, evaluates if termination of psychotherapy is appropriate |
| *Provides multi-person psychotherapy to youth at various developmental stages* | ● Co-leads OCD group therapy, first a course of therapy with adolescents, followed by a course with elementary school-aged children |
| **Level 5** *Mentors other learners in psychotherapy and seeks additional psychotherapy education and collaboration when needed* | ● Teaches patient and family members about future treatment directions for OCD, provides resources for evaluating new treatment approaches (e.g., the International OCD Foundation, National Institute of Mental Health (NIMH) website), and mentors other learners regarding issues of fidelity in using evidence-based treatment modalities while tailoring therapy to the individual patient and family |
| Assessment Models or Tools | ● Direct observation with retrospective video review<br>● Medical record (chart) review<br>● Multidisciplinary group supervision<br>● Patient surveys or debriefing |
| Curriculum Mapping | ● |

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| Notes or Resources | ● Psychodynamic therapy includes the capacity to generate a case formulation, to demonstrate techniques of intervention, and to understand the concepts of resistance/defenses, transference/countertransference.<br>● CBT includes the capacity to generate a case formulation, to demonstrate techniques of intervention, including behavior change, skills acquisition, and to address cognitive distortions.<br>● Supportive therapy includes the capacity to generate a case formulation, to demonstrate techniques of intervention, and to strengthen the patient's adaptive defenses, resilience, and social supports.<br>● AACAP. Child Psychodynamic Psychotherapy Toolkit. https://www.aacap.org/AACAP/Member_Resources/How-to-use-the-Psychodynamic-Play-Psychotherapy-Train-the-Trainer-Tool.aspx<br>Note: Requires login and password.<br>● American Association of Directors of Psychiatric Residency Training (AADPRT). Benchmarks for Psychotherapy Training. https://portal.aadprt.org/public/vto/categories/Psychotherapy%20Committee%20Tips%20of%20the%20Month/2012/57c7898088044_psychotherapy_benchmarks.pdf<br>● AADPRT. AADPRT Virtual Training: Psychotherapy Competency Tools. https://portal.aadprt.org/user/vto/category/483.<br>Note: Requires login and password.<br>● AADPRT. Psychiatric Interview. https://portal.aadprt.org/user/vto/category/593.<br>Note: Requires login and password.<br>● Gabbard GO, Roberts LW, Crisp-Han H, Ball V, Hobday G, Rachal F. Professionalism, and the clinical relationship: boundaries and beyond. In: Gabbard GO, Roberts LW, Crisp-Han H, Ball V, Hobday G, Rachal F. *Professionalism in Psychiatry*. Arlington, VA: American Psychiatric Publishing; 2012: 35-59. |

| **Patient Care 5: Psychopharmacology and Other Somatic Therapies**<br>**Overall Intent:** To understand the mechanisms of action, indications, and evidence base for somatic therapies and appropriately apply them to patient care; educate patients about somatic therapies including access to accurate psychoeducational resources; and appropriately monitor a patient's response to treatment | |
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| **Milestones** | **Examples** |
| **Level 1** *Reviews general indications and common adverse effects for commonly prescribed drugs and other somatic treatments with a patient's parent/guardian and the patient* | ● Explains to parents why fluoxetine is prescribed to their child with depression and when to expect to see a benefit, discusses the US Food and Drug Administration (FDA) black box warning, and educates the parents about the warning signs of activation syndrome |
| *Identifies necessary key baseline assessments before initiating somatic treatments to ensure patient safety* | ● Reviews with patient that taking selective serotonin reuptake inhibitors (SSRIs) such as fluoxetine may cause common side effects like gastrointestinal upset and sexual dysfunction for adolescent patients<br>● Documents BMI and orders fasting lipid profile, HbA1c, and glucose as baseline assessments before initiating an antipsychotic medication |
| **Level 2** *Uses resources to provide psychoeducation to the patient and patient's parents/guardians to optimize their understanding and adherence, including discussion of when medication is not indicated or is unlikely to be helpful* | ● When treating ADHD in an adolescent with comorbid conduct disorder, explains to the guardian that the medication guanfacine ER will not help with non-impulsive premeditated aggression<br>● Selects appropriate medication information handout, reviews with patient and the legal guardian, and answers any questions |
| *Obtains necessary baseline assessments before initiating treatment with commonly used somatic treatments* | ● Orders and reviews baseline renal function, pregnancy test, and thyroid stimulating hormone before starting lithium treatment for a female patient |
| **Level 3** *Explains mechanisms of action, risks, and benefits of commonly prescribed drugs and other somatic treatments to patients and their families* | ● Explains to a patient with ADHD, using developmentally appropriate language, how a stimulant might help reduce hyperactivity, inattention, and impulsivity; discusses the common side effects that may occur including appetite suppression, and moodiness, and that these will need to be monitored<br>● Explains the theoretical mechanism of action of antipsychotics to parents of a youth diagnosed with autism and describes the monitoring needed to be followed for safest use |
| *Monitors relevant assessments and adverse effects throughout treatment and incorporates findings from the literature into treatment strategy* | ● Chooses alternative treatment for a patient with bipolar disorder when A1C and lipid profile becomes elevated while taking risperidone |
| **Level 4** *Explains less common somatic treatment choices to patients and their families* | ● Consistently follows up to date evidenced based guidelines when prescribing medications to a patient with severe recurrent major depression |

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| *in terms of proposed mechanisms of action, impact of development, potential risks and benefits, and the evidence base*<br><br>*Manages adverse effects and safety concerns in complex or treatment refractory cases, including de-prescribing medication* | ● Describes the utility of prescribing lithium for a patient with severe treatment refractory depression and clearly explains the potential side effects, including toxicity and when to alert the treatment team<br><br>● Manages a patient with catatonia using benzodiazepines or electroconvulsive therapy (ECT) with supervisor support |
| **Level 5** *Mentors other learners by developing novel patient educational processes or materials*<br><br>*Incorporates new evidence-based developments into treatment to optimize safety, minimize adverse effects, and improve response* | ● Teaches a group of residents how to successfully simplify medication regimen for an adolescent being treated with six psychotropic medications<br><br>● Develops a peer-reviewed educational online resource for AACAP or other regional or national organization on the comparative efficacy of the long list of approved stimulants for ADHD<br>● Incorporates new findings on drug metabolism for patients with autism that have specific genetic abnormalities revealed by chromosomal microarray testing |
| Assessment Models or Tools | ● ABPN CSE<br>● Assessment of case presentations<br>● Direct observation<br>● Medical record (chart) audit<br>● Multisource feedback<br>● Patient surveys or debriefing<br>● Portfolio |
| Curriculum Mapping | ● |
| Notes or Resources | ● AACAP. Annual AACAP Psychopharmacology Institutes. https://www.aacap.org/AACAP/Learning_CME/Meetings/AACAP/CME_and_Meetings/Home_CME.aspx?hkey=6c1902dd-d1da-40b8-aef9-a1503a3585e3; https://www.psychiatry.org/psychiatrists/practice/clinical-practice-guidelines Note: Information from the annual meetings may become clinical practice guidelines.<br>● Azzam P, Gopalan P. *Psychosomatic Medicine Model Curriculum*. AADPRT. June 2, 2013. https://portal.aadprt.org/public/vto/categories/Virtual%20Classroom/Model%20Curricula%20--%20AADPRT%20Peer-Reviewed/Psychosomatic%20Medicine/57feb5bab2063_Psychosomatic_Medicine_Model_Curriculum.pdf<br>● Lorberg B, Davico C, Martsenkovskyi D, Vitiello B. Principles in using psychotropic medication in children and adolescents. In Rey JM, Martin A, eds. *IACAPAP e-Textbook of Child and Adolescent Mental Health.* Geneva: International Association for Child and |

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| | Adolescent Psychiatry and Allied Professions; 2019. https://iacapap.org/content/uploads/A.7-Psychopharmacology-2019.1.pdf<br>● Nelson, S. General principles of psychopharmacotherapy for children and adolescents. I' n Bowers Weston, Masrt Nelson Jackson, eds. *Green's Child and Adolescent Psychopharmacology*. Philadelphia: Wolters Kluver; 2019. |

| **Patient Care 6: Clinical Consultation**<br>**Overall Intent:** To consult in interdisciplinary/integrated care settings | |
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| **Milestones** | **Examples** |
| **Level 1** *Respectfully, clearly, and concisely requests the appropriate consultation* | ● Under close supervision, orders a cardiology consultation for a patient who is a candidate for psychostimulant medication and has a history of early cardiac events in first-degree family members; provides abbreviated patient information and the reasons for the consultation request |
| *Respectfully receives a consultation request and asks for additional information needed to respond to the request* | ● Promptly answers request for psychiatric consultation from pediatric hospitalist service and offers to provide recommendations within 24 hours |
| **Level 2** *Requests the appropriate consultation for a pediatric setting* | ● Under close supervision, orders a cardiology consultation for a patient who is a candidate for psychostimulant medications and has a family history of Wolff-Parkinson-White syndrome; accurately summarizes the patient's relevant medical information, including electrocardiogram (EKG) results |
| *Respectfully, clearly, and concisely communicates recommendations to the consulting team* | ● Assesses a child on a medical floor with a change in mental status; develops a differential diagnosis including psychiatric and medical comorbidities and makes recommendations regarding work-up and management to the medical team |
| *Demonstrates understanding of the consultation model, including direct/indirect care and system/individual care* | ● Under supervision, clarifies consult question with the team, reviews patient's record, interviews the patient, gathers collateral information, and provides treatment recommendations and ongoing assistance to the team |
| **Level 3** *Applies consultant recommendations judiciously to patient care* | ● A medical consultant recommends a complex diagnostic or treatment regimen including Holter monitoring and echocardiogram; discusses the recommendations with the cardiology consultant, including the family's cognitive, financial, and adherence limitations |
| *Assists the consulting team in identifying unrecognized clinical care issues and provides relevant recommendations, checking for understanding* | ● Recommends safety precautions and takes time to answer the medical team's questions<br>● Assists the consulting team in considering how family dynamics may be interfering with diet/insulin regimen in an adolescent newly diagnosed with diabetes mellitus |
| *Distinguishes models of integrated interprofessional care across medical and non-medical settings* | ● Distinguishes between integrated, collaborative, co-located, and consultation liaison models of care |

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| | ● Refers a patient to collaborative care team to ensure the patients are included in patient panel discussion |
| **Level 4** *Critically appraises and integrates various recommendations* | ● In a child with ADHD and family history of Wolff-Parkinson-White syndrome, recognizes the patient is unlikely to adhere to a daily regimen and may experience rebound hypertension when the cardiology consultant recommends an alpha agonist instead of a stimulant; asks about atomoxetine instead |
| *Manages complicated and challenging consultation requests* | ● Coordinates care for an adolescent with depression in the context of multiple past traumas and ongoing substance use by working with the interdisciplinary team including nurses, case managers, risk management, child protective services, ethics committee, and the family/guardians, if appropriate |
| *Develops complex treatment plans in collaboration with the interprofessional team in medical and non-medical settings* | ● Develops a safety plan that can be implemented in the school and the emergency room |
| **Level 5** *Contributes to identifying and improving potential deficiencies in the consultation system* | ● Manages and leads a consultation liaison service and delegates tasks to medical students and more junior level residents |
| *Leads consultation liaison psychiatry teams across medical and non- medical settings* | ● Leads consultation liaison rounds and develops a didactic curriculum for more junior level residents or medical students |
| *Serves as a leader of interprofessional care teams* | ● Develops an outpatient service that integrates mental health in a primary care setting |
| Assessment Models or Tools | ● Assessment of case conference presentation<br>● Clinical skills verification/annual clinical skills assessment<br>● Direct observation<br>● Multisource feedback |
| Curriculum Mapping | ● |
| Notes or Resources | ● “Integrated care” can refer the collaborative team process with other health care professionals<br>● The “respectful attitude” refers to Professionalism milestones later in this document.<br>● AADPRT Virtual Training Office (Model Curricula and Integrated Care Resources) https://www.aadprt.org/training-directors/virtual-training-office<br>● Ratzliff A, Basinski J. Collaborative Care Consultation Psychiatry: A Clinical Rotation Curriculum for Psychiatry Residents. 2013. https://aims.uw.edu/sites/default/files/CollaborativeCareConsultationPsychiatry_AClinicalRotationCurriculumforPsychiatryResidents.pdf. Accessed 2019. |

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| | ● Azzam P, Gopalan P. *Psychosomatic Medicine Model Curriculum*. AADPRT. June 2, 2013. https://portal.aadprt.org/public/vto/categories/Virtual%20Classroom/Model%20Curricula%20--%20AADPRT%20Peer-Reviewed/Psychosomatic%20Medicine/57feb5bab2063_Psychosomatic_Medicine_Model_Curriculum.pdf<br>● Huang H, Barkil-Oteo A. Teaching collaborative care in primary care settings for psychiatry residents. *Psychosomatics*. 2015;56(6):658-661. https://www.sciencedirect.com/science/article/abs/pii/S0033318215000596?via%3Dihub. Accessed 2019.<br>● APA. Integrated Care. https://www.psychiatry.org/psychiatrists/practice/professional-interests/integrated-care. Accessed 2019.<br>● Levenson JL. *The American Psychiatric Association Publishing Textbook of Psychosomatic Medicine and Consultation-Liaison Psychiatry*. 3rd ed. Washington, DC: American Psychiatric Association Publishing; 2019.<br>● Multiple authors. *Psychosomatics: The Journal of Consultation-Liaison Psychiatry*. Philadelphia, PA: Elsevier. https://www.journals.elsevier.com/psychosomatics. |

| **Patient Care 7: Digital Health**<br>**Overall Intent:** To optimally use electronic health records (EHRs) and technology to enhance patient care, reflecting the increasing role of technology in the management of patients | |
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| **Milestones** | **Examples** |
| **Level 1** *Uses the EHR for routine patient care activities* | ● Performs accurate and thorough medication reconciliation<br>● Manages clinical inbox<br>● Enters basic patient care orders<br>● Documents clinical encounters (e.g., ambulatory, inpatient, consult, communications)<br>● Reviews clinical data and information (e.g., laboratory results, radiology results, medication lists, other provider notes) |
| *Identifies the required components for a telehealth visit and identifies clinical situations that can be managed through a telehealth visit* | ● Identifies secure telehealth software as a legal requirement<br>● Knows that the patient must have access to a smart phone or computer with a microphone with adequate internet connection |
| *Describes how technology can augment face-to-face visits with patients (e.g., apps, websites, online therapies)* | ● Describes some appropriate additional technologies such as meditation and mood-tracking apps, psychoeducational websites (e.g., NIDA information on substances), internet-based treatments (e.g., Coping Cat for anxiety), including the informed consent/assent process and appropriate documentation of the potential risks and benefits including privacy concerns and evidence base or lack thereof |
| **Level 2** *Expands use of the EHR to include and reconcile secondary data sources in patient care activities* | ● Reconciles and updates information accurately in the EHR on admission to hospital with information from outside pharmacies, and outside hospital visits |
| *Performs assigned telehealth visits using approved technology* | ● Conducts videoconferencing evaluation and treatment sessions with youth and families following appropriate guidelines and compliance requirements<br>● Initiates a consult using secure electronic communication<br>● Communicates with patients through approved electronic systems (e.g., patient portal, secure health system email) |
| *Evaluates the pros and cons of integrating specific digital technologies into treatment* | ● Discusses the pros and cons of integrating an app, website or internet-based treatment into the treatment plan considering the individual characteristics of the patient and family |
| **Level 3** *Effectively uses EHR capabilities in managing acute and chronic care of patients* | ● Uses screening instruments that are integrated in the EHR, e.g., Vanderbilt Assessment Scales for ADHD, Abnormal Involuntary Movement Scale (AIMS) for youth on antipsychotics<br>● Uses tools such as “smart phrases,” order sets, templates |
| *Integrates telehealth effectively into clinical practice for medication management,* | ● Communicates effectively with other team members through EHR |

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| *psychotherapy, and consultation and recognizes limitations of telehealth*<br><br>*Incorporates at least one digital technology into clinical care appropriately* | ● If unable to evaluate abnormal movements via video, appreciates the need to assess patient in person<br>● Uses electronic data sources to monitor vital signs, BMI, etc.<br>● Practices telehealth professionally with a range of patients and families, clinical settings, and treatment modalities, and moves to in-person visits when appropriate; completes required billing and documentation for telehealth<br>● Integrates an app, website, or internet-based resource into the in-person treatment, e.g., Headspace for meditation for anxiety, CBT for insomnia, a wearable technology, a diet, or mood tracker, with appropriate informed consent/assent |
| **Level 4** *Uses the EHR to facilitate achievement of quality targets for patient panels*<br><br>*Integrates telehealth effectively into clinical practice for evaluation and treatment of new and complex patients*<br><br>*Integrates multiple different digital technologies to augment clinical experience appropriately* | ● Uses EHR to track Vanderbilt Assessment Scales scores over the course of a psychostimulant trial; Tracks BMI data over the course of an antipsychotic trial; uses the data to adjust medication appropriately<br><br>● Remotely evaluates and treats patients of all ages with developmental disorders, safety risks, and medical illness; triages appropriately, managing acute safety issues and moving to in-person care when necessary, collaborating with staff and caretakers at the remote/originating site in a manner sensitive to the local culture<br><br>● Integrates apps, websites, and online resources appropriately into the care of patients of all ages routinely and appropriately; considers the risks/benefits of technology use with each patient and family |
| **Level 5** *Leads improvements to the EHR*<br><br>*Leads innovation of the telehealth system*<br><br>*Develops innovative and transformative digital technologies for use in pediatric mental health* | ● Uses telepsychiatry and innovative ways, including digital play with children<br>● Serves as a “super-user” for the EHR<br>● Develops clinical decision-making pathways<br><br>● Serves on steering or advisory committees for EHR<br>● Shares advancements in EHR functionality with peers and colleagues in formal and informal ways<br><br>● Manages a patient from diagnosis through treatment through digital means including review of data, referral to consultants and initiation of a treatment plan |
| Assessment Models or Tools | ● Chart stimulated recall<br>● Direct observation (e.g., professional mini-evaluation exercise for pediatric telepsychiatry simulation)<br>● Multisource feedback<br>● Patient/Child Satisfaction Questionnaires in the use of Telepsychiatry<br>● Portfolio<br>● Quality dashboard (metric of defined quality measures) |

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| | ● Retrospective chart/EHR review/audit<br>● Telehealth patient log |
| Curriculum Mapping | ● |
| Notes or Resources | ● AACAP Telepsychiatry and Quality Committee. Clinical Update: Telepsychiatry with Children and Adolescents. *J Am Acad Child Adolesc Psychiatry* 2017;56(10):875–893. https://www.jaacap.org/article/S0890-8567(17)30333-7/pdf<br>● American College of Physicians (ACP). Health Information Technology. Web page. https://www.acponline.org/practice-resources/business-resources/health-information-technology. Accessed July 2020.<br>● ACP. Telemedicine: A Practical Guide for Incorporation into your Practice. https://www.acponline.org/cme-moc/online-learning-center/telemedicine-a-practical-guide-for-incorporation-into-your-practice<br>Note: Requires login and password.<br>● APA. APP Advisor [an app-evaluating system]. https://www.psychiatry.org/psychiatrists/practice/mental-health-apps<br>● APA and AACAP. Telepsychiatry Toolkit. https://www.psychiatry.org/psychiatrists/practice/telepsychiatry/toolkit/child-adolescent<br>● APA and ATA. Best Practices in Videoconferencing Based Telemental Health. https://www.psychiatry.org/File%20Library/Psychiatrists/Practice/Telepsychiatry/APA-ATA-Best-Practices-in-Videoconferencing-Based-Telemental-Health.pdf. Published April 2018.<br>● American Telemedicine Association (ATA). Practice Guidelines for Telemental Health with Children and Adolescents. March 2017. https://www.cdphp.com/-/media/files/providers/behavioral-health/hedis-toolkit-and-bh-guidelines/practice-guidelines-telemental-health.pdf?la=en<br>● Center for Connected Health Policy. https://www.cchpca.org<br>Note: Provides updated legal and regulatory policies updates.<br>● Centers for Medicare and Medicaid Services. Telehealth. http://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/index.html. Accessed April 21,2020.<br>● DeJong SM. Professionalism and technology: competencies across the tele-behavioral health and e-behavioral health spectrum. *Acad Psychiatry* 2018;42(6):800-807.<br>● DeJong SM et al., Pediatric Telepsychiatry Curriculum: Graduate Medical Education (GME) and Continuing Medical Education (CME). May 2020. https://www.aacap.org/App_Themes/AACAP/Docs/clinical_practice_center/business_of_practice/Telepsych/Pediatric_Telepsychiatry_Curriculum_Oct_2020-web.pdf<br>● King SL, Shipman SA. Telehealth in academic medicine: roles, opportunities, and risks. *Acad Med*. 2019 Jun;94(6):915. doi: 10.1097/ACM.0000000000002708 |

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| | ● Sieja A, Markley K, Pell J, et al. Optimization sprints: improving clinician satisfaction and teamwork by rapidly reducing electronic health record burden. *Mayo Clinic Proceedings.* 2019;94(5):793-802. www.mayoclinicproceedings.org/article/S0025-6196(18)30788-2/pdf. Accessed 2019.<br>● Yellowlees P and Shore JH, eds. *Telepsychiatry and Health Technologies: A Guide for Mental Health Professionals.* Washington DC: American Psychiatric Association Publishing; 2018. |

| **Medical Knowledge 1: Development through the Life Cycle (including the Impact of Psychopathology on the Trajectory of Development and Development on the Expression of Psychopathology)**<br>**Overall Intent:** To demonstrate knowledge of human development and the impact of pathological and environmental influences | |
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| **Milestones** | **Examples** |
| **Level 1** *Describes the basic stages of typical biological, sociocultural, sexual, moral, and cognitive development from infancy to young adulthood* | ● Lists different stages of motoric, linguistic, and cognitive developmental milestones from infancy through senescence |
| *Recognizes major deviations from typical development, including disruptions and regressions* | ● When evaluating a seven-year-old for ADHD, expresses concern that the patient's failing grade in mathematics while her other grades are passing suggests a need to consider a specific learning disorder |
| *Gives examples of biological, psychological, sociocultural, cognitive, and sexual factors that may influence developmental processes* | ● Discusses how parent's religious beliefs may influence identity development in a male teen |
| **Level 2** *Demonstrates basic knowledge of the major developmental theories across all developmental domains* | ● Describes basic tenets of Piaget's theory of cognitive development and Erikson's stages of psychosocial development<br>● Recognizes that a child reared in an immigrant family with non-Western norms is valuing family or community over autonomy<br>Recognizes that a child reared in an immigrant family may breast feed or co-sleep until older ages |
| *Describes appropriate evaluation and testing methods (genetic, psychological, neuropsychological, or other) to evaluate for specific developmental deficits and disorders* | ● Knows to order a chromosomal microarray and Fragile X testing for a child be evaluated for autism |
| *Describes the effects of developmental trauma and neglect and other adverse experiences, including social determinants* | ● Recognizes that childhood trauma influences long-term changes in physiologic and psychological response to stressors<br>● Recognizes that a teen who was removed from parental custody when she was nine months old due to neglect related to substance use disorders may struggle with attachment with current foster family when possibility of adoption begins to be discussed<br>● Recognizes that experiences of discrimination can modulate the course of typical development |
| **Level 3** *Explains developmental tasks and transitions throughout the life cycle using multiple conceptual models* | ● Uses Erikson's stages as part of a case formulation presented to the clinical team, explaining to a junior resident how the concept of seeing nutritional needs being met with |

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| | nourishment by mother during trust versus mistrust correlates with more secure attachment |
| *Describes how developmental level can influence the expression of psychopathology* | ● Discusses how a traumatic injury causing blindness during childhood influences language and vocabulary as well as the onset of depressive symptoms<br>● Describes how social skills and pragmatic communication deficits in a child with autism spectrum disorder may interplay with the child's social anxiety |
| *Describes the potential harmful and protective influence of biological, psychological, sociocultural, cognitive, and sexual factors on atypical personality development and psychopathology* | ● Explains how the interplay between trauma, invalidating environment, and temperament may lead to the development of borderline personality disorder moving into the transitional age |
| **Level 4** *Describes developmental stages in detail and articulates an integrated understanding of typical development* | ● Applies attachment theory and ideas of object constancy to relationship disturbances in a specific patient, noting traumatic experiences and separation from mother at three years of age affected development of social and family relationships through childhood and adolescence |
| *Recognizes subtle deviations from typical development, including disruptions and regressions* | ● Recognizes how constitutional growth delay may affect a child's psychological and sexual development<br>● Recognizes how mild auditory processing difficulties may negatively impact learning and social interactions |
| *Describes how risk factors can be mitigated and resilience promoted* | ● In a child with a long-recognized speech disorder and newly diagnosed ADHD, describes how updating IEP to incorporate his newly identified needs can better foster academic and social development. |
| **Level 5** *Serves as a role model regarding educating patients, patients' families, and other learners about normal and abnormal development of children and adolescents* | ● Develops a set of presentations for third-year medical students rotating on the inpatient child unit, teaching them about attachment theory and typical cognitive development |
| *Identifies and teaches new theories of typical and atypical development* | ● Reconceptualizes adolescent development to include non-Western ideas about individual and community following an international elective rotation |
| Assessment Models or Tools | ● ABPN CSV<br>● Assessment of case conference presentation<br>● Didactic exams<br>● Direct observation<br>● Medical record (chart) audit |

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| | ● Psychotherapy supervision<br>● Retrospective care review<br>● Standardized patients<br>● Standardized testing such as the Child Psychiatry Resident In-Training Examination (CPRITE) |
| Curriculum Mapping | ● |
| Notes or Resources | ● AADPRT. Child Development Curriculum. https://portal.aadprt.org/user/vto/category/566. Note: This requires a login.<br>● AACAP. Residents and Fellows. https://www.aacap.org/AACAP/Medical_Students_and_Residents/Residents_and_Fellows/Home.aspx?hkey=a673b0f1-563d-45bd-a586-4420cfef8ead. Accessed 2019.<br>● Guerra N, Williamson A, Lucas-Molina B. Normal development: infancy, childhood and adolescence. In Rey JM, Martin A, eds. *IACAPAP e-Textbook of Child and Adolescent Mental Health*. Geneva: International Association for Child and Adolescent Psychiatry and Allied Professions; 2019. https://iacapap.org/content/uploads/A.2.-DEVELOPMENT-072012.pdf |

| **Medical Knowledge 2: Psychopathology**<br>**Overall Intent:** To identify and treat psychiatric conditions, assess risk, and determine level of care, and understand the interface of psychiatry and the rest of medicine | |
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| **Milestones** | **Examples** |
| **Level 1** *Identifies the major psychiatric diagnostic categories across the lifespan* | ● Identifies that ADHD is likely to present in childhood while depression is more likely to present in adolescence |
| *Gives examples of interactions between medical, substance use, and psychiatric symptoms and disorders* | ● Identifies that an adolescent's cannabis use may cause or worsen depression |
| *Describes relevant sociocultural factors that contribute to patient presentations* | ● Describes the effects of socioeconomic factors on the self-esteem of an adolescent who identifies as part of a minority group |
| **Level 2** *Demonstrates knowledge to identify and assess common psychiatric conditions in childhood and adolescence* | ● Distinguishes between social anxiety disorder versus high-functioning autism spectrum disorder |
| *Demonstrates knowledge to identify common medical conditions in patients with psychiatric illness* | ● Identifies nutritional deficiencies in a child with depression and fatigue |
| *Identifies social determinants of health relevant to patient presentations* | ● Identifies lack of transportation as a contributory factor to an adolescent's depression and intermittent adherence with scheduled appointments |
| **Level 3** *Demonstrates knowledge to treat common psychiatric conditions, incorporating developmental factors* | ● Prescribes appropriate medication and recommends appropriate psychosocial interventions at home and school to treat a patient with ADHD |
| *Integrates knowledge to identify and treat common psychiatric symptoms due to other medical illness, including chronic pain and SUDs* | ● Describes how iron deficiency can be caused by inadequate dietary intake in a child with depression and fatigue and identifies treatment |
| *Formulates psychopathology drawing upon patients' sociocultural context* | ● Considers the experience of being bullied as a contributor to an adolescent's depression |
| **Level 4** *Demonstrates knowledge to identify and treat atypical and complex psychiatric conditions across a developmental spectrum* | ● Diagnoses and appropriately treats a child with comorbid ADHD, autism spectrum disorder, and intellectual disability |

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| *Integrates knowledge to identify and treat a wide range of psychiatric conditions in patients with co-occurring medical and SUDs*<br><br>*Demonstrates knowledge to address the drivers of social determinants of health in formulating psychopathology* | ● Prescribes appropriate psychiatric treatment for a child with major depressive disorder (MDD) and coordinates the treatment of Tetralogy of Fallot with the primary care physician<br><br>● Considers the experience of being in foster care as a contributor to a child's impulsivity in school and acts as a liaison between the health care organization, foster care caseworker, and school to facilitate behavioral accommodations and monitor for improvement |
| **Level 5** *Applies knowledge to identify and manage uncommon conditions at the interface of psychiatry and the rest of medicine* | ● With pediatric neurology, o-manages a patient with psychosis secondary to lupus cerebritis |
| Assessment Models or Tools | ● ABPN CSV<br>● Didactic exams<br>● Direct observation<br>● Medical record (chart) audit<br>● Standardized patient exams<br>● Standardized testing, e.g, CPRITE |
| Curriculum Mapping | ● |
| Notes or Resources | ● This milestone includes knowledge of diagnostic criteria, epidemiology, pathophysiology, course of illness, comorbidities, and differential diagnosis of psychiatric disorders, including substance use disorders and presentation of psychiatric disorders across the life cycle and in various patient populations<br>● "Atypical" and "complex" psychiatric conditions refer to unusual presentations of common disorders, co-occurring disorders in patients with multiple comorbid conditions, and diagnostically challenging clinical presentations.<br>● APA. Psychiatry Online. https://psychiatryonline.org/. Accessed 2019.<br>● DSM-5® Outline for Cultural Formulation |

| **Medical Knowledge 3: Clinical Neuroscience, including Knowledge of Neurology and Developmental Neuropsychiatry**<br>**Overall Intent:** To complete neurodiagnostic and neuropsychological testing, identify neuropsychiatric comorbidity, and apply neuroscientific findings in psychiatry | |
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| **Milestones** | **Examples** |
| **Level 1** *Lists commonly available neuroimaging, neurophysiologic, and neuropsychological tests* | ● Identifies and describes neurological diagnostic modalities including neuroimaging (CT, MRI, PET) and electroencephalography<br>● Identifies that psychological testing can evaluate for specific learning disorders and neurodevelopmental delays |
| *Appreciates that neurobiological processes interact dynamically with the developing brain* | ● Recognizes that school performance difficulties can be presenting features of genetic syndromes, seizures, learning disorders, or other neurodevelopmental disorders such as ADHD |
| *Describes basic phenomenology of common neurologic and neurodevelopmental disorders* | ● Describes the core features of Autism Spectrum Disorder, ADHD, and tic disorders |
| **Level 2** *Describes indications for common neuroimaging, neurophysiologic, and neuropsychological tests* | ● Identifies historical features or localizing impairments on physical and cognitive exams that warrant structural neuroimaging such as new onset of behaviors after head injury warrants non-contrast CT looking for acute bleed<br>● Identifies historical elements concerning for seizure and warranting EEG |
| *Describes major neurobiological processes in child and adolescent development and in common psychiatric presentations* | ● Describes that neuronal pruning is slowed in autism as compared to normal development<br>● Identifies potentially relevant brain regions for behavioral dysregulation (e.g., prefrontal cortex, limbic system) or perceptual abnormalities (e.g., sensory cortices) |
| *Describes the common psychiatric sequelae of neurologic and neurodevelopmental disorders* | ● Identifies association between Fragile X Syndrome with intellectual disability and ADHD |
| **Level 3** *Identifies the significance of findings in routine neuroimaging, neurophysiologic, and neuropsychological tests* | ● Uses results of neuropsychological testing to identify specific learning disorders, and recognizes that other disorders such as ADHD or depression can still be present |
| *Includes atypical neurobiological findings in case formulations* | ● Recognizes that atypical EEG findings may contribute to changes in attention, mood, and behavior, and recognizes that a normal spot EEG does not rule out the diagnosis of seizures/epilepsy |
| *Identifies common co-occurrences between psychiatric and neurologic and neurodevelopmental disorders* | ● Recognizes the high rates of co-occurring disorders in individuals with autism spectrum disorder, including intellectual disability, anxiety disorders, mood disorders, and ADHD |

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| **Level 4** *Correlates significant findings of neuroimaging, neurophysiological, and neuropsychological tests to case formulation and treatment planning* | ● Integrates data from EEG and neuropsychological testing to develop a treatment plan in a child with both epilepsy and ADHD, including coordination with the family, school, and other specialty providers to provide behavioral and pharmacologic interventions |
| *Integrates neurobiological findings into case formulation and treatment planning* | ● Presents case formulation of child for whom learning disorders and poor school performance contributed to depression and makes a treatment plan to include interventions for learning disorders as well as depression |
| *Synthesizes knowledge of psychiatric and neurologic/neurodevelopmental co-occurring disorders for case formulation and treatment* | ● Integrates a history of in-utero exposure to alcohol and adverse childhood experiences in formulating a case of a child with impulsive behavior |
| **Level 5** *Integrates new research in neuroimaging, neurophysiologic, and neuropsychological testing into understanding of psychopathology* | ● Serves as a consultant to other providers, helping demonstrate physical and cognitive exam techniques relevant for exploring differential diagnostic possibilities; develops teaching materials relevant to neuropsychiatric presentations |
| *Engages in scholarly activity related to neuroscience and psychiatric disorders* | ● Conducts research exploring the neurobiological basis of behavioral agitation |
| *Integrates recent research into an understanding of the interface between neurology/neurodevelopment and psychiatry* | ● Teaches other providers about neurodevelopmental disorders and psychiatric symptoms, including developing education resources or lectures. |
| Assessment Models or Tools | ● ABPN CSV<br>● Direct observation<br>● Standardized patients or case vignettes<br>● Standardized testing such as the CPRITE |
| Curriculum Mapping | ● |
| Notes or Resources | ● Cell Press. Trends in Neuroscience. https://www.cell.com/trends/neurosciences/home. Accessed 2019.<br>● Cold Spring Harbor Laboratory. Genes to Cognition Online. http://www.g2conline.org/3dbrain/ Accessed 2019.<br>● Multiple authors. *Biological Psychiatry Journal*. https://www.biologicalpsychiatryjournal.com/. Accessed 2019.<br>● National Neuroscience Curriculum Initiative. https://www.nncionline.org. Accessed 2019.<br>● Nature. Neuropsychopharmacology Reviews. https://www.nature.com/collections/hvxwcvcbwm. 2019.NIMH.<br>● Research. https://www.nimh.nih.gov/research/index.shtml. Accessed 2019. |

| **Medical Knowledge 4: Psychotherapy**<br>**Overall Intent:** To understand the fundamentals, practice and indications, and evidence base of psychotherapy | |
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| **Milestones** | **Examples** |
| **Level 1** *Identifies the major evidence-based individual, dyadic, family, and group therapies in treating children and adolescents* | ● Lists both relationship-based therapies (psychodynamic, interpersonal psychotherapy (IPT)) and cognitive-based therapies (CBT, dialectical behavioral therapy (DBT)) as useful in adolescents with depression |
| *Describes short-term, intermediate, and long-term goals of psychotherapy for patients across the developmental spectrum* | ● Identifies the need and goals for short-term CBT for a six-year-old patient with separation anxiety versus a six-month treatment for a 10-year-old adjusting to parental divorce versus long-term treatment for an adolescent with complex trauma |
| *Compares the evidence base for various forms of psychotherapy from different theoretical frameworks* | ● Compares the evidence base supporting IPT and CBT in adolescents |
| **Level 2** *Describes the common elements across psychotherapeutic modalities, including the dual alliance and limits of confidentiality* | ● Describes the need for a therapeutic alliance with both child/adolescent and caregivers<br>● Recognizes the need to prioritize safety over confidentiality when the child/adolescent is at risk of serious harm |
| *Identifies the indications of various psychotherapeutic modalities, including developmental level of the patient and cultural context* | ● Identifies cognitive behavioral therapy as a treatment indicated for major depression, but not the first-line treatment for a patient with major depression with psychotic features<br>● Identifies that a 13-year-old patient with borderline intellectual function may progress through the sessions in the CBT manual more slowly than a typically developing 13-year-old patient |
| *Describes the importance of the concepts of fidelity and flexibility of manualized treatments* | ● Describes the important pros and cons of maintaining fidelity to a treatment as opposed to applying it flexibly based on patient parameters |
| **Level 3** *Describes the adaptations of commonly used psychotherapy modalities for children and adolescents* | ● Describes how caregiver involvement is almost always necessary for best outcomes, and how caregivers can help reinforce ideas and techniques the therapist has been using with the child/adolescent |
| *Identifies the contraindications of various psychotherapeutic modalities, including developmental level of the patient and cultural context* | ● Identifies that the parent who recently sexually assaulted the child should not be involved in family therapy |
| *Describes clinical factors, such as patient preferences and the patient-doctor relationship,* | ● Refers a 14-year-old patient with MDD for CBT to a therapist in the community who specializes in work with youths |

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| *that affect the clinical response to evidence-based psychotherapies* | |
| **Level 4** *Describes the theoretical mechanisms of change in various forms of psychotherapy and how they vary with developmental level*<br><br>*Integrates knowledge of child and adolescent development, resilience, and protective factors in psychotherapy with children and adolescents*<br><br>*Continuously analyzes the evidence for using psychotherapy alone or in combination with pharmacotherapy and how best to communicate this to patients and their families/caregiving systems* | ● Describes extinction as mechanism of change for cognitive behavioral and exposure therapy for anxiety<br><br>● Understands that success in school is a developmental task that needs to be mastered by a school-age child recently placed in custody of grandparents due to neglect arising from maternal substance use and recognizes the child's strong relationship with grandparents and academic achievement as protective factors<br><br>● Integrates new evidence about effectiveness of psychiatric medication and psychotherapy into the formulation of whether psychotherapy alone or a combination of psychotherapy and medication is most likely to be beneficial for the patient; describes how to communicate to the patient and family members the probability of success of each option |
| **Level 5** *Continues to critically evaluate new forms of psychotherapy based on evidence of efficacy, cultural relevance, and developmental appropriateness*<br><br>*Critically evaluates new forms of psychotherapy and potential future directions as the science matures* | ● In a continuous case conference, explains how they apply psychodynamic theory to the treatment of a complex patient<br><br>● Develops a curriculum and teaches more junior residents about how scientific research on toxic stress, inflammation, and the hypothalamic-pituitary-adrenal HPA axis is related to psychodynamic ideas, and implications for patient care |
| Assessment Models or Tools | ● Assessment of case conference presentations<br>● Direct observation<br>● Medical record (chart) review<br>● Multidisciplinary group supervision<br>● Psychotherapy supervision<br>● Review of session audio and/or video recordings<br>● Standardized testing, e.g., CPRITE |
| Curriculum Mapping | ● |
| Notes or Resources | ● This subcompetency refers to knowledge of psychotherapies (e.g., psychodynamic psychotherapy, CBT, supportive psychotherapy, IPT, DBT, group/couples/family therapy, and combining psychotherapy with psychopharmacology). This includes understanding the different types of psychotherapy, their indications, contraindications, and applications to patient care. Further, knowledge in this area involves understanding psychotherapeutic |

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| | techniques, the doctor-patient relationship, theoretical underpinnings, and the evidence base behind each “core” psychotherapeutic modality.<br>● Throughout this subcompetency, the three “core” individual psychotherapies refer to supportive, psychodynamic, and cognitive behavioral therapy.<br>● Common factors refer to elements that different psychotherapeutic modalities have in common, and that are considered central to the efficacy of psychotherapy. These include accurate empathy, therapeutic alliance, and appropriate professional boundaries.<br>● AADPRT. Virtual Training Office. https://www.aadprt.org/training-directors/virtual-training-office. Accessed 2019.<br>● AADPRT. Curriculum. https://www.aadprt.org/training-directors/curriculum. Accessed 2019.<br>● California Evidence-Based Clearinghouse for Child Welfare CEBC). https://www.cebc4cw.org<br>● CEBC. CEBC Scientific Rating Scale. www.cebc4cw.org/ratings/scientific-rating-scale. Updated April 2021.<br>● Kendall P, Frank, H. Implementing evidence-based treatment protocols: Flexibility within fidelity. *Clin Psychology (New York)* 2018:25(4);e12271. |

| **Medical Knowledge 5: Somatic Therapies**<br>**Overall Intent:** To understand the mechanisms of action, indications for use, and evidence base for somatic therapies | |
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| **Milestones** | **Examples** |
| **Level 1** *Accesses practice guidelines and resources to answer questions about somatic treatments* | ● Summarizes the existing evidence base for treatment of common disorders (ADHD, anxiety, depression) |
| *Describes indications and side effects for commonly prescribed psychopharmacologic agents for children and adolescents* | ● Lists the common side effects of stimulants, antidepressants, and antipsychotic medication |
| *Identifies the indications of different somatic therapies for specific child/adolescent psychiatric disorders* | ● Summarizes the common indications for SSRI and serotonin and norepinephrine reuptake inhibitors (SNRIs) in the context of both anxiety and depression |
| **Level 2** *Describes hypothesized mechanisms of action and metabolism for commonly prescribed psychopharmacologic agents* | ● Summarizes the expected effects of stimulants, antidepressants, and antipsychotics on neurotransmitters and receptors (pharmacodynamics) for commonly prescribed medications including stimulants, SSRIs, and antipsychotic medications |
| *Describes the physical findings and lab studies necessary to initiate and monitor treatment with commonly prescribed medications* | • Identifies glucose metabolism, lipid abnormalities, and weight gain as important areas to monitor when initiating antipsychotics |
| *Discusses appropriate evidence-based somatic therapies when indicated* | • Summarizes the evidence-based treatments for mood disorders including anti-depressants, mood stabilizers, transcranial magnetic stimulation (TMS), and ECT |
| **Level 3** *Demonstrates knowledge of developmental impacts on pharmacokinetics and pharmacodynamic agent interactions* | ● Summarizes the developmental differences in pharmacokinetics and pharmacodynamics observed in children and adolescents as compared to adults for commonly prescribed medications during treatment planning |
| *Demonstrates knowledge of psychotropic selection based on practice guidelines or treatment algorithms for common psychiatric disorders in children and adolescents* | • Recognizes different clinical expectations from stimulants, central alpha-2 agonists, and norepinephrine uptake inhibitors for treatment of ADHD and can select treatment most appropriate for other comorbid diagnoses, such as depression, eating disorders, anxiety, and Tourette's syndrome |
| *Researches and cites the evidence base when developing treatment plans that include both FDA-approved and off-label somatic treatments* | • States the limits of the evidence base for the pharmacological treatment of major depressive disorder, bipolar disorder, and psychosis using off-label medications and alternative therapies |

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| **Level 4** *Describes the strengths and limitations of the evidence supporting the use of medications and other somatic therapies in treatment situations in children and adolescents*<br><br>*Demonstrates knowledge of the potential risks and appropriate management for children and adolescents when using off-label somatic therapies*<br><br>*Integrates evidence, including emerging studies, into treatment plans for complex cases* | ● Describes the limits of the evidence base for common disorders such as PTSD, autism spectrum disorders, and disruptive mood dysregulation disorder (DMDD)<br>● Summarizes the evidence for the use of ECT for neuroleptic malignant syndrome (NMS) in adolescents<br><br>● Summarizes the evidence and the limits of the evidence regarding the management of aggression in a child with autism spectrum disorder with guanfacine.<br><br>● Discusses the evidence and limits of evidence for the use of pharmacogenomic testing in the management of common disorders such as generalized anxiety, major depression, and ADHD<br>● Describes the use of ketamine in treating refractory depression |
| **Level 5** *Effectively mentors other learners on the concepts and usability of evidence-based or best somatic treatment practices* | ● Designs and teaches a neuroscience teaching module focusing on the effects of antidepressants on the developing brain |
| Assessment Models or Tools | ● Assessment of case presentation<br>● Case discussion during supervision<br>● CPRITE<br>● Literature review |
| Curriculum Mapping | ● |
| Notes or Resources | ● Lorberg B, Davico C, Martsenkovskyi D, Vitiello B. Principles in using psychotropic medication in children and adolescents. In Rey JM, Martin A, eds. *IACAPAP e-Textbook of Child and Adolescent Mental Health*. Geneva: International Association for Child and Adolescent Psychiatry and Allied Professions, 2019. https://iacapap.org/content/uploads/A.7-Psychopharmacology-2019.1.pdf |

| **Systems-Based Practice 1: Patient Safety and Quality Improvement**<br>**Overall Intent:** To analyze patient safety events, appropriately disclose patient safety events, and participate in quality improvement | |
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| **Milestones** | **Examples** |
| **Level 1** *Demonstrates knowledge of common patient safety events*<br><br>*Demonstrates knowledge of how to report patient safety events*<br><br>*Demonstrates knowledge of basic quality improvement methodologies and metrics* | ● Recognizes mortality, morbidity, adverse events, sentinel events, and near misses as reportable events<br><br>● Identifies institutional mechanisms for reporting patient safety events through hospital reporting system and/or through child protective services hotline<br><br>● Lists and describes the basic elements of a Plan, Do, Study, Act (PDSA) cycle |
| **Level 2** *Identifies system factors that lead to patient safety events*<br><br>*Reports patient safety events through institutional reporting systems (simulated or actual)*<br><br>*Describes local quality improvement initiatives (e.g., reduced restraint rates, suicide rates)* | ● Identifies hand-off and data reporting deficiencies which have led to errors in patient care<br>● Uses the fishbone diagram to identify system factors that led to a specific adverse event such as a medication error<br>● Files a report with Child Protective Services regarding suspected child abuse, with minimal supervision/direction<br>● Reports an incidence of self-harm of a child while in the inpatient setting<br><br>● Describes a hospital quality improvement initiative to improve medication reconciliation in the EHR |
| **Level 3** *Participates in analysis of patient safety events (simulated or actual)*<br><br>*Participates in disclosure of patient safety events to patients and their families (simulated or actual)*<br><br>*Participates in local quality improvement initiatives* | ● Meaningfully participates in a root cause analysis of a patient medication error<br><br>● With supervisor assistance, can determine when and how to safely inform families about a pending child abuse report<br>● With supervisor assistance, discloses to parents that child self-harmed while in the inpatient setting<br><br>● Participates in the hospital quality improvement initiative on medication reconciliation |
| **Level 4** *Conducts analysis of patient safety events and offers error prevention strategies (simulated or actual)*<br><br>*Discloses patient safety events to patients and their families (simulated or actual)* | ● Organizes a morbidity and mortality (M and M) conference on a patient medication error and identifies that improved communication between the pharmacist, physician, and the nurse could prevent similar errors in the future<br><br>● Knows when and how to safely inform families about a child abuse report that is going to be made |

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| *Demonstrates the skills required to identify, develop, implement, and analyze a quality improvement project* | ● With appropriate consultation with the treatment team, discloses to parents that child self-harmed while in the inpatient setting<br>● Designs and conducts their own quality improvement project which demonstrates understanding of institutional barriers to change |
| **Level 5** *Actively engages teams and processes to improve systems to prevent patient safety events*<br><br>*Role models or mentors others in the disclosure of patient safety events*<br><br>*Creates, implements, and assesses quality improvement initiatives at the institutional or community level* | ● Becomes a resident patient safety representative at their institution<br><br>● Teaches residents legal definitions of child abuse and how to make an accurate and effective report to child welfare agency<br><br>● Develops and leads an institution-wide quality improvement initiative related to reducing self-harm with plastic cutlery by inpatients |
| Assessment Models or Tools | ● Assessment of case presentation<br>● Assessment of M and M presentation<br>● Direct observation<br>● Quality improvement project<br>● Simulation |
| Curriculum Mapping | ● |
| Notes or Resources | ● AACAP. Clinical Care and Quality Improvement. https://www.aacap.org/AACAP/Clinical_Practice_Center/Clinical_Care/Home.aspx. Accessed 2019.<br>● AADPRT. Model Curricula in Quality Improvement. https://portal.aadprt.org/user/vto/category/600. Note: A login and password are required.<br>● ABPN. Patient Safety Activity. Accessed 2019. https://www.abpn.com/maintain-certification/moc-activity-requirements/patient-safety-activity/.<br>● Child Welfare Information Gateway. State Laws on Reporting and Responding to Child Abuse and Neglect. https://www.childwelfare.gov/topics/systemwide/laws-policies/can/reporting/#sss<br>● US Department of Veterans Affairs. Patient Safety Curriculum Workshop. Accessed 2019. https://www.patientsafety.va.gov/professionals/training/curriculum.asp.<br>● Institute for Healthcare Improvement. Open School. Accessed 2019. http://www.ihi.org/education/ihiopenschool/Pages/default.aspx.<br>● World Health Organization. Patient Safety Curriculum. https://www.who.int/health-topics/patient-safety#tab=tab_1 |

| **Systems-Based Practice 2: System Navigation for Patient-Centered Care**<br>**Overall Intent:** To effectively navigate the health care system, including the interdisciplinary team and other care providers, to adapt care to a specific patient population to ensure high-quality patient outcomes; to coordinate patient care, safely transition care, and appropriately adapt care to meet community needs | |
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| **Milestones** | **Examples** |
| **Level 1** *Demonstrates knowledge of care coordination* | ● Identifies the members of the interprofessional team, including physicians, nurses, psychologists, and other allied health professionals and describes their roles |
| *Identifies key elements for safe and effective transitions of care and hand-offs* | ● Lists the essential components of an effective sign-out and care transition including sharing information necessary for successful on-call/off-call transitions |
| *Demonstrates knowledge of population and community health determinants and needs* | ● Recognizes how a teenager living in crowded housing may have difficulty using telepsychiatry because of lack of privacy in the home. |
| **Level 2** *Effectively coordinates routine clinical care in individual and interprofessional care situations* | ● Contacts interprofessional team members for routine cases and with occasional supervision can ensure all necessary referrals, testing, and care transitions are made |
| *Performs safe and effective transitions of care and hand-offs in routine clinical situations* | ● Performs routine case sign-outs, occasionally needing direct supervision to identify and triage cases or calls |
| *Identifies specific population and community health needs for the local population* | ● Identifies that teens are at higher risk for suicide and require more vigilant screening |
| **Level 3** *Effectively coordinates complex care in individual and interprofessional care situations* | ● Evaluates a patient in the emergency room and effectively coordinates care and consults with the patient's community-based intensive treatment team |
| *Performs safe and effective transitions of care and hand-offs in complex clinical situations* | ● Performs safe and effective transitions of care on clinical service at shift change, rarely needing supervision |
| *Uses local resources effectively to meet the needs of a patient population and community* | ● Informs teenage patient of private meeting spaces available in the community for telepsychiatry appointments. |
| **Level 4** *Role models effective coordination of patient-centered care among different professionals and systems* | ● Coordinates team-based care for a 16-year-old patient with anorexia nervosa with pediatrician, nutritionist, family therapist, and school representatives |
| *Role models and serves as a patient advocate for safe and effective transitions of care and hand-offs within and across health care delivery systems, including outpatient settings* | ● For a patient with anorexia nervosa, transitions care from inpatient to partial hospital program to maintain implementation of behavioral contract |

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| *Adapts practice to provide for the needs of specific populations* | ● Works with a Latinx teen who lives with extended family to provide confidential care in the office rather than relying on telepsychiatry |
| **Level 5** *Analyzes the process of care coordination and leads in the design and implementation of improvements*<br><br>*Improves quality of transitions of care within and across health care delivery systems and non-medical settings to optimize patient outcomes*<br><br>*Leads innovations and advocates for populations and communities with specific health care needs* | ● Works with hospital or ambulatory site team members or administration to analyze care coordination; takes a leadership role in designing and implementing changes to improve care coordination<br><br>● Works with a quality improvement mentor to identify better hand-off tools for on-call services<br><br>● Participates in program design and grant proposal to adapt clinic building and treatments to be more welcoming to the diverse community of patients |
| Assessment Models or Tools | ● Assessment during interdisciplinary rounds<br>● Direct observation<br>● Medical record (chart) audit<br>● Multisource feedback<br>● Portfolio review<br>● Review of sign-out tools, use and review of checklists<br>● Simulation |
| Curriculum Mapping | ● |
| Notes or Resources | ● AACAP. Systems of Care Resources. https://www.aacap.org/AACAP/Clinical_Practice_Center/Systems_of_Care/Resources.aspx APA. APA Community Programs. https://www.psychiatry.org/psychiatrists/cultural-competency/engagement-opportunities/apa-community-programs.<br>● CDC. Population Health Training in Place Program (PH-TIPP). https://www.cdc.gov/pophealthtraining/whatis.html. Accessed 2019.<br>● Metzl JM, Hansen H. Structural competency: theorizing a new medical engagement with stigma and inequality. *Soc Sci Med*. 2014;103:126-133. https://www.sciencedirect.com/science/article/pii/S0277953613003778?via%3Dihub.<br>● Skochelak SE, Hawkins RE, Lawson LE, Starr SR, Borkan JM, Gonzalo JD. *AMA Education Consortium: Health Systems Science*. 1st ed. Philadelphia, PA: Elsevier; 2016. https://commerce.ama-assn.org/store/ui/catalog/productDetail?product_id=prod2780003. |

| **Systems-Based Practice 3: Physician Role in Health Care Systems and Non-Medical Settings (Schools, Legal System, and Others)**<br>**Overall Intent:** To identify components of the health care system, to promote health care advocacy, and to transition to independent practice | |
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| **Milestones** | **Examples** |
| **Level 1** *Identifies key components of health care systems and non-medical settings in which children, adolescents, and families present* | ● Recognizes the key role of schools in providing mental health care to youths |
| *Describes practice models and basic mental health payment systems* | ● Lists large health care delivery systems relevant to the region such as accountable care corporations, community mental health and state hospital systems, and integrated care; understands the basic differences between private insurance, Medicaid, and other payors |
| *Identifies basic knowledge domains for effective transition to practice* | ● Reviews the AACAP Toolbox for Clinical Practice and Outcomes |
| **Level 2** *Describes how components of complex health care systems and non-medical settings are interrelated, and how these impact patient care* | ● Discusses the process for insurance company reviews, denials, appeals, and approvals with the multidisciplinary treatment team |
| *Identifies resources and options for accessing care in different health care and non-health care systems* | ● Identifies that a patient with autism might access therapies through the healthcare system, special education, or the developmental care system |
| *Demonstrates compliant use of basic administrative systems (documentation, billing, scheduling, etc.)* | ● Uses appropriate CPT and International Classification of Diseases (ICD) coding to ensure requirements are met |
| **Level 3** *Discusses how individual practice affects broader systems* | ● Raises concern about how non-evidence-based treatments may result in minimal benefit to the child/adolescent with high costs to the family and health care system |
| *Engages with patients in shared decision-making and advocates for appropriate care and parity* | ● Presents several medication options to a child/adolescent and caregivers, works through the choice of medication with them, and communicates the rationale for a more expensive medication |
| *Describes the core administrative knowledge needed for transition to practice* | ● Has a basic understanding of contract negotiations, malpractice insurance, and regulatory requirements for physician practice |
| **Level 4** *Manages various components of complex health care systems and other non-* | ● Works with members of the interdisciplinary team to advocate for health care parity for patients on an inpatient unit |

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| *medical settings to provide high-value, efficient, and effective patient care and transitions of care*<br><br>*Advocates for patient care needs, including mobilizing community resources*<br><br>*Analyzes individual practice patterns and professional requirements in preparation for practice* | ● Works with the state psychiatric society legislative committee on issues related to access to mental health treatment<br><br>● Uses a "Performance In Practice" module to review their own stimulant-prescribing practices for children/adolescents with ADHD |
| **Level 5** *Advocates for or leads systems change that enhances high-value, efficient, and effective patient care and transitions of care*<br><br>*Participates in advocacy activities for access to care in mental health and reimbursement*<br><br>*Educates others to prepare them for transition to practice* | ● Works with community or professional organizations to advocate for smoking and e-cigarette prevention programs to be embedded in psychiatric services<br><br>● Participates in congressional visits on behalf of the state psychiatric society regarding issues of mental health parity, including coverage of medications and psychotherapy<br><br>● Develops a presentation for senior fellows on how to open a private-pay or insurance-based private practice |
| Assessment Models or Tools | ● Direct observation<br>● Multisource feedback<br>● Review of committee service<br>● Review of leadership roles<br>● Self-evaluation<br>● Simulation |
| Curriculum Mapping | ● |
| Notes or Resources | ● AACAP. Clinical Practice Center. https://www.aacap.org/AACAP/Clinical_Practice_Center/Home.aspx<br>● AACAP. Toolbox for Clinical Practice and Outcomes. https://www.aacap.org/AACAP/Member_Resources/AACAP_Toolbox_for_Clinical_Practice_and_Outcomes/Home.aspxAADPRT. Systems-Based Practice Curriculum for Psychiatry Residents. https://portal.aadprt.org/public/vto/categories/Virtual%20Classroom/Model%20Curricula%20--%20AADPRT%20Peer-Reviewed/Systems%20Based%20Practice/57febe5a885bc_SBP%20Curriculum.pdf. 2019.<br>● APA. Resident Guide to Surviving Psychiatric Training. https://www.psychiatry.org/File%20Library/Residents-MedicalStudents/Residents/Guide- |

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| | Surviving-Psychiatric-Training/Resident-Guide-Surviving-Psychiatric-Training.pdf. Note: This requires a login.2019.<br>● APA. Transition to Practice and Early Career Resources. https://www.psychiatry.org/psychiatrists/practice/transition-to-practice. Accessed 2019.<br>● American Board of Psychiatry and Neurology, Inc. Improvement in Medical Practice (PIP). https://www.abpn.com/maintain-certification/moc-activity-requirements/improvement-in-medical-practice-pip/. Accessed 2019.<br>● APA. Quality Improvement. https://www.psychiatry.org/psychiatrists/practice/quality-improvement. Accessed 2019.<br>● National Association of State Mental Health Program Directors. National Framework for Quality Improvement in Behavioral Health Care. June 2011. https://nasmhpd.org/sites/default/files/SAMHSA%20Quality%20Improvement%20Initiative.pdf.<br>● Oldham JM, Golden WE, Rosof BM. Quality improvement in psychiatry: why measures matter. *Focus* Published online April 1, 2011. https://focus.psychiatryonline.org/doi/10.1176/foc.9.2.foc232. |

| **Practice-Based Learning and Improvement 1: Evidence-Based and Informed Practice**<br>**Overall Intent:** To appraise and apply evidence-based best practices | |
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| **Milestones** | **Examples** |
| **Level 1** *Demonstrates how to access and summarize available evidence for routine conditions* | ● Reviews the latest clinical guidance available (e.g., NIMH website) for treatment of autism spectrum disorders |
| **Level 2** *Formulates clinical questions and completes literature searches to provide evidence-based care* | ● Devises a PubMed and PsychInfo search to determine best psychotherapy approach for treatment of a female patient with depression who does not want to take medications because of a blood-clotting disorder that could worsen with SSRIs |
| **Level 3** *Critically appraises and compares the best available evidence and applies to patient care using a hierarchy of evidence* | ● Selects the best medication option for a patient with bipolar disorder by prioritizing meta-analysis data over case or anecdotal reports |
| **Level 4** *Critically appraises and applies evidence to guide care tailored to the patient and patient's family, even in the face of uncertainty and conflicting evidence* | ● Assesses the evidence base for non-medication treatment options when their patient with bipolar disorder does not respond to first line treatment options |
| **Level 5** *Coaches other learners to critically appraise and apply evidence for complex patients, and/or participates in the development of guidelines* | ● Formally teaches others how to judicially apply knowledge in pharmacogenomics to patient care |
| Assessment Models or Tools | ● Assessment of case presentation<br>● Case review<br>● Direct observation<br>● Learning portfolio<br>● Written examination |
| Curriculum Mapping | ● |
| Notes or Resources | ● APA. APA Treatment Guidelines that meet the Agency for Healthcare Quality and Research (AHRQ) criteria for i the National Guidelines Clearinghouse https://www.psychiatry.org/psychiatrists/practice/clinical-practice-guidelines<br>● Drake RE, Goldman HH, Leff HS, et al. Implementing evidence-based practices in routine mental health service settings. *Psychiatry Serv.* 2001;52(2):179-182. https://ps.psychiatryonline.org/doi/full/10.1176/appi.ps.52.2.179.<br>● Guyatt G, Rennie D, Meade MO, Cook DJ. *Users' Guides to the Medical Literature: A Manual for Evidence-Based Clinical Practice.* 3rd ed. New York, NY: McGraw Hill; 2015. https://jamaevidence.mhmedical.com/book.aspx?bookId=847. 2019.<br>● US National Library of Medicine. PubMed Tutorial. https://www.nlm.nih.gov/bsd/disted/pubmedtutorial/cover.html. Accessed 2019. |

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| | ● US Department of Veterans Affairs (VA). VA-DoD [Department of Defense] Clinical Practice Guidelines. https://www.healthquality.va.gov/<br>● Note: These meet the AHRQ criteria for the National Guidelines Clearinghouse |

| **Practice-Based Learning and Improvement 2: Reflective Practice and Commitment to Personal Growth**<br>**Overall Intent:** To know how to seek performance data, to conduct reflective practice, and to create and use a learning plan | |
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| **Milestones** | **Examples** |
| **Level 1** *Accepts responsibility for personal and professional development by establishing personalized goals at the beginning of the educational program* | ● Sets a goal to improve their knowledge on pediatric ADHD treatment |
| *Identifies the factors that contribute to gap(s) between one's expected and actual performance* | ● Identifies ineffectual time management as a factor in late clinical documentation |
| *Seeks and accepts opportunities to improve professional growth* | ● Signs up for a time management class |
| **Level 2** *Demonstrates openness to performance data (feedback and other input) to inform goals* | ● Accepts and incorporates feedback into goals |
| *Analyzes and reflects on the factors that contribute to gap(s) between one's expected and actual performance* | ● After working on inpatient service for a week, notices own difficulty in describing psychotic symptoms and asks the attending for assistance in better distinguishing and identifying symptoms of thought disorder in patients with psychosis |
| *Designs and implements a learning plan, with prompting* | ● Uses feedback with a goal of improving communication skills with peers/colleagues, staff members, and patients the following week |
| **Level 3** *Seeks performance data episodically, with openness and humility* | ● Proactively asks faculty for performance feedback, humbly acts on input, and is appreciative and not defensive |
| *Analyzes, reflects on, and institutes behavioral change(s) to narrow the gap(s) between one's expected and actual performance* | ● Integrates input from peers/colleagues and supervisors to improve insight into personal strengths and opportunities to improve |
| *Independently creates and implements a personalized learning plan* | ● Uses process notes to discuss feedback regarding communication skills in a psychotherapy session and proposes to review videotaped session in supervisions for the next few weeks to improve nonverbal communication |
| **Level 4** *Uses feedback data to promptly change practice and improve performance* | ● Consistently and independently creates a learning plan for each rotation |

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| *Challenges one's own assumptions and considers alternatives in narrowing the gap(s) between expected and actual performance*<br><br>*Uses performance data to measure the effectiveness of the learning plan and, when necessary, improves it* | ● Identifies a trend of low CPRITE scores despite a more positive self-assessment in neuroscience and identifies additional reading materials to improve personal knowledge base<br><br>● Adapts learning plan using updated feedback when multisource assessments do not improve performance |
| **Level 5** *Role models consistently seeking performance data with openness and humility*<br><br>*Mentors other learners on reflective practice*<br><br>*Facilitates the design and implementation of learning plans for other learners* | ● Consistently acknowledges own areas of weakness with supervisors and colleagues<br><br>● Encourages other learners on the team to consider how their behavior affects the rest of the team<br><br>● Assists a more junior resident in devising a learning plan |
| Assessment Models or Tools | ● Direct observation<br>● Learning portfolio<br>● Multisource feedback<br>● Review of learning plan |
| Curriculum Mapping | ● |
| Notes or Resources | ● Burke AE, Benson B, Englander R, Carraccio C, Hicks PJ. Domain of competence: practice-based learning and improvement. *Acad Pediatr.* 2014;14(2 Suppl):S38-S54. https://doi.org/10.1016/j.acap.2013.11.018.<br>● Hojat M, Veloski JJ, Gonnella JS. Measurement and correlates of physicians' lifelong learning. *Acad Med.* 2009;84(8):1066-74. doi: 10.1097/ACM.0b013e3181acf25f.<br>● Lockspeiser TM, Schmitter PA, Lane JL, Hanson JL, Rosenberg AA, Park YS. Assessing residents' written learning goals and goal writing skill: validity evidence for the learning goal scoring rubric. *Acad Med.* 2013;88(10):1558-1563. doi: 10.1097/ACM.0b013e3182a352e6. |

| **Professionalism 1: Professional Behavior and Ethical Principles**<br>**Overall Intent:** To recognize and address lapses in ethical and professional behavior, demonstrates ethical and professional behaviors, and use appropriate resources for managing ethical and professional dilemmas | |
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| **Milestones** | **Examples** |
| **Level 1** *Identifies and describes core professional behavior, including adherence to legal requirements* | ● Lists compliance with mandated reporting laws, accountability, and a sense of patient ownership as professionalism |
| *Recognizes that one's behavior in professional settings affects others* | ● Recognizes that arriving late to hand-off is a burden to peers and a risk for patients |
| *Demonstrates knowledge of core ethical principles* | ● Discusses the basic principles underlying ethics (beneficence, nonmaleficence, justice, autonomy) and professionalism (professional values and commitments), and how they apply in various situations (e.g., informed consent process) |
| **Level 2** *Demonstrates professional behavior in routine situations* | ● Completes clinical documentation within mandated timeframe |
| *Takes responsibility for one's own professionalism lapses and responds appropriately* | ● Recognizes their bias in addressing a colleague and takes steps to apologize and make amends |
| *Analyzes straightforward situations using ethical principles* | ● Recognizes the conflict between autonomy and beneficence in decisions regarding hospitalization when the guardian consents and child/adolescent does not assent |
| **Level 3** *Demonstrates professional behavior in complex or stressful situations* | ● Remains calm and respectful when dealing with a family that is arguing with each other in front of the child/adolescent |
| *Describes when and how to appropriately report professionalism lapses in others, including strategies for addressing common barriers to reporting* | ● Cites institutional policies and procedures regarding clinicians who act in a discriminatory manner |
| *Analyzes complex situations using ethical principles and recognizes when help is needed* | ● Recognizes the conflict between autonomy and beneficence in decisions regarding whether to breech an adolescent patient's confidentiality to notify a parent/guardian about substance use and seeks help |
| **Level 4** *Recognizes situations that may trigger professionalism lapses and intervenes to prevent lapses in oneself and others* | ● Recognizes that an on-call colleague appears to be experiencing fatigue and offers to help with coverage or support |

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| *Responds appropriately to professionalism lapses of colleagues*<br><br>*Recognizes and uses appropriate resources for managing and resolving ethical dilemmas as needed (e.g., ethics consultations, literature review, risk management/legal consultation)* | ● Gives feedback to a colleague who consistently arrives late for a shift<br><br>● Refers to AACAP Code of Ethics to resolve an identified ethical issue |
| **Level 5** *Role-models professionalism through behavior and produces academic materials*<br><br>*Identifies and seeks to address system-level factors that induce or exacerbate ethical problems or impede their resolution*<br><br>*Participates in generating codes of ethics and writing of laws involved in the practice of child and adolescent psychiatry* | ● Serves as a peer consultant on difficult professionalism and ethical issues<br><br>● Participates in an organizational work group to have mental health questions removed from licensing forms<br><br>● Seeks to join AACAP Ethics Committee |
| Assessment Models or Tools | ● Direct observation<br>● Multisource feedback<br>● Oral or written self-reflection (e.g., of a personal or observed lapse, ethical dilemma, or systems-level factors)<br>● Simulation |
| Curriculum Mapping | ● |
| Notes or Resources | ● AACAP. *AACAP Code of Ethics* 2014(September). https://www.aacap.org/App_Themes/AACAP/docs/about_us/transparency_portal/aacap_code_of_ethics_2012.pdf<br>● ABIM Foundation. American Board of Internal Medicine. Medical professionalism in the new millennium: a physician charter. *Annals of Internal Medicine*. 2002;136(3):243-246. https://doi.org/10.7326/0003-4819-136-3-200202050-00012.<br>● AMA. Ethics. https://www.ama-assn.org/delivering-care/ama-code-medical-ethic. Accessed 2019.<br>● American Osteopathic Association (AOA). Code of Ethics. https://osteopathic.org/about/leadership/aoa-governance-documents/code-of-ethics/. Accessed 2019.<br>● APA. Ethics. https://www.psychiatry.org/psychiatrists/practice/ethics. Accessed 2019.<br>● APA. *The Principles of Medical Ethics: With Annotations Especially Applicable to Psychiatry.* Arlington, VA: American Psychiatric Publishing; 2013. |

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| | https://www.psychiatry.org/File%20Library/Psychiatrists/Practice/Ethics/principles-medical-ethics.pdf<br>● Bynny RL, Paauw DS, Papadakis MA, Pfeil S, Alpha Omega Alpha. *Medical Professionalism Best Practices: Professionalism in the Modern Era.* Menlo Park, CA: Alpha Omega Alpha Honor Medical Society; 2017. https://www.alphaomegaalpha.org/monographs/#monograph-2017.<br>● Cruess RL, Cruess SR, Steiner Y. *Teaching Medical Professionalism – Supporting the Development of a Professional Identity,* 2nd ed. Cambridge, UK: Cambridge University Press; 2016.<br>● Gabbard GO, Roberts LW, Crisp-Han H, Ball V, Hobday G, Rachal F. *Professionalism in Psychiatry*. Arlington, VA: American Psychiatric Publishing; 2012.<br>● Levinson W, Ginsburg S, Hafferty FW, Lucey CR. *Understanding Medical Professionalism*. New York, NY: McGraw-Hill Education; 2014. https://accessmedicine.mhmedical.com/book.aspx?bookID=1058.<br>● The two Professionalism subcompetencies reflect the following overall values: residents/fellows must demonstrate a commitment to carrying out professional responsibilities and adherence to ethical principles and develop and acquire a professional identity consistent with values of oneself, the specialty, and the practice of medicine. Residents/fellows are expected to demonstrate compassion, integrity, and respect for others; sensitivity to diverse populations; responsibility for patient care that supersedes self-interest; and accountability to patients, society, and the profession. |

| **Professionalism 2: Accountability/Conscientiousness**<br>**Overall Intent:** To take responsibility for one's own actions and the impact on patients and other members of the health care team | |
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| **Milestones** | **Examples** |
| **Level 1** *Takes responsibility to complete tasks and responsibilities, identifies potential contributing factors for lapses, and describes strategies for ensuring timely task completion in the future* | ● Responds promptly to reminders from program administrator to complete work-hour logs and creates an email calendar reminder for future due dates |
| *Introduces oneself as a fellow physician* | ● Introduces self as a fellow physician to the participants of a family meeting |
| **Level 2** *Performs tasks and responsibilities in a timely manner with appropriate attention to detail in routine situations* | ● Writes an order within the required time limit for a patient in restraints |
| *Accepts one's role as the patient's physician and takes responsibility (under supervision) for ensuring the patient receives the best possible care* | ● Follows up to ensure that an at-risk patient presented to the emergency room as directed, even if after normal clinic hours |
| **Level 3** *Performs tasks and responsibilities in a timely manner with appropriate attention to detail in complex or stressful situations* | ● Notifies resident/fellow on day service about overnight health issue (fever) with patient during transition of care or hand-off |
| *Is recognized by oneself, the patient, the patient's family, and professional staff members as the patient's psychiatrist* | ● Patients refer to fellow as their psychiatrist |
| **Level 4** *Anticipates tasks and responsibilities and proactively prepares for unmet needs* | ● Anticipates being absent for a school meeting and arranges coverage |
| *Displays increasing autonomy and leadership in taking responsibility for ensuring patients receive the best possible care* | ● Fellow realizes that a patient being discharged does not have a follow-up appointment within two weeks for medications and offers to provide a bridging appointment |
| **Level 5** *Takes ownership of system outcomes* | ● Sets up a meeting with the clinic leadership to streamline clinic safety procedures |
| *Serves as a role model in demonstrating responsibility for ensuring that patients receive the best possible care* | ● Leads the inpatient team in advocating with the state agencies to find appropriate disposition for difficult to place patients |
| Assessment Models or Tools | ● Compliance with deadlines and timelines |

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| | ● Direct observation<br>● Multisource feedback<br>● Self-evaluations and reflective tools<br>● Simulation |
| Curriculum Mapping | ● |
| Notes or Resources | ● Expectations of fellowship program regarding accountability and professionalism<br>● Institutional policies and procedures for appropriate conduct |

| **Professionalism 3: Well-Being**<br>**Overall Intent:** To continually manage and improve own personal and professional well-being | |
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| | **Examples** |
| **Level 1** *Recognizes limits in knowledge/skills in promoting one's own well-being, with assistance* | ● Open to discussing the impact of fatigue during the biannual program director meeting |
| **Level 2** *Independently recognizes limitations in one's own knowledge/skills in promoting well-being and demonstrates appropriate help-seeking behavior*<br><br>*Recognizes one's own responsibility towards the well-being of the team*<br><br>*Describes institutional resources designed to promote well-being* | ● Independently identifies the stress of the doctor patient relationship when treating complex and emotionally challenging patients and their families and seeks help from supervisors in a timely manner<br><br>● Seeks supervision to determine the best way to resolve a conflict with a team member<br><br>● Identifies available institutional mental health resources and support systems |
| **Level 3** *Proposes a plan to promote personal and professional well-being, including addressing limitations in one's own knowledge and skills, with assistance*<br><br>*Monitors and raises appropriate concerns about the well-being of team members and the team as a whole*<br><br>*Recognizes which institutional factors affect well-being* | ● Speaks to supervisor about psychotherapy referrals for self<br><br>● Meets with peers to discuss level of fatigue related to a specific rotation and discusses at next training meeting<br><br>● Identifies how institutional changes, such as changes in the electronic medical health record, affect workflow and time management |
| **Level 4** *Independently develops a plan to promote personal and professional well-being and improve upon limitations in one's own knowledge and skills*<br><br>*Promotes the well-being of the whole team in an ongoing way while maintaining professional altruism* | ● Proactively schedules vacation to help recover from the emotional impacts of treating patients in high-risk settings (e.g., emergency departments)<br><br>● Develops a plan to support peers who are on a demanding rotation by suggesting changes in the call schedule and helping to arrange extra coverage to help when patient volume is particularly high |

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| *Describes institutional factors that positively and/or negatively affect well-being* | ● Reaches out to graduate medical education (GME) office to learn about institutional resources for dealing with stress and burnout |
| **Level 5** *Is considered by faculty members and peers as a model of promoting one's own well-being while maintaining professional altruism*<br><br>*Creates systemic interventions that promote colleagues' well-being*<br><br>*Describes institutional programs designed to examine systemic contributors to burnout* | ● Establishes a mindfulness program open to all employees<br><br>● Creates a comfortable "safe-room" with soft lighting, music, and positive messaging where peers can take a break, use breathing and mindfulness techniques or talk together for support<br><br>● Encourages development of walking trails, provides markers between various areas of the hospital to allow people to measure distances, steps, etc. to track fitness goals, encourages cafeteria to provide fresh fruits and vegetables |
| Assessment Models or Tools | ● Direct observations<br>● Institutional online training modules<br>● Participation in institutional or community well-being programs |
| Curriculum Mapping | ● |
| Notes or Resources | ● This subcompetency is not intended to evaluate a fellow's well-being, but to ensure each fellow has the fundamental knowledge of factors that impact well-being, the mechanisms by which those factors impact well-being, and available resources and tools to improve well-being.<br>● Local resources, including Employee Assistance Plan (EAP)<br>● AAMC. Transition to Residency. https://news.aamc.org/video/transition-residency/. Accessed 2019.<br>● AAMC. Well-Being in Academic Medicine. https://www.aamc.org/initiatives/462280/well-being-academic-medicine.html. Accessed 2019.<br>● AMA. About STEPS Forward. https://edhub.ama-assn.org/steps-forward/pages/about. Accessed 2019.<br>● APA. Well-being and Burnout. https://www.psychiatry.org/psychiatrists/practice/well-being-and-burnout. Accessed 2019.<br>● ACGME. "Well-Being Tools and Resources." https://dl.acgme.org/pages/well-being-toolsresources. Accessed 2022.<br>● Chaukos D, Chad-Friedman E, Mehta DH, et al. SMART-R: a prospective cohort study of a resilience curriculum for residents by residents. *Acad Psychiatry*. 2018;42(1):78-83. https://doi.org/10.1007/s40596-017-0808-z.<br>● Hicks PJ, Schumacher D, Guralnick S, Carraccio C, Burke AE. Domain of competence: personal and professional development. *Acad Pediatr*. 2014;14(2 Suppl):S80-97. https://doi.org/10.1016/j.acap.2013.11.017. |

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| | ● Ishak W, Lederer S, Mandili C, et al. Burnout During Residency Training: A Literature Review. *J Grad Med Educ.* 2009; 1(2):236-242. doi: 10.4300/JGME-D-09-00054.1<br>● Magudia K, Bick A, Cohen J. et al. Childbearing and family leave policies for resident physicians at top training institutions. *JAMA*. 2018;320(22):2372-2374. doi:10.1001/jama.2018.14414.<br>● NAM. Action Collaborative on Clinician Well-Being and Resilience. https://nam.edu/initiatives/clinician-resilience-and-well-being/. Accessed 2019.<br>● Professional behavior refers to the global comportment of the resident in carrying out clinical and professional responsibilities. This includes:<br>○ timeliness (e.g., reports for duty, answers pages, and completes work assignments on time);<br>○ maintaining professional appearance and attire;<br>○ being reliable, responsible, and trustworthy (e.g., knows and fulfills assignments without needing reminders);<br>○ being respectful and courteous (e.g., listens to the ideas of others, is not hostile or disruptive, maintains measured emotional responses and equanimity despite stressful circumstances);<br>○ maintaining professional boundaries; and,<br>○ understanding that the role of a physician involves professionalism and consistency of one's behaviors, both on and off duty.<br>● These descriptors and examples are not intended to represent all elements of professional behavior. Fellows are expected to demonstrate responsibility for patient care that supersedes self-interest. It is important that fellows recognize the inherent conflicts and competing values involved in balancing dedication to patient care with attention to the interests of personal well-being and responsibilities to families and others. Balancing these interests while maintaining an overriding commitment to patient care requires, for example, ensuring excellent transitions of care, sign-out, and continuity of care for each patient during times that the fellow is not present to provide direct care for the patient. |

| **Interpersonal and Communication Skills 1: Patient and Family-Centered Communication**<br>**Overall Intent:** To deliberately use language and behaviors to form constructive relationships with patients, to identify communication barriers including self-reflection on I biases, and minimize them in the doctor-patient relationships; to organize and lead communication around shared decision making | |
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| **Milestones** | **Examples** |
| **Level 1** *Uses verbal and non-verbal communication to demonstrate empathy, curiosity, and respect* | ● Self-monitors and controls tone, non-verbal responses, and language and asks questions to invite patient/family participation when in high expressed emotion clinical situations |
| *Identifies biases that may become barriers to therapeutic relationships* | ● Identifies biases when evaluating patients and families from cultural backgrounds different from their own |
| *Recognizes communication strategies may need to be adjusted based on clinical, family, or cultural context* | ● Avoids medical jargon when talking to patients, makes sure communication is at the appropriate developmental level |
| **Level 2** *Establishes therapeutic communication using active listening and clear language with adolescent patients and their families* | ● Establishes rapport and professional relationship with defiant adolescents using active listening and validation of emotions |
| *Identifies complex barriers to forming a therapeutic alliance, including differences in power, identity, and lived experience* | ● Identifies the need for alternatives when a patient declines to use an interpreter |
| *Organizes and initiates communication with child/adolescent and family by introducing stakeholders, setting the agenda, clarifying expectations, and verifying understanding of the clinical situation* | ● Takes lead in organizing a meeting with a complex patient's family and team and reassesses the patient and family's understanding of the reason for the meeting |
| **Level 3** *Establishes therapeutic communication and relationships using verbal and non-verbal methods in treatment with school-age and adolescent patients and their families* | ● Establishes and maintains a therapeutic relationship with non-communicative adolescent patients and can articulate personal challenges in the relationship, how their biases may impact the relationship, and strategies to use going forward |
| *When prompted, takes steps to surmount communication barriers and obstacles to a therapeutic alliance* | ● Attempts to mitigate identified communication barriers, including reflection on biases when prompted |

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| *With guidance, sensitively and compassionately delivers medical information, elicits the patient's/patient's family's values, goals, and preferences; acknowledges uncertainty and conflict* | ● Offers a diagnosis of schizophrenia to a family, inquires about the family's cultural narrative of psychosis, and acknowledges the prognostic uncertainty of the disorder |
| **Level 4** *Establishes therapeutic communication and relationships using verbal and non-verbal methods in treatment with preschool through adolescent patients and their families*<br><br>*Independently takes steps to surmount communication barriers and obstacles to a therapeutic alliance*<br><br>*Independently uses shared decision-making to align the patient's/patient's family's values, goals, and preferences with treatment options to make a personalized care plan* | ● Engages a preschooler in ongoing play therapy with intermittent parent guidance sessions<br><br>● Explicitly discusses biases in supervision<br><br>● Engages in shared decision-making process with patient and family refusing medication, despite a clear indication, to develop an appropriate treatment plan acceptable to all |
| **Level 5** *Mentors others in situational awareness and critical self-reflection to consistently develop positive therapeutic relationships*<br><br>*Role models cultural awareness and successfully forming relationships with patients and patients' families of all identities, cultures, lived experiences, and family configurations*<br><br>*Role models shared decision-making, including in situations with a high degree of uncertainty, conflict, or even hostility from the child/adolescent and the family* | ● Demonstrates an ongoing openness to discussing personal clinical errors and resolutions in mentoring and teaching<br><br>● Leads a peer supervision group in treating adolescent patients with borderline personality disorder and chronic non-suicidal self-injury<br><br>● Develops a workshop for community providers on patient family communication with an emphasis on difficult communications with resistant teen patients |
| Assessment Models or Tools | ● Direct observation<br>● Self-assessment including self-reflection exercises<br>● Standardized patients or structured case discussions |
| Curriculum Mapping | ● |
| Notes or Resources | ● Laidlaw A, Hart J. Communication skills: an essential component of medical curricula. Part I: Assessment of clinical communication: AMEE Guide No. 51. *Med Teach*. |

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| | 2011;33(1):6-8. https://www.tandfonline.com/doi/full/10.3109/0142159X.2011.531170. 2019.<br>● Lempp T, de Lange D, Radeloff D, Bachmann C. The clinical examination of children, adolescents and their families. In Rey JM (ed), IACAPAP e-Textbook of Child and Adolescent Mental Health. Geneva: International Association for Child and Adolescent Psychiatry and Allied Professions 2012.<br>● Mares S, Woodgate S. The clinical assessment of infants, preschoolers and their families. In Rey JM ed. *IACAPAP e-Textbook of Child and Adolescent Mental Health*. Geneva: International Association for Child and Adolescent Psychiatry and Allied Professions 2017.<br>● Symons AB, Swanson A, McGuigan D, Orrange S, Akl EA. A tool for self-assessment of communication skills and professionalism in residents. *BMC Med Educ*. 2009;9:1. https://bmcmededuc.biomedcentral.com/articles/10.1186/1472-6920-9-1. |

| **Interpersonal and Communication Skills 2: Interprofessional and Team Communication**<br>**Overall Intent:** To effectively communicate with the health care team, including consultants, in both straightforward and complex situations | |
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| **Milestones** | **Examples** |
| **Level 1** *Uses language that demonstrates respect and value for all members of the professional care team*<br><br>*Recognizes the need for ongoing feedback with the professional care team* | ● Uses respectful communication to clerical and technical staff members<br><br>● Listens to and considers others' points of view, is nonjudgmental and actively engaged, and demonstrates humility |
| **Level 2** *Communicates information effectively with all professional care team members*<br><br>*Solicits feedback on performance as a member of the professional care team* | ● Demonstrates active listening by fully focusing on the speaker (other health care provider, patient), actively showing verbal and nonverbal signs (eye contact, posture, reflection, questioning, summarization)<br><br>● Asks supervisor for feedback on performance as a team member |
| **Level 3** *Uses active listening to adapt communication style to fit team needs*<br><br>*Communicates concerns and provides feedback to peers and learners* | ● Simplifies language and avoids medical jargon when the team has difficulty understanding<br><br>● Respectfully provides feedback to other members of the team for the purposes of improvement or reinforcement of correct knowledge, skills, and attitudes, when appropriate |
| **Level 4** *Integrates recommendations from different members of the professional care team to optimize patient care*<br><br>*Respectfully communicates feedback and constructive criticism to superiors* | ● Synthesizes recommendations from pediatricians, nutritionists, therapists, and family therapists in speaking with a patient with an eating disorder<br><br>● Provides respectful and candid feedback to attending on their teaching style when they ask |
| **Level 5** *Role models flexible communication strategies that value input from all professional care team members, resolving conflict when needed*<br><br>*Facilitates regular professional care team-based feedback in complex situations* | ● Organizes a team meeting to discuss and resolve conflicting feedback on a plan of care<br><br>● Organizes a team check-in after an adverse patient outcome in collaboration with the supervising attending |
| Assessment Models or Tools | ● Clinical skills exam<br>● Direct observation<br>● Medical record (chart) review audit |

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| | ● Multisource feedback<br>● Simulation encounters |
| Curriculum Mapping | ● |
| Notes or Resources | ● Dehon E, Simpson K, Fowler D, Jones A. Development of the faculty 360. *MedEdPORTAL*. 2015;11:10174. https://www.mededportal.org/publication/10174/.<br>● Fay D, Mazzone M, Douglas L, Ambuel B. A validated, behavior-based evaluation instrument for family medicine residents. *MedEdPORTAL*. 2007. https://www.mededportal.org/publication/622/.<br>● François J. Tool to assess the quality of consultation and referral request letters in family medicine. *Can Fam Physician*. 2011;57(5):574–575. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3093595/.<br>● Green M, Parrott T, Cook G. Improving your communication skills. *BMJ*. 2012;344:e357. https://www.bmj.com/content/344/bmj.e357.<br>● Henry SG, Holmboe ES, Frankel RM. Evidence-based competencies for improving communication skills in graduate medical education: a review with suggestions for implementation. *Med Teach*. 2013;35(5):395-403. https://www.tandfonline.com/doi/full/10.3109/0142159X.2013.769677.<br>● Roth CG, Eldin KW, Padmanabhan V, Freidman EM. Twelve tips for the introduction of emotional intelligence in medical education. *Med Teach.* 2018:1-4. https://www.tandfonline.com/doi/full/10.1080/0142159X.2018.1481499. |

| **Interpersonal and Communication Skills 3: Communication within Health Care Systems**<br>**Overall Intent:** To effectively communicate with the health care team, peers, learners, and faculty members using a variety of methods | |
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| **Milestones** | **Examples** |
| **Level 1** *Accurately records information in the patient record* | ● Documents appropriate patient history and clearly identifies the source of the information |
| *Obtains patient and family/caregiver assent/consent prior to seeking out collateral information* | ● Reviews need for obtaining information from school with adolescent patient and their parents and obtains appropriate assent and consent |
| *Communicates about administrative issues through appropriate channels, as required by institutional policy* | ● Uses appropriate procedure to report a change in the patient's insurance |
| **Level 2** *Demonstrates organized diagnostic and therapeutic reasoning through notes in the patient record* | ● Organized and accurate documentation outlines clinical reasoning that supports a clinical decision to admit an adolescent patient to the inpatient psychiatric hospital |
| *Respects specific confidentiality across clinical situations and settings* | ● During a family meeting with parents, respects the confidentiality of an adolescent inpatient relating to their experimentation with cannabis |
| *Respectfully communicates concerns about the system* | ● Recognizes that a communication breakdown has happened during a patient transition to a lower level of care and respectfully brings the breakdown to the attention of the chief resident or responsible faculty |
| **Level 3** *Concisely reports diagnostic and therapeutic reasoning in the patient record* | ● For a 12-year-old patient in foster care who has post-traumatic stress disorder (PTSD), documents concise but comprehensive biopsychosocial formulation that corresponds to treatment recommendations for trauma-focused CBT |
| *Uses multiple modes of communication (in-person, telephone, email) to seek out collateral information and coordinate care* | ● Uses Health Insurance Portability and Accountability Act (HIPAA)-compliant electronic messaging system whenever communicating about patients with colleagues |
| *Uses appropriate channels to offer clear and constructive suggestions to improve the system* | ● Knows when to direct concerns locally, departmentally, or institutionally when reporting safety concerns within hospitals (i.e., appropriate escalation) |
| **Level 4** *Communicates clearly and concisely and in an organized written form, including providing anticipatory guidance* | ● Documents a clinical visit for treatment of adolescent depression with SSRI antidepressant including rationale for its use and incorporates anticipatory guidance about monitoring for activation syndrome |

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| *Selects the mode of communication most likely to strike the optimal balance between patient confidentiality and sharing information to facilitate effective collaboration*<br><br>*Initiates difficult conversations with appropriate stakeholders to improve the system* | ● Notes balance the need to convey important clinical information about treatment of an adolescent patient with PTSD with providing information that is understandable and helpful to the patient and family who will read the note on a EHR patient portal<br><br>● Talks directly to an emergency room physician about breakdowns in communication about the management of an oppositional adolescent patient with recurrent emergency room visits who was given an intramuscular injection of high-dose antipsychotic despite an existing plan to avoid them |
| **Level 5** *Creates documentation templates or other written content that can be used by multiple providers to educate the patient and patient's family/caregivers, and to improve coordination of care*<br><br>*Contributes to departmental or organizational initiatives to improve communication systems within the health care system and between multiple systems of care*<br><br>*Facilitates dialogue regarding systems issues among larger community stakeholders* | ● Leads a task force established by the hospital quality improvement committee to develop a plan to improve house staff hand-offs<br><br>● Meaningfully participates in a committee to examine community emergency response systems including psychiatric emergencies<br><br>● Works with schools, community outpatient clinics, and crisis response team to identify alternatives to hospitalization when a child makes potentially unsafe statements |
| Assessment Models or Tools | ● Direct observation of sign-outs, observation of requests for consultations<br>● Medical record (chart) audit<br>● Multisource feedback<br>● Semi-annual meetings with the program director |
| Curriculum Mapping | ● |
| Notes or Resources | ● Bierman JA, Hufmeyer KK, Liss DT, Weaver AC, Heiman HL. Promoting responsible electronic documentation: validity evidence for a checklist to assess progress notes in the electronic health record. *Teach Learn Med.* 2017;29(4):420-432. https://www.tandfonline.com/doi/full/10.1080/10401334.2017.1303385.<br>● Haig KM, Sutton S, Whittington J. SBAR: a shared mental model for improving communication between clinicians. *Jt Comm J Qual Patient Saf*. 2006;32(3)167-175. https://www.ncbi.nlm.nih.gov/pubmed/16617948.<br>● Peters, TE. Transformational impact of health information technology on the clinical practice of child and adolescent psychiatry. *Child Adolesc Psychiatr Clin N Am* 2017;26(1)55-66. |

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| | ● Starmer AJ, Spector ND, Srivastava R, et al. I-PASS, a mnemonic to standardize verbal handoffs. *Pediatrics*. 2012;129(2):201-204. https://ipassinstitute.com/wp-content/uploads/2016/06/I-PASS-mnemonic.pdf. |

To help programs transition to the new version of the Milestones, the ACGME has mapped the original Milestones 1.0 to the new Milestones 2.0. Indicated below are where the subcompetencies are similar between versions. These are not exact matches but are areas that include similar elements. Not all subcompetencies map between versions. Inclusion or exclusion of any subcompetency does not change the educational value or impact on curriculum or assessment.

| Milestones 1.0 | Milestones 2.0 |
|---|---|
| PC1: Psychiatric Evaluation | PC1: Psychiatric Evaluation |
| PC2: Psychiatric Formulation and Differential Diagnosis | PC2: Psychiatric Formulation and Differential Diagnosis |
| PC3: Treatment Planning and Management | PC3: Treatment Planning and Management |
| PC4: Psychotherapy | PC4: Psychotherapy |
| PC5: Somatic Therapies | PC5: Psychopharmacology and Somatic Therapies |
| No match | PC7: Digital Health |
| MK1: Development through the lifecycle | MK1: Development through the Life Cycle |
| MK2: Psychopathology | MK2: Psychopathology |
| MK3: Clinical Neuroscience | MK3: Clinical Neuroscience |
| MK4: Psychotherapy | MK4: Psychotherapy |
| MK5: Somatic Therapies | MK5: Somatic Therapies |
| MK6: Practice of Psychiatry | PROF2: Accountability/Conscientiousness |
| SBP1: Patient Safety and the Healthcare Team | SBP1: Patient Safety and Quality Improvement<br>SBP2: System Navigation for Patient-Centered Care |
| SBP2: Resource Management | SBP3: Physician Role in Health Care Systems |
| SBP3: Community-Based Care | SBP2: System Navigation for Patient-Centered Care |
| SBP4: Consultation to non-psychiatric medical providers and non-medical systems | PC6: Clinical Consultation |
| No match | PBLI1: Evidence-Based and Informed Practice |
| PBLI1: Development and execution of lifelong learning through constant self-evaluation, including critical evaluation of research and clinical evidence | PBLI2: Reflective Practice and Commitment to Personal Growth |
| PBLI2: Teaching | No match |
| PROF1: Compassion, integrity, respect for others, sensitivity to diverse patient populations and adherence to ethical principles | PROF1: Professional Behavior and Ethical Principles |
| PROF2: Accountability to self, patients, colleagues, and the profession | PROF2: Accountability/Conscientiousness |
| No match | PROF3: Well-Being |

| | |
|---|---|
| ICS1: Relationship development and conflict management with patients, families, colleagues, and members of the health care team | ICS1: Patient- and Family-Centered Communication<br>ICS2: Interprofessional and Team Communication |
| ICS2: Information sharing and record keeping | ICS3: Communication within Health Care Systems |

## Available Milestones Resources

*Milestones 2.0: Assessment, Implementation, and Clinical Competency Committees Supplement,* 2021 - *https://meridian.allenpress.com/jgme/issue/13/2s*

*Milestones Guidebooks: https://www.acgme.org/milestones/resources/*

- *Assessment Guidebook*
- *Clinical Competency Committee Guidebook*
- *Clinical Competency Committee Guidebook Executive Summaries*
- *Implementation Guidebook*
- *Milestones Guidebook*

*Milestones Guidebook for Residents and Fellows: https://www.acgme.org/residents-and-fellows/the-acgme-for-residents-and-fellows/*

- Milestones Guidebook for Residents and Fellows
- Milestones Guidebook for Residents and Fellows Presentation
- Milestones 2.0 Guide Sheet for Residents and Fellows

Milestones Research and Reports: https://www.acgme.org/milestones/research/

- *Milestones National Report*, updated each fall
- *Milestones Predictive Probability Report,* updated each fall
- *Milestones Bibliography*, updated twice each year

*Developing Faculty Competencies in Assessment* courses - https://www.acgme.org/meetings-and-educational-activities/courses-and-workshops/developing-faculty-competencies-in-assessment/

Assessment Tool: Direct Observation of Clinical Care (DOCC) - https://dl.acgme.org/pages/assessment

Assessment Tool: Teamwork Effectiveness Assessment Module (TEAM) - https://team.acgme.org/

Improving Assessment Using Direct Observation Toolkit - https://dl.acgme.org/pages/acgme-faculty-development-toolkit-improving-assessment-using-direct-observation

Remediation Toolkit - https://dl.acgme.org/courses/acgme-remediation-toolkit

Learn at ACGME has several courses on Assessment and Milestones - https://dl.acgme.org/