

AMERICAN BOARD *of*
PEDIATRICS

Annual Report 2017



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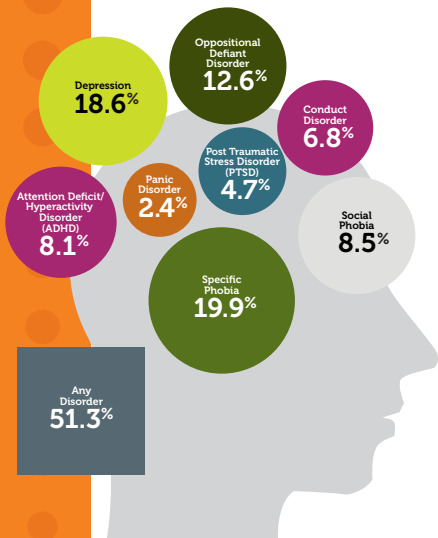
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Cover page, left to right: Dr. Christian Lawrence (second-year resident), Dr. Laura Cannon (Chief Resident), Dr. Kenya McNeal-Trice (Program Director), and Dr. Katie Jordan (Chief Resident) discuss continuous learning and the pediatric training program at the University of North Carolina at Chapel Hill School of Medicine. Photo by Tom Fuldner Photography



PRESIDENT'S LETTER

Dear Colleagues,

We are in a period of intense and productive discussions about how medical specialties regulate themselves. The certification process in general – and maintenance of certification (MOC) in particular – is a significant focus of the discussion, but it also includes the governance of the American Board of Medical Specialties (ABMS), the role and requirements of continued medical education (CME), and many other processes.

I am energized and encouraged by these discussions.

No, I haven't put rose-colored lenses in my glasses, and yes, some of the harsh criticism of MOC and medical specialty boards is painful, but I see many pediatricians, pediatric groups, and members of the public coming together to examine our values and priorities. Despite differences of opinion about some details, we are all in total agreement that the improved health and well-being of children is our ultimate goal.

In that spirit, several actions are underway. The national specialty societies and certifying boards (ABMS member boards) met in December and adopted a statement of shared purpose, which says, in part, "ABMS certifying boards and national medical specialty societies will collaborate to resolve differences in the process of ongoing certification and to fulfill the principles of professional self-regulation, achieving appropriate standardization and assuring that ongoing certification is relevant to the practices of physicians without undue burden."

The national specialty societies, ABMS, and the state medical societies are collaborating to appoint a Commission on Certification, with representatives from the Accreditation Council for Graduate Medical Education (ACGME), the American Medical Association (AMA), and other important medical organizations represented. We are all committed to listening to each other and strengthening the certification process so that patients and their caregivers will know that we adhere to high standards of knowledge and practice.

This report contains many success stories about how MOC projects and processes have encouraged improvements in the care of children. There are also stories about how the ABP has worked diligently to reduce the burden and increase the value of the MOC process. A shining example is the [development of MOCA-Peds](#), a new assessment model designed to promote learning as well as assessment of knowledge.


I am excited about MOCA-Peds for many reasons, but perhaps the greatest is the involvement of hundreds of practicing pediatricians in the development of the model. As always with our assessments, the questions are written by pediatricians, but with MOCA-Peds, we also have relied on pediatricians in focus groups, user groups, and the pilot to help build a useful tool for both assessment and learning. And, based on positive experiences from participants in the MOCA-Peds pilot, the ABP Board of Directors has voted to make MOCA-Peds the default option for all ABP assessment (including subspecialties), beginning in 2019.

This is exactly the kind of thoughtful collaboration that will allow us to strengthen the entire certification process, and with it, the practice of pediatric medicine. I am looking forward to the discussions to come and the advances I'm certain will grow from them.

Sincerely,

David G. Nichols, MD, MBA
President & CEO





Dr. Richard Shugerman (center) chairs the ABP's Education and Training Committee and is joined here by Dr. Gail McGuinness and 2017 ABP Chair Dr. David Gremse.

BUILDING STRONG CAREERS FROM RESIDENCY TO RETIREMENT

Pediatricians in practice have spent, on average, four years in medical school and have successfully completed three years in pediatric residency (plus another two-to-three years if they trained in a subspecialty).

These pediatricians have qualified for a medical license in each state in which they practice. And the majority have taken and passed an intense, seven-hour, 335-question exam to become certified by the American Board of Pediatrics (ABP).

This wealth of skills and knowledge provides a strong foundation on which to start a successful and rewarding career.

Then, to remain current with evolving best practices, pediatricians must keep up with medical literature, confer with other pediatricians, and evaluate the outcomes of their own patients – in short, continue to build their medical knowledge and improve their practices so they can provide the best care possible for patients.

"Instilling the culture of continuous learning starts in residency," says Ann Burke, MD, Professor of Pediatrics, Pediatric Residency Director, and Vice Chair for Pediatric Education, Boonshoft School of Medicine, Wright State University.

"They need to be open to learning new things."



"We have to make sure that our trainees are graduating from our residency programs understanding that what they know the day they graduate will change in five to 10 years – and maybe even in three months," she says.

"They need to be able to check their insights and self-assessments with physician colleagues, other staff, patients and families, and against objective data. And most importantly, they need to be open to learning new things."

Keeping abreast of fast-paced advances is not easy, especially after pediatricians are out practicing on their own. The ABP supports their efforts through continuous certification activities. The four parts of Maintenance of Certification (MOC) are professional standing, lifelong learning and self-assessment, cognitive expertise, and improving professional practice. "I finished my residency in 1987," says Richard Shugerman, MD, Professor of Pediatrics, Seattle Children's Hospital/University of Washington, and Chair of the ABP's Education and

Training Committee. "The ways we practiced medicine then are radically different than they are now in 2017. If you really want to provide the best possible care for patients and families, you've got to find a way to stay up on the latest literature and adapt your practice to the latest approaches. It's challenging, but it's something that we all have to do."

The best approach is to work learning into daily life, he says.

"What can you do in 15 minutes that's going to advance your knowledge?" he says. "What can you do in 10 minutes between patients, rather than saying, 'Well today I'm going to spend four hours reading.' That's why I think MOCA-Peds makes a lot of sense."

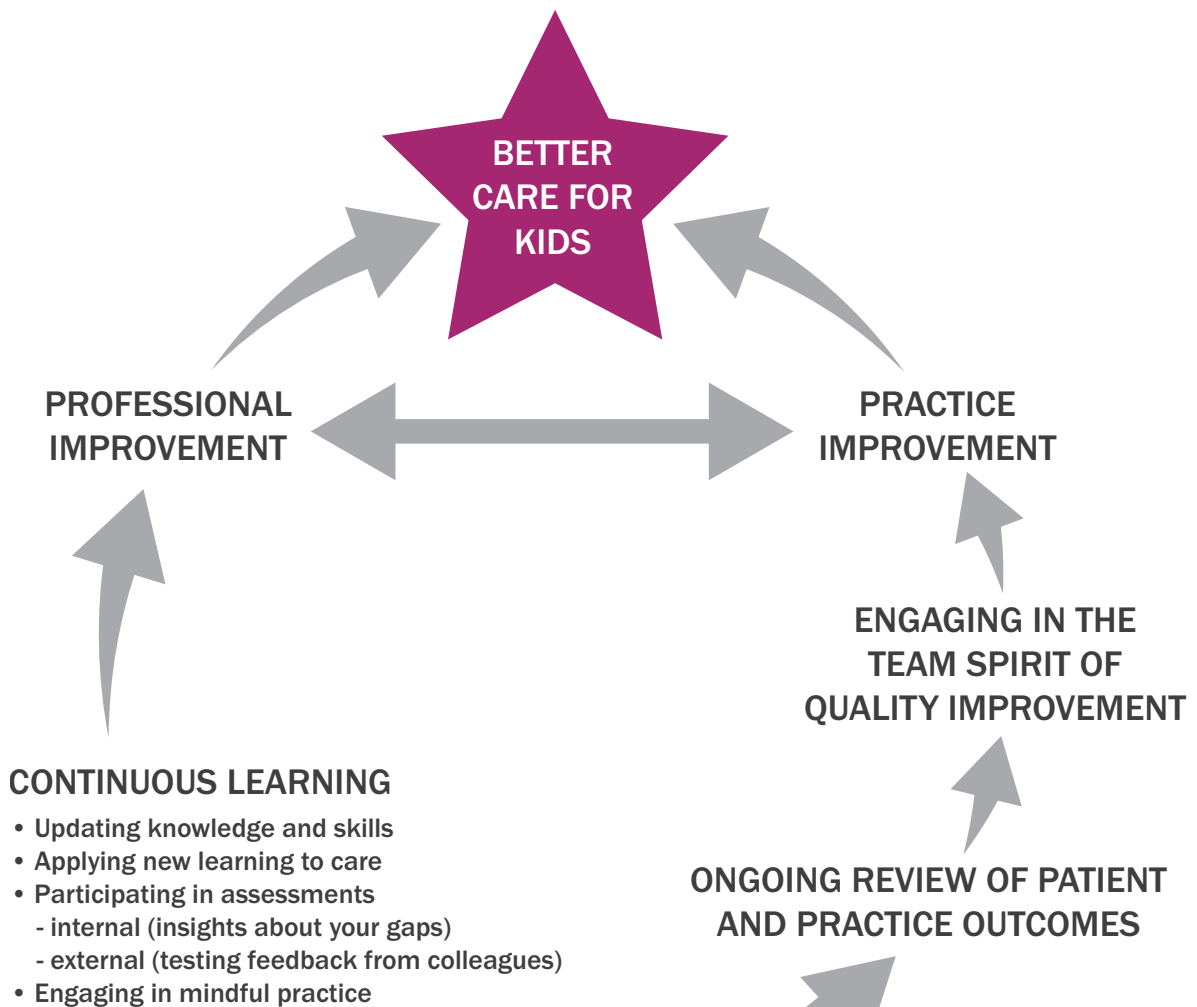
MOCA-Peds (Maintenance of Certification Assessment for Pediatrics) is a web-based (and mobile) approach to assessing cognitive expertise that is currently being piloted by the ABP. MOCA-Peds delivers multiple-choice questions to pediatricians quarterly. Pediatricians have five minutes to answer and can use resources. They find out immediately if they answered correctly and get references to articles that support the correct answer (see page 6).

"The ABP is balancing assessment of learning with assessment for learning."

"The board is intentionally providing more learning opportunities," says Carol Carraccio, MD, MA, ABP Vice President of Competency-Based Assessment. "MOCA-Peds is a great example of this. Rather than focusing only on assessment of learning, the ABP is balancing assessment of learning with assessment for learning."

Other examples of how the board is encouraging pediatricians' continuous learning are through practice improvement activities – MOC Part 4. At Texas Children's Hospital in Houston, Manish Shah, MD, and former pediatric emergency medicine fellow Megan Marino, MD, earned MOC credit for a project that implemented treatment guidelines they developed for first



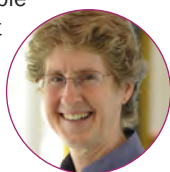


Graphic by Dr. Carol Carraccio

responders transporting children who are having seizures or anaphylaxis. [To earn MOC credit, the doctors showed how the guidelines and training led to improved care.](#)

“We’re developing new ways to support their learning opportunities and practice improvements.”

“This is a great illustration of how the ABP was able to recognize and provide MOC credit for a project these pediatricians were already doing,” says Virginia Moyer, MD, MPH, ABP Vice President of Maintenance of Certification and Quality. “MOC activities should be relevant to practice, and with input from many pediatricians, we’re developing new ways to support their learning opportunities and practice improvements.”



The ABP is trying to help pediatricians identify and fill gaps in their knowledge that could hinder their ability to help children and their families. For example, research shows that many pediatricians feel unprepared to diagnose and/or treat mental and behavioral health issues. The ABP is leading efforts to improve pediatric readiness to diagnose and manage these conditions. [A variety of MOC activities are available to strengthen pediatricians’ knowledge of when and how to intervene.](#)

Meanwhile, the ABP also is strengthening the connection between continuing medical education (CME) activities and MOC lifelong learning activities. [Working with the Accreditation Council for Continuing Medical Education \(ACCME\) and CME activity providers, the ABP can now award MOC credit to pediatricians who complete qualifying CME activities.](#)

Kenya McNeal-Trice, MD, Associate Professor of Pediatrics and Pediatric Residency Program Director at the University of North Carolina School of Medicine, says that continuous learning is essential for pediatricians in all stages of their career.

“Being a good pediatrician goes beyond just simply caring for patients. It also involves ensuring that we’re lifelong learners and that we’re engaged within our communities — not only to make sure our practice continues to improve, but to ensure that our medical systems continue to improve to provide higher standards of care.”





THE AMERICAN BOARD of PEDIATRICS

EMPHASIZING LEARNING AND ASSESSMENT OF KNOWLEDGE

NEW ASSESSMENT FORMAT TO BECOME DEFAULT OPTION
IN 2019 FOLLOWING SUCCESSFUL PILOT



The ABP gave its first examination — administered orally before a panel of three distinguished pediatricians — in June 1934. Since then, just as advances in medicine and technology have improved patient care, testing also has evolved, from oral to paper to computer-based exams.

Now, in response to pediatricians' comments, and in keeping with modern assessment methods, the ABP has explored ways to make the Maintenance of Certification (MOC) exam better reflect current pediatric practice. The result is Maintenance of Certification Assessment for Pediatrics (MOCA-Peds) — a continuous web-based assessment, comprising timed, multiple-choice, clinical vignettes.



After oral examinations in the 1970s, the examiners would meet and collectively grade each candidate.



"I love this pilot!! I will be so terribly disappointed if it ends and I can't continue. I am learning so much more by seeing gaps in my knowledge and using those gaps to dive deep into learning more. So much better than just cramming for the board exam. This is really supporting my learning and fits my learning style. I love it."

All quotes in this article were provided by pilot participants via anonymous surveys.

MOCA-Peds emphasizes continuous learning, allowing pediatricians to determine when and where they take questions. Instead of a single exam day, for which some examinees felt they needed to cram, pediatricians may answer questions as they go, on the go.

"MOCA-Peds emphasizes learning as well as assessment of knowledge."

"A significant additional benefit is that MOCA-Peds emphasizes learning as well as assessment of knowledge," says Linda Althouse, PhD, ABP Vice President of Psychometrics and Assessment Services. "When someone answers a question, they immediately find out whether they answered correctly, and get a rationale for the correct answer plus additional supporting references."

The road to MOCA-Peds began in 2015 when the ABP invited about 75 leaders from pediatric and education communities around the world to come together to share presentations and work in small groups to explore new assessment methods. The outcome was overwhelming enthusiasm for developing and piloting a continuous web-based assessment similar to that being implemented by the American Board of Anesthesiology.

With the help of more than 300 pediatricians, the ABP developed a model of this assessment method for pediatrics. Pediatricians from across the country and in a variety of practice settings (rural and urban, academic and independent) helped write questions, test the web-based platform, comment on communications, and complete many other tasks.

"The response from the pediatric community has been amazing," said Laurel K. Leslie, MD, MPH, ABP Vice President of Research. "Their suggestions and recommendations have molded the whole project and have been critical for making MOCA-Peds a useful tool for pediatricians."

By January 2017, more than 5,000 pediatricians with MOC exams due were enrolled in the MOCA-Peds pilot. They each received 20 multiple-choice questions per quarter and were given five minutes to answer each question. Participants could answer all 20 questions in one sitting or just do the number they had time for. They could use any resources they like within the time limit, although talking with one's colleagues was not permitted.

Based on the 2017 pilot, the anticipated pass rate for MOCA-Peds will be approximately 95 percent, similar to that of the proctored MOC exam for general pediatrics.

In 2018, another 6,000 have joined the pilot, and beginning in 2019, MOCA-Peds will be an option for all general pediatricians starting a new five-year cycle. At that time, questions will be administered years one through four during the five-year cycle. Pediatricians who decide MOCA-Peds is not the best option for them can still choose to take the proctored exam at a secure testing facility for each cycle period.

Subspecialists also will have a MOCA-Peds option. In 2019, it will be available for Child Abuse Pediatrics, Pediatric Gastroenterology, and Pediatric Infectious Diseases. MOCA-Peds will become available for other subspecialties over the next several years.



Laura Brooks, MD, (right), a general pediatrician in Lynchburg, VA, is one of more than 300 certified pediatricians who worked with the ABP to develop MOCA-Peds. In addition to helping write questions for the pilot, Dr. Brooks brought the practicing pediatrician's perspective to the MOCA-Peds Work Group and Executive Committee. Linda Althouse, PhD, ABP Vice President of Psychometrics and Assessment Services (left), who oversaw the MOCA-Peds development, says volunteers like Dr. Brooks have helped tailor the new assessment model to better meet the needs of busy pediatricians in a world of rapid medical advancements.





WHAT YOU NEED TO KNOW ABOUT MOCA-PEDS

BASED ON THE EXPERIENCES OF PILOT PARTICIPANTS, THIS ASSESSMENT METHOD WILL GIVE PEDIATRICIANS FLEXIBILITY, CHOICE, AND INSTANT FEEDBACK.

"I love having the ability to do a few questions when I have time."

"MOCA-Peds is actually interesting and fun, although there is still some stress when you press the button to submit your answer."

"Thank you for offering this option!!!"

"It's better than I thought it would be. You might have won me over."

FLEXIBILITY

MOCA-Peds participants will answer a set number of questions per quarter (approximately 20) using any device (mobile phone, tablet, laptop, or desktop) in any setting (office, home), on any day, and at any time within a given quarter. Each pediatrician's four lowest-performing quarters will be dropped from his or her score during each MOC cycle. The fifth year is available for finishing other MOC activities or taking the proctored exam if the pediatrician has not achieved a passing score for MOCA-Peds.

CHOICE

Pediatricians will be able to choose their preferred assessment method — either MOCA-Peds or the proctored exam at a secure testing facility. MOC enrollment fees will cover the cost of MOCA-Peds. Those who choose the proctored exam will incur a testing center and administration fee.

FEEDBACK

One of the most popular features of the platform is the incorporation of instant feedback that places an emphasis on learning. After a question is answered on MOCA-Peds, the pediatrician immediately receives the correct answer, rationale, and references that they can use as they care for patients.

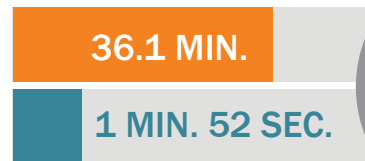
NEXT STEPS

MOCA-Peds updates will be shared as they become available. Details about the pilot and plans for the 2019 launch are available now at www.abp.org/mocapeds.

TIME IS ON YOUR SIDE

Based on participation data, half of the 4,923 MOCA-Peds participants in the last quarter answered all 20 questions in 36.1 minutes or less.

The average time spent on each question was 1 min 52 seconds.

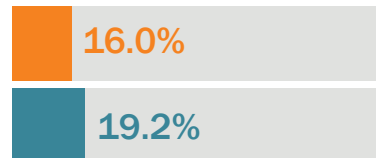


"LOVE this format – much less anxiety-provoking than a proctored exam. The purpose is to review and learn, not be intimidated and afraid! Thank you for this format!"

CHECK YOUR ANSWERS

In the most recent quarterly survey, 16.0% of the 3,785 survey participants said they did not use resources.

19.2% said they used resources on 10 or more questions.



“Please keep this program. It is so much more practical and useful than a proctored exam. It simulates real life in which I would have a question in clinic, then reference online [resources] for answers. This is how real pediatricians practice medicine in 2017.”

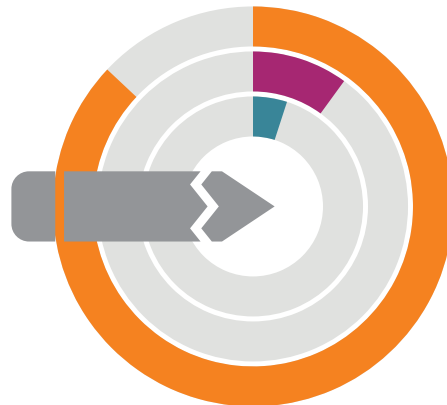
All quotes in this article were provided by pilot participants via anonymous surveys.

“Great work. In all the years I have recertified in pediatrics, I feel like this program strikes a wonderful balance between assessing my knowledge, keeping me up to date on important topics, and maintaining my interest in continuing medical education in a comfortable atmosphere.”

MOCA PEDS QUESTIONS PROMOTE LEARNING

In the same survey, 3,785 participants responded to whether they agreed or disagreed with the following:

“MOCA-Peds questions were useful learning tools.”



“I have really enjoyed this, something I would never have thought I would have said about the certification exam. I am both learning and meeting my requirement for certification, which is reflective of real practice!”

GET INSTANT FEEDBACK

In the same survey, 3,785 participants responded to whether they agreed or disagreed with the following:

“The MOCA-Peds program helps me stay current in general pediatrics.”



“It is a great way for a subspecialist to keep up to date on general pediatrics. I would do it again. I think I will retain the general peds information and actually be able to improve the clinical care I provide my subspecialty patients better than when I just cram for the re-cert exam every 10 years.”



Dr. Kenya McNeal-Trice (right), a program director at the UNC School of Medicine, advises first-year resident Dr. Paige Dudley.



Tom Fuldner Photography

ABP WORKS WITH PROGRAM DIRECTORS

IMPROVING TRAINING TO PROMOTE LIFELONG LEARNING



The journey of continuous learning for pediatricians begins during residency, when they are gaining the competencies to provide medical care for children without direct supervision. During these years of training, they are guided by pediatric program directors who, along with other pediatric faculty members, monitor their progress and help them identify and fill gaps in their knowledge and skills.



Although residents are often unaware of the connection, it is during training that the ABP begins supporting their continuous efforts to provide outstanding health care for children throughout their careers. The ABP partners with program directors in both residency and fellowship programs and with affiliated organizations — including the Association of Pediatric Program Directors (APPD) and the Accreditation Council for Graduate Medical Education (ACGME) — to set standards for specific competencies and prepare trainees for their initial certification exam.

MEASURING KNOWLEDGE

The ABP's annual in-training exams (ITEs) help program directors measure how well their training program is performing regarding medical knowledge, and how well individual trainees are progressing. Residents take an ITE after the first two weeks of residency, and again early in their second, third and, sometimes, fourth years.

"The in-training exam is an annual opportunity for residents to self-assess their knowledge and see how they compare to residents around the country," says Franklin Trimm, MD, Professor and Vice Chair of Pediatrics and Director, Pediatric Residency Program, University of South Alabama Children's and Women's Hospital. Dr. Trimm also serves as President of the Association of Pediatric Program Directors (APPD). "Their score sets the stage for what can be very meaningful conversations between a resident and their program director about what is working and what they might need to do differently."



"The in-training exam is an annual opportunity for residents to self-assess their knowledge and see how they compare to residents around the country."

Kenya McNeal-Trice, MD, Associate Professor of Pediatrics and Pediatric Residency Program Director at the University of North Carolina School of Medicine, says she meets with all trainees twice a year to review how well they are filling knowledge gaps identified in the ITE.

"We try to individualize our curriculum, so our trainees will be successful when they take their initial general pediatrics certification exam," she says.

CLINICAL COMPETENCE

Readiness to practice involves much more than knowledge, however. At the end of training, program directors must attest to trainees' clinical competence. To help, the ABP provides program directors various resources to help trainees master the ACGME's competency standards.

"Each year, we assess the resident's professionalism, patient care skills, communication skills, and all the ACGME's core competencies — not only medical knowledge," says Ann Burke, MD, Professor of Pediatrics, Pediatric Residency Director and Vice Chair for Pediatric Education at Boonshoft School of Medicine at Wright State University. Dr. Burke also is the 2018 Chair of the ABP Board of Directors.

"We assess the resident's professionalism, patient care skills, communication skills, and all the ACGME's core competencies."

"We rely on program directors to tell us when a trainee is clinically competent. Only then can they sit for their initial certification exam," says Gail McGuinness, MD, ABP Executive Vice President, who led the ABP's Department of Credentialing and Examination Administration for 15 years until her retirement Dec. 31, 2017.

MILESTONES

The ABP also has been closely involved in establishing milestones, which are narrative descriptions of behaviors for each of the competencies along a continuum of development, ranging from novice (an early medical student) to a master clinician who is years into practice. Program directors use these descriptions to measure a trainee's progress.

Victoria Norwood, MD, Subspecialty Program Director for Nephrology at the University of Virginia (UVA) School of Medicine, says milestones help her subspecialty trainees see their progress toward a specific goal.



"I find the milestones to be a much more specific way for faculty to think about trainees and their strengths and weaknesses. And it provides a real framework and granularity of detail for me to discuss those performance issues with trainees in a way that was not really available before," says Dr. Norwood, who oversees all UVA educational programs in pediatrics as Vice Chair for Academic Affairs.

ASSESSMENT PRIMER

In addition to milestones, the ABP's Education and Training Committee (ETC) created a primer to help program directors accurately assess residents and fellows in all six competencies.

"The primer is a terrific way of helping program directors keep up with that science."

"The science of assessment in medical education has really advanced in the last 15 or 20 years," says Richard Shugerman, MD, Chair of the ETC and Vice-Chair for Faculty Development and Professor of Pediatrics at Seattle Children's Hospital, University of Washington (UW). "The primer is a terrific way of helping program directors keep up with that science."

Assessment in Graduate Medical Education: A Primer for Pediatric Program Directors is available at www.abp.org in the Program Directors section.



PROFESSIONALISM GUIDE

The critical competency of professionalism can be one of the most difficult to define and measure. To support program directors, the ABP's ETC recently updated *Teaching, Promoting and Assessing Professionalism Across the Continuum: A Medical Educator's Guide*, which also is available at www.abp.org in the Program Directors section.

Dr. Trimm, an ETC member and an editor of the guide, says studies have shown that if professionalism issues are not addressed early in training, then doctors are at greater risk of exhibiting poor professionalism throughout their careers.

The revised professionalism guide addresses not just residents, but also medical students and fellows. It includes new topics, such as digital professionalism and how to use social media in ways that promote child well-being while maintaining professionalism.

UW's Dr. Shugerman says the guide is "structured for program directors as a teaching tool that they can use to put together learning sessions with residents in a variety of different formats, including case studies with questions. You can take just one case study at a time, depending on how that fits your needs."

"It's nice to be able to turn to the guide as a program director advisor and say, 'This isn't just my opinion.'"

UVA's Dr. Norwood says the Professionalism Guide is helpful when working with trainees who may not understand why something they have done is unprofessional. "It provides a very solid, real-life way to counsel anyone who's having troubles in that area," she says. "It's nice to be able to turn to the guide as a program director advisor and say, 'This isn't just my opinion.'"

CONTINUOUS LEARNING AND CERTIFICATION

Program directors also plant the seeds for continuous learning, says Dr. Norwood. She says it is the program director's role to help bring trainees into the world of certification and encourage them to maintain their certification throughout their career.

"We remind everyone that providing the best care for children for the lifetime of your career mandates that you stay up-to-date in relevant practices — and that means continuous learning," she says.

She uses a fellows' forum to go over the processes for reaching subspecialty certification, then bridging into MOC. She holds similar forums for faculty and encourages them to guide trainees to follow ABP MOC standards for their quality improvement projects so that the residents can bank credits to claim during their first five-year MOC cycle. Faculty members also can claim MOC Part 4 credit for projects they work on with trainees.

UNC's Dr. McNeal-Trice agrees. "The learning continuum keeps going once they finish residency training and are working in an independent practice or in specialty fellowship training. We get our trainees used to continuous learning and improvement while they're in training, so it becomes a normal part of their routine once they are in independent practice," she says.

Suzanne Woods, MD, ABP Vice President of Credentialing and Initial Certification, says, "We need to ensure that trainees understand how critical it is to keep learning throughout their careers." [Dr. Woods, who joined the ABP staff Jan. 1, 2018](#), was previously a program director at Duke University Medical School. "When trainees are engaged with the ABP early on, they learn how instrumental the Board can be in helping them stay on top of medical advances and best practices."



Tom Fuldner Photography



UNC first-year resident Dr. Pamela Londres confers with second-year resident Dr. Christian Lawrence.





Dr. Richard Mink



Dr. Daniel Schumacher

WHEN TO TRUST TRAINEES TO PRACTICE ON THEIR OWN

Entrustable professional activities (EPAs) describe the routine and essential activities physicians perform in practice and help program directors determine when trainees can be trusted to perform these activities. Although scales (to determine if trainees can work unsupervised) for EPAs had been proposed, they had not been validated — until now. Two new studies, one involving fellows and the other involving general pediatric residents, shed light on the best uses of EPAs.

CREATING SUPERVISORY SCALES FOR PEDIATRIC FELLOWS

In a study led by Richard B. Mink, MD, MACM, and conducted by the Subspecialty Pediatrics Investigator Network (SPIN), researchers created new supervisory scales for six of the seven common pediatric subspecialty EPAs and then examined their validity by having pediatric fellowship program directors and Clinical Competency Committees across the country use them to evaluate fellows in fall 2014 and spring 2015. The study was published online ahead of print on July 11, 2017, in *Academic Medicine*.

“When we talk about how we assess fellows, it’s different from residency,” says Dr. Mink, Chief of the Division of Pediatric Critical Care and Director of the Pediatric Critical Care Fellowship Program at Harbor-UCLA Medical Center, and Professor of Pediatrics at the David Geffen School of Medicine at the University of California-Los Angeles. “While there are some published scales looking at the required

level of supervision, these have never been validated and may not be suitable for fellows. Fellows work with the same core group of attending physicians over three years, making a trust assessment easier because of the longitudinal experience.”

SPIN determined that one supervisory scale would not fit all EPAs, so it created separate scales for each of six EPAs. Dr. Mink says not only did the new scales address direct versus indirect supervision, but also considered the complexity of the case.

“Fellows might need direct supervision for a complex case, but they’re okay working alone for a simple case,” Dr. Mink explains. For example, he says caring for a baby who has respiratory syncytial virus (RSV) is usually fairly straightforward. “I may feel comfortable with a fellow six months into pediatric critical care fellowship doing that and taking care of that baby without me being there. But if a child comes in with an overwhelming infection and septic shock, I may say ‘Let me help you with this one’ or ‘Let me watch you a little bit more closely.’”

The study assessed fellows from more than 200 programs at 80 institutions in each year of training. For each time period and EPA, there was a progressive increase in entrustment levels. Second-year fellows were rated higher than first-year fellows, and third-year fellows rated higher than second-year fellows.

The research provided strong evidence for the validity of the scales as effective supervisory tools and showed an excellent correlation between levels of supervision and performance levels on milestones.

ASSESSING EPAS FOR GENERAL PEDIATRIC RESIDENTS

Assistant Professor of Pediatrics at Cincinnati Children’s Hospital Daniel Schumacher, MD, MEd, is leading a research study that explores how program directors assess their residents using EPAs. The study involves 22 general pediatrics residency programs that vary in size and geographic location. Twice a year, the Clinical Competency Committee for each program reports on six EPAs.

“We ask them to review assessment data about their residents and make a decision on the level of supervision needed to safely and effectively perform each EPA,” Dr. Schumacher says. “Following a cohort of residents from each of these programs through their three years of training will help to set performance standards that will provide consistency in skills needed to advance to the next level of training or go on to practice.”

Dr. Schumacher designed a second component of this study as a large multi-institutional quality improvement project to enhance the quantity and the quality of the data collected. He applied for ABP approval so that Clinical Competency Committee members with meaningful participation in the study could apply to earn MOC Part 4 credit from the ABP.

The study will be completed in spring 2019.



NEW YEAR, NEW LEADERSHIP

THE ABP EXTENDED A FOND FAREWELL IN 2017 TO GAIL A. MCGUINNESS, MD, AND OFFERS A WARM WELCOME IN 2018 TO SUZANNE K. WOODS, MD

GAIL A. MCGUINNESS, MD

Dr. McGuinness joined the ABP in 2002 as Senior Vice President of Examination Administration and Credentialing, responsible for exam administration, credentialing, oversight of the subboards, and new subspecialties. Also named Executive Vice President in 2006, she provided redundancy for internal operations activities for the President and CEO. In this role, she served as a voting member on the ABP Board of Directors and the ABP Foundation Board of Directors.



“Dr. McGuinness is an outstanding leader and well-respected throughout the pediatric community,” says ABP President and CEO David G. Nichols, MD, MBA. “We are grateful for her insight, compassion, good nature, and immense dedication to pediatricians, trainees, patients, and the ABP.”

The ABP was not the only organization to benefit from Dr. McGuinness’ inspiring career. She served on the Review Committee for Pediatrics of the Accreditation Council for Graduate Medical Education (ACGME), sat on two working committees of the American Academy of Pediatrics, and was a voting member of the board of directors of the American Board of Medical Specialties.

Before joining the ABP, Dr. McGuinness spent the majority of her academic career at the University of Iowa where she had completed her residency in pediatrics, followed by fellowship training in neonatology at both the University of Colorado and the University of Iowa. While at Iowa, she rose to full professor, directed the residency program, and was associate chair for education, all in the Department of Pediatrics.

Author of more than 70 publications and a coveted presenter, Dr. McGuinness has received several awards throughout her career, including two teaching awards, an alumni achievement award, a faculty chair endowment, the Association of Pediatric Program Directors’ Walter Tunnessen Jr. Award, the Parker Palmer Courage to Teach Award from the ACGME, and the Federation of Pediatric Organizations’ Joseph W. St. Geme Jr. Leadership Award.

SUZANNE K. WOODS, MD

Dr. Woods became ABP Vice President of Credentialing and Initial Certification on Jan. 1, 2018. She provides oversight for the development of training standards, the tracking and evaluation of residents and fellows, and the credentialing for and administration of examinations. She also oversees the development of the certification process for new subspecialties and serves as the ABP’s liaison to a number of organizations with common interests in graduate medical education.



“I am excited to join the ABP and work with a fantastic team on credentialing and initial certification,” says Dr. Woods. “As a longtime program director, I believe in the commitment to training physicians to provide outstanding, high-quality, and safe patient care.”

Before joining the ABP, Dr. Woods was Associate Professor of Pediatrics and Medicine, Director of the Med-Peds Residency Training Program, and Section Chief for Combined Medicine Pediatrics, all at Duke University. She was the residency program director for 16 years.

Previously, Dr. Woods received her medical degree from the Medical College of Ohio, completed her combined pediatrics and medicine residency at Duke, and spent a year on the faculty in the Department of Medicine at Emory University before being recruited back to Duke in 1999 as the first combined Med-Peds physician to practice both specialties there.

Dr. Woods has served as a member of the ABP’s Education and Training Committee, chair of the Review Committee for Pediatrics of the ACGME, and president of the Medicine-Pediatrics Program Directors Association. She is board-certified by the ABP and meets the requirements of Maintenance of Certification (MOC).

“Although we will sorely miss our valued colleague Dr. McGuinness, we are looking forward to the new ideas and perspectives that Dr. Woods will bring to our leadership team,” says Dr. Nichols.



ABP STAFF PARTNERS WITH PROGRAM DIRECTORS TO PREPARE PEDIATRIC TRAINEES



CREDENTIALING AND INITIAL CERTIFICATION STAFF, LEFT TO RIGHT, AND THEIR YEARS OF ABP EXPERIENCE:

- Front row: Lee Currin (31+) Wendy Lea-Walker (27+) Ashley Smith (2+)
- Back row: Monique Seed (14+) Angela Godwin (11+) Jordan Bohn (1+)
Justin Goad (3+) Anne Justus (36+) Sheleria Cushman (24+)
- Not pictured: Atina Andrews (2+) Adrienne Coles (10+) Kimberly Durham (7+)
Tammy Poole (10+) Angela Rhodes (9+)

Tom Fuldner Photography

Pediatric trainees receive structure and guidance during their training years from a pediatric program director or coordinator who has a mind for completing each detail and a heart to see each resident to the transition point in their pediatric journey.

But who guides the program directors and coordinators to ensure that each applicant for certification meets all requirements to proceed to the certifying exam? The ABP's Credentialing and Initial Certification Department does. The department partners with training programs, answers questions, and provides support to program directors as they:

- Track the progress of residents and fellows;
- Evaluate them in their last year of training;
- Verify their training dates and completion;
- Assess their clinical competence against the six core competencies adopted by the American Board of Medical Specialties (ABMS) and the Accreditation Council for Graduate Medical Education (ACGME); and
- Assure that each applicant meets the standards expected of a certified pediatrician or pediatric subspecialist.

The Credentialing and Initial Certification team, with more than 185 total years of experience, values their relationships with program directors and coordinators and looks forward to assisting them with any and all questions.

**Telephone: (919) 929-0461
Business Hours: 8:30 am–5 pm ET, M–F
Email: support@abpeds.org**



QUALITY IMPROVEMENT OFTEN ROOTED IN COLLABORATIVE NETWORKS

Collaborative networks are a growing and transformative model for improving patient care and outcomes for children. They provide a forum for physicians to share expertise and experience and offer a framework for measuring and tracking the impact of changes. Networks exist for numerous patient populations, including asthma care, behavioral and mental health, inflammatory bowel disease, rheumatoid arthritis, renal disease, and many others.

The ABP recognizes the valuable quality improvement achievements of collaborative networks across the country and offers Maintenance of Certification (MOC) Part 4 credit for many collaborative improvement projects.

The following articles describe two successful collaborative networks that have improved the care of children. Participating physicians have claimed MOC credit for the work they have done within these networks.

SOLUTIONS FOR PATIENT SAFETY

Since 2012, safety interventions are estimated to have spared more than 9,000 children from serious harm caused by medical errors in nearly 130 hospitals across the United States and Canada, reports Children’s Hospitals’ Solutions for Patient Safety (SPS).¹

SPS is a collaborative network of children’s hospitals that share a vision to eliminate serious harm among hospitalized children. The interventions also have saved an estimated \$148 million in health care costs.¹



“One child harmed is too many,” says Daniel Hyman, MD, Chief Medical and Patient Safety Officer at Children’s Hospital Colorado, which is part of the SPS network. “We’re moving closer and closer to zero harm,” he says.

Establishing a culture of safety and learning to prevent errors has helped his hospital reduce the rate of serious harm to patients by two-thirds, he says. The network leadership notes that the keys to such significant harm reduction are threefold: improving processes, implementing a safety culture, and analyzing the root cause of errors.

The medical teams collect and share data to track their progress over time and discuss their successes and challenges. They analyze and learn from the data. These collaborations take place during weekly calls as well as during semi-annual in-person training sessions, monthly webinars, password-protected website discussions, process data reports for chief executive officers, and publications highlighting best results.

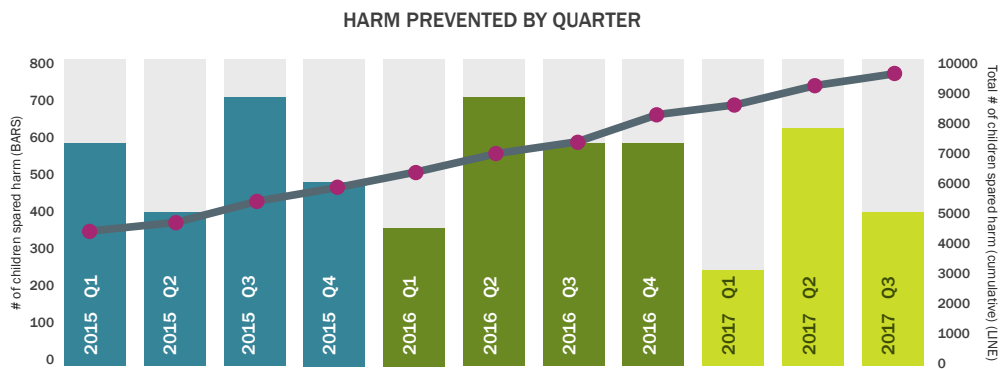
Transforming an institution’s culture must happen at all levels, Hyman says. Boards of trustees and senior leaders at SPS network hospitals are challenged to transform their organizational culture and set the expectation of personal accountability for safety from all levels of staff within their institutions.

The network’s work helps all members of interdisciplinary teams speak up by defining what behaviors are acceptable and encouraged, says Trey Coffey, MD, SPS Associate Clinic Director and Associate Professor of Pediatrics at the University of Toronto. “We have a common language,” she says. “If we all get the same training on error prevention, it becomes easier to speak up.”

The SPS coalition helps members discover and correct the root causes of risks. “The proximate cause of an error might be a nurse giving a patient the wrong medicine, but we need to discover the root cause — why was the error not prevented, or not caught sooner,” Dr. Hyman says. “That kind of analysis is what will help us avoid the same error in the future.”

Participation in the network provides the tools and framework to make patient safety more achievable, Dr. Hyman says. “It makes us all proud to know we’re focused on the right things.”

Trainees and faculty participating in SPS initiatives may be eligible for MOC Part 4 credit from the ABP.



Measures include: adverse drug events, catheter-associated urinary tract infections, central-line associated blood stream infections, obstetrical adverse events (in cumulative totals only), falls, pressure injuries, readmissions (7-day), surgical site infections, ventilator-associated pneumonia, and venous thromboembolism

¹ www.solutionsforpatientsafety.org/our-results





Samerra Lewis reads to Dr. Jessica Walters in the waiting room at Cincinnati Children’s Hospital. The hospital reports that children served by Reach Out and Read score three to six months ahead of their non-Reach Out and Read peers on vocabulary tests. Since the program started in Boston nearly 30 years ago, it has spread to all 50 states. Pediatricians who work to enhance their Reach Out and Read programs may be able to claim MOC Part 4 credit.

THRIVE AT FIVE

When a young child comes into the primary care center at Cincinnati Children’s Hospital, the medical team reviews vaccination records, checks weight, and screens for dental, vision, and hearing health. As part of the hospital’s Thrive at Five project, the team also checks the child’s speech, literacy, and mental, emotional, and behavioral health. If a child is lagging in any of these areas, the medical team helps the parent or guardian find appropriate resources to prepare the child to succeed in kindergarten.

Thrive at Five is part of Cincinnati Children’s All Children Thrive (ACT) learning network. The network brings together families, community and civic leaders, educators, social service providers, faith leaders, health care providers, researchers, and others to collaborate, discover, and implement findings to create environments where children thrive.

“We started around 2010 trying to solve problems closely associated with poverty – unintended injury, infant mortality, obesity, and uncontrolled asthma,” says Robert Kahn, MD, MPH, Physician Lead, Community and Population Health, James M. Anderson Center for Health System Excellence at the University of Cincinnati. “We had enough success in these four areas that the hospital has made leading community health efforts a pillar of our hospital’s strategic plan.”



As a result, the learning network has expanded to include many more community members with resources to address root causes of problems that prevent children from thriving – including food insecurity, inadequate housing, social isolation, and low literacy, in addition to physical health.

Pediatricians who participate in the program by collecting baseline data, implementing interventions to improve health, and then measuring outcomes, can and do claim Maintenance of Certification (MOC) credit for Quality Improvement (Part 4).

“The quality improvement requirements of MOC are intended to encourage and reward innovations in practice,” says Virginia Moyer, MD, MPH, ABP Vice President of MOC and Quality. “As programs like ACT spread across the country, we all can discover new ‘best practices’ from each other’s work.”

Thrive at Five is one example of a concerted effort to set achievable markers for children, says Courtney Brown, MD, MSc, a pediatrician at Cincinnati Children’s and Assistant Professor of Pediatrics at the University of Cincinnati. Specific markers of physical health, cognitive development, and social competence are measured from birth. The goal is to have the children at acceptable levels in all categories by age 5½.



“It’s exciting,” Dr. Brown says. “We try to solve the problems of one child at a time, and from that, we figure out ways to make the whole system better for everybody.”

As one part of Thrive at Five, the medical team encourages parents and children to read together. Cincinnati Children’s serves as the leader of the Greater Cincinnati Reach Out and Read Coalition and supports nearly 20 primary care medical centers across Cincinnati that participate in Reach Out and Read, serving nearly 30,000 children and families.

LEARN MORE AT WWW.CINCINNATICHILDRENS.ORG/SERVICE/R/REACH-OUT-AND-READ, WWW.ACTNOWCINCY.ORG, AND WWW.ALLCHILDRENTHRIVE.ORG.



PEDIATRIC PORTFOLIO SPONSORS PROVIDE LOCALLY MEANINGFUL QI PROJECTS

In hospitals, universities, and practices across the United States, pediatricians work on quality improvement (QI) activities. Some pediatricians work independently to create their own projects, while others earn Maintenance of Certification (MOC) Part 4 credit for work they are already doing with hospitals and other medical organizations.

“Pediatric Portfolio Sponsors evaluate local and institutional QI projects against the ABP’s standards and then approve QI projects for MOC credit,” says Kristi Gilreath, Director of MOC External Activities at the ABP. “Hospitals, health care organizations, professional societies, and improvement collaboratives all can apply to become Portfolio Sponsors.”

The Children’s Hospital of Philadelphia (CHOP) became a Pediatric Portfolio Sponsor in 2012 to “meet both the growing need for locally meaningful QI activities and the internal requirements for physicians to maintain board certification as a condition of practice,” according to Maintenance of Certification Part 4: From Trial to Tribute, published in *The Journal of Pediatrics* in June 2017.¹

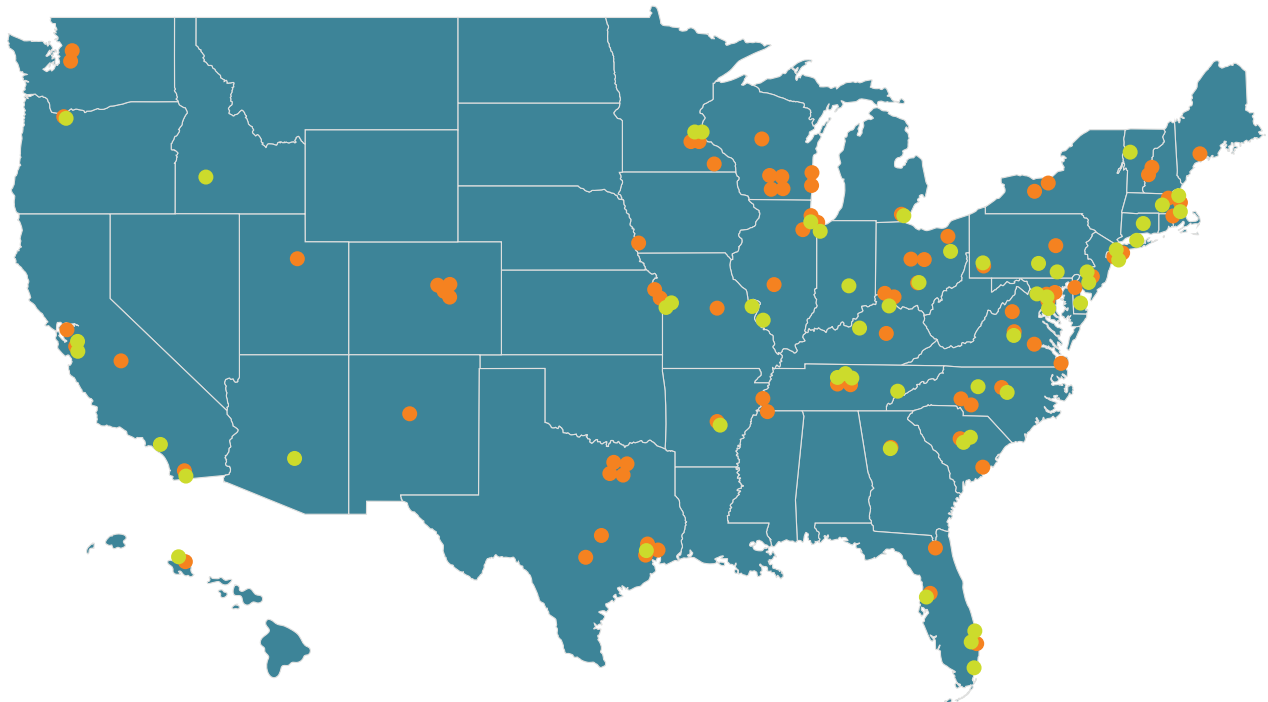
The authors wrote: “The engagement of critical stakeholders throughout the development of our MOC portfolio has helped

ensure alignment of the hospital’s QI agenda and our MOC program, resulting in a mutually beneficial outcome for the institution and the physicians participating in the work.”

Children’s National Health System, another Pediatric Portfolio Sponsor, initially focused on local primary care and regional quality improvement projects before its hospital began aligning QI projects with MOC credit. Now the system provides support, infrastructure, and guidance to hospital teams, too.

“They own the quality improvement projects, goals, and initiatives, and we are able to provide the ABP’s framework for MOC recognition,” says Mark Weissman, MD, Chief, Division of General Pediatrics and Community Health at Children’s National Health System, and the Diane and Norman Bernstein Professor of Community Pediatrics at George Washington University.

“But we realized that we really have begun to change the landscape when, based on success of past QI projects, new proposals for QI initiatives come from our state Medicaid agency or our city’s health department,” he adds.



Pediatric Portfolio Sponsors
Full list: abp.mymocam.com/portfolio/sponsors

Multi-Specialty Portfolio Program Sponsors
Full list: mocportfolioprogram.org/about-us/portfolio-program-sponsors

The ABP has approved more than 50 hospitals and medical organizations across the United States as Pediatric Portfolio Sponsors, while the American Board of Medical Specialties (ABMS) has approved nearly 90 such organizations as Portfolio Program Sponsors in ABMS’s Multi-Specialty Portfolio Program. Some large pediatric organizations participate in both of these programs. If your organization would like to become a Portfolio Sponsor, please contact the ABP (for pediatric projects only) or the ABMS (for projects involving physicians in many specialties). Pediatricians who want to earn MOC Part 4 credit through their organization’s portfolio should directly contact their organization.

¹ [www.jpeds.com/article/S0022-3476\(17\)30365-7/fulltext](http://www.jpeds.com/article/S0022-3476(17)30365-7/fulltext)



Tamara John Li, MPH, Project Lead-MOC, Dr. Mark Weissman, Chief, Division of General Pediatrics and Community Health, and Dr. Lee Beers, MD, Medical Director of Municipal and Regional Affairs, all at Children's National Health System



PORTFOLIO SPONSOR SPOTLIGHT: CHILDREN'S NATIONAL HEALTH SYSTEM

In our nation's capital, DC Medicaid requires that participating primary care providers offer annual behavioral and mental health screenings for all Medicaid-enrolled children. Despite these mandates, most pediatricians in the District of Columbia were not routinely screening for behavioral or mental health issues at annual well-child visits.

To improve treatment and outcomes for children, the Children's National Health System worked with key partners — the American Academy of Pediatrics DC Chapter, the DC Partnership to Improve Children's Healthcare Quality, and other District organizations — to create the DC Collaborative for Mental Health in Pediatric Primary Care. The learning collaborative aims to help participating pediatricians improve their identification, referral, and management of childhood behavioral and mental health problems during annual well visits.

The District of Columbia has seen notable improvements in screening rates for behavioral and mental health in the two years since the project launched, says Children's National's Dr. Weissman.

"The DC Collaborative is also trying to move into the space of improving the referral system between the primary care

practices, early childhood mental health services, and early education providers so there's more of a closed-looped process for kids who screen positive or need some extra services."

Pediatricians who participate meaningfully in the mental health collaborative can earn Maintenance of Certification (MOC) Part 4 points for their participation because Children's National Health System is a Pediatric Portfolio Sponsor with the ABP.

"This project demonstrates not just that we can develop great QI collaboratives with community-wide stakeholders, but also that we can align the work with the ABP requirements for practitioners to get MOC credit," says Dr. Weissman.

"We've been doing this quality improvement approach long enough that the framework is pretty well recognized across our community and region. People come up with ideas, and they now come to us. They identify areas where they can make improvements and use some of the tools that we've given them to do the work. They come back a year later and say, 'Hey, we've been doing this work without anybody prompting us to do it. And it made our lives so much better.'"



"This project demonstrates not just that we can develop great QI collaboratives with community-wide stakeholders, but also that we can align the work with the ABP requirements for practitioners to get MOC credit."



YOU HAVE TO BE COMFORTABLE BEING INCREDIBLY UNCOMFORTABLE

FELLOW EARNS MOC CREDIT FOR CREATING MEDICAL RESPONSE TO VICTIMS OF DOMESTIC MINOR SEX TRAFFICKING

Approximately one month into her child abuse pediatrics fellowship at Hasbro Children's Hospital, Dana Kaplan, MD, had a 16-year-old patient in the clinic who had been exchanging sex for money.

"I went to go speak with her, and I didn't know what to say," says Dr. Kaplan, who is now Director of Child Abuse and Neglect for the Department of Pediatrics at Staten Island University Hospital. "I didn't know what was relevant to ask. I didn't know what was pertinent to provide her medically."

Before those questions could be answered, Dr. Kaplan searched on her laptop for a definition of this population of patients. "Domestic Minor Sex Trafficking (DMST)" describes activities involving a person under the age of 18 who resides in the United States and is exchanging sex for money. Starting there, she was able to learn about the dynamics of this population.

"But my main question was, what do we do medically?" she says.

This question was the impetus for a three-year quality improvement (QI) project, Creating a Medical Response to Victims of Domestic Minor Sex Trafficking. Dr. Kaplan earned 25 points of quality improvement credit (MOC Part 4) for her project by completing the ABP's simple, online application.

"The first step is to remove judgment and to let them know they can talk to me about anything."

"There was nothing in the published research in terms of medical follow up," says Dr. Kaplan. "The existing information on medical evaluation was limited to the guidelines that are utilized to treat the patients when they seek medical care after an acute sexual assault. That's really limiting in DMST because of the ongoing risks to a patient's physical well-being, such as ongoing exposure to sexually transmitted infections."



Most of the patients told me, 'I don't care what you tell me. I'm going back out there.'

With this in mind, Dr. Kaplan began to explore how to reframe her approach, to understand how to talk with this patient population, how and when to take a medical history, and what to ask and what not to ask.



"I needed to know how to help this patient population, but also understand that I am not going to be able to make my patients stop going back out there," Kaplan says. "That's not something I'm going to be able to do in a single encounter, and I really had to come to terms with that. I think the hardest part of coming to terms with that is you have to get comfortable being incredibly uncomfortable when you send a patient back out into 'the life' of DMST."

"Most of the patients told me, 'I don't care what you tell me. I'm going back out there.'"

"The life" is a term used to describe someone who is involved in DMST.

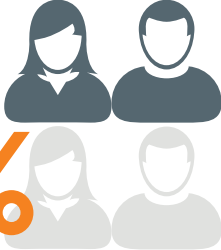
Dr. Kaplan says her focus was to try to find ways to get DMST patients to return for follow-up appointments because of the victims' ongoing exposure to violence, illegal substances, untreated medical needs, risk for acquiring sexually transmitted infections, risk for pregnancy, and risk for acquiring HIV.

"You need to have this person know that they can trust you," she says. "I needed to find a way to gain rapport and really make these patients know that they could find a safe place with me — truly become their medical home. The first step is to remove judgment and to let them know they can talk to me about anything."

At the end of her QI project, approximately 50 percent of the patients evaluated at The Lawrence A. Aubin Sr. Child Protection Center at Hasbro Children's Hospital had returned for at least one follow-up visit.

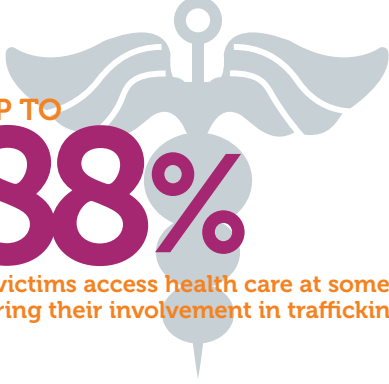
"That is unheard of in acute sexual assault, let alone sex trafficking," she says.

BY PROJECT'S END



50%

of the patients evaluated had returned for at least one follow-up visit.



UP TO

88%

of victims access health care at some point during their involvement in trafficking.

Dr. Kaplan says because each patient and situation is different, it is hard to create a standardized care pathway.

"What I came to at the end of that phase of the fellowship QI project is that physicians should provide STI [sexually transmitted infection] testing and treatment based on risk and the patient's disclosure," Dr. Kaplan says. "So if they say, 'I know I was just here a couple weeks ago, but I was actually out, and I've had many different encounters since then. And I really think I need to be tested and maybe treated again,' then you hear that and consider that in your approach. It's not a guideline. It's really hearing the needs of your patient and being able to assess that risk and then test accordingly."

Dr. Kaplan says another component of the project was to determine how to best prevent pregnancy.

"It does not work for this population to be on birth control pills. If they're on the run, they're not taking their pills with them, and they're not going to a pharmacy to refill their pills," she says. "Even if they have something like Depo-Provera [a contraceptive injection], which is every three months, again, are they going to come back in three months to get that Depo?"

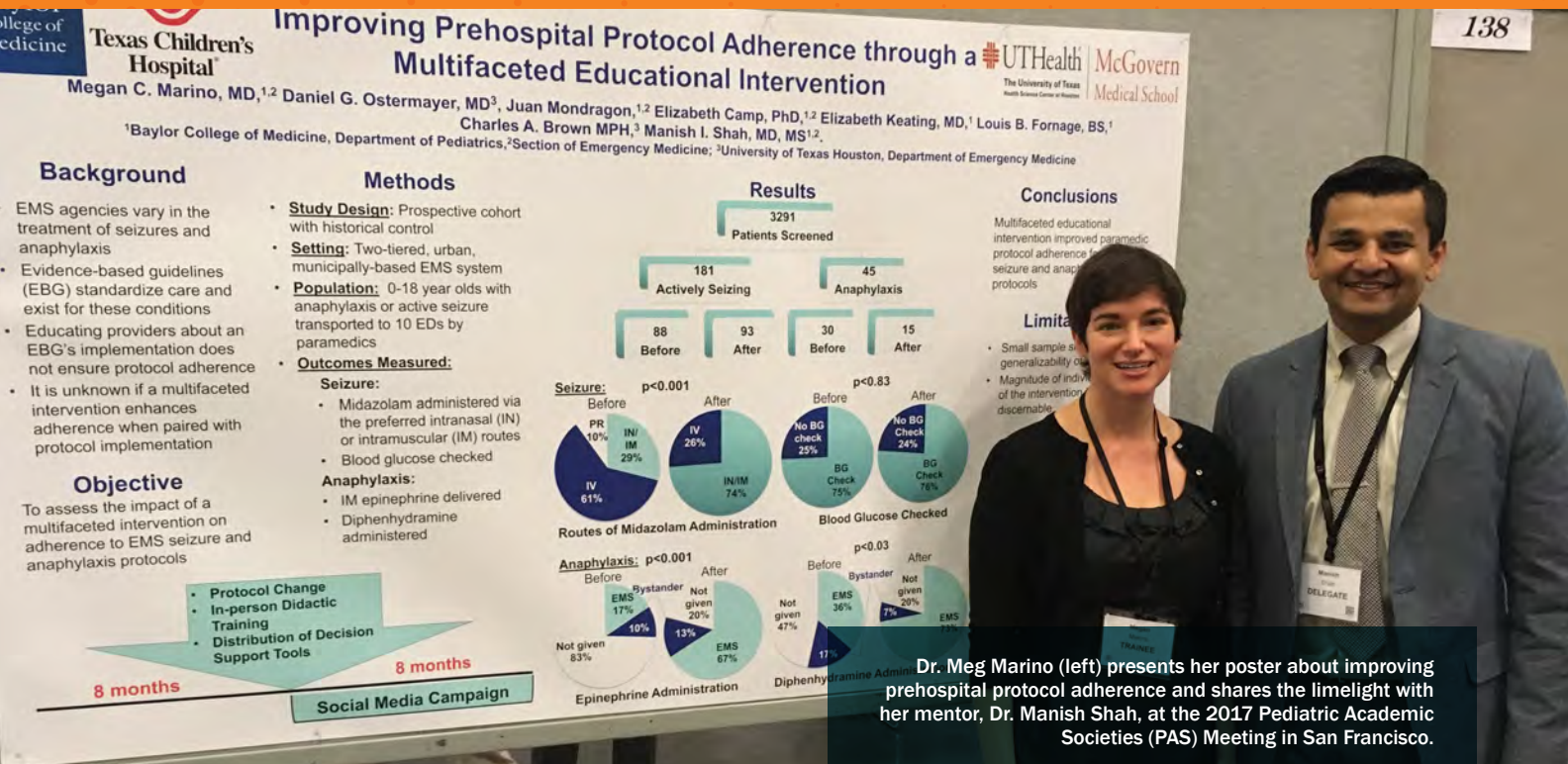
To improve her patients' birth control options, Dr. Kaplan became trained in Nexplanon, which is a long-acting reversible contraceptive implant that goes into the arm and prevents pregnancy for up to three years.

While Dr. Kaplan has completed the QI project and her fellowship, this patient population is still her passion. After fellowship, in addition to her role as the Director of Child Abuse and Neglect at Staten Island University Hospital, she began to collaborate with Love146, an international human rights organization that focuses on child trafficking and exploitation, assisting the organization as their medical liaison. She collaborates with Love146 to raise awareness and to develop resources and strategies for creating a medical response for victims of domestic minor sex trafficking.

"The literature demonstrates that 30 to 88 percent of victims access health care at some point during their involvement in trafficking," she says. "So the health care setting is an incredibly important venue, not only to identify patients involved in DMST, but to provide medical intervention."



QI PROJECT IMPROVES PREHOSPITAL PROTOCOL COMPLIANCE



As a pediatric emergency medicine (PEM) physician, Manish Shah knows that a seizure or a severe allergic reaction can be deadly for children if they are not treated quickly and appropriately. With a grant from the U.S. Department of Health and Human Services, Health Resources and Services Administration's Emergency Medical Services for Children program, he led the creation of guidelines for treating children during ambulance transport.

That was just the first step, though. He had to find a way to help paramedics understand and implement those new guidelines.

"As part of the project, we created nine different guidelines," says Dr. Shah, Prehospital/State Partnership Lead, National EMS for Children Innovation and Improvement Center; Associate Professor, Department of Pediatrics, Section of Emergency Medicine, Baylor College of Medicine; and Attending Physician, Emergency Center, Texas Children's Hospital. "But when it came time to update existing protocols or implement them as new protocols, we were faced with the challenge of training the providers in our local EMS system in Houston."

"It's difficult to start an IV in a bouncing ambulance with a seizing patient."

Thus, the quality improvement project, Improving Prehospital Protocol Adherence through a Multifaceted Educational Intervention, was born. The project is an example of applying

quality improvement methods — part of maintaining certification — that can lead to significantly improved care for children.

Dr. Shah and PEM fellow Megan Marino, MD developed a curriculum to conduct five in-person training sessions for the 400 paramedics in the Houston Fire Department. Each session was three and a half hours.

"I showed the visuals that I had used in the training, such as a figure showing how to manage an airway and the progression for pediatric airway management. I would use a little picture, as well as a one-line blurb, just as a reminder."

"When we designed the curriculum, we made it case-based, so we would provide a case scenario and then ask some questions related to the case about how they should manage it," Dr. Shah says.

They also offered hands-on learning stations, and Dr. Marino created pocket field guides with pediatric dosing information, as well as information about when to use epinephrine for anaphylaxis and how to determine when to use a lower or higher dose epinephrine auto-injector.

Drs. Shah and Marino used rapid cycle improvement to enhance their curriculum: "After each training day, we would get feedback



“After the training and through the follow-up that Meg used on social media, and with the use of reference cards that we distributed, we saw an increase to 74 percent.”

from the paramedics and tweak what was needed before the following day,” Dr. Marino says.

After training paramedics over a two-week period, Dr. Marino launched a social media campaign.

“I showed the visuals that I had used in the training, such as a figure showing how to manage an airway and the progression for pediatric airway management. I would use a little picture, as well as a one-line blurb, just as a reminder,” she said.

She did this every other day during a nine-month period to reinforce the concepts used in training. She and Dr. Shah then looked at what paramedics did before and after the training and protocol implementation. The results showed improvement in how the paramedics treat anaphylaxis and seizures.

“We saw that they really are treating more anaphylaxis patients with epinephrine, which was one of the things that we looked at in the study,” Dr. Marino says. “As far as the patients with seizures, the protocol changed to have paramedics either give intranasal or intramuscular midazolam as the initial dose instead of [intravenous (IV)] midazolam because it’s difficult to start an IV in a bouncing ambulance with a seizing patient. And we saw a really significant shift.”

Prior to the change in the protocol and training, only 29 percent of the patients were getting their midazolam intranasally or intramuscularly.

“After the training and through the follow-up that Meg used on social media, and with the use of reference cards that we distributed, we saw an increase to 74 percent,” Dr. Shah says.

Before the training, only 17 percent of children who were transferred by paramedics received intramuscular epinephrine for anaphylaxis, rising to 67 percent after the training.

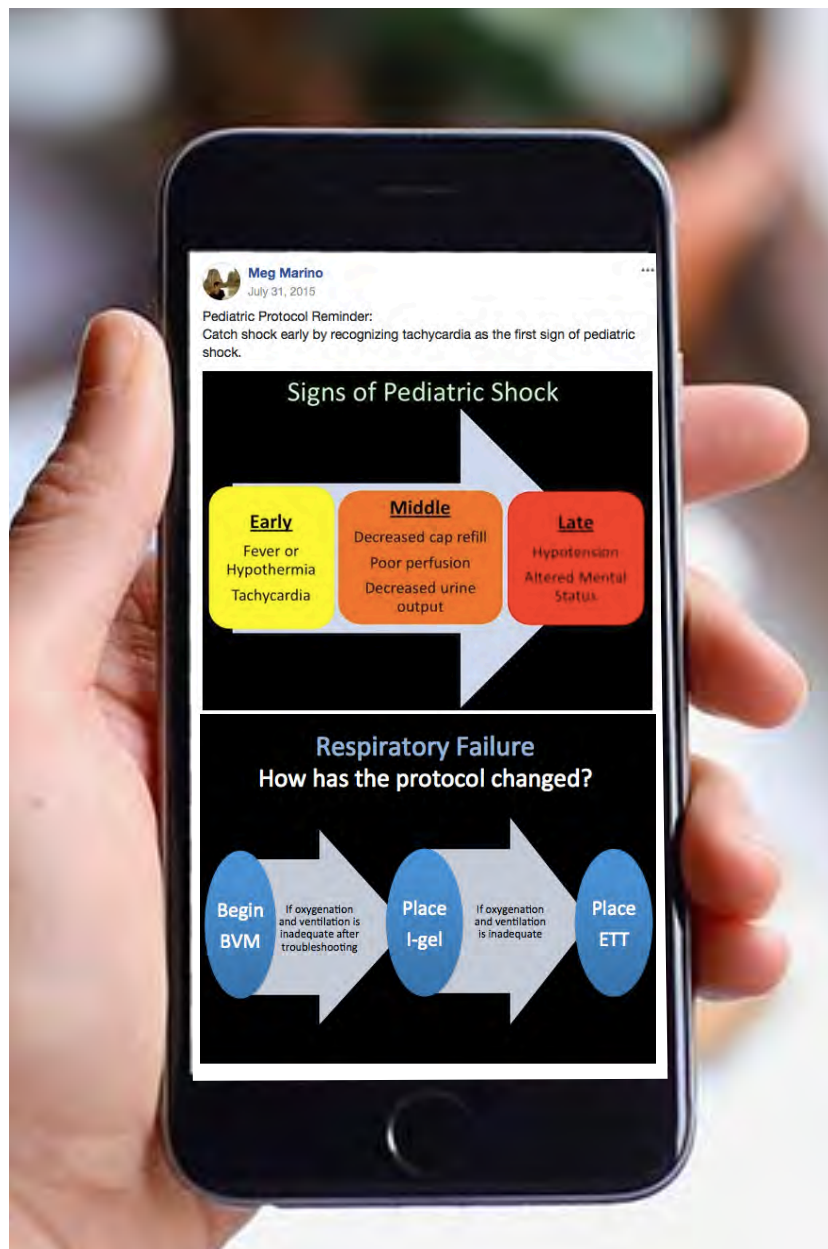
“All these protocol changes that we made were based on some sort of evidence, and to see that shift in how the paramedics were using the medication was really satisfying,” Dr. Shah says. “We could make a change in evidence-based practice through that protocol modification because of the training we did. Both seizures and anaphylaxis are life-threatening conditions, and a delay in treatment, or giving treatment in a sub-optimal manner, has a negative impact on the health of children. So we’re really pleased with the findings that making a system-wide change like this — using the education that Meg developed and that we implemented in the system — has that sort of an impact on two very life-threatening conditions for kids.”

The ABP recognized this quality improvement work with MOC Part 4 credit.

Dr. Marino completed her fellowship in 2017 and now is Director of Pediatric Prehospital Education, Pediatric Emergency Medicine, at Ochsner Health System in New Orleans.

“Good education really does translate into improved patient care in the prehospital setting.”

“I feel more motivated to continue this kind of work in New Orleans because I see what a difference it makes,” Dr. Marino says. “Good education really does translate into improved patient care in the prehospital setting.”



WHO'S ON THE PHONE?

SUPPORT CENTER HELPS PEDIATRICIANS NAVIGATE MAINTENANCE OF CERTIFICATION (MOC)

The ABP's support center received more than 25,000 telephone calls and more than 9,000 emails in 2017 from board-certified pediatricians, candidates, and others affiliated with the ABP. That's about 2,800 interactions per month. The professionals who respond to phone calls and emails have more than 110 years of combined experience at the ABP and know how to find answers. In addition to the front-line staff pictured here, calls and emails are also managed by MOC Administration Director Amy Hodak (10+) and Operations Manager Travis Dodson (19+).

Are you unable to call the ABP during regular business hours? In 2017, we extended our support center hours during periods of increased call volume to better meet your needs. Please refer to our website for exact hours.

Telephone: (919) 929-0461
Business Hours: 8:30 am–5 pm ET, M–F
Email: support@abpeds.org



MOC ADMINISTRATION STAFF, LEFT TO RIGHT, AND THEIR YEARS OF ABP EXPERIENCE:
Vincent Clark (9+) Nate Clark (6+) Kimberly Allen-Walker (12+) Jay Crumpler (3+)

Tom Fuldner Photography

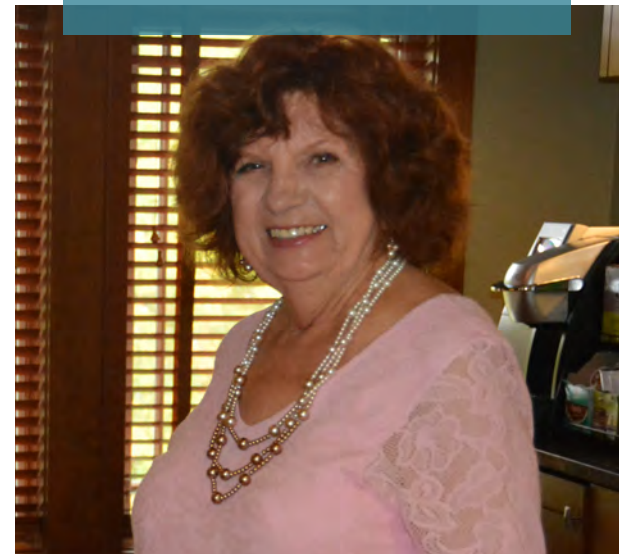


The ABP's External Activities staff members guide board-certified pediatricians working to earn MOC Part 4 credit. Whether it's approving a small-group quality improvement application, defining meaningful participation, or supporting a Pediatric Portfolio Sponsor, the team is available and ready to help pediatricians earn credit for the work they are already doing. External Activities Director Kristi Gilreath (11+) leads this team.

Louise White retired from the ABP in 2017 after more than 13 years of service to board-certified pediatricians. Pediatricians have commended her hard work, excellent rapport, and patience. "Louise worked very hard to help diplomates navigate MOC and we often hear how much she is appreciated," says Amy Hodak, ABP Director of MOC Administration. "She has been a great asset to the ABP and we are thrilled for her to begin this next chapter in her life, but will miss her greatly."



MOC EXTERNAL ACTIVITIES STAFF, LEFT TO RIGHT, AND THEIR YEARS OF ABP EXPERIENCE:
 Patience Leino (1+) Amy Roberts (14+) Laura Couch (10+)
 Not pictured: Melissa Lamaffar (11+)



ABP SUPPORT STAFF, LEFT TO RIGHT, AND THEIR YEARS OF ABP EXPERIENCE:
 Audrey Wiltshire (2+) Gina Cook (2+)

Top Question Topics in 2017

- MOC requirements
- Exam eligibility and application process
- Reciprocal credit for MOC
- Requirements to regain certification
- MOCA-Peds

BEHAVIORAL AND MENTAL HEALTH: GAPS AND CHALLENGES

Pediatricians are often the first professionals parents turn to when their child needs behavioral or mental health services — because of their trusting doctor-patient relationship or to avoid the perceived stigma of going to a mental health professional.

So when Alexis King's* middle child needed mental health services, she looked for help where Simon* was already receiving care.

"Unfortunately, our pediatrician was not trained to help us find support," she says, "and I was left with desperately searching for mental health services for my son. I worry about Simon every day as his self-esteem goes from bad to worse and his depression is left untreated."

Recent surveys indicate that one in seven children younger than age 8 and one in five adolescents have a diagnosable behavioral, mental, or developmental disorder.¹ Yet many pediatricians do not feel adequately trained to identify or treat these conditions.²

Madison Barnes* thinks her first pediatrician's inability to explain her son's atypical behavior came from a lack of knowledge. She says she spent years looking for answers on her own before finding a new pediatrician when she moved to another state.

"It's tough to find a doctor who understands," she says. "If [our first pediatricians] just had a little bit of knowledge, they could have saved us years of struggle, confusion, and heartache."

The ABP has been focusing more closely on behavioral and mental health since 2014, when its Strategic Planning Committee recommended that the ABP rank behavioral and mental health needs as its highest strategic priority. Since then, the ABP has been raising awareness of the scope, morbidity, and mortality associated with this issue, and is leading an effort with other organizations to help pediatricians better care for children with behavioral and mental health needs. In 2016, the ABP convened a conference of 10 other pediatric and medical organizations to share interests and insights about training residents and fellows to prevent, identify, diagnose, and treat behavioral and mental health issues. This group acknowledged the American Academy of Pediatrics' earlier work to publish a toolkit for primary care providers, identify seven symptom

clusters, and begin developing mental health modules for residents and training faculty who might use the modules.

"Awareness of behavioral and mental health symptoms and treatment is critical because pediatricians may be in a position to identify children at risk, sometimes before symptoms appear," says Marshall Land Jr., MD, a general pediatrician in South Burlington, Vermont, who was a member of the ABP's Strategic Planning Committee that identified the importance of behavioral and mental health.

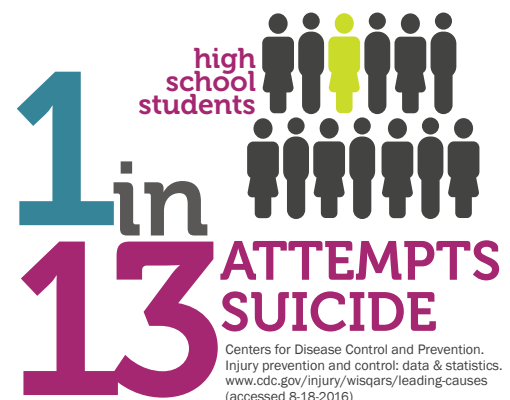


Although the ABP can create expectations for the education, training, and assessment of pediatricians, partnerships with the organizations that conduct training and assessment are needed to make an impact. In early 2017, the ABP published a call to action paper in *Pediatrics*.³ "The paper sets goals that cannot be reached without the collaboration of other pediatric organizations," says primary author Julia McMillan, MD, Professor Emerita of Pediatrics at the Johns Hopkins School of Medicine.



As a follow-up to the paper, the Association of Pediatric Program Directors (APPD) and the ABP hosted a daylong session — "The Mental Health Crisis: Preparing Future Pediatricians to Meet the Challenge" — during APPD's annual meeting in April. Directors of residency and fellowship programs discussed the magnitude and urgency of the mental health crisis, barriers and facilitators to incorporate behavioral and mental health experience into training programs, and ways to achieve resident and fellow competence in providing care.

*Names have been changed.



CHILDHOOD DISABILITY 2001-2011



“We need to focus our efforts on improving the knowledge and skills of both general pediatricians and subspecialists around behavioral and mental health issues, starting with trainees and continuing into lifelong learning and practice improvement.”

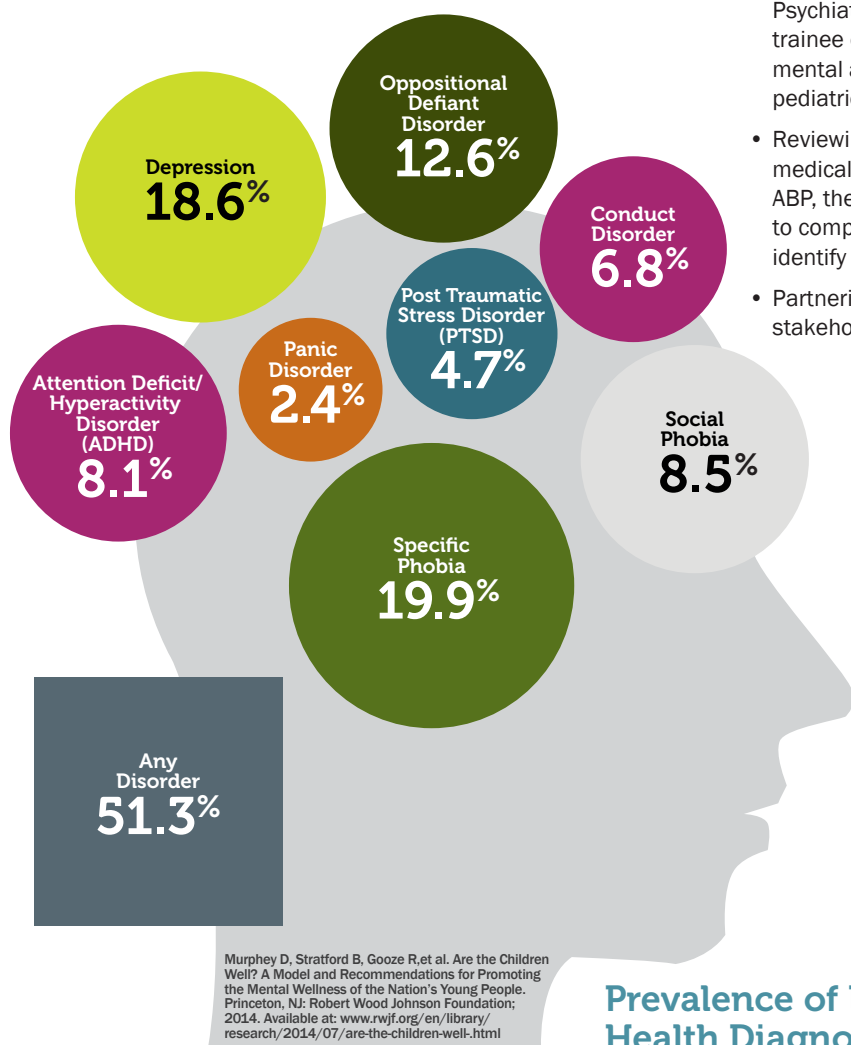
Laurel K. Leslie, MD, MPH, ABP Vice President for Research, says improvements should go beyond training programs. “We need to focus our efforts on improving the knowledge and skills of both general pediatricians and subspecialists around behavioral and mental health issues, starting with trainees and continuing into lifelong learning and practice improvement.”



Additional ABP behavioral and mental health activities in 2017 included:

- Encouraging pediatric subspecialty committees to include behavioral and mental health competencies in the subspecialty entrustable professional activities (EPAs);
- Analyzing the current questions in the general pediatrics certifying exam to evaluate behavioral and mental health content;
- Enlisting members of the American Academy of Child and Adolescent Psychiatry (AACAP) and the American Board of Psychiatry and Neurology (ABPN), who write questions for trainee exams in child psychiatry, to help write questions on mental and behavioral health for the ABP’s general pediatrics exam;
- Reviewing MOC Part 2 and Part 4 activities and continuing medical education (CME) activities available through the ABP, the American Academy of Pediatrics (AAP), and AACAP to compile behavioral and mental health activities and identify gaps; and
- Partnering with parents, young adult patients, and other key stakeholders to identify levers of change.

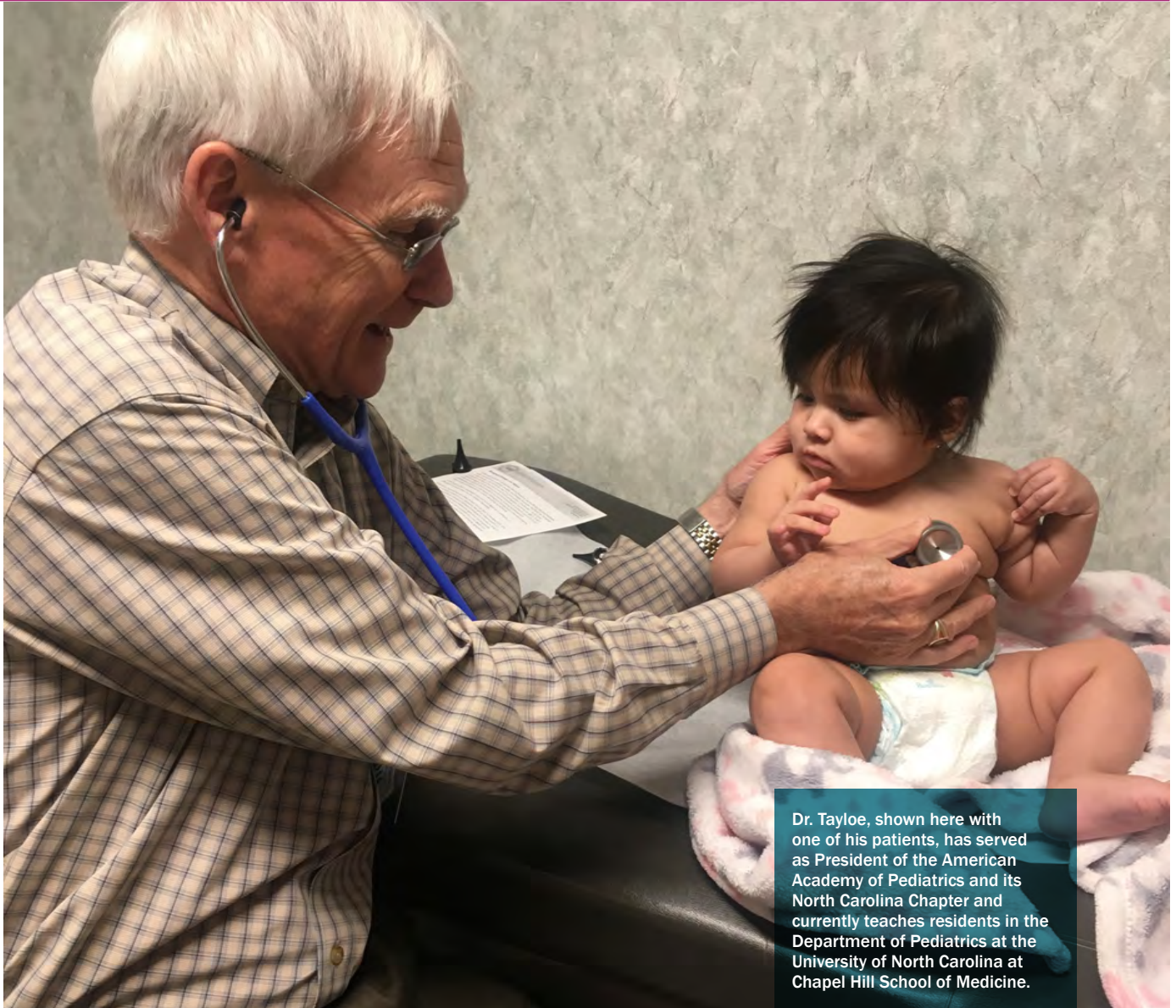
The ABP will continue to partner with other organizations and focus on the behavioral and mental health of pediatric patients (and their families) in 2018 and beyond.



Prevalence of Behavioral and Mental Health Diagnoses up to Age 18

1. McMillan JA, Land M, Leslie LK. Pediatric Residency Education and the Behavioral and Mental Health Crisis: A Call to Action. *Pediatrics*. 2017;139(1):e20162141
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INTEGRATING BEHAVIORAL AND MENTAL HEALTH INTO YOUR PRACTICE



Dr. Taylor, shown here with one of his patients, has served as President of the American Academy of Pediatrics and its North Carolina Chapter and currently teaches residents in the Department of Pediatrics at the University of North Carolina at Chapel Hill School of Medicine.



When David Taylor Jr., MD, began practicing pediatrics in 1977, he did not have formal training about childhood behavioral and mental health issues. But when he realized that many of his patients needed help in these areas, he found resources to supplement his knowledge and ways to apply what he learned. It's essential, he says, for all pediatricians to learn more about diagnosing and treating these conditions.

"Over 15 years ago, we incorporated a mental health professional into our practice," he says. "She teaches us, and we take care of patients together. Then we recruited a clinical social worker, so we have two people now." Dr. Taylor founded Goldsboro (NC) Pediatrics soon after he completed his residency and still sees children there today.

The practice also collaborates with a child psychiatrist, who conducts telemedicine interviews for children with serious

mental illness, and partners with local schools so behavioral health services are available on site for at-risk students.

In addition, Dr. Taylor and his associates focus on prevention. They participate in the national Reach Out and Read (www.reachoutandread.org) early literacy program, screen mothers for postpartum depression, consider family risk based on the social determinants of health, weave parenting fundamentals into visits, and remind parents of the many helpful allies in the community, including schools, churches, nonprofits, behavioral health professionals, social workers, and care coordinators.

"It will take years for medical education systems to improve the preparation of pediatricians to prevent and manage behavioral and mental health problems," Dr. Taylor says. "But pediatricians do not need to wait until they are formally educated to begin addressing the epidemic now."



WHAT PEDIATRICIANS CAN DO NOW

Continuing medical education (CME) and Maintenance of Certification (MOC) activities about behavioral and mental health can help pediatricians increase their knowledge or improve their practice. A few of the options are listed below, but pediatricians also can plan their own quality improvement projects about behavioral and mental health.

SELF-ASSESSMENTS (MOC PART 2): WWW.ABP.ORG/ABPLANDING

- ADHD: Diagnosis and Management Self-Assessment (ABP)
- Developmental-Behavioral Pediatrics Self-Assessments (ABP)
- Media's Impact on Child Health (AAP)
- PREP DBPeds (AAP)

QUALITY IMPROVEMENT (MOC PART 4): WWW.ABP.ORG/ABPLANDING

- Developmental and Behavioral Screening Performance Improvement Module (ABP)
- EQIPP: Bright Futures - Infancy and Early Childhood (AAP)
- EQIPP: Bright Futures - Middle Childhood and Adolescence (AAP)
- Screening for Adolescent Depression Performance Improvement Module (ABP)

“It will take years for medical education systems to improve the preparation of pediatricians to prevent and manage behavioral and mental health problems.”



2017 STOCKMAN LECTURE: THRIVE, NOT JUST SURVIVE



The Kinebrew's sons
growing up: Kameron,
Kevin, and Kaleb

Children who battle chronic illness are “warriors,” says Robyn Kinebrew, the mother of twins who have Sickle Cell Disease. “They fight when they are tired, bruised, and backed up against a wall. The parents and guardians of these warriors want nothing but the best quality care for them.”

She and her husband, Kevin, presented the 4th Annual Stockman Lecture at the American Academy of Pediatrics’ National Conference and Exhibition in September to share their experiences as parents of children with chronic disease.

Kevin Kinebrew explained to about 500 physicians, “You, as health care professionals, play a major role in partnering with families to navigate the health care system.”

“We never lost our hope and faith.”

The Kinebrew’s twin sons, Kaleb and Kameron, were born prematurely and were in a neonatal intensive care unit (NICU) when their parents received their diagnosis.

“We received a phone call that our sons were diagnosed with sickle cell disease,” Kevin Kinebrew said. “Our initial dreams for our sons were suddenly replaced with uncertainty and fear. However, we never lost our hope and faith. This is what has guided us throughout the last 20 years.”

“Every interaction we have with doctors, nurses, or any medical professional are teachable moments for us and our sons.”

Families of children with chronic conditions must vigilantly understand their children’s disease, symptom triggers, and treatments, the Kinebrews explained.

“Every interaction we have with doctors, nurses, or any medical professional are teachable moments for us and our sons,” Kevin Kinebrew said. “We emphasize how important it is for them to be respectful — while advocating for themselves — during trips to hospital.”

Medical care providers, teachers, and others didn’t always understand their sons’ disease and accompanying symptoms, including intense pain. For example, one son was hospitalized after a winter fire drill at school. A teacher who didn’t understand his condition hurried him out the door with other



“Our new dream for our sons — and other children with a chronic illness — is that they thrive and not just survive.”



students and didn't allow him to get his coat. The cold caused a pain crisis that resulted in a four-day hospital stay.

Sometimes, Robyn Kinebrew said, physicians treat physical symptoms, but don't understand the emotional impact of chronic disease. “The family and the patient feel overwhelmed,” Robyn Kinebrew explained. “We have cried, we have prayed, we have researched — to see if there was anything we were missing. We had our ‘we can handle it’ face on, but inside we were crushed, thinking, ‘not again’ or ‘when will this end?’”

They see themselves and their sons' medical providers as a team.

“When we question a procedure that has been recommended or have a different point of view,” Kevin Kinebrew said to the physician audience, “my only request is that you seek to understand the patient's point of view.”

“Caring for a child with chronic illness is often a difficult journey and they will face many issues. Please tell your patients and families that ‘It’s okay to admit you need help.’”

Robyn Kinebrew advised, “Please let your patients and families know that caring for a child with chronic illness is often a difficult journey and they will face many issues. Please tell your patients and families that ‘It's okay to admit you need help.’”

Despite missing many days of school (34 in one year), the Kinebrew twins graduated cum laude from high school and are now third-year college students and campus leaders. Their younger brother, Kevin, 16, does not have sickle cell disease, but has felt the impact of his brothers' illness as the whole family has dealt with their physical and emotional health.

“Our new dream for our sons — and other children with a chronic illness — is that they thrive and not just survive,” she told the physicians. “Remember, as you are interacting with patients and their family, it is a moment of truth for everyone involved. Each encounter will either be positive or negative. It can affect us. It can affect our children's care. And it will affect our children's outcomes.”

The Stockman Lecture, honoring former ABP President & CEO James A. Stockman III, MD, highlights issues regarding pediatric education and the workforce.



The Kinebrews (left to right): twins Kaleb and Kameron, parents Kevin and Robyn, and younger son Kevin



PASSIONATE ABOUT IMPROVING VALUE

Matthew D. Garber, MD, received the ABP's 2017 Paul V. Miles (PVM) Fellowship Award, given annually to an accomplished mid-career pediatrician dedicated to improving the quality of health care for children. Dr. Garber is Professor of Pediatrics at the University of Florida College of Medicine and a hospitalist at Wolfson Children's Hospital.

"Dr. Garber is a leader in the commitment to quality improvement in community hospital settings where so many children are cared for."

Dr. Garber is one of the founders and the current medical director of the Value in Inpatient Pediatrics (VIP) Network, originally a grass-roots group for hospital medicine that is now part of the American Academy of Pediatrics (AAP). Hospitalists in the network strive to improve hospital-based care for children, especially at small community hospitals and at children's hospitals located within adult hospitals.

"Dr. Garber is a leader in the commitment to quality improvement in community hospital settings where so many children are cared for," said Virginia Moyer, MD, MPH, Vice President, Maintenance of Certification and Quality at the ABP.

In the early years of VIP, Dr. Garber co-led BQIP, the Bronchiolitis Quality Improvement Collaborative, with Shawn Ralston, MD, MA, now editor of *Hospital Pediatrics*. During his four years of network leadership, the VIP Network has grown to include projects about urinary tract infection and community acquired pneumonia, as well as projects with an emergency department and hospital focus in bronchiolitis, fever in infants, and asthma.

"Dr. Garber embodies the spirit of [the] Paul V. Miles Fellowship award."

"Dr. Garber embodies the spirit of [the] Paul V. Miles Fellowship award," said Steven Kairys, MD, MPH, QuIN Medical Director for the AAP, in his nomination letter.

"He is passionate about improving value, he is persistent and dogged in his efforts to connect with the community hospitalist, he is innovative in ways to support and fund and sustain the projects, and he is charismatic in engaging new members in his quest for improvement."

In addition to his work as a professor, hospitalist, and VIP Network medical director, Dr. Garber has published more than 50 peer-reviewed articles and has given more than 10 national presentations on pediatric hospital medicine and quality improvement. He is the current chair of the AAP Section on Hospital Medicine.

Other awards won by Dr. Garber include the 2016 Frank P. Boyer Faculty Teaching Award, the 2015 Society of Hospital Medicine Choosing Wisely national competition, the President's Award of the South Carolina Chapter of the American Academy of Pediatrics in 2008, and the John P. Matthews Jr., MD, Outstanding Teaching Award in 2002 and 2007.

The Paul V. Miles Fellowship honors Dr. Miles' years of service as Senior Vice President for Maintenance of Certification and Quality at the ABP. PVM Fellows bring their experiences and insights to help focus and improve the ABP's efforts to support pediatricians as they improve care for children.

Dr. Matthew Garber (center) with hospital colleagues



WORKFORCE DATA BOOK SEES MAJOR ENHANCEMENTS

The ABP has published information relating to the pediatric workforce for 25 years. The medical community, including program directors, hospital administrators, and policymakers, uses the ABP Workforce Data Book to help assess trends in the number of pediatricians and pediatric subspecialists by geography, type of practice, full- or part-time schedule, and other measures. These factors provide a unique vantage point to help track the current and future pediatric workforce committed to the health care needs of infants, children, adolescents, young adults, and their families.

Since 2015, when Laurel K. Leslie, MD, MPH, was named ABP Vice President of Research, she and her team have reviewed and enhanced the workforce data book, which may be found at www.abp.org/content/workforce.

“We recognize the numbers within the pediatric workforce continue to change,” Dr. Leslie says. “It’s important to carefully collect, analyze, and track trends in the current and future workforce. We are delighted that educators, researchers, and policymakers find these data as useful as we do. We look forward to opportunities to enrich and improve this resource and relay data in an accurate and accessible way.”

Some of this year’s enhancements include:

- Adding new graphs and enhancing existing tables to parallel tables used by other workforce publications or websites
- Adding supporting information to the book to familiarize readers with the publication’s history, key definitions, and methodology (how data are collected and analyzed)
- Adding footnotes to tables, figures, and maps to aid in data interpretation
- Including only ACGME-accredited programs within the residency and subspecialty fellowship tracking data. In prior versions, the inclusion of Canadian residency programs led to confusion when estimating the pipeline of residents preparing to enter the US workforce. Within this latest version, previous years’ data have been recalculated under this framework for comparison purposes

“It’s important to carefully collect, analyze, and track trends in the current and future workforce. We are delighted educators, researchers, and policymakers find these data as useful as we do.”



Between 1934 and 2016, the ABP certified 118,292 pediatricians.



In 2016, 3,572 first-year pediatric residents were in training, a 17% increase since 2001. In addition, 1,383 first-year fellows were in training, an 84% increase since 2001.



Of those recently taking their GP certifying examination, 40% plan on conducting research during their career.



Since 2001, the percent of females entering a subspecialty fellowship program has risen from 50% to 68%.



Since 2001, the pediatric subspecialty experiencing the most growth in the number of first-year fellows has been pediatric emergency medicine (134%).



NEWS ROUNDUP

CARRACCIO RECEIVES 2017 ST. GEME AWARD

Carol Carraccio, MD, MA, received the 2017 Joseph W. St. Geme Jr. Leadership Award from the Federation of Pediatric Organizations (FPO) during the opening general session of the Pediatric Academic Societies Meeting in San Francisco, CA, in May. Dr. Carraccio is the ABP Vice President of Competency-Based Assessment.



Dr. Carraccio is credited with being one of a handful of leaders worldwide whose vision will have a lasting impact on how medical educators envision, teach, and assess current and future physicians.

The award was created in honor of Dr. St. Geme to recognize a pediatrician who serves as a role model clinician, educator, and/or investigator. Recipients have made broad and sustained contributions to improve child health.

Dr. Carraccio is credited with being one of a handful of leaders worldwide whose vision has changed the way pediatricians are trained and whose contributions will have a lasting impact on how medical educators envision, teach, and assess current and future physicians.

An early proponent of competency-based medical education, Dr. Carraccio led the development and implementation of the Pediatrics Milestone Project and is now integrating it within the framework of entrustable professional activities (EPAs). She has published more than 100 scholarly works in the field and has served in numerous leadership roles, including President of the Association of Pediatric Program Directors (APPD).

FPO is composed of the American Academy of Pediatrics, Academic Pediatric Association, American Pediatric Society, American Board of Pediatrics, Association of Medical School Pediatric Department Chairs, Association of Pediatric Program Directors, and Society for Pediatric Research.

QOW IMPROVEMENTS IN 2017

ABP's most popular self-assessment tool, Question of the Week (QOW), received several upgrades in 2017 to improve the self-assessment experience for board-certified pediatricians.

QOW participants can now receive CME credit — in addition to 10 MOC self-assessment (Part 2) points — for every 20 questions answered correctly.

“You can kind of double dip. You get the educational question of the week where we learn something interesting and it counts toward the Board [Maintenance of Certification], and we also get CME credit,” says general pediatrician Dr. Phyllis Waring from Slidell, Louisiana.

Additional upgrades:

- Twenty correct QOWs (five fewer than previous years) give 10 MOC Part 2 points.
- A Medical Pearl is available at the end of each question, whether the QOW is answered correctly or not.
- Questions older than three years are stored in a viewable archive.
- References are hyperlinked to reduce internet searching.

QOW participants are sent a link to a newly published question every week for 50 weeks of the year. Each QOW includes a pediatric case study, abstract with commentary, and references and can be answered at any time and from any device that has internet access.



PEDIATRIC HOSPITAL MEDICINE UPDATE: ELIGIBILITY CRITERIA ESTABLISHED

In 2017, the ABP established eligibility criteria for its newest subspecialty certification of Pediatric Hospital Medicine (PHM). Currently, two pathways — a training pathway or a practice pathway — can lead to PHM certification. Details about the pathways, including a combination pathway, are shown at www.abp.org/content/pediatric-hospital-medicine-certification.

In addition to the PHM eligibility criteria, a candidate for the subspecialty certification must be currently certified in general pediatrics and meet the general eligibility criteria for all ABP subspecialties.

The first exam will be given in November 2019, and hospitalists will be able to apply in their ABP Portfolio in the spring of 2019. Exact dates will be determined in 2018. Thereafter, the ABP expects to administer the exam in odd years in the fall.

The American Board of Medical Specialties officially recognized the PHM subspecialty certification at its annual board meeting in 2016.



ABP EXPANDS CME OPTIONS FOR MOC CREDIT

Board-certified pediatricians can now receive both continuing medical education credit and MOC Part 2 credit when they participate in approved CME activities through a collaboration between the ABP and the Accreditation Council for Continuing Medical Education (ACCME).

The collaboration not only increases the number and types of activities for which MOC Part 2 credit can be offered, but also expands the types of assessments allowed. CME providers are no longer restricted to multiple-choice, best-answer “quizzes.”

By the end of 2017, nearly 2,000 CME activities had been registered with ACCME to offer ABP MOC Part 2 credit, making it easier for pediatricians to earn MOC credit for activities they are already doing.

CME providers report on which pediatricians have completed approved CME activities, and MOC Part 2 points appear automatically in the pediatrician’s ABP Portfolio.



ABP WELCOMES PEDIATRICIANS AT THE PEDIATRIC ACADEMIC SOCIETY (PAS) MEETING



“You have to keep up with medicine, otherwise you get rusty. It takes your patients longer to get better if you don’t have the latest available knowledge.”

– Dr. Ravindra Rao, Professor of Pediatrics at the Loma Linda University Medical Center



“I love MOCA-Peds. It is more practical and ‘real world’ than the old test.”

– Dr. Mark Vining, Associate Professor of Pediatrics and Program Director for pediatric residency training at the University of Massachusetts Memorial Children’s Medical Center

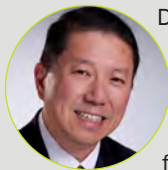


Hundreds of pediatricians, including Dr. Rao and Dr. Vining, stopped by the ABP’s booth in May to visit Dr. Marshall (Buzz) Land Jr., Donna Land, and ABP staff members Amy Hodak and Kimberly Allen-Walker.



INFORMATION TECHNOLOGY UPGRADES EXCEED EXPECTATIONS

Technology plays an essential role in the way the ABP informs, supports, and assesses pediatricians who train and work toward improving the health of children. Yet, as with medicine, technology today is changing at an unprecedented pace. To ensure a consistent, high quality digital experience, the ABP is transforming the information technology infrastructure and applications through which we interact with our candidates, general and subspecialist pediatricians, pediatric faculty, program directors, trainees, and researchers.



Dongming Zhang, Vice President of Information Technologies and Informatics, says the ABP had been operating with outdated legacy technologies for years amid high expectations from pediatricians for superior service and expectations from senior management for cost effectiveness.

“In the past three years, ABP IT has been carrying out migration projects to transform online applications and services onto a new, modern infrastructure,” he says.

The road to the largest technology overhaul in the ABP’s history began when its senior management realized that the ABP could not continue to rely on current systems with significant vulnerabilities that could slow the speed of, limit accessibility to, and/or impair the functionality of important applications and programs. They enlisted the help of Deloitte, a world-renowned business consulting firm that recommended a complete overhaul of the ABP’s core technology system and infrastructure to create a sustainable, long-term solution. The consultants estimated the migration would take 10 years.

But improvements were needed immediately, the ABP concluded, so the Board focused resources on updating IT infrastructures and hired Zhang to lead the effort.

In only three years, [Zhang and his team have developed MOCA-Peds for continuous assessment](#), redesigned the ABP Portfolio, redeveloped the Certification Management System (CMS), started an online tracking system for program directors, built a system to allow for annual MOC payments, and upgraded the database infrastructure to improve security and reduce vulnerabilities. “We are close to the end of this endeavor, and look forward to continuing to improve ABP online services in a modern technology environment.”

Initiative	Description
MOCA-Peds	This is a completely new option to meet MOC assessment requirements and has been designed to be delivered online or by mobile app.
ABP Portfolio Redesign	Focus groups and surveys informed specific changes to the ABP Portfolio pages — where pediatricians find their individual and unique ABP information, requirements, and results for all ABP certifications. Pediatrician input was included in the redesigned ABP Portfolio to improve the diplomate experience. For example, in the diplomate’s document archive, all exam results are available in one place. Also, the letter declaring they are “in good standing” (often required by credentialers) is available in the diplomate portfolio.
Certification Management System (CMS)	CMS is the core processing system for trainee and diplomate information. It has been completely redeveloped and enhanced with new functionalities and features.
Online Tracking (OLT)	This system manages all information that verifies a trainee has completed accredited training and has met the requirements to sit for an initial certifying examination. As the paper-based system moves online, program directors and trainees will be able to access information more quickly and easily. It also allows program directors to provide information and evaluations online to the ABP. The first stage of OLT launched in 2016.
MOC Annual Payment Option	IT has created a new user-friendly enrollment page that supports a new payment option. When pediatricians enroll in a new MOC cycle, they may either pay the MOC fee annually (currently \$275 per year) or once every five years for the full fee (\$1304).
Database Upgrade and Migration	The programs and applications developed by the ABP rely heavily on the stability of the database infrastructure. We are moving to a new Microsoft/SQL platform with improved stability and security.



ABP STAFF MEMBER WINS NATIONAL PARTNERS IN HEALING IMPACT AWARD

Patience Leino, Senior Administrator for MOC External Activities at the ABP, received a 2017 Partners in Healing Award from the Patients' View Institute (PVI). She accepted the award, together with the University of North Carolina at Chapel Hill (UNC) Medical Center, on Dec. 7, 2017.

Leino received the award for sharing her story and a video about the challenging, but ultimately rewarding, journey she embarked upon following the birth of her son, who was born with Hypoplastic Left Heart Syndrome (HLHS). Her story was among nearly 60 that were submitted for award consideration.

"Isaac spent 110 days in UNC's Neonatal and Pediatric ICUs — undergoing open-heart surgery at 3 days old and enduring four additional operations by his 10th week of life," says Leino. "In less than six months, my son was out of options and died in my arms."

Leino says she was an equal partner with Isaac's medical team when it came to making decisions about her son's care.

"They valued a scared mom across a hospital bed and engaged me in Isaac's care," she says. "Through them, I became an expert in my son's many health challenges and an involved member in his care team. UNC's PICU did not merely treat my broken boy's medical problems; they cared for my family. In doing so, they bestowed a gift I could never repay: the priceless ability to bury my son without regrets."

Since then, Leino turned her heartache into a passion for collaboration with medical teams and became a key ally to ensure the patient perspective is integrated at UNC and elsewhere. She volunteered for many years as a PICU Family Advisor and co-founded and chaired the North Carolina Children's Hospital Family Advisory Board.

"It goes beyond patients and providers," says Leino. "Ultimately, we are people caring for people. When we can bridge that connection, when we can make those conversations happen and work together as a team, everyone is better off, no matter the medical outcome."

At the ABP, Leino coaches pediatricians seeking to claim Maintenance of Certification (MOC) credit for quality improvement work and reviews QI projects. She also trains residents about partnering with patients and families as a faculty member of UNC's Institute for Healthcare Quality Improvement and speaks at national conferences about patient advocacy.

"I am forever grateful for my beautiful, broken son," Leino adds. "That precious, blue-eyed, ginger boy turned my pity into compassion, my fears into strengths, my tears into joy, my loss to others' gain. His broken heart grew mine tenfold."

The PVI is a small nonprofit organization dedicated to organizing and amplifying the voice of the patient. The Impact Awards are PVI's signature event.



"It goes beyond patients and providers," says Leino. "Ultimately, we are people caring for people. When we can bridge that connection, when we can make those conversations happen and work together as a team, everyone is better off, no matter the medical outcome."



2017 PUBLICATIONS

Research papers, reports, and commentaries that were supported in part or in full by the ABP or ABP Foundation or on which ABP staff serve as authors — and were published in major journals from January through October 2017 — are listed below. A complete list can be found at abp.org/publications.

Andrews JS, Bale JF Jr, Soep JB, Long M, Carraccio C, Englander R, Powell D, EPAC Study Group. Education in Pediatrics Across the Continuum (EPAC): First steps toward realizing the dream of competency-based education. *Acad Med*. Oct 11, 2017. [ePub ahead of print.] doi: 10.1097/ACM.0000000000002020.

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Arvanitis M, deJong NA, Leslie LK, DeWalt DA, Randolph GD, Flower KB. Pediatrician maintenance of certification using American Board of Pediatrics' performance improvement modules. *Acad Pediatr*. 2017;17(5):550–561. doi: 10.1016/j.acap.2017.03.014.

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Boat TF, Land ML Jr, Leslie LK. Health care workforce development to enhance mental and behavioral health of children and youths. *JAMA Pediatr*. Sept 5, 2017. [ePub ahead of print.] doi: 10.1001/jamapediatrics.2017.2473.

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Brinkman WB, Lipstein EA, Taylor J, Schoettke PJ, Naylor K, Jones K, Vora SS, Mims CC, Roth-Wojcicki E, Gottlieb B, Griffin N, Lannon CM, Morgan E. Design and implementation of a decision aid for juvenile idiopathic arthritis medication choices. *Pediatr Rheumatol Online J*. 2017;15(1):48. doi: 10.1186/s12969-017-017.

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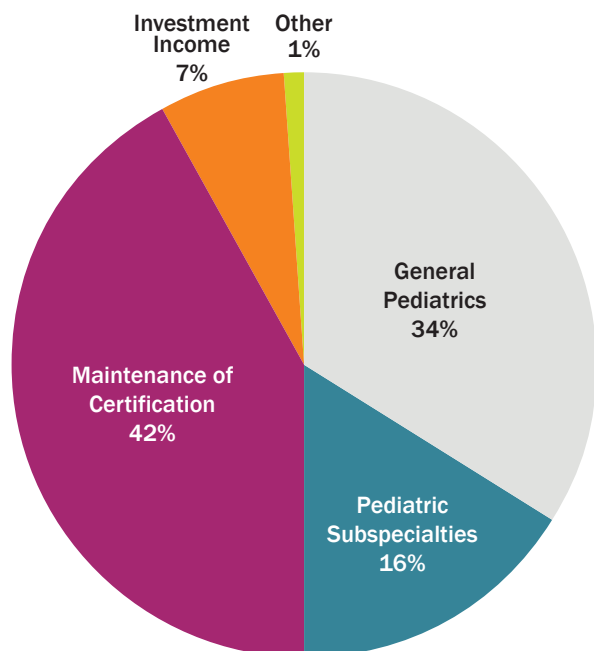
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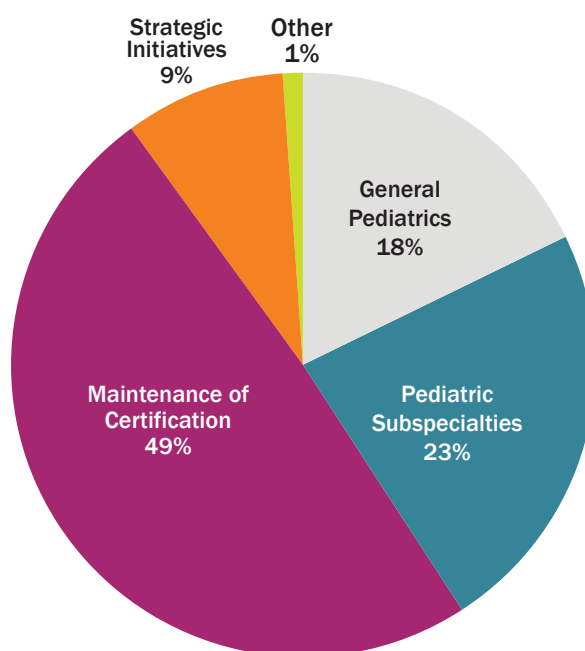
FISCAL YEAR 2016 FINANCIALS

REVENUE



General Pediatrics	10,770,680	34%
Pediatric Subspecialties	4,885,110	16%
Maintenance of Certification	13,443,137	42%
Investment Income	2,423,943	7%
Other	193,377	1%
Total Revenue	\$31,716,247	100%

EXPENSES



General Pediatrics	5,316,323	18%
Pediatric Subspecialties	7,078,474	23%
Maintenance of Certification	14,543,239	49%
Strategic Initiatives*	2,646,000	9%
Other	198,964	1%
Total Expenses	\$29,783,000	100%

*Funding for research and other pediatric initiatives to ensure excellence in the education of pediatricians and the delivery of pediatric care.

WHAT DO PEDIATRICIANS AND PEDIATRIC TRAINEES GET IN RETURN FOR THEIR FEES?

Initial certification fees cover the costs of credentialing candidates (making sure they have met standards for training set by the ABP); developing, administering, and scoring the exams; and reporting the results. Although questions are written by pediatrician volunteers, travel and administrative costs are associated with bringing them together and with editing and vetting the test questions to ensure they are valid and fair.

The fee also helps underwrite the ABP's extensive work with residency program directors to help mold training so that newly licensed and certified pediatricians are better prepared to address the most prominent and emerging issues influencing the health of children. The fee also includes enrollment for the first five-year cycle of Maintenance of Certification (MOC).

MOC fees cover the costs of developing, providing, and administering MOC activities that promote lifelong learning with self-assessment and quality improvement. MOC fees traditionally have covered the cost of one exam every 10 years and now are also covering the cost of a new, flexible assessment method called Maintenance of Certification Assessment for Pediatrics (MOCA-Peds). Learn more about MOCA-Peds on page 6. Learn more about the value of MOC at <https://www.abp.org/content/value-maintenance-certification-moc>.

The cost of MOC compares favorably with the cost of most specialty society dues. Investing in certification pays dividends in the form of self-assessments, quality improvement strategies, exams and other activities that help pediatricians gain and retain essential knowledge for providing expert medical care to children.

NEW: ANNUAL PAYMENT OPTION

Pediatricians may now choose to break up the payment of their Maintenance of Certification (MOC) fees into annual payments or continue to pay the full fee once every five years when they enroll in a new MOC cycle. Once enrolled, the pediatrician has access to all ABP activities, including MOCA-Peds. For 2018, the five-year fee for general pediatrics is \$1,304. The annual payment in 2018 is \$275. The ABP Board of Directors has not raised fees for the past three years.

If you have questions, contact moc@abp.org or call (919) 929-0461.



AT-A-GLANCE: THE ABP'S WORK BY THE NUMBERS

SINCE THE ABP BEGAN IN 1933:

- More than 118,000* have been certified in General Pediatrics, 3,498 newly certified in 2017
- More than 28,000* have been certified in a subspecialty, 1,179 newly certified in 2017

*American Board of Pediatrics, *Pediatric Physicians Workforce Data Book, 2016-2017*, Chapel Hill, NC: American Board of Pediatrics, 2017.

CERTIFICATES AWARDED BY THE ABP

The ABP awards certificates in General Pediatrics and in 14 pediatric subspecialty areas. The subspecialties and the first exam year for each are:

- Adolescent Medicine, 1994
- Cardiology, 1961
- Child Abuse Pediatrics, 2009
- Critical Care Medicine, 1987
- Developmental-Behavioral Pediatrics, 2002
- Emergency Medicine, 1992
- Endocrinology, 1978
- Gastroenterology, 1990
- Hematology-Oncology, 1974
- Infectious Diseases, 1994
- Neonatal-Perinatal Medicine, 1975
- Nephrology, 1974
- Pulmonology, 1986
- Rheumatology, 1992

CERTIFICATES AWARDED IN COLLABORATION WITH OTHER SPECIALTY BOARDS

- Hospice and Palliative Medicine, 2008
- Medical Toxicology, 1994
- Pediatric Transplant Hepatology, 2006
- Sleep Medicine, 2007
- Sports Medicine, 1993

2017 INITIAL CERTIFYING EXAMS

Pass Rates (First-Time Test Takers)

Examination	First-Time Takers	Pass Rate (%)
General Pediatrics	3,278	88.1
Child Abuse Pediatrics	20	95.0
Developmental-Behavioral	67	95.5
Emergency Medicine*	304	87.2
Endocrinology	154	90.3
Gastroenterology	182	95.7
Hematology-Oncology	305	78.0
Infectious Diseases	122	91.8
Rheumatology	47	95.7

*Includes 29 candidates from the American Board of Emergency Medicine

2017 MOC EXAMS

(All Subspecialties Combined and General Pediatrics)

Examination	First-Time Takers	Pass Rate (%)
MOC General Pediatrics*	1,208	94.9
All MOC Subspecialties**	1,104	96.9

*5,081 pediatricians registered to participate in the MOCA-Peds pilot in lieu of taking the proctored exam. The passing rate for those registrants was 95.6%.

**Excludes candidates certified by other boards and examinations administered by other boards



VOLUNTEERING TO HELP

The ABP appreciates the excellent work of pediatricians and members of the public who contribute their time, energy, and expertise to our committees and subboards that produce examinations and provide direction for certification activities.

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The ABP extends a special thank you to the following ABP committee and subboard members who completed their service in 2017 (beginning service dates noted after names), and especially to those who have dedicated decades to serving the ABP.

We appreciate your dedication and commitment to our mission.

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Maintenance of Certification and Quality

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Operations and COO

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Vice President
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MISSION

The American Board of Pediatrics (ABP) certifies general pediatricians and pediatric subspecialists based on standards of excellence that lead to high quality health care during infancy, childhood, adolescence, and the transition into adulthood. The ABP certification provides assurance to the public that a general pediatrician or pediatric subspecialist has successfully completed accredited training and fulfills the continuous evaluation requirements that encompass the six core competencies: patient care, medical knowledge, practice-based learning and improvement, interpersonal and communication skills, professionalism, and systems-based practice. The ABP's quest for excellence is evidenced in its rigorous evaluation process and in new initiatives undertaken that not only continually improve the standards of its certification but also advance the science, education, study, and practice of pediatrics.

VISION

The "North Star" for the ABP is and will remain the improvement of health outcomes for children, adolescents, and young adults.

GUIDING PRINCIPLES

- The ABP is primarily accountable to the children and families that we serve.
- The ABP is also accountable to the public, including insurers, consumer groups, payers, and credentialers.
- To promote professional self-regulation and empower pediatricians to continually improve child health outcomes, the ABP has a responsibility to diplomates to utilize assessments that are fair, valid, reliable, and contribute to their lifelong professional development.
- The ABP acknowledges the importance of the varied professional roles that pediatricians play in improving the health care of children and strives to align assessments with professional activities.
- The ABP sets standards for key elements of accredited training based on health needs of populations served, recognizing the value added by the interdependence of the relationship between certification and accreditation.
- The ABP balances assessment strategies to embrace both assessment "of" and "for" learning across the professional life of the diplomate.
- The ABP is committed to the assessment of all core competencies.
- The leadership of ABP invites open dialog and communication with the public, our diplomates, other organizations, and stakeholders.
- The ABP's strong belief in improvement leads us to continually evaluate and improve our policies, programs, and processes.
- The ABP priorities focus on work that our organization is uniquely positioned to do.
- The ABP joins forces with other organizations and parent groups that align with our mission, each bringing its unique perspective but harmonizing our voices to advocate for enhanced quality in pediatric care.





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FOR GENERAL PEDIATRICS INQUIRIES:

In-Training Examinations: ite@abpeds.org

Initial Certification Examinations: gpcert@abpeds.org

Maintenance of Certification: moc@abpeds.org

FOR PEDIATRIC SUBSPECIALTIES INQUIRIES:

In-Training Examinations: site@abpeds.org

Initial Certification Examinations: sscert@abpeds.org

Maintenance of Certification: moc@abpeds.org

