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2014 Annual Report

Stepping Up for a Healthier Tomorrow
## Stepping Up for a

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Dear Colleagues,

Maintenance of Certification (MOC) has been at the center of an intense debate about the demonstration of professionalism in medicine. These debates are healthy and reflect the vital role society has assigned the physician—namely protecting, improving and restoring the health of the patient. The pediatrician has a special duty because a society has no future without healthy children.

For these reasons, we have chosen to make MOC the theme of the 2014 ABP Annual Report. You will certainly read about other important work carried out by the ABP, but most of this report is devoted to MOC. Dr. Virginia Moyer, the ABP’s vice president for MOC and Quality, will explain what MOC is and respond to some questions and criticisms about it. Of equal importance are the stories of how practicing pediatricians are applying quality improvement (QI) principles to improve care while earning MOC credit along the way. So learn about Decatur, Georgia, general pediatrician Brad Weselman and Lansing, Michigan, intensivist Stephen Guertin.

Because collaboration is an essential component for QI, participation in a QI Collaborative Network is the QI gold standard for which MOC credit (Part 4) is awarded. The Annual Report discusses several collaboratives from different perspectives. The American Academy of Pediatrics and many major pediatric institutions are pediatric portfolio providers that sponsor QI collaboratives. In addition to the Academy’s efforts, you can read about the Vermont Child Health Improvement Program (VCHIP), part of the National Improvement Partnership Network (NIPN), and about the various parent advocacy groups that are integral components of the QI Collaborative Networks for cystic fibrosis, congenital heart disease and inflammatory bowel disease, among others.

MOC is evolving rapidly based on feedback and experience in the field. We have continued to expand ways for diplomates to receive MOC credit for QI work they are already doing. In the past year, we upgraded our website and added an MOC dashboard that allows diplomates to see every aspect of their personal MOC status in one place. Our goal is to constantly improve our own processes so the focus remains on the pediatrician improving the care of children. Some ask, “What is the evidence that MOC works?” My reply is there is nothing magic about MOC per se. What works is dedicated pediatricians as part of a team improving the care delivered to their patients and keeping up with an ever-expanding knowledge base required for excellent care. MOC is the way our profession recognizes and records those efforts at a national level.

I thank our volunteers, staff, collaborators and diplomates for their relentless dedication to improving the care of children.

Become part of the discussion and improvements by:

- Emailing us at moc@abpeds.org.
- Responding to the “feedback” button on the right side of any page on abp.org.

Sincerely,

David G. Nichols, MD, MBA
President & CEO
What does board certification really mean, and is it important? Not every pediatrician is board certified. The process is voluntary, although many hospitals and physician networks require their physicians to be board certified. The process goes beyond licensure, which is mandated by states to practice medicine.

Certification—and maintenance of certification—requires diplomates to demonstrate that they are keeping up to date with the latest medical information and “best practices” in their field and are working to improve the care they provide.

“Certification is more than a title and different from a degree,” says Dr. Virginia A. Moyer, ABP vice president of Maintenance of Certification (MOC) and Quality. “It’s a demonstration of commitment to continuous improvement, leading to opportunities to improve the care we provide.”

When certification began in the first half of the 20th century, it reflected the completion of formal training and was designed to signify mastery of a specialty that would last a professional lifetime. That was probably true at the time. The rapid rate of change of biomedical knowledge in the 21st century has required adaptation of the certification process to include continuous learning and quality improvement throughout a pediatrician’s career. Participation in the MOC program signals to parents and the public the pediatrician’s conscious and sustained commitment to learning and improvement.

A pediatrician (or pediatric subspecialist) who is certified by the ABP has prepared for and passed a comprehensive examination that measures his or her expertise in medical knowledge, one of six core competencies every physician should possess. The other five competencies are assessed by direct observation in residency training and reported to the ABP. Once certified, the diplomate completes self-assessment and quality improvement activities every five years and must pass an exam every 10 years to maintain certification.

The complexity of the modern health care system is staggering and the demands on physician time and energy are unprecedented. In this context, some question whether the commitment to learning and quality improvement should be added to all the other demands on a physician’s time. Yet the compact with society is that, in exchange for the privilege of self-regulation, the profession of medicine will develop a rigorous method to certify a physician’s competence.

MOC activities are designed not only to keep their clinical skills sharp. Activities to measure and improve communication, professionalism and patient care also are part of MOC.

MOC is evolving rapidly, with close collaboration among various pediatric societies, diplomates and the ABP. Many children’s hospitals, practice groups, quality improvement collaboratives and the American Academy of Pediatrics have received delegated authority through the ABP pediatric or multispecialty portfolio program so that pediatricians participating in the quality improvement programs of those organizations receive MOC credit. Data from these organizations show how care is improving.

“Medical science evolves exponentially, and checking in every 10 years is not often enough to ensure patients, their caregivers and the public at large that pediatricians are prepared for modern practice,” says Dr. Moyer. “The health of our children requires a mechanism to verify ongoing preparation and sustained competence.”

MOC activities are designed not only to help physicians stay up to date with medical innovations, but also...
“We also recognize that quality improvement is important not only for pediatricians—it’s also critical for MOC itself. We continuously look for ways to improve the process.”

– Dr. Virginia Moyer

Four Parts of Maintenance of Certification

• Maintain valid, unrestricted medical licensure (Part 1)
• Complete approved self-assessment and continued learning activities every five years (Part 2)
• Pass the MOC exam every 10 years (Part 3)
• Complete approved performance in practice activities every five years (Part 4)

During the last year of the five-year MOC cycle, once all requirements are completed, diplomates must re-enroll in MOC so that there is no lapse in certification.

Get More Info

More details about MOC are available on the “Maintain Certification” pages at abp.org. Information about your specific requirements may be found within your ABP portfolio. If you have further questions or need help logging in, email us at moc@abpeds.org, or call 919-929-0461 and ask for MOC.
In his Pediatric Intensive Care Unit (PICU) at Sparrow Regional Children’s Center in Lansing, Michigan, Stephen Guertin, MD, says about 5 percent of admissions are adolescents who have attempted suicide. Depression and despair clearly play a role, but getting a better understanding of the level of depression—and also the parents’ perception of it—can be a challenge.

He began using the ABP’s Adolescent Depression Screening Performance Improvement Module (PIM), and was pleasantly surprised at the results.

“We began using the PIM to meet Maintenance of Certification requirements, but started noticing very positive results pretty quickly,” says Dr. Guertin, who is director of the PICU. “It really became a neat tool to teach kids and their families about depression. We started administering it to both teens and parents.”

The questionnaire asks the patients to rate areas such as loss of appetite, lack of energy and interest in activities, and feeling down or hopeless, and also to indicate how often they have experienced these feelings. This provides measurements that allow the instrument to calculate whether depression is indicated and, if so, its level of severity.

The fact that the screening lets health care providers quantify depression in terms of frequency and severity is helpful, Guertin says.

“Often, we’d see situations where the child would have a stark understanding of his or her depression, but the parent would have no idea. Conversely, there are cases where the parents will paint a pretty dark picture, indicating they understood that depression was a risk factor, but the child would deny having any symptoms, partly because there’s still a stigma to this among teens and they may not want to admit it or have to take medication for it.

“Kids are really good at hiding things from parents, especially when it comes to the depths of depression,” he says.
Overall, the screening PIM is helpful “because it gives you a much more realistic picture of what is going on with the child,” Dr. Guertin says.

Also helpful is that the tool creates a basis for crucial dialogue between parents and their children, especially when it becomes clearer to the parent that depression exists. By quantifying depression, the screening tool enables PICU staff to refer families to appropriate mental health services or other resources.

“It compels everybody to talk about it—mainly the kids, but also the health care provider, the parents, the whole family,” Dr. Guertin says. “They receive the family guide and have the baseline information, and it closes that discrepancy between reality and what people thought they were seeing.”

He says the most interesting result of using the PIM is finding out how prevalent depression is among the adolescents he was seeing.

“It really should be a routine part of well-child care and certainly a routine part of hospitalization,” he says.

What is a PIM?

ABP Performance Improvement Modules (PIMs) are web-based tools that enable pediatricians to implement improvements in clinical care using quality improvement methods. You can conduct this activity within your practice, working with your own patients. You also can work in collaboration with other pediatricians.

This allows you to:

- Collect the relevant prospective performance data using visit forms downloaded from the PIM, or using online survey tools.
- Enter baseline and post-intervention performance data.
- Select improvement strategies suggested by the PIM.
- View performance feedback presented as run charts on summary measures calculated by the PIM.
- Work independently or compare your progress with other colleagues.
- Link to external resources from within the PIM.

Some PIM topics include ADHD, breast milk use, critical congenital heart disease, hand hygiene, health literacy, asthma, obesity, preschool vision screening and influenza immunization rates.

Information about PIMs is found under the Performance in Practice (Part 4) section of the ABP website.
Obesity has increased dramatically in recent decades, but “who wants to deal with the fallout of telling an adolescent girl that she’s overweight?” asks Brad Weselman, MD.

However, studies show that obese children are more likely than those of normal weight to grow into obese adults. Children’s Healthcare of Atlanta consulted with Dr. Weselman, Stephanie Walsh, MD, and other physicians in Atlanta in the development of a provider training program to increase physicians’ confidence and effectiveness in counseling children and their caregivers about healthy weight.

The provider training program, which is just one element of the Children’s Strong4Life movement, is designed to take two hours and focuses on strategies for promoting healthy weight management. Four healthy habits are emphasized:

- Eat more fruits and vegetables
- Drink more water and fewer sugar-sweetened beverages
- Decrease screen time
- Increase physical activity

Dr. Weselman, who is a 2014 Paul V. Miles Fellow, says that overwhelming a child with health goals isn’t very effective, so the program counsels physicians to encourage children to set just one or two goals at a well-child visit.

“The child may agree to limit screen time to an hour a day, and eat French fries only once a week, instead of every day,” he says. “You give them goals they can reach, then the next time they come in, if they’re making progress with those goals, you help them set some more. It doesn’t have to be all or nothing.”

Physicians who complete the Strong4Life training receive a toolkit to support their counseling efforts. The toolkit includes a color-coded body mass index (BMI) chart, a Healthy Habits questionnaire for parents and tips to jump-start Strong4Life healthy habits.

A pilot study of the Strong4Life program showed after training, more physicians calculated BMI at well-child visits (86 percent before training, 97 percent after training). The greatest difference, though, was seen in physician confidence. Only 19 percent of physicians in the trial perceived themselves as effective in treating obese patients before training; nearly 56 percent perceived themselves as effective after training. Before training, about 28 percent perceived themselves as effective in motivating patients to change their habits; after training, nearly 64 percent perceived themselves as effective.

Children’s Healthcare of Atlanta partnered with Kids Health First Pediatric Alliance to make Strong4Life Provider Training eligible for 25 MOC Quality Improvement points—a win for everyone!
Vermont Project Boosts Developmental Screening In Well-Child Visits

Children who are screened early for autism and other developmental issues can be helped with the proper resources, greatly benefitting them and their families.

A quality improvement project of the Vermont Child Health Improvement Program (VCHIP) has resulted in more screenings for young children, leading to additional observation or referrals. By meeting requirements for ABP Part 4 MOC, the project also benefits participating pediatricians.

VCHIP, a population-based maternal and child health services research and quality improvement program of the University of Vermont College of Medicine, initiated the project in 2009 with its partners. The project promotes guideline-based developmental care by providing routine surveillance, recommended developmental and autism screening and connection to evaluation and intervention services for children with a concern or developmental delay. The results showed significant improvement in documented monthly screening.

VCHIP Executive Director Judy Shaw, EdD, MPH, RN, FAAP, says the project illustrates many strategies that VCHIP uses to ensure that improvement initiatives succeed.

“In this project, we broke goals down to test small, clearly defined changes, assembled creative and committed practice-based teams and used run charts to monitor progress,” she says. “Teams collaborated across practices to share learning about successes and challenges and took part in bimonthly conference calls.”

“It was an integral part of the QI process to build and support one-on-one connections between healthcare practitioners and community members so that teams knew their referral resources and how to access them.”

She also says that working with the ABP on MOC Part 4 credit eligibility provided an incentive for physicians to participate. Currently 92 percent of the pediatric practices in Vermont participate in VCHIP, which is part of the National Improvement Partnership Network (NIPN). The NIPN is a network of more than 20 states that have developed Improvement Partnerships to advance quality and transform healthcare for children and their families.

“By making developmental screening a routine part of well-child visits, children and families are helped and pediatricians improve the overall quality of care they provide to patients,” she says.
To Dr. Ramesh C. Sachdeva, being an ABP portfolio sponsor has several benefits: It helps members of the American Academy of Pediatrics (AAP) earn MOC credit, it has helped to jump-start the process of accelerating quality improvements across the AAP’s membership and it offers exciting potential for including specialties and subspecialties in quality improvement efforts.

“Quality continues to be a top priority at the AAP, ensuring that every child gets the right care every time,” says Dr. Sachdeva, MD, PhD, JD, FAAP, associate executive director for the AAP. “As a portfolio sponsor, the Academy can more efficiently and effectively conduct quality improvement initiatives that meet the standards for MOC, and identify greater opportunity for collaboration among AAP groups working on QI.”

“Most importantly, it offers AAP members a unique opportunity to generate and participate in member-driven QI projects that will benefit children and also receive MOC credit,” he says.

In November 2012, the ABP granted portfolio sponsorship status to the AAP, which means that the Academy reviews and approves its own projects for Part 2 and Part 4 MOC. The Quality Cabinet, an AAP executive leadership group, oversees the AAP MOC Portfolio Program.

The Academy is one of more than 30 groups that have become portfolio sponsors. Others include hospitals, state or nationwide collaboratives, national professional societies and corporations.

“We are happy to have so many portfolio sponsors. The program is designed to streamline the application process for organizations who are running multiple quality improvement projects,” says Kristi Johnson, ABP manager of MOC External Activities.

As an approved portfolio sponsor, organizations evaluate their own QI projects against the ABP standards and approve QI projects internally for MOC credit.

The AAP response has been terrific. In just two years since becoming a portfolio sponsor, 33,058 physicians received MOC Part 2 credit and 1,236 physicians received MOC Part 4 credit.

At the Academy, 88 projects have been approved for both Part 2 MOC (self-assessment) and Part 4 (quality improvement). Some project topics include:

- Sports medicine
- Immunizations
- Asthma
- Diabetes
- Obesity
- Medical homecare coordination

Some benefits of participating in the AAP portfolio include:

- Use of a national asthma registry
- Implementation of AAP policy and clinical practice guidelines
- Development of policies and protocols around improved processes (especially in delineating roles and responsibilities)
- Use of team “huddles”
- Use of reminder-recall systems
- Employment of planned care approach
- Modification/improvements to electronic health record templates and functionality
- Use of standardized tools

### Number of Physicians Receiving MOC Credit for Projects in the AAP MOC Portfolio

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<tr>
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<th>Portfolio-Approved Only (since 2012)</th>
<th>All AAP MOC Activities (includes projects grandfathered into Portfolio since 2007)</th>
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<tr>
<td>Part 2</td>
<td>33,058</td>
<td>61,737</td>
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<tr>
<td>Part 4</td>
<td>1,236</td>
<td>8,034</td>
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<tr>
<td>Total Number of Projects</td>
<td>88</td>
<td>129</td>
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Source: American Academy of Pediatrics (includes only those activities that have submitted completion data)
“Quality continues to be a top priority at the AAP, ensuring that every child gets the right care every time ...”

– Dr. Ramesh C. Sachdeva

In addition to these improvements in office systems and process, project participants and the children they serve have seen improvements in the delivery of care, patient experience of care and child health outcomes.

Dr. Sachdeva says in addition to tracking project outcomes—an effort overseen by Jill Healy, MS, AAP manager for Quality Improvement and Certification Initiatives—the Academy is moving toward getting MOC credit at the specialty level.

“For example, we are working with the emergency medicine section to see how we can help move the needle forward for quality of care in the emergency center,” he says. “What better group to implement specialty projects than professionals in those specialties? That is what makes it clinically meaningful.”

Dr. Sachdeva says that future potential for the Academy and MOC lies in identifying projects that span the continuum of care and cut across multiple specialties.

“If we can implement this across interdisciplinary fields, we think we can impact care even more,” he says.

While MOC credit can sometimes be seen as a hurdle to jump, showing how the projects can be clinically effective is a motivator for Academy members. If the Academy gets a “critical mass” engaged in MOC, it helps move those who may be reluctant, Dr. Sachdeva says. Also, he points out that the nice thing about pediatricians is they always keep the children in mind.

“That’s the real driver—they want to do this because it’s the right thing to do for the children, and they will always go the extra mile for children.”

What is Pediatric Portfolio Sponsorship?

Pediatric Portfolio Sponsorship allows an organization to approve and manage quality improvement projects for Part 4 ABP MOC credit entirely within the organization. To qualify, an organization must have a minimum of three QI projects that have been approved for Part 4 MOC credit. This program is appropriate only for organizations with a well-developed infrastructure for the design, central oversight and management of multiple QI projects. Once approved, Pediatric Portfolio Sponsors will evaluate and approve their own QI projects using published ABP standards for Part 4 MOC credit. ABP oversight of portfolio sponsorship will include an annual report of all approved projects to ensure compliance with ABP standards for Part 4 MOC credit. Organizations will be approved for a period of two years from the time of application approval.

Click here to see a list of Portfolio Sponsors.
Partnerships and Collaboratives
MOC Part 4 Quality Improvement Projects

Collaborative learning among multiple teams represents a transforming and growing model—with well-documented results—saving lives and improving patient care across multiple sites. Through networking, physicians from around the country can share their expertise and experience, adding value to patient care in all areas of pediatrics, particularly subspecialties that might not be well represented in some geographic areas.

“Collaboration and networking have improved child health care,” says ABP Senior Quality Advisor Carole Lannon, MD, MPH. “The Institute of Medicine says it takes an average of 17 years for knowledge generated by randomized controlled trials to be incorporated into practice. We’re seeing a great deal of evidence that pediatric collaborative improvement networks can shorten the time it takes to get knowledge into practice, and the results are better outcomes for many, many children.”

The ABP recognizes collaboratives among the many quality improvement (QI) activities that meet Part 4 MOC requirements. Both sponsoring organizations and individual project leaders can use the QI Project Application (QIPA) to gain ABP approval of planned, ongoing or completed QI projects. (See page 32 for some publications that feature QI projects that have earned MOC credit.)

In 2002, the ABP established a workgroup of more than 45 pediatric subspecialists to develop a framework for a performance in practice component of MOC. A major recommendation of this workgroup was to support multisite efforts that would combine enough data from patients to clearly and quickly see what treatments and strategies work best. The Children’s Oncology Group was considered a

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Stepping Up for a Healthier Tomorrow
model of how this system could work, along with the Northern New England Cardiovascular Disease Study Group and the Cystic Fibrosis Foundation quality improvement efforts.

**Types of collaborative learning include:**

**Portfolios of QI projects** are managed by a single institution or organization (for example, a children’s hospital or an American Academy of Pediatrics state chapter). Portfolio projects have addressed primary care, hospital and subspecialty topics, and can involve multisite collaborative improvement projects. The portfolio approach is appropriate for organizations with a well-developed infrastructure for the design, central oversight and management of QI projects that would have three or more QI projects that meet ABP standards in a two-year period. *(See more about portfolio sponsorship on pages 8-9.)*

**Multisite Collaborative QI projects** engage multiple practice teams working together, sharing data and quality improvement methods and learning in a variety of ways (in person or virtual meetings, monthly webinars, listserves). These projects involve multiple practices and

include short-term, time-bounded learning collaboratives and long-term enduring collaborative improvement networks.

Since beginning a decade ago, the number of collaborative multisite improvement projects and diplomates participating for MOC credit has rapidly increased, with significant impact on care and outcomes for children and families. These multisite collaborative quality improvement projects can be classified in four categories:

- **Primary Care:** Participating primary care quality collaboratives have provided MOC credit for 2,191 general pediatricians in initiatives such as the national Reach Out and Read Quality Improvement effort, the Oregon Pediatric Society START project, AAP’s Quality Improvement Innovation Network, the Ohio chapter of AAP and the Vermont Child Health Improvement Program *(VCHIP, see page 7).*

- **Neonatal and Perinatal:** These projects include both national and state-based efforts and have provided MOC credit for 1,440 neonatologists. Portfolio sponsors such as the Vermont Oxford Network and Pediatrix Group have supported multiple collaborative QI efforts across NICU practices. State-based efforts include the California Perinatal Quality Care Consortium, the Perinatal Quality Collaborative of North Carolina, the Ohio Perinatal Quality Collaborative and the Tennessee Initiative for Perinatal Quality Care.

- **Hospital-Based:** These projects have involved 407 hospitalists, critical care and emergency medicine physicians. An example is the Children’s Hospital Association’s Eliminating Central Line-Associated Bloodstream Infections in Pediatric Intensive Care Unit network initiative. Between its 2006 launch and mid-2013, it is estimated that this network has prevented 502 deaths and 4,179 infections with an estimated $146.3 million in savings. The national Solutions for Patient Safety network includes more than 80 children’s hospitals that care for 25 percent of all children hospitalized in the country.

- **Subspecialty Care:** These improvement efforts have involved 1,072 pediatric diplomates across multiple subspecialty areas and topics.

**Examples of impact include:**

- Pediatric teams in the ImproveCareNow network, focused on children with inflammatory bowel disease, have improved the percentage of children in remission from 48 percent to 78 percent.

- The National Pediatric Cardiology Quality Improvement Collaborative has improved growth outcomes and decreased mortality in infants with complex congenital heart disease.

- The Pediatric Rheumatology Care and Outcomes Improvement Network focused on juvenile arthritis, has increased the percentage of children in medication-controlled remission from 37 percent to 45 percent, with 137 more kids in remission over the past year.

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When your child is sick, you want to get them the best health care possible — but that no longer just means “finding the best doctor,” says Justin Vandergrift, whose daughter has Crohn’s disease.

“It shouldn’t matter whether you live in rural South Carolina or the middle of New York City,” he says. “If you and your child’s doctor have access to the best information, then you can have access to the best treatment.”

That’s one of the great benefits of learning healthcare networks, he says. His child’s doctor, Ricardo Caicedo, MD, at Levine Children’s Hospital in Charlotte, N.C., can talk to other experts across the country about her case, and get their opinions. Through these networks, physicians share knowledge and experiences — both success and failure. They combine data on various treatments to get a clearer picture of how certain treatments and procedures work. Such collaboration leads to improved quality of care.

Dr. Caicedo, a gastroenterologist, is part of the ImproveCareNow network. This network has centers in 34 states and in the UK, and includes more than 580 pediatric gastroenterologists treating more than 19,600 children with inflammatory bowel disease (IBD).

“It’s an amazing resource for the doctors—and especially for their patients,” Vandergrift says, adding that physicians aren’t the only collaborators. Parents network, too.

“When our daughter was diagnosed with Crohn’s disease (a form of IBD), my wife and I felt absolute fear and isolation,” he says. “We didn’t know what the disease was, much less what to do about it.”

But through ImproveCareNow, he’s part of an organized group of parents and caregivers who share their experiences.

“You learn from other patients and parents, and it gives you hope,” he said. “You meet someone who’s been through worse than what you’re facing, and have come out the other end. Some days, the best thing you can give someone is hope.”

Vandergrift and other network parents and kids are sharing their stories. They’ve created a group called “Empowered by Kids” that shares stories of inspiration, lists of resources and news of interest to people dealing with IBD. The group has expanded now to include cystic fibrosis (CF) patients and their families. Empowered by Kids also published booklets, called “Books of Hope,” which include stories and messages from families and from the young patients themselves. These booklets (one for IBD, another for CF) have been placed in clinics and waiting rooms of many ImproveCareNow participating institutions. For parents and patients, it’s often their first link to other families dealing with the same chronic conditions.

“Nobody should feel like an island,” he says.
Maintenance of Certification (MOC) at a Glance

Added in 2014

Part 2: 44 self-assessments
Part 4: 13 PIMs and Web-based activities
355 QI projects
8 Portfolio sponsors
57 posters and articles approved for credit

MOC’s Wide Reach:
By the Numbers

Since the ABP started certifying pediatricians in 1933:

More than 110,000 have been certified in General Pediatrics
More than 25,000 have been certified in a subspecialty
More than 68,000 are currently participating in MOC

The Certificates

The ABP awards certificates in General Pediatrics and in the following subspecialty areas:

- Adolescent Medicine
- Cardiology
- Critical Care Medicine
- Developmental-Behavioral Pediatrics
- Emergency Medicine
- Endocrinology
- Gastroenterology
- Hematology-Oncology
- Infectious Diseases
- Neonatal-Perinatal Medicine
- Nephrology
- Pulmonology
- Rheumatology
- Child Abuse Pediatrics

Certificates are awarded in conjunction with other specialty boards in the areas of:

- Hospice and Palliative Medicine
- Medical Toxicology
- Pediatric Transplant Hepatology
- Neurodevelopmental Disabilities
- Sleep Medicine
- Sports Medicine

MOC First-Time Test Takers in 2014

Total taking MOC
General Pediatrics exam: 5,557
4.4% Pass
95.6% Fail

Total taking MOC
Subspecialty exams: 1,600
4.5% Pass
95.5% Fail
Ways to Earn MOC Credit in 2014

Question of the Week (QOW) Tests
Knowledge and Offers Feedback

**The category:** Convenient MOC Credits

**The answer:** This self-assessment tool is sent out weekly and consists of a case, question, abstract and additional commentary. It covers the latest concepts, breakthroughs and best practices in recent medical journals and publications, and should take about 20 minutes of your time.

**The correct response:** What is Question of the Week?

Instead of playing *Jeopardy,* you’ll be earning self-assessment (Part 2) MOC points if you take part in this popular online activity and educational tool. A new Question of the Week (QOW) is published every week except during the year-end holidays.

For every 25 correct responses, you will receive 10 Part 2 MOC points. You may answer all 50 in one year, and receive 20 points.

Here’s how it works: the case study sets the stage, giving you a patient or issue as if you were the practicing physician. Then you can try the question. If you miss it, no worries. It counts as practice. The abstract outlines concepts and breakthroughs, and the commentary brings everything full circle, taking the abstract’s findings, offering background and providing application for your case in the real world. Then you answer the question for credit.

Once you correctly answer the question, you can read the “medical pearl,” an added bonus of interesting information, and join the forum to read or write comments if you wish. You can go at your own pace, because questions remain archived for three years.

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**Sample QOW:**

Is there a ‘cure’ for peanut allergy?

Your patient has peanut allergy. He’s 15, and afraid that if his girlfriend eats a peanut butter sandwich, her kiss could kill him. His mother has heard of possible benefits of oral immunotherapy. They want to know if there’s a way to desensitize his peanut allergy.

What do you tell the patient and his parents?

This is the topic of one Question of the Week, and an idea of the types of questions that are posed. Recently published studies on the topics are provided for reference and learning.

Enroll now by logging in to your ABP Portfolio at abp.org
About 75 percent of infants with pertussis acquire it from someone in their household, so if new moms receive Tdap immunization, the babies have a better chance of not catching this highly contagious and serious respiratory disease.

Henry Bernstein, MD, MHCM, FAAP, saw an opportunity to improve Tdap immunization rates in new mothers before they are discharged from the hospital. He presented the poster created with his colleagues called “Increasing Tdap Immunization Rates for Postpartum Women” at the Pediatric Academic Societies’ annual meeting in Vancouver in May 2014.

An added bonus was that the poster was eligible for MOC Part 4 credit.

“Quality improvement is front and center in everyone’s professional world. This was an opportunity for me to do a QI project around infectious diseases, which is a special interest of mine,” says Dr. Bernstein, professor of pediatrics at Hofstra North Shore – LIJ School of Medicine and affiliated with Cohen Children’s Medical Center and North Shore University Hospital in New York.

The QI initiative increased Tdap immunization rates by 33 percent in postpartum women before discharge, providing an impetus for birth hospitals to review their own postpartum vaccine administration processes. Dr. Bernstein’s next step is a QI initiative to increase the percentage of women who receive Tdap vaccine during pregnancy.

Click here to learn more about how posters qualify for MOC Part 4 credit.

Below: Dr. Lewis First, Chair of Pediatrics at the University of Vermont College of Medicine, discusses a poster with his residents. Courtesy of the University of Vermont College of Medicine.
Medication Adherence Is One Focus of ABP Efforts to Move Patient-Centered MOC Activities into Practice

The best treatments in the world won’t help sick children manage chronic illnesses if they don’t get medicine on time and at the right doses.

Of course, there are many reasons why parents/caregivers don’t follow their pediatrician’s instructions.

- Medications can be costly
- Dosing and administration of some medications are confusing (for example: even those cute little fish masks don’t make using a nebulizer easy!)
- Children often don’t like to take medicine, even if it makes them feel better

Medication adherence can mean life or death to a child, so overcoming these and other obstacles is critical.

The ABP received a grant in 2013, through the U.S. Agency for Healthcare Research and Quality (AHRQ), to learn about how certifying boards can be used to disseminate and translate patient-centered evidence into practice. The initial focus of the ABP project is on medication adherence with a goal to highlight evidence-based activities that can help clinicians improve outcomes for children with chronic illness.

Collaborating with the Cincinnati Children’s Hospital Medical Center, the ABP developed both self-assessment and quality improvement Maintenance of Certification (MOC) activities on medication adherence. An essential part of the project is finding effective ways to notify pediatricians that these activities are available and increase participation rates.

Virginia Moyer, MD, ABP vice president of MOC and Quality, is the principal investigator on the Patient-Centered Outcomes Research (PCOR) project. Carole Lannon, MD, MPH, professor of pediatrics and director of Learning Networks at the James M. Anderson Center for Health Systems Excellence at Cincinnati Children’s Hospital Medical Center, is lead co-investigator. The team reached out to subspecialty groups representing rheumatologists, gastroenterologists, hematologist/oncologists and nephrologists, in addition to general pediatricians.

“There are significant gaps in what we know, which is our research, and what we do, which is our clinical practice,” Dr. Lannon says. “Studies have shown that adults get only 50 to 60 percent of recommended health care, and the quality of care for children
is even poorer. And children present unique challenges because they’re growing so rapidly—physically, emotionally, cognitively, socially and developmentally. All these factors have profound implications for the safety, dosage and metabolism of medications. Parents and caregivers have to play a major role in giving medications or using devices properly, so the child gets the full benefit of treatment. Doctors need tools to help get families more involved in their children’s care.”

In the PCOR study’s first year, the research team developed and launched MOC activities, including a self-assessment (Part 2) and performance improvement module (PIM), focused on how physicians can help parents/caregivers adhere more closely to medication instructions for children with chronic conditions. Both activities were launched in June 2014.

Also in June, the ABP surveyed all ABP diplomates about their preferences for getting and sharing information. (See charts for more survey results.) In general, the survey showed that most diplomates rely on email messages from the ABP to learn about new MOC activities.

The next step was to determine whether pediatricians were more likely to participate in an activity if the email announcement came from a physician thought leader in their own subspecialty than if the email were a generic one from the ABP.

“The survey results help us understand how we can most effectively reach physicians with information about important tools that can help make a difference in the health of their patients,” Dr. Moyer says. “Pediatricians are incredibly busy, and we need to know how to deliver messages that are short and to the point.”

“Professional development and improving quality of care are ongoing activities for pediatricians,” she says. “The ABP can play a vital role in helping clinicians incorporate important research findings into their daily clinical practice. This process is a major part of MOC, and the better we are at letting physicians know what activities are available, the better the health outcomes will be for children.”
Answers to MOC Questions

Many suggestions for improvement come as questions and criticisms. The ABP’s Dr. Virginia Moyer takes on the most common.

Does the ABP make a profit from MOC?
No, the expenses associated with administering the MOC program significantly exceed the revenue generated from MOC. Founded by pediatricians in 1933, the ABP is nonprofit and governed completely by pediatricians. More than 250 dedicated pediatricians in clinical practice, education and research volunteer their time to develop and verify test questions and advise on MOC activities so that pediatrics can continue to be a self-regulating profession.

How are the fees set?
The fees cover some costs of developing, administering, evaluating and reporting the results of the nearly 50 examinations that are administered by the ABP, as well as the credentialing process, resident and fellow tracking and evaluation, development and approval of MOC activities, and other functions essential to certification and MOC. Each year the ABP Board of Directors reviews and votes on the proposed fee schedule. Adjusted for inflation, the MOC fee is not significantly different from the recertification fee from two decades ago. In 2014, the ABP worked closely with various subspecialty societies to insure there would be no fee increase for the initial certification exams in 2015.

Why do I have to re-enroll and pay a fee to be listed as “meeting requirements” when I have just finished my requirements at the end of a five-year cycle?
MOC is a continuous process of learning and improving the care we provide. Once a diplomate enrolls in a five-year cycle, he/she has access to all the resources on the ABP website (at no additional cost) to complete his/her requirements at any time during the five years. Enrollment fees are due at the beginning of every five-year cycle. Although not recommended, some diplomates delay actual completion of their MOC activities until the very end of their five-year cycle. When that happens, the diplomate will need to immediately enroll in the next cycle in order to be counted as meeting requirements in the continuous process.

What is the purpose of MOC?
It is widely known that there is a substantial gap between what medicine/health care could do and what it does do—this is the quality chasm that was identified by the Institute of Medicine reports in the early 2000s. The explosion of medical knowledge and the delays in translating discovery into care practices represent well-known challenges of modern medicine. MOC is designed to assure the parent and the public that the diplomates are keeping up with medical knowledge and improving care in their practice. More than 70,000 ABP diplomates are doing just that.

MOC seems to take a lot of time. Does it?
Diplomates are asked to participate in three to five Part 2 self-assessment activities over five years. For Part 4, diplomates are asked to participate in two quality improvement activities over five years. The minimum time commitment for Parts 2 and 4 would be approximately 35 hours, averaging seven hours per year. Because physicians are natural lifelong learners who take seriously their responsibility to stay well informed, most choose to spend more time.

Do the exams reflect some types of practices better than others?
Exam questions are selected from a large pool of questions that are based on the exam content outlines that are posted on the ABP website (abp.org – search for “content outlines”). Pediatrics is a vast specialty, with many different kinds of practices, so no one exam will reflect any one practice perfectly. However, our question writing committees and subboards consist of practicing pediatricians who regularly review the content outlines, revise each question in our pool and develop new questions to ensure that exams reflect contemporary practice as closely as possible.

How can I find a QI (Part 4) activity that relates to my practice?
We are strongly committed to awarding Part 4 MOC credit for quality improvement activities in which physicians are engaging within their own practice settings. Practice organizations can apply directly to the ABP’s project approval program to award credit to pediatricians who participate in activities and larger organizations can apply to sponsor portfolios of QI projects, with oversight from the ABP. For those who are not involved in or prepared to design their own QI activities, the ABP has many approved activities available. Diplomates can log in to their ABP portfolio at abp.org and click on MyMOCRequirements >> Search Activities to search for suitable activities by topic or specialty. We are continuously developing new activities and new pathways to obtain credit, including qualifying projects that have been presented in peer-reviewed settings. Our MOC staff are delighted to assist diplomates who need help finding a suitable activity (see page 19). Simply call the ABP main number at 919-929-0461.
Who you gonna call?

Have an idea or plan for a quality improvement project in your office or institution and want to get MOC Part 4 credit for it?

Our experienced ABP staff stands ready to answer your questions about MOC quality improvement (QI) projects and standards for approval.

“We’re happy to work with you,” says MOC & Quality Activity Coordinator Amy Roberts, one of three staff members who take calls from individuals, sponsors and other organizations seeking MOC credit for QI projects they are conducting in their organization. “We’re here to help people through the process. We want physicians who are meaningfully involved in a workplace QI project to receive credit for the work they are already doing.”

So when sponsors and other organizations with questions about credit for QI projects call, here’s who they will reach:

Laura Couch  Kristi Gilreath  Amy Roberts

Also, reach them through email: mocampeds@abpeds.org

Are you a diplomate with questions about Part 2 or Part 4 MOC credit?

Our staff members are here to help.

Chances are that we’ve gotten similar questions before and have the answers ready. If not, we’ll find the answers for you. You’ll reach one the folks at left.

Email questions to: moc@abpeds.org

Nathan Clark  Vincent Clark  Amy Hodak

Alix McKay-Powell  Kimberly Pierce  Louise White
“It was probably one of the best emails I’ve received in my entire life,” says Houston professor Michael Yafi, MD, referring to being asked to help write ABP examination questions.

In spring 2014, Dr. Yafi, an associate professor of Pediatric Endocrinology practicing at the University of Texas Health Science Center at Houston, stepped up to an invitation on ABP President & CEO David Nichols’ blog to all diplomates to provide examples of the type of questions they think are appropriate for an open-book exam.

Linda Althouse, PhD, vice president of Psychometrics, Research & Testing Services, says Dr. Yafi’s question examples were thoughtful and well constructed.

“‘I didn’t know if anyone was going to look at it,’” Dr. Yafi says. “‘I really worked hard to find an interesting case and follow the instructions. It wasn’t something that I spent 10 minutes on, just to reply to the email.’”

The blog’s exercise was just one avenue in which diplomates are becoming more involved in advancing ABP exams to reflect changes in medical science and clinical practice.

Dr. Rachel Dawkins, medical director of the General Pediatric and Adolescent Clinic at All Children’s Hospital/Johns Hopkins Medicine in St. Petersburg, Fla., sits on the ABP’s Strategic Planning Committee, and also has joined the test writing efforts. Her perspective about the challenges young physicians face as they start practicing medicine is valuable.

“The Board wanted to hear from us about what it’s like in practice now, and the challenges the young pediatricians are facing now as they begin their careers. That’s where my voice was coming in,” says Dr. Dawkins, who was first certified in General Pediatrics in 2007, working full time in outpatient medicine at an academic center.

Yafi and Dawkins were two of 24 new ABP volunteers who attended an orientation in Chapel Hill, N.C., in September to learn how they can share their time and expertise to help the Board develop exams that reflect today’s pediatric care and are more representative of today’s pediatricians.

Yafi says the experience was both more difficult and more fulfilling than he anticipated. The ABP not only read his question and circulated it to the exam committee, but later invited him to sit on the General Pediatrics Exam Committee.

“It was the greatest honor I’ve ever had,” says Yafi, who hopes to create a better connection to real life with his test question contributions. “I write questions on what I see, like a mother who made a diagnosis by herself. How do you reply to that?”
Join Our Testing Process

The ABP invites you to nominate yourself or someone else to be considered for our exam committees, other committees or subboards. The responsibilities and accomplishments of our volunteers often extend beyond item writing. Those who serve can influence policy and assist in developing training requirements. They also act as advocates for their areas of expertise or subspecialties and help the board better understand the diversity of real-world practice within the pediatric community.

Click here to use the new online nomination form.
Marlene R. Miller, MD, MSC

A professor of pediatrics at the Johns Hopkins University School of Medicine, Dr. Marlene Miller has a strong history of focusing on quality improvement. She is vice chair of Quality and Safety, and chief of the Division of Quality and Safety at Johns Hopkins School of Medicine. Before joining the faculty, she was acting director and medical officer for the Center for Quality Improvement and Patient Safety at the Agency for Healthcare Research and Quality in the U.S. Department of Health and Human Services. She also was vice president of quality transformation at the National Association of Children’s Hospitals and Related Institutions (NACHRI), an association of children’s hospitals in the United States, Canada, Australia, the United Kingdom, Italy, China, Mexico and Puerto Rico.

George Dover, MD, professor of medicine and oncology and director of the Department of Pediatrics at Johns Hopkins, praised Dr. Miller’s leadership abilities, saying her efforts “have changed medicine with respect to pediatric health care quality and safety.”

Brad C. Weselman, MD

Dr. Brad Weselman, a pediatrician practicing in Decatur, Ga., and chairman of Atlanta’s Kids Health First Quality/Utilization Management Committee, is known for his tireless work with other pediatricians in quality improvement efforts.

He is co-chair of the Atlanta Area Quality Assurance Council and a volunteer faculty member at Emory University School of Medicine and at the Woodruff School of Nursing in Atlanta. For the past decade, he has led the quality and utilization management committee of Kids Health First, a clinically integrated Independent Practice Association (IPA) comprising 210 primary care pediatricians in Atlanta.

Thomas Finnerty, CEO of Kids Health First, says that Dr. Weselman has championed the development of the IPA’s clinical integration program, resulting in more than 50 quality improvement programs and the development of 26 clinical guidelines.

Robert Wiskind, MD, president of the Georgia chapter of the American Academy of Pediatrics, says that Dr. Weselman “works tirelessly to help pediatricians assess the care they give, develop processes for change that can be implemented in busy primary care practices and continuously monitor the results of these efforts.”

See story about Dr. Weselman’s work on page 6.

Paul V. Miles Fellowship

The Paul V. Miles Fellowship in Quality Improvement honors the passion for improving healthcare for children that Dr. Paul V. Miles has exhibited throughout his career. As Senior Vice President for Maintenance of Certification before retiring in 2013, Dr. Miles championed quality improvement efforts and established improved outcomes in child health as the cornerstone of the Maintenance of Certification process. Recipients receive a cash award and are invited to meet with the ABP to share their experiences and insights on how the Board can further advance the mission of pediatricians devoted to better health care for children.
PMAC Established to Move Milestones Project Forward

If Dr. Carol Carraccio’s dreams come true, then one day, all pediatric residents and fellows will receive feedback that is specific, immediate and behaviorally-based.

A coherent system of competency-based assessment milestones will be used in every teaching hospital, verifying continued competence beyond standardized testing of medical knowledge. It will drive continuous performance improvement, and set the stage for lifelong learning, guiding both professional and personal growth.

It’s not just a dream for ABP’s vice president of Competency-Based Assessment. It’s the vision and mission of the newly established Pediatric Milestones Assessment Collaboration (PMAC).

In March, the ABP, the Association of Pediatric Program Directors and the National Board of Medical Examiners announced the formation of PMAC to develop a national assessment system that will allow these organizations to partner with the medical education community in advancing assessment.

The goal, Dr. Carraccio says, is to use physician assessment as a means of providing evidence of individual physician competence, training program effectiveness and, ultimately, the provision of optimal healthcare.

“The idea is to give residents and fellows useful feedback on specific competencies,” Dr. Carraccio says. “This collaborative gives us all the opportunity to work together and pool our resources and achieve what none of us could do alone.”

SCTC Initiative Featured in *Pediatrics*

The May 2014 supplement to *Pediatrics* offers the most comprehensive examination of pediatric subspecialty training ever published. The initiative on Subspecialty Clinical Training and Certification (SCTC) was led by the ABP in conjunction with the Council of Pediatric Subspecialties.

The publication contains background information, recommendations, data, commentaries and more, and is the culmination of three years of work by a 20-member task force that examined the model of subspecialty fellowship training and certification as it currently stands and considered the needs of competency-based clinical training of the future. (Additional data specific to subspecialties is available at abp.org.)

The pediatric community provided valuable information, collected through surveys conducted by the Child Health Evaluation and Research Unit at the University of Michigan under the direction of Gary F. Freed, MD, MPH.

“We are very pleased to provide such comprehensive information for the subspecialty community,” says ABP Executive Vice President Dr. Gail A. McGuinness. “It will enhance their ability to strategically plan training programs for the future.”

The ABP Board of Directors approved the task force’s final recommendations in June 2013.
New Adult Congenital Heart Disease Certificate Offered to ABP Diplomates

The American Board of Internal Medicine (ABIM) is now offering two pathways for admission to exams for its new area of certification, Adult Congenital Heart Disease. The first three exams will be given in 2015, 2017 and 2019, and will be offered to qualified ABIM and ABP diplomates. (ABP candidates must first request a candidate number from ABIM starting in March 2015.) The two pathways for admission are:

- The practice pathway, available only to candidates who complete the training required for certification in Cardiovascular Disease or Pediatric Cardiology prior to July 1, 2016.
- The training pathway, which involves satisfactory completion of the training required for certification in Cardiovascular Disease or Pediatric Cardiology, plus 24 months of adult congenital heart disease fellowship training, including 18 months of full-time clinical training.

Stockman: Critically Evaluate Where Profession is Going

When the American Academy of Pediatrics (AAP) and the ABP created a new lectureship in honor of former ABP President James A. Stockman III, naturally they chose the man himself to give the inaugural lecture.

And, just as naturally, Dr. Stockman chose a provocative topic—“Predicting the Future of Pediatrics: Wise or Unwise? (There’s Always a Little Bit of Truth at the Heart of Any Delusion.)”

“The rapidity of changes in health care delivery that have occurred over the past decade have affected our ability to provide an adequately composed pediatric workforce for the future, especially at the subspecialty level,” he told AAP fellows gathered in San Diego for the first Stockman Lectureship on Pediatric Education and Workforce.

“The factors influencing this and how they can be modified, or not, are important to understand.”

The lectureship offers a platform for exploring topics related to pediatric medical education and factors influencing practice.

“I’m honored to have this lectureship named for me, and delighted I could be the first lecturer,” Stockman says. “It’s important that we take a critical look at where our profession is going—do we have the right training and the right people in place to provide the best health care for children? I’m pleased that the AAP and ABP have provided this opportunity for a thoughtful presentation every year.”
Workforce Data: Who are the Pediatricians Dedicated to a Healthier Tomorrow?

Each year, the ABP collects data about pediatricians, ranging from basic demographics, such as gender, age, and geographic location to certification status and subspecialties.

The data are gathered by various ways, including surveys of residents, questionnaires for first-time test takers and the latest demographic information the ABP has on file for its diplomates.

“We provide data so others—those involved in advocacy, policy, education, resource allocation and even medical students deciding their future—can have an accurate view of the landscape of pediatric medicine,” says Gail A. McGuinness, MD, ABP executive vice president.

By evaluating the data collected, the ABP can identify emerging trends in pediatrics and track their progress over time.

The Workforce Data also provide answers to some of the ABP’s most frequently asked questions, including how many pediatricians become certified each year and how many choose general pediatrics versus subspecialties.

The New ABP.org Website: Responding to Your Needs

If an organization’s homepage is its virtual front door to the world, then the ABP ramped up its “curb appeal” in fall 2014 by launching its newly designed website.

In designing the site’s new features, the ABP considered how the site was being used by key audiences, including certified pediatricians (diplomates), residents, fellows, program directors and the public, including parents and caregivers.

Changes include:

- Enhanced navigation
- Faster, more accurate search function
- Information specific to pediatricians, program directors, residents and fellows, and parents and caregivers
- More feedback options

Another significant change makes our site easier to use on mobile devices.

To the right is a view of what the abp.org homepage looks like on various devices.

New Hire: Meet IT Leader

Dongming Zhang

Dongming Zhang, MS, MLS, joined the ABP as vice president of Information Technology in March 2014. He determines the IT initiatives aligned with the ABP’s overall mission and strategic plan.

One of his most visible projects since joining the organization has been leading IT efforts to redesign the ABP website.

Zhang also has led the effort to build the infrastructure and initiatives for informatics research and applications that align with the ABP’s mission. He will work with a recently formed task force comprising researchers and scientists from biomedical informatics areas to support novel approaches to collect, visualize and use data.

Joining the ABP from the Johns Hopkins School of Medicine, Zhang most recently served as the school’s director of Office of Information Technology, as well as the associate director of Welch Medical Library and associate director of the Division of Health Science Informatics.
2014 Committees and Subboards

The ABP appreciates the fine work of the pediatricians and other experts who volunteer for committees and subboards, producing examinations and providing direction for MOC activities.

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A special thank you to the following ABP committee and subboard members who completed their service in 2014 (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.

Myles B. Abbott (1992)  
William F. Balistreri (1989)  
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Spotlight:  
The Maintenance of Certification Committee  

In 2014, the MOC Committee completed two major objectives. First, it proposed ways to streamline the Performance Improvement Modules (PIMs), reorganizing and clarifying the way these activities are presented online. The changes are being piloted with a simulated data PIM. After testing and making any appropriate adjustments, the changes will be rolled out to other PIMs, improving the experience for all diplomates.

The committee also developed guidelines for Small Quality Improvement Project Approvals (SQIPA). These are similar to the established Quality Improvement Project Approval (QIPA), but with requirements that can be met by small numbers of people—for example, in individual practices instead of large institutions.

SQIPAs must meet the same general requirements (specific aims, measures tied directly to the aims, standard QI methods, data collected and reported over time, documentation of participation and results), but are tailored to smaller organizations.

The SQIPA application will be available in early 2015 at:  
www.mocactivitymanager.org.
Publications by ABP Staff in 2014


Landmark QI Projects Earn MOC Credit

These publications describe important QI projects that have earned MOC credit for those participating.


*Improvements in the outcomes of patients with Crohn’s disease and ulcerative colitis were associated with improvements in the process of chronic illness care. Variation in the success of implementing changes suggests the importance of overcoming organizational factors related to quality improvement success.*


*Addition of MOC Part 4 Credit increased recruitment success and increased enrollment of pediatricians working in underserved areas. Including QI initiatives meeting MOC Part 4 criteria in practice-based research protocols may enhance participation and aid in recruiting diverse practice and patient populations.*


*A virtual learning collaborative was successful in providing a framework for pediatricians to implement a continuous QI process and achieve practice improvements. This format can be utilized to address multiple health issues.*


*Since 2008, Improvement Partnerships (IPs) have offered credit toward Part 4 of Maintenance of Certification for participants in some of their projects. To date, IPs have focused on achieving improvements in care delivery through individual projects. Rigorous measurement and evaluation of their efforts and impact will be essential to understanding, spreading, and sustaining state/regional child health care QI programs. We describe the origins, evolution to date, and hopes for the future of these partnerships and the National Improvement Partnership Network (NIPN), which was established to support existing and nurture new Improvement Partnerships.*


*Implementation of the handoff program was associated with reductions in medical errors and in preventable adverse events and with improvements in communication, without a negative effect on workflow. (Funded by the Office of the Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services, and others.)*
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## Our Mission Statement

The American Board of Pediatrics 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 evident 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.
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Certifying excellence in pediatrics – for a healthier tomorrow

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2014 Annual Report
Stepping Up for a Healthier Tomorrow