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DEAR PEDIATRICIANS:

Life is full of milestones—taking our first step, graduating from school, getting married, starting a family. Professional measures reflect career accomplishments. A personal milestone for me is completing my first full year as ABP President and CEO. It has been a special honor for me to follow the distinguished service of Dr. James Stockman.

All of us—ABP staff, board members and diplomates—measure our work against the most important milestone of all: the health and well-being of children.

In 2013, approximately 7,600 pediatricians re-enrolled in Maintenance of Certification, meaning they have completed a cycle of meeting benchmarks that demonstrate their competence and knowledge of the latest advances in medical science and clinical care. More than 3,000 physicians became certified in general pediatrics for the first time, and 1,250 became certified in a pediatric subspecialty.

As we support those pediatricians, the ABP celebrates a number of accomplishments in 2013, including:

- Moving the Milestone Project to its next level by identifying Entrustable Professional Activities, or EPAs. Because the milestones are behavioral descriptors, faculty can make more focused judgments about trainee performance. Additionally, the milestones serve as a learning tool for trainees who can set their goals according to descriptions of behaviors at each next step along the continuum.
- We continued to meet our service commitment to the broader pediatric medical community by collecting and updating workforce data, which is useful for training program planning and child health advocacy.
- New Performance Improvement Modules were developed in a number of areas, including health literacy of patients and parents, and ADHD diagnosis and follow up. A new feature—Question of the Week—was developed to help pediatricians meet self-assessment requirements and apply information from current medical publications to evaluate a case study.
- The ABP’s Subspecialty Clinical Training and Certification (SCTC) Task Force completed a three-year review of pediatric subspecialty training and affirmed the three-year subspecialty training model but also highlighted the use of EPAs to assess clinical competency and the great flexibility of pediatric training pathways.

Looking ahead, we remain true to our mission and will continue to evaluate how effective we are at assessing pediatricians’ competence in core areas, and improving standards of certification. One way we will do this is to examine our current testing model, and consider ways to strengthen the value and relevance of the tests. Already, we are eliciting your ideas through the ABP blog. Later this year, we will gather testing and evaluation experts as well as practitioners to discuss options for evolving the testing model.

It is said that our true measure as human beings is how we face adversity, how we treat others when nobody is looking and whether we leave the world a better place. At the ABP, we consider a healthier child to be the true measure of our success, treated by outstanding physicians who continue to meet standards of excellence. This work is possible only because of the tireless efforts of our dedicated staff, hundreds of volunteers on ABP committees and subboards, and the thousands of diplomates who make a commitment to assess and improve the quality of their care. I am profoundly grateful to all.

David G. Nichols, MD, MBA
President & CEO
After Eyal Muscal, MD, MS, returned from an ABP meeting on how to better assess trainees, he found himself thinking about how to provide feedback to two pediatricians at different levels of training.

“One was a senior resident about six months from finishing, and one a pediatric fellow about three months from finishing,” says Dr. Muscal, a pediatric rheumatologist and fellowship program director at the Baylor College of Medicine at Texas Children’s Hospital. “I found that because I had just attended this conference about EPAs, I was thinking more about the skills and knowledge base the two trainees need to have to be entrusted, on their own and unsupervised (to take care of patients), and felt I was more focused and clear about what I was looking for from them.”

That’s precisely what the ABP’s conference focused on: identifying Entrustable Professional Activities, or EPAs. These are essential activities that physicians are entrusted to perform safely and effectively without supervision. As medical specialties and subspecialties continue to emerge and grow, it becomes increasingly important to find ways to assess trainee competence.

In 2000, the American Board of Medical Specialties (ABMS) partnered with the Accreditation Council for Graduate Medical Education (ACGME) in adopting six core competencies for physicians, which would become the foundation for initial certification and maintenance of certification (MOC). In the ensuing years since competencies were introduced, the medical education community has grappled with how to teach and assess them.

In an effort to advance the field, ABMS member boards in 2009 partnered with ACGME in the Milestone Project. The Pediatrics Milestones are narrative descriptions of behaviors for each of the competencies along a developmental continuum from a novice or early medical student to a master clinician who is years into practice. Because the milestones are behavioral descriptors, they provide a shared idea of what novice behavior looks like or what proficient behavior looks like for a given competency.

“The narrative descriptions not only provide faculty with behaviors to look for when directly observing learners, they also provide the substrate for formative feedback,” says Carol Carraccio, MD, MA, ABP Vice President, Competency-based Assessment. “In addition, the milestones serve as a road map for learners who can look at the descriptions of behaviors at each next step along the continuum and set their goals accordingly.”
In addition, the milestones serve as a road map for learners who can look at the descriptions of behaviors at each next step along the continuum and set their goals accordingly.

An example of an EPA for a general pediatrician would be “providing care to a well newborn.” In order for a trainee to perform this activity, she needs to be able to integrate a number of the competencies. So, EPA assessment looks at a learner’s ability to integrate competencies while milestones assess the level of performance of a trainee in performing a specific competency. Combined, these two lenses provide assessors with a much more comprehensive look at a learner’s ability to care for patients.

“EPAs allow programs and faculty to integrate multiple competencies as decisions are being made regarding the ability of a trainee to make the transition toward independent practice,” says David A. Turner, MD, director of the Pediatric Critical Care Medicine Fellowship and the Pediatric Intensive Care Unit at Duke University Medical Center. “This framework represents an important step toward consistency within pediatrics as a whole, across subspecialties and across the continuum of medical education.”

Daniel J. Schumacher, MD, MEd, one author of the pediatrics milestones and an emergency medicine pediatrician who oversees residents at Boston Medical Center, agrees that the new assessment model offers promise in achieving a more valid and reliable way of tracking a trainee’s progress.

“Right now, we do not have a common mental model for what the outcomes of training are, and milestones and EPAs seek to explicitly define those outcomes and their associated behaviors that can be observed in learners. They also provide descriptions of the ‘milestones’ along the way leading to the point of entrusting someone with unsupervised practice,” he says. “This gives a common mental model of what the end goal is as well as the steps that lead to it. Through study, the hope is that we will be able to make valid and reliable decisions about whether learners are meeting these outcomes or not.”

Dr. Schumacher, an associate program director for the Boston Combined Residency Program in Pediatrics, the residency program of Boston Children’s Hospital and Boston Medical Center, says traditional assessment efforts—for instance, rating residents on Likert scales—can lead to “value-laden scores” that are subjective, unclear, and not very useful for the residents.

“What I think is OK for trainees at a specific level of training may be different than what someone else thinks, and we all have our own frame of reference for making these judgments,” he says. “Did a resident get an average score because the faculty didn’t like him or because he is only average? In choosing a score, is the faculty comparing the resident to attending physicians, to resident peers, or the ideal physician? These will likely result in quite different scores.”

However, milestones shift the focus from these scores to matching observed behaviors of residents with a predetermined series of descriptions of behaviors along a developmental continuum. “The power here is that everyone has a common mental model for why they have been placed at that milestone level—they were placed there because others thought that their behaviors matched those tied to a particular performance level or milestone along the developmental continuum,” he says. “This is much more useful.”

He says this is borne out by a study he and the other authors of the milestones published (Schumacher DJ et al., Acad Pediatr Jan-Feb 2013) that found that residents did see the milestones as more useful and meaningful than
traditional assessment efforts, especially in helping them identify the next expected steps in their development.

The ABP sponsored a meeting in March 2013, bringing together leaders from each of the 14 pediatrics subspecialties, including Drs. Muscal and Turner, and chaired by Dr. Carraccio. The meeting was aimed at identifying EPAs common to all of the subspecialties and preparing participants to go back to their communities and lead them through the process of identifying their subspecialty specific EPAs. This is the first phase of a multi-phase process to advance assessment and provide better evidence upon which to make the judgment that a trainee has met the clinical competency requirements to sit for the certification examination.

Dr. Muscal says the tools will give “academic physicians in charge of training pediatricians and subspecialists a sense of what their day-to-day jobs require and they can guide them in giving better feedback.”

For instance, he says, one EPA in draft stages focuses on the importance of working in interdisciplinary teams that include physicians, nurses, social workers, chaplains and other health professionals. In this case, communication and learning to function effectively as a team member are important skills.

“From the trainee perspective, it also allows for much more real-time feedback, and realistic goals and expectations of our trainees that give them a sense of what they need to do to grow and achieve. Much of what we look for in trainees is the same but now we are giving them much clearer expectations.”

The clearer expectations, more precise feedback and better assessment of skills means that ultimately, everyone is better served, not just the trainees.

“EPAs can help us assure our stakeholders—patients, their families, our institutions—that trainees have been comprehensively assessed and have a true sense of their responsibility as they move from training to practicing in an unsupervised environment,” he says.
The physical exam is complete. The diagnosis is made. Now the pediatrician needs to make sure the parent understands what to do next.

This is sometimes the trickiest part of the visit. A recent comprehensive analysis of the literature revealed that one in three parents taking their child to the emergency room has low health literacy, and health literacy interventions decrease the rate of future emergency room visits. (Morrison AK et al., Acad Pediatr Sep-Oct 2013).

Likewise, if a doctor’s instructions about how and when to give medicine, what foods to avoid, or how long to keep a child out of school aren’t followed, the child’s recovery could be slowed.

A new PIM has been designed to help physicians and staff ensure that parents and other caregivers understand what the doctor is telling them before they leave the office. PIMs are web-based tools that enable pediatricians to implement improvements in clinical care using quality improvement methods. Pediatricians collect and analyze practice data over time and document improved quality of care. ABP PIMs allow pediatricians to conduct this activity within their practice and with their own patients. Pediatricians earn Part 4 credit for the PIMs.

In April, the ABP launched the Health Literacy Self-Assessment and PIM, which helps diplomates assess their knowledge of “health literacy”—how well a person reads, comprehends and interprets information about medical care, including a doctor’s instructions and dosage information for prescription medicine.

The fundamentals of the Health Literacy PIM were based on a quality improvement project conducted by the Myers Park Pediatrics Clinic at Carolinas Medical Center in Charlotte, N.C. Through the project, the health care team learned to identify and address health literacy issues using techniques called “Encourage Questions” and “Teach Back.”

“Encourage Questions” is used during the check-out process to find out if patients and/or caregivers had all of their questions and concerns addressed before leaving the office.
ABP offers 15 PIMs ranging from breast milk use to adolescent depression. In 2013, we launched four new PIMs:

- Congenital Heart Disease Screening
- Health Literacy
- ADHD Initial Diagnosis
- ADHD Follow-up

In 2013, 9,261 diplomates completed PIMs.

“One time, a Spanish-speaking patient said that she still had questions,” said Dr. Laura Noonan, a Myers Park pediatrician. “The front office person called the interpreter to come meet with the patient. The interpreter was able to figure out that the patient really didn’t understand how to use the medicine that the physician had just given her, so the interpreter took her back to the nurse and helped her understand what to do.”

The team also implemented “Teach Back,” a technique in which patients would relay back to the physician—in their own words—their understanding of the medical advice or instructions.

For physicians, identifying limited health literacy may be difficult because many patients facing this obstacle are well spoken, may have completed high school and/or college, or look over written materials and report that they understand its content. The ABP’s Health Literacy PIM provides a way to identify those who require more effective communication strategies, and offers physicians proven tools to address barriers.
Obesity Assessment and Management PIM

Dr. Kevin Albert claims he had a flat spot on his forehead from banging it against the scale because he was not reducing the incidence of obesity in his practice. But no more. Since the New York pediatrician has begun participating in the ABP’s Obesity PIM, he more reliably orders tests that help him with treatment plans for his young patients.

Childhood obesity rates in the United States continue to cause alarm. Approximately one-third of children and adolescents are overweight or obese, more than twice the number of children and three times the number of adolescents than two decades ago, according to the American Academy of Pediatrics.

Obesity, excess body weight due to fat, can lead to physical and emotional health risks, including Type 2 diabetes, high blood pressure, asthma, sleep apnea, depression and low self-esteem, as well as social stigma. The continued rise in the rate of childhood and adolescent obesity prompted the ABP to develop a new Obesity Assessment and Management PIM for its diplomates to help improve treatment plans for children suffering from obesity.

The PIM was inspired by successful projects focusing on obesity treatment in New York and North Carolina.

In New York, 25 practices participated in a quality improvement collaborative over three years, using color-coded body mass index (BMI) growth curves to assess and identify overweight and obese children, and develop age-appropriate tools to screen for healthy eating and activity at well child visits. The collaborative teams offered caretakers and parents guides to local resources to improve eating habits and encourage activity.

In North Carolina, the YMCA developed a Healthy, Fit and Strong program aimed at 59 children ages 6 to 11 and between the 85th and 99th BMI percentile for age. These children and their families participated in a family-centered obesity prevention and treatment program, with parents receiving a weekly nutrition class and children participating in physical activity sessions three times a week.

After 12 months, 43 percent of the children had decreased their BMI percentile. Many of the families saw significant increases in physical activity and consumption of fruits.

The goal of ABP’s Obesity PIM is to provide tools and improvement strategies to replicate the two programs’ success.

Physicians learn to optimally evaluate and treat overweight and obese children by measuring blood pressure, screening for obstructive sleep apnea, diabetes, dyslipidemia, and fatty liver, discussing weight with parents and caretakers, and helping families improve eating habits and activity levels.
Diplomate Offers Valuable Testing Feedback

Ken Roberts, MD, has taken all types of the exams offered by ABP: written, oral, open-book, floppy discs and computer-based.

Each had advantages and disadvantages, as well as a different purpose, he says, which is why ABP’s work to continually evolve testing and other educational activities is so important.

“The oral exams gave us a chance to rub shoulders with the luminaries of the field,” he says. “It was a privilege to be in the room with them, and here they were, telling us, ‘Welcome to the club.’”

The results of an early written exam shocked him because, “The area where I felt most comfortable, I scored the worst,” he says. “I was working in infectious diseases at the CDC (Centers for Disease Control and Prevention) at the time, and I scored much better on neonatology than in infectious diseases.”

Perhaps his experiences at CDC were on a different level or different scale from what pediatricians were seeing in their offices, or the infectious disease questions that year were particularly difficult. ABP test developers say the tests are balanced for difficulty overall, not at individual topic levels.

Each of the tests he has taken, Dr. Roberts says, has provided an opportunity to learn more, making him better at taking care of his patients.

“Whether I was looking things up during the open book MOC exam, figuring them out over a three-month period, or sitting in a testing site remembering what I’ve learned in the past, it was all part of keeping us pediatricians up to speed on our practice,” he says.

Dr. Roberts wasn’t obligated to take any more tests after his initial certification in 1973, but because he served on numerous ABP committees, he was expected to enroll in Maintenance of Certification programs.

“The board had the expectation that those of us working on committees would be fulfilling the same requirements as everybody else,” he says. “That was reasonable—if not us, then who? We needed to have a good sense of how the programs worked for individual physicians.”

Like many dedicated diplomates, especially those who have served on ABP committees and the board, Dr. Roberts is willing to offer his thoughts to the current board.

“The perspective offered by diplomats who have experienced the evolution of certification is critically important to the board,” says David Nichols, MD, CEO and President of the ABP. “People like Dr. Roberts help us remember who we are here to serve, and that’s the patients and their parents and guardians.”
Testing Migrates to Criterion-Based Assessment

The passing standard for the eight subspecialties initial certification examinations offered by the ABP in 2013 was changed through a process called criterion-referencing. With criterion-referenced scoring, an absolute standard or specific level of performance is set. The score required to pass is independent of the performance of any group of candidates. The subboards for each of the examinations participate in multiple standard setting activities to arrive at their recommended passing standard, which is then approved by the ABP Board of Directors.

With these new standards, pass/fail decisions are based on a candidate's demonstrated mastery of content and whether they have met the defined standard—not on how a candidate's performance compares to other test-takers. As a result, it is possible for all candidates to pass the examination if they have met the defined standard. Similarly, it is possible that no candidates pass.

With the move to the new scoring model, scores are reported in 1-point increments on a new scale from 1 to 300, with a passing standard of 180. Prior to 2013, scores on initial certification examinations were reported in 10-point increments on a scale from 0 to 800, while percent scores were provided for MOC examinations.

The migration to criterion-reference scoring will continue in 2014 for the remaining six subspecialty initial certification examinations. All other ABP examinations, both initial and MOC, already use criterion-referenced scoring for making pass/fail decisions.
Who Measures Up?

2013 Maintenance of Certification Examination Pass Rates

<table>
<thead>
<tr>
<th>Subspecialty</th>
<th>First-Time Takers</th>
<th>Pass Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>General Pediatrics</td>
<td>95%</td>
<td></td>
</tr>
<tr>
<td>Subspecialties*</td>
<td>91% - 99%</td>
<td></td>
</tr>
</tbody>
</table>

* Includes pass rates for 12 subspecialties. Subspecialty exams with less than five candidates are not included.

2013 Subspecialty Certifying Examination Pass Rate

<table>
<thead>
<tr>
<th>Subspecialty</th>
<th>First-Time Takers</th>
<th>Pass Rate</th>
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<tbody>
<tr>
<td>Child Abuse Pediatrics</td>
<td>61</td>
<td>82.0%</td>
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<tr>
<td>Developmental-Behavioral Pediatrics</td>
<td>65</td>
<td>87.7%</td>
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<tr>
<td>Pediatric Emergency Medicine</td>
<td>255</td>
<td>89.8%</td>
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<td>Pediatric Endocrinology</td>
<td>172</td>
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<td>Pediatric Gastroenterology</td>
<td>187</td>
<td>89.3%</td>
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<td>Pediatric Hematology-Oncology</td>
<td>274</td>
<td>85.8%</td>
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<tr>
<td>Pediatric Infectious Diseases</td>
<td>133</td>
<td>88.7%</td>
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<tr>
<td>Pediatric Rheumatology</td>
<td>57</td>
<td>84.2%</td>
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</tbody>
</table>

* All other subspecialty exams co-sponsored by the ABP are available on the ABP website.
Subspecialty Training
Quantitative Data Available

If data is what you thirst for—quantitative data, that is—then you can soon look forward to oceans of it!

A supplemental report and survey data supporting recommendations finalized in 2013 from the Initiative on Subspecialty Clinical Training and Certification (SCTC) is slated for publication in the May 2014 issue of *Pediatrics*. The supplement was edited by David K. Stevenson, MD, the Harold K. Faber Professor of Pediatrics, Stanford University School of Medicine, and Gail A. McGuinness, MD, ABP Executive Vice President. This initiative represents the dedication and hard work of many individuals and organizations, especially a partnership with the Council of Pediatric Subspecialties.

In 2010, the ABP announced the Task Force on SCTC, which focused its efforts on examining the current model of subspecialty fellowship training. In addition to the length of training, the task force evaluated other existing requirements and new considerations for future training. In spring 2013, a summary of the findings and recommendations were presented in draft form and circulated to the subspecialty community for feedback. The task force presented its final recommendations to the ABP Board of Directors for approval in June 2013.

With the recommendations finalized and available on the ABP website, the torch is now passed to the pediatrics community to continue the dialogue within subspecialties around competency definition and assessment, Entrustable Professional Activities (EPAs) and modification of training.

Subspecialty leaders, professional societies, program director associations and other organizations are working with the ABP to further the development of competency-based medical education across the continuum. With their help, training programs will continue to evolve and advance their educational standards with the goal of providing the best care for all children.

The ABP website will host the subspecialty-specific quantitative data that will help all of us determine what’s working as we move through these new recommendations and transition to new ways of providing medical education and training.
Workforce Data Book

Who are the pediatricians taking care of America’s children?

Are they male or female? Parents of a boy may prefer a male doctor—and vice versa for girls. Some may feel more comfortable with an older, more experienced physician, while others may relate better to someone younger, fresh out of residency. Is the pediatrician working part time or full time?

What subspecialties are most popular? These data may help medical educators, policy makers, insurers, hospitals and community leaders understand whether there are enough physicians in the right specialties and the right locations to meet the needs of our children.

The American Board of Pediatrics collects data on the pediatrics workforce, including gender, age, certification status, subspecialty, full- or part-time status, and even practice ownership. The numbers are broken down many ways, including by state. By looking in the Workforce Data Book (visit www.abp.org and select the “Workforce & Research” tab), the public is able to learn about many trends in pediatrics. For example, one can see the number of pediatricians and pediatric subspecialists who were ever certified per child in a given state. In Texas, 144 pediatricians have been certified in cardiology—that’s a ratio of one to 48,339 children in the state in 2012-13. Conversely, Idaho has two certified pediatric cardiology subspecialists available for 214,058 children. Not every child needs a cardiologist, but knowing what resources are available might help parents of a child with these needs decide where to live.

The data are gathered several ways – from surveys of residents, to questionnaires for first-time test takers, to the latest information the ABP has on file for its diplomates.

“The board serves the larger community by tracking and providing these data,” said Dr. Gail A. McGuinness, ABP Executive Vice President. “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.”
First-Year Residents & Fellows Entering Training in 2013

### First-Year Residents Entering General Pediatrics: 3,627 Total

- **Male:** 28%
- **Female:** 72%

### Subspecialties: 1,462 Total

<table>
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<th>Subspecialty</th>
<th>Total</th>
<th>Female</th>
<th>Male</th>
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<td>General Pediatrics</td>
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<td>Child Abuse Pediatrics</td>
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<td>Developmental-Behavioral Pediatrics</td>
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<td>Pediatric Rheumatology</td>
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<td><strong>Total of all 14 ABP Subspecialties</strong></td>
<td>1,462</td>
<td>65</td>
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</table>
ABP’s World View of Children’s Health

Children’s health is a global priority, and finding ways to improve pediatric health care has become a global quest. One way to do that is to make sure that their doctors receive high-quality training and meet rigorous standards for care.

The ABP is playing a significant role in promoting quality health care for children in other countries as well as in the United States. In particular, one of the ABP’s global efforts is having a significant impact in Brazil and has the potential to make a tremendous positive difference in health care for Brazilian children.

In 2009, driven by the vision and leadership of Dr. James A. Stockman III, the American Board of Pediatrics Foundation (ABPF) sponsored a meeting for leaders from 16 national and regional pediatric organizations responsible for setting standards for training and accreditation in more than 50 countries. This group became the Global Pediatric Education Consortium (GPEC) in 2010 and its singular focus has been improving children’s health care by working collaboratively to develop and promote global standards for training and assessment. GPEC’s vision is to improve children’s health care in countries worldwide and, in particular, in less-resourced countries.

The concept of global standards quickly broadened to encompass curricula, evaluation methods, accreditation and certification standards, as well as guidelines for continuous professional development—all of which are based on best practices from around the world.

“GPEC represents a true advancement for children and adolescent health because we are making a more significant, long-term impact by focusing on the entire training system, as opposed to just one element like examinations,” says Dr. Dioclécio Campos Jr., GPEC Delegate, former President of the Brazilian Pediatric Society, and currently the Executive Secretary of the Southern Cone Forum of Pediatric Societies.

In May 2011, GPEC reached consensus on the Global Pediatric Curriculum for post-graduate training. The curriculum contains a competency-based outline covering the depth and breadth of pediatric knowledge, skills, and abilities/behaviors that GPEC believes are basic to quality residency training worldwide.

The curriculum also specifies guidelines for post-graduate training programs, national certification programs and continuous professional development. The curriculum was published in fall 2012 on the GPEC website (globalpediatrics.org) and has been nationally adopted by seven countries: Argentina, Bolivia, Brazil, Chile, Paraguay, Spain and Uruguay. It also is being used in Rwanda to develop the first standardized curriculum for pediatric training.

Brazil is a good example of the GPEC’s goals in action. The Brazilian Pediatric Society (BPS) adopted the GPEC’s curriculum as a pilot project in which 10 pediatric university centers will use the guidelines to improve resident trainer qualifications.
One significant outcome of the GPEC’s influence is that the Brazilian government has changed the previously required two-year training track to a more comprehensive three-year training track.

Additionally, Dr. Campos says the next edition of the Brazilian Pediatric Treatise (the national textbook used in Brazil), planned for 2016, will be entirely founded on the GPEC curriculum. Further, a continuous web-based pediatric education course, also based on the curriculum, is slated to launch in early 2014 to provide trainers and residents full access to this scientific program.

Most significantly, the BPS pediatric certification system, a training and evaluation process, will be implemented in 2014. This process entails that residents take a national exam based on the GPEC curriculum each year of their training. If the trainee’s performance on the three annual exams is satisfactory, he will be certified by BPS at the end of his training program.

“This is a huge accomplishment for the country,” says Dr. Campos. “The ABP and the ABPF should be proud to be a part of this immensely significant reform in Brazil’s pediatric training and we look forward to its first application in early 2014.”

“It’s an exciting time for GPEC as we seek to move the organization from the patronage of the Foundation to a more permanent funding source,” says Dr. Hazen Ham, Executive Secretary of GPEC and ABP’s Vice President of Global Initiatives. “The impact of ABP’s involvement with GPEC in the development of a global curriculum has been astounding and far greater than we ever anticipated.”
Measuring Excellence with Awards

Paul Sharek, MD, MPH

Dr. Paul Sharek was named the inaugural Paul V. Miles Fellow in Quality Improvement, an area that has been central to Dr. Sharek’s career. As Medical Director of Quality Management and Chief Clinical Patient Safety Officer at the Lucile Packard Children’s Hospital in Palo Alto, Calif., he has emerged as one of the movement’s leaders at the local, state, and national levels. He also serves as medical director of the hospital’s Center for Quality and Clinical Effectiveness, which he was instrumental in establishing. As Medical Director of the Child Health Accountability Initiative (CHAI), Dr. Sharek served as principal investigator of a four-year, $1.3-million Partnership for Quality grant, which funded a series of QI initiatives for the 14 children’s hospitals within CHAI. By expanding this Partnership for Quality program to all 43 member hospitals in the Child Health Corporation of America, he had a positive impact on the lives of countless children. He also serves as the Director of Quality for the California Perinatal Quality of Care Collaborative (CPQCC), a data-driven quality improvement organization of 132 California neonatal intensive care units that collects standardized data, provides benchmarks, and conducts extensive quality improvement activities. Through research and publication of dozens of peer-reviewed journal articles, Dr. Sharek has had a swift and profound impact on the field of pediatrics. With his tremendous ability to coordinate organizations’ efforts in pediatric quality of care, transforming concepts and goals into results, Dr. Sharek is a deserving recipient of this prestigious award.

Paul V. Miles, MD

The Paul V. Miles Fellowship in Quality Improvement award honors the passion for improving health care for children that Dr. Paul V. Miles has exhibited throughout his career, including his years of service with the ABP. 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.
New Lectureship Honors Former ABP President

James A. Stockman III, MD, past president and CEO of the ABP, will be honored in October 2014 at the American Academy of Pediatrics Conference for his outstanding lifelong contributions to pediatrics. The ABP and AAP are sponsoring the inaugural Stockman Lectureship on Pediatric Education and Workforce at the medical education conference, which is expected to draw more than 12,000 pediatricians and other health care professionals to San Diego. Dr. Stockman will serve as the first speaker at the Stockman Lectureship, which is intended to offer a platform for many relevant topics for pediatricians and honor his legacy of improving health care for children by promoting lifelong learning and advanced training for pediatricians. Nominations for future lecturers will be reviewed by the Executive Committees of the AAP and ABP.
Since 2009, the American Board of Pediatrics Foundation (ABPF) has supported a longitudinal survey project led by Gary L. Freed, MD, MPH, of the Children's Health Evaluation and Research Unit at the University of Michigan. The project tracks the work experiences and choices of pediatricians throughout their career, beginning from residency throughout Maintenance of Certification.

“These surveys will ultimately allow the ABP to better understand training, current workforce, and workforce trends,” say Linda A. Althouse, PhD, ABP Vice President for Psychometrics, Research, and Testing Services. “Research resulting from these data will help to inform policy decisions and priorities of the ABP, federal and state governmental agencies, and other leadership organizations within the field of pediatrics.”

Dr. Freed’s work is among many projects supported by the ABPF. The foundation extends the impact of the ABP by supporting innovative research and strategic initiatives that enhance the practice of pediatrics and the health and well-being of children throughout the world.

In December 2013, experts in the types of research supported by the ABPF met for a two-day retreat to discuss the foundation’s future course.

As Dr. David Nichols, ABP President and CEO, explains, “This group of inspired leaders came together to help us ensure that the American Board of Pediatrics and the ABP Foundation continue to foster rigorous research and effectively support the special initiatives needed to meet our common goal of improving the health of children.”

Through a series of breakout and plenary sessions, more than 40 participants offered insights and opinions to help define key research priorities for the ABP and best practices for the foundation, including potential improvements to the foundation’s structure and operations.

During the retreat, participants reviewed the types of research projects that the foundation funds and discussed how that research supports the ABP’s mission of improving the health and well-being of children. Retreat participants suggested future areas of research for the ABP to consider with regard to certification, as well as global and educational projects supported by the foundation.

“The ABP Foundation provides opportunities for us to fulfill our commitment to provide guidance and insight to future generations of pediatricians and the children we all serve,” Dr. Nichols says.
Examining Strengths and Opportunities

Just as ABP diplomates continue to learn and grow professionally throughout their careers from medical school on, ABP staff also are constantly evolving and aspiring to higher standards—and, like diplomates, are using milestones as measures for reaching those goals. In 2013, ABP senior management examined strengths, threats, limitations, and opportunities (STLOs) for each department in order to develop strategic priorities for the organization. Progress is being made in each initiative identified. Highlights of the initiatives include promoting excellence among staff and investing in staff professional development, fostering excellence in relationships with ABP committees, pursuing external partnerships that support the ABP mission, ensuring that the ABP has state-of-the-art technology, developing an overall communication strategy, expanding MOC, and exploring ABP engagement in the global arena. Ultimately, ABP diplomates and staff have the same goal: healthier children the world over.

Virginia A. Moyer, MD, MPH

Virginia A. Moyer, MD, MPH, was named Vice President for Maintenance of Certification (MOC) and Quality in April, bringing experience that includes primary care pediatric practice in underserved areas, academic leadership as a professor and editor of major pediatric journals, and policy direction as chair of the U.S. Preventive Services Task Force. She served as professor of pediatrics and chief of academic general pediatrics at Baylor College of Medicine and Texas Children’s Hospital since 2006. She completed medical school at Baylor and her residency at the Children's National Medical Center in Washington, DC, and later earned a master’s degree in public health from the University of Texas. Dr. Moyer was first certified by the ABP in 1984 and is a permanent certificate holder. She believes strongly in the importance of lifelong learning and continues to meet the requirements of MOC. With her passion for quality of care and her belief in the principles of MOC and quality improvement, Dr. Moyer will continue to advance collaboration with other organizations.

Ramona DuBose

Ramona DuBose joined the ABP as Director of Communications in November. She is responsible for developing the ABP’s communications strategy, directing online and print materials, the website, media and public relations, executive communications, and social media efforts. With more than two decades of experience in health-related public relations and strategic planning in corporate, academic, and nonprofit environments (including GlaxoSmithKline and the University of North Carolina Gillings School of Global Public Health), she is skilled at developing professional and effective communications, key messages, and strategies that will advance the ABP’s mission.
The ABP appreciates the fine work of its committee and subboard members and acknowledges their continued service in producing examinations.

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Publications

These publications are based on work conducted by ABP staff or with ABP staff involvement. Some of the research was funded by the ABP Foundation with oversight by the Research Advisory Committee.


Senior Management Team

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Gail A. McGuinness, MD, Executive Vice President

Virginia A. Moyer, MD, MPH, Vice President, Maintenance of Certification and Quality

Linda A. Althouse, PhD, Vice President, Psychometrics, Research & Testing Services

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Hazen P. Ham, PhD, Vice President, Global Initiatives

Ann E. Hazinski, MBA, CPA, Vice President, Finance & CFO

Michele J. Wall, MA, PMP, Vice President, COO
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.