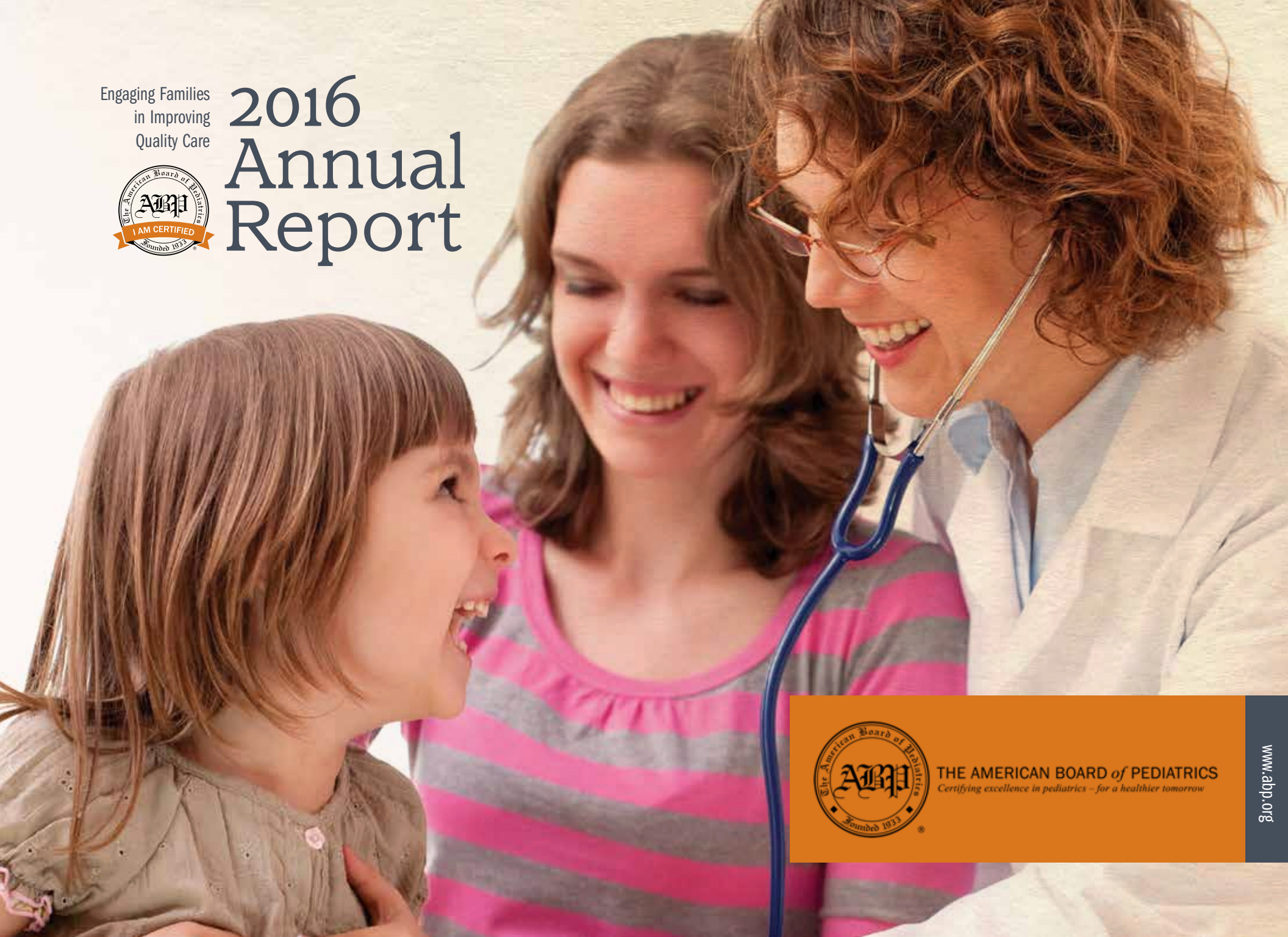


Engaging Families  
in Improving  
Quality Care



# 2016 Annual Report



THE AMERICAN BOARD *of* PEDIATRICS  
Certifying excellence in pediatrics – for a healthier tomorrow

[www.abp.org](http://www.abp.org)

# Table of Contents

Letter from CEO David G. Nichols .....	1
Bringing Parents into the Conversation Changes Everything.....	2
Collaborative Improvement Networks .....	4
Being a Patient Will Make Her a Better Doctor .....	17
Grace's Advocates .....	18
ADHD Conversations.....	20
It's More than Just the Science: Patient Safety Can Be Life or Death.....	22
Latoshia's Joy .....	24
What is Certification? .....	26
MOC Credit Provides "Sweet Cookie" Incentive for Improving Implementation .....	28
EPAs, Competencies and Milestones .....	30
The MOCA-Peds Pilot .....	32
Making the MOC Process Easier .....	34
Steal Shamelessly, Share Seamlessly.....	36
News Roundup .....	38
At a Glance.....	40
Financials .....	41
2016 Committees.....	42
2016 Subboards.....	44
Our Leadership .....	46
2015-2016 Guiding Principles .....	47
2016 Published Works .....	48



## Dear Colleagues,

For the ABP, 2016 was a year of reaching out — to individual pediatricians, professional organizations, parents and patients, residents and fellows, and colleagues at other boards.

I am delighted to say that you have reached back to us, and together we have taken important steps toward achieving our common goal — to improve and protect the health and wellbeing of children from infancy through their transition to adulthood.

Many of you have graciously hosted me at your meetings, and engaged in constructive dialogue about ways we can make maintaining certification (MOC) more effective and efficient. Among these groups are the Federation of Pediatric Organizations (FOPO), the Council of Pediatric Subspecialties (CoPS), the Association of Medical School Pediatric Department Chairs (AMSPDC), the Association of Pediatric Program Directors (APPD), the American Pediatric Society/Society for Pediatric Research (APS/SPR), and several boards and committees of the American Academy of Pediatrics (AAP). I also have had the pleasure of meeting with many pediatricians at AAP district meetings, conferences, grand rounds and teaching visits. With other pediatricians, I have corresponded through emails, phone calls and letters.

We have agreed on many ideas, even if we haven't resolved all our different points of view. I believe the dialogue not only has improved MOC,

it also has enhanced our mutual determination to promote professionalism and excellence in health care for children.

In this quest, we also have reached out to the public. Through our new website, MyCertifiedPediatrician.org, we are helping families understand the dedication and effort you put into earning and maintaining your certification. Also, we have reached out specifically to parents who have experience working with general pediatricians and pediatric subspecialists to care for children with chronic conditions. Many of these parents are active participants in quality improvement projects conducted through collaborative learning networks. We have brought them together twice over the past year to help us explore how to fulfill the part of the ABP mission that promises, “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.”

One of these parents, Diane Pickles, now sits on our Board of Directors. She's not alone. Other parents have joined different committees (see list on page 3). They are in addition to the public members who already bring a broader perspective to the work of our committees and subboards.

In addition to the summaries of the Board's work, the 2016 Annual Report concentrates on the intersection of parent stories and the efforts by diplomates to improve the quality of care to children. And you will read how the partnership among patients, parents, and pediatricians has given these families hope.

Thank you for your commitment to preserving and improving the health of children and for continuing to work with us to build a healthier tomorrow.

Sincerely,

David G. Nichols, MD, MBA  
President and CEO



Dr. Nichols with his grandchildren (from left), Iliana (5) and Jaxon (2)

# Bringing Parents into the Conversation Changes Everything

There's a saying among parents of children with chronic conditions — “Nothing about me without me.”

These parents want to have a voice in their children's treatment plan, both to understand options and, in many cases, to help find new best practices by participating in quality improvement activities. By offering their perspective on what their child is experiencing and how it affects the entire family, they can help improve the quality of child health care.

Recognizing the importance of parents' roles in children's health care, the American Board of Pediatrics (ABP) has established a new committee, called the Family Leadership Advisory Group (FLAG), who serve as parent representatives to several other ABP committees (*see the facing page*), including the ABP Board of Directors. Public members have served on ABP committees since 1979, but these new members specifically bring the parents' perspective. All of these people bring the perspectives of parents and the public. Most also have children with chronic health conditions and are associated with a Collaborative Improvement Network. These networks link physicians with other health care providers who are treating patients with specific diseases and conditions, and with the patients' families.

“These parent advisors have a strong understanding of board certification and, in particular, quality improvement activities,” says ABP President and CEO, David G. Nichols, MD, MBA. “Through their experience caring

for a child with a chronic condition — with so much of their lives entwined with the health care community — they help us stay focused on our mission to set standards of excellence for pediatricians.”

Diane Pickles, a parent who serves on the ABP Board of Directors, has a son who was born in 1994 with hypoplastic left heart syndrome (HLHS) and aortic atresia. Jake is thriving as an adult now. Pickles says Jake's care team listened to his family's perspective, and she believes their voices improved his care. She explains, “I think I've become a pretty savvy parent, but that's only after living 21 years through an awful lot of care delivery.”

That same experience and perspective has made her a valuable parent leader in the National Pediatric Cardiology Quality Improvement Collaborative (NPC-QIC).

Jeffrey Anderson, MD, MPH, MBA, a pediatric cardiologist at Cincinnati Children's Hospital Medical Center and recipient of the 2016 Paul V. Miles Fellowship in Quality Improvement (*see story page 36*), is the Cardiology Lead for the NPC-QIC.



Parent advisors met with ABP leadership in September.

“These parent advisors have a strong understanding of board certification and, in particular, quality improvement activities.”





He says that clinicians, centers, parents and “anyone trying to improve health care” will be more successful much sooner if they work together. “Bringing parents into the conversation changes everything.”

Many pediatricians already involve parents in the care of their patients, with excellent results. For example, Vineeta Mittal, MD, MBA, in the Department of Pediatrics at the University of Texas Southwest Medical Center has practiced family-centered rounds with pediatric trainees for several years.

“The residents get to see the attending [physicians] talking with families,” she says. “This is a very effective way for residents to learn compassion, dignity, respect. You can’t teach these professionalism skills in the classroom. And the parents are very happy to see the residents working with the senior people as a team. The families feel like they are contributing to the education of the next generation and helping them understand the families’ perspectives and needs.”

It is only natural, then, that the ABP also could benefit from including parents in discussions about certification standards.

“Parents bring a new level of energy to the committees on which they serve and have provided the ABP with closer links to the powerful work being done by collaborative networks,” says Christopher Cunha, MD, a general pediatrician in Crestview Hills, Kentucky, and 2016 Chair of the ABP Board of Directors.

“The addition of parents is one of the most important things that has happened at the ABP,” Dr. Cunha says. “Their stories inspire and focus us. Patients and parents provide valuable feedback to the Board about what outcomes matter to them and help to focus work around communication, quality and safety.”

Parent advisors to the ABP have encouraged the Board to educate all parents about board certification so they understand how much effort pediatricians put into earning and maintaining their certification. While certification is not the only factor parents consider when choosing a doctor for their children, it does assure parents and patients that a pediatrician is making the effort to keep up to date and improve the quality of the care they deliver.

Parents also helped the ABP develop a website — **MyCertifiedPediatrician.org** — to explain to parents and the public what certification is and what pediatricians do to earn and maintain their certification. The site also includes resources that physicians can use in their offices to distinguish themselves as being certified. (see story, page 26).

“I believe that while the partnership between parents and the ABP is still young, it has resulted in some shifts in thinking and approach by the ABP,” Pickles says. “It is hugely significant that parents have been given a seat at leadership tables within the organization — Board of Directors, Foundation Board of Directors, and other key committees. My hope is that this will lead to a much deeper culture shift within not just the ABP but within pediatrics.”



## ABP Family Leadership Advisory Group Members

ABP Board of Directors

**Diane M. Pickles**

ABP Foundation Board of Directors

**Stacey L. Lihn**

Maintenance of  
Certification Committee

**Tara B. Rouse**

Research Advisory Committee

**Kathryn A. Sabadosa**

Three other family leadership  
advisors have been appointed to  
join committees in 2017:

Conflict of Interest Committee

**Amy L. Kratchman**

Credentials Committee

**V. Robyn Kinebrew**

New Subspecialties Committee

**Jennifer Bolden-Pitre**

# Collaborative Improvement Networks Share Data, Best Practices, to Improve Children's Health

Collaborative improvement networks connect clinical teams that treat patients with specific diseases and conditions in regional settings, at locations across the United States, and sometimes even around the world. These networks offer an opportunity to work together to use data for improvement, and facilitate the sharing of strategies, experience and expertise by clinicians with a goal to improve treatment and outcomes for children. Many networks partner with parent/patient groups who contribute the insights of patient concerns, priorities and ideas for change.

The American Board of Pediatrics (ABP) recognizes that these networks facilitate improvements in the care physicians are providing. The ABP supports these collaborative improvement networks by awarding Maintenance of Certification (MOC) credit for Improving Professional Practice (Part 4) to pediatricians involved in quality improvement (QI) projects through the networks. ABP staff can help diplomates and organizations identify the most effective way to recognize these activities with MOC Part 4 credit. 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.

“Every year, these collaborative improvement networks provide a platform for clinicians,

patients and families to work together to identify and implement strategies that improve and protect children's health,” says Carole Lannon, MD, Senior Quality Advisor for the ABP. “Those involved are enthusiastic about ‘stealing shamelessly and sharing seamlessly’ what is working, with a goal to improve care and outcomes. Pediatricians participating in collaborative improvement efforts are advancing the quality of care and driving results, and the Board recognizes these data-driven efforts by providing MOC credit. Most importantly, the better outcomes benefit children and families.”

Following are examples of important improvements contributed by these organizations during 2016.

“Those involved are enthusiastic about ‘stealing shamelessly and sharing seamlessly’ what is working.”



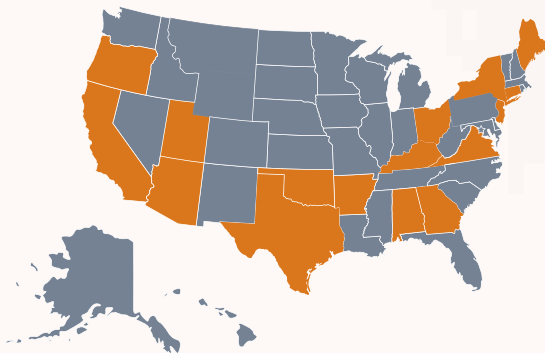


## Primary-Care Focused Collaborative Improvement Efforts

### The American Academy of Pediatrics Chapter Quality Network

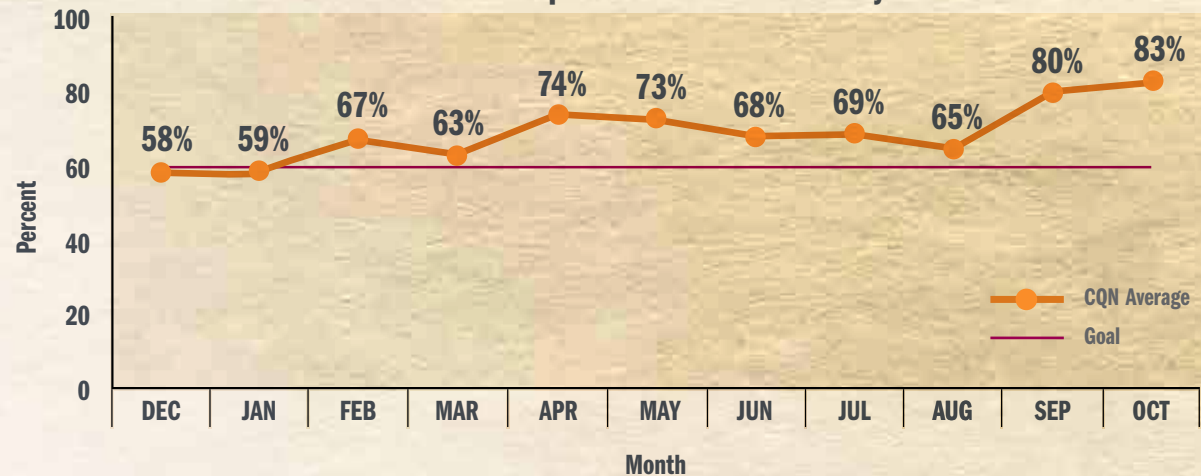
The Chapter Quality Network (CQN) began in 2009 as a pilot project to improve care for children with asthma in the Alabama, Ohio, Oregon and Maine American Academy of Pediatrics (AAP) chapters. Since then, CQN projects have expanded to collaboratives in 18 state chapters and extended their focus beyond asthma to include attention deficit hyperactivity disorder (ADHD), mental health/adolescent substance use, immunizations and judicious use of antibiotics in children. The CQN model works at the national, chapter and practice levels to improve care and outcomes for children at a population level, using evidence-based guidelines.

### 18 chapters in 16 states participate in AAP's CQN



Source: American Academy of Pediatrics Chapter Quality Network

### CQN ADHD project: Monitoring the percentage of patients whose medication initiation is followed up by Vanderbilt assessment scales from multiple sources within 30 days



Source: AAP CQN

- The CQN ADHD project is ongoing in the AAP chapters of Arkansas, Georgia, New York 1, New York 2, Ohio and Texas. This learning collaborative has engaged 133 pediatricians to improve outcomes for children with ADHD by focusing on increasing the number of Vanderbilt assessments completed by parents and teachers to assist in diagnosis, medication titration and behavior therapy. As shown in the chart above, practices are monitoring the number of Vanderbilt assessments returned by parents and teachers within 30 days of initiation of medication.
- The CQN Mental Health/Adolescent Substance Use project is ongoing in the Utah, Connecticut and Georgia chapters and has practice teams working to increase the use of validated screening tools, brief intervention techniques and referral to treatment. (See one family's story of dealing with ADHD, page 20)
- The CQN U.S. Immunizations project launched recently in AAP chapters that include practices in California 2, California 4, Georgia, New Jersey, New York 2 and Oklahoma. The project aims to improve

vaccination rates for children 19-24 months of age by focusing on missed opportunities to receive vaccinations and implementing an effective recall system.

Recently, the CQN was awarded a grant from the U.S. Centers for Disease Control and Prevention (CDC) to develop a QI initiative focused on improving the prescribing of antibiotics for outpatient children. The Virginia chapter will pilot a program with primary care practices using the learning collaborative model to reduce the use of antibiotics in children with upper respiratory infections and otitis media.

### State-based Primary Care Collaborative Improvement Partnerships

The National Improvement Partnership Network (NIPN) mentors more than 20 states that have developed collaborative improvement efforts with the goal of advancing the quality of health care and transforming it for children and their families. An improvement partnership is a durable state or regional collaboration of public and private partners that uses the science of QI and a systems approach to change health care infrastructure and practice. Vermont's improvement partnership, the Vermont Child Health Improvement Program (VCHIP), provides leadership to NIPN (More on VCHIP later). Here are examples of state

improvement partnerships that offer QI projects that allow participating pediatricians the opportunity to claim MOC Part 4 credit.

#### Alabama Child Health Improvement Alliance

In 2016, the Alabama Child Health Improvement Alliance (ACHIA) completed a statewide quality-improvement learning collaborative on screening for development, autism and social-emotional risks as well as a collaborative for HPV vaccinations. Previous participants from ACHIA's 2014 Healthy Active Living collaborative submitted data that demonstrated sustained improvement in obesity prevention and treatment.

#### Children's National Health Network

As an American Board of Pediatrics MOC Part 4 approved sponsor since 2013, Children's National Health Network (CNHN) has worked with more than 300 pediatric providers in Maryland, Virginia and the District of Columbia to improve the care provided to the region's children through structured QI learning collaboratives. During the past two years, CNHN partnered with the D.C. Collaborative for Mental Health in Pediatric Primary Care to support a city-wide mental health learning collaborative in the District of Columbia. The collaborative aims to improve practice-readiness to implement and sustain mental health (MH) screening at well-child visits by using a standardized tool and tracking the number of well visits in

## Georgia is Model for Growing QI Initiatives

Georgia's American Academy of Pediatrics (AAP) chapter has been particularly active in quality improvement (QI) projects in 2016, says Suzanne Emmer, director of the AAP Chapter Quality Network (CQN) Improvement Initiatives. Since participating in the CQN Asthma initiative, the chapter has participated in several other quality improvement projects, including those involving ADHD, mental health and immunizations.

"They have been a model for growing their 'bench strength' in QI at the chapter level," Ms. Emmer says.

Pediatricians in Georgia have been enthusiastic, says Ben Spitalnick, MD, MBA, President of the Georgia chapter of the AAP.

"What's been most encouraging is the interest in repeat QI involvement," he says. "Practices that have done one project are seeing the benefit of involvement to their own practice and are the first to want to sign up for repeat opportunities."

The Georgia AAP chapter has promoted the QI opportunities avidly, he says. "We have been vocal in mentioning our QI efforts in our newsletters, website, meetings, blast-faxes and any other media we use to reach our membership."

All these efforts bring high-quality, data-driven, cost-efficient health care to pediatric practices across the state, he says, and "ultimately the children benefit most."



which a mental health screen is administered, documented, addressed and billed.

By using an approved tool, more than 50 providers from 10 DC-based practices (community health centers, federally qualified health centers, and private practices) standardized MH screening and workflows and improved screening from 1 percent (baseline) to 76 percent (post-intervention) as well as billing rates from 39 percent (baseline) to 89 percent (post-intervention). As MH screening rates continue to improve, the D.C. Collaborative for Mental Health in Pediatric Primary Care is working to expand the learning collaborative model with new practices in the District of Columbia, Maryland and Virginia areas.

### Idaho Health and Wellness Collaborative for Children

The intent of the Idaho Health and Wellness Collaborative for Children (IHAWCC) is to create a meaningful, long-term collaboration of stakeholders invested in child health care quality, with the common purpose of improving the health of the children and youth of Idaho. IHAWCC has facilitated a learning collaborative on adolescent immunizations over the last year that provided MOC Part 4 credit to participating pediatricians. IHAWCC has partnered with local health departments and the National Association of City and County Health Officials (NACCHO) to increase the vaccination coverage for Tdap, MenACWY

and the HPV 3 dose series for adolescents 11 to 17 years of age in Idaho. Teams focused on assessing and documenting the immunization status of adolescents, reducing the number of missed immunization opportunities and scheduling appropriate follow-up appointments for those receiving the HPV 3 dose series. They used a nine-month learning collaborative model with 15 practices that included 39 physicians. The practices saw a decrease in the rate of missed opportunities, and 14 of the 15 participating teams' practices experienced an increase in HPV appointment scheduling.

### Maryland Pediatric Improvement Partnership

The Maryland Pediatric Improvement Partnership (MPIP), the improvement partnership for the Maryland Chapter of the American Academy of Pediatrics (MDAAP), engaged in three QI projects in 2016. These projects were learning collaboratives on epilepsy, autism spectrum disorder and obesity. In addition, MDAAP has embarked on an evaluation of a previous year's obesity collaborative. Now, work has begun on a second obesity QI project, primarily with federally qualified health centers. MDAAP is conducting an evaluation project with the Maryland state health department in which it re-engages with its last obesity cohort and conducts three more chart reviews to see whether participants are maintaining their success, using measures from that project.

### New Hampshire Pediatric Improvement Partnership:

The New Hampshire Pediatric Improvement Partnership (NHPIP) is a state-level multi-disciplinary collaborative of private and public partners dedicated to improving child health care quality, using systems- and measurement-based QI processes. NHPIP completed its initial developmental screening QI learning collaborative. During the nine-month collaborative, practices increased the percentage of children screened for developmental delays by the age of one year from 0 percent to a mean of 70.4 percent. More information about the project may be found at: **[www.nhpip.org/node/32](http://www.nhpip.org/node/32)**.

### Vermont Child Health Improvement Program (VCHIP)

During the past year, the Vermont Child Health Improvement Program (VCHIP) has supported QI opportunities to pediatricians in primary care practices via a project on Care Coordination in Primary Care, with clinicians from eight practices participating. In addition, VCHIP's longitudinal QI network, Child Health Advances Measured in Practice (CHAMP), recently concluded its project on asthma and has begun its newest project on Vermont health care reform metrics: Developmental Screening and Adolescent Well Care. In each case, pediatricians from more than 20 practices are also earning MOC Part 4 credit.

## The American Academy of Pediatrics Quality Improvement Innovation Networks

The American Academy of Pediatrics (AAP) Quality Improvement Innovation Networks (QuIIN) supports networks in the use of quality improvement science and a systems approach to changing health care infrastructure and practice. Here are two examples:

### Practice Improvement Network (PIN)

Reducing Diagnostic Errors in Primary Care Pediatrics (Project RedDE!), a quality improvement collaborative funded by the Agency for Health care Research and Quality (AHRQ), is engaging 30 primary care practices in the diagnosis, screening and recognition of elevated blood pressure, adolescent depression and missed appointments for lab work. A significant impact from this collaborative involved an electronic health record (EHR) vendor incorporating the National Heart, Lung, and Blood Institute/National Institutes of Health (NHLBI/NIH) evidenced-based pediatric blood pressure alerts into its EHR for all children up to the age of 17.

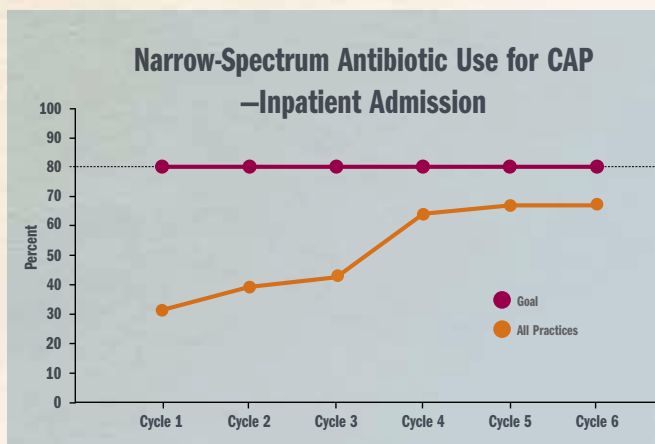
## Hospital-Focused Collaborative Improvement Efforts

### Value in Inpatient Pediatrics Network (VIP)

VIP supports several inpatient pediatric quality improvement initiatives, including these:

#### Improving Community-Acquired Pneumonia (ICAP)

ICAP is a collaborative of 52 hospital teams (U.S. and international) working to increase compliance with evidence-based practices for CAP diagnosis and treatment. The collaborative uses the 2011 Infectious Disease Society of America/Pediatric Infectious Disease Society (IDSA/PIDS) clinical practice guidelines on CAP. Improvements included increased inpatient and emergency department use of narrow spectrum antibiotics, while use of unnecessary macrolide antibiotics decreased in both settings.



Source: AAP Value in Inpatient Pediatrics Network

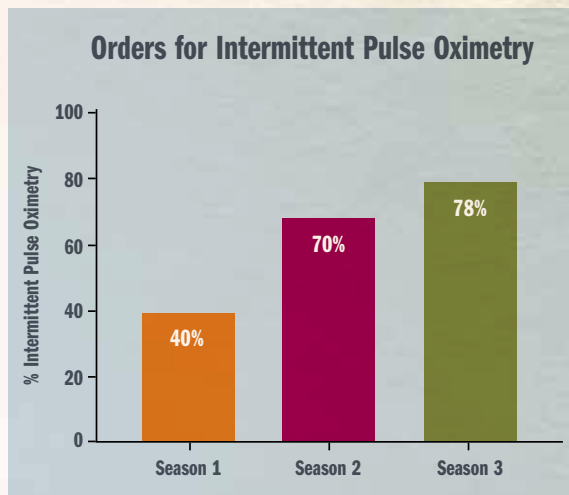
## The Bronchiolitis Guideline (B-QIP) Collaborative

The Bronchiolitis Guideline (B-QIP) collaborative focuses on improving hospital teams' compliance with the AAP Diagnosis and Treatment of Bronchiolitis clinical practice guideline. Interventions were implemented during bronchiolitis "seasons," or the months during which bronchiolitis is most often diagnosed. In the post-intervention period (season 3), sustainability data indicated that all improvements achieved in season 2 were sustained in season 3. Consistent with practice guidelines, the orders for intermittent pulse oximetry to measure oxygen saturation levels increased significantly during the project period.

### Stewardship in Improving Bronchiolitis (SIB)

As part of the collaborative's work, other components were added to bronchiolitis treatments, including engaging emergency department physicians as co-leads and adding a measurement to assess the discharge summary communication to the child's outpatient physician. The addition of the emergency department physician as a co-lead ensured improved management of infants identified with bronchiolitis across the care continuum. Preliminary results indicate bronchodilator use decreased in both the inpatient and emergency department settings, and communication improved between providers. To date more than 100 participating physicians have been awarded MOC Part 4 credit for this project.





Source: AAP's Bronchiolitis Guideline Collaborative

## Children's Hospitals' Solutions for Patient Safety

Children's Hospitals' Solutions for Patient Safety (SPS) Network, comprising more than 100 children's hospitals, is driven by a shared goal to urgently reduce and ultimately eliminate serious harm across all children's hospitals. Network members account for approximately 50 percent of admissions to children's hospitals in the U.S.

From 2012 through May 2016, the SPS Network has significantly improved pediatric patient safety by:

- Reducing the rates of three hospital-acquired conditions (HACs) by more than 40 percent,
- Preventing serious harm to 6,686 children, and maintaining a consistent upward trend in harm prevented every month,
- Saving more than \$121 million.

The SPS Network offers numerous "All Teach/All Learn" opportunities, which have included hundreds of webinars, 12 regional meetings and two national learning sessions.

The SPS Network recognizes the critical role that patients and families play in safety and includes the patients and their families into the network learning sessions.

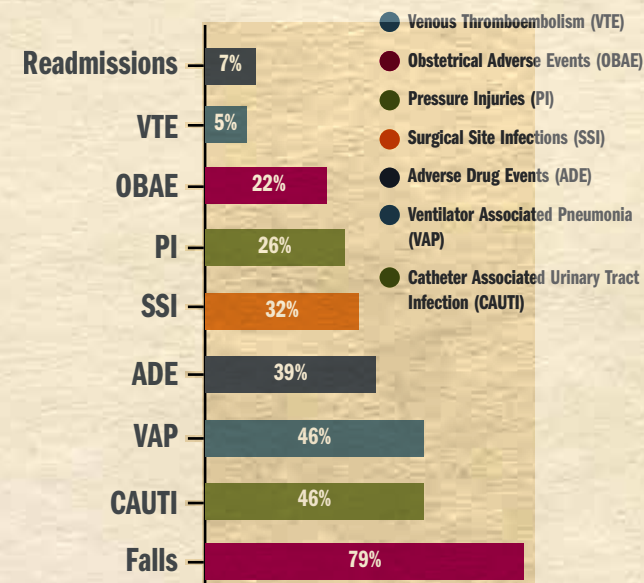
The SPS Network is funded in part by the Cardinal Health Foundation, Children's Hospital Association and the federal Partnership for Patients program. (See one family's story about patient safety, page 22)

## Children's Hospital Association

The Children's Hospital Association (CHA) sponsors collaborative networks achieving improvements in a variety of health care settings, including ambulatory care in hematology and oncology and prevention of catheter-related infections in pediatric dialysis centers.

The following (SCOPE and CCBDN) are examples of CHA projects.

## Percentage of Reduction in Cases



Source: Children's Hospitals' Solutions for Patient Safety Network



## SCOPE Collaborative

CHA's SCOPE (Standardizing Care to Improve Outcomes in Pediatric End Stage Renal Disease) Collaborative focuses on preventing infections in pediatric peritoneal dialysis (PD) and hemodialysis (HD) patients across 41 participating centers. As of May 2016, SCOPE Collaborative sites:

- Prevented an estimated 275 peritonitis infections and 169 hospitalizations,
- Saved an estimated \$3.6 million,
- Reduced the exit-site infection rate 25 percent (in the prior 12 months),
- Dropped the peritonitis rate 37 percent (in the prior 12 months),
- Added five new centers, published three papers, and gave five presentations at professional meetings in 2016.

## Childhood Cancers and Blood Disorders Network

The CHA Childhood Cancer and Blood Disorders Network (CCBDN) focuses on prevention of central line infections in children with cancer and blood disorders. In 2016, the network has:

- Reduced ambulatory central line-associated blood stream infection (CLABSI) rates by 7 percent, resulting in 179 infections prevented,
- Saved an estimated \$6.2 million.

CCBDN recently launched a port infections innovation group after data showed that infection rates in the ambulatory population are highest in tunneled external central lines. In 2016, the collaborative published two articles and has four more in development.

## Subspecialty/Disease-Focused Collaborative Improvement Efforts

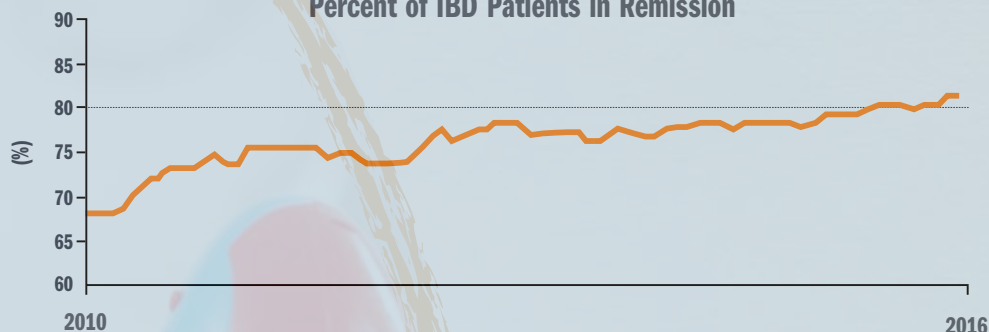
### Cystic Fibrosis Foundation

The Cystic Fibrosis Foundation has launched a learning network that it considers the cystic fibrosis (CF) care model of the future. The goal is to ensure that everyone involved with CF care has access to the information, resources and treatments they need to enable people with CF to live full and productive lives. The design of the model was created in partnership with about 80 experts in CF care, including clinicians, people with CF, family caregivers, researchers and foundation leadership. Beginning in August 2016, 13 CF clinics enrolled in the pilot CF Learning Network to test, refine and implement the recommended changes by engaging in continuous, collaborative quality improvement together. A number of measures are being tested following the official launch of the network in October 2016. Teams plan to identify 90- and 180-day goals and commit to monthly data collection to monitor progress toward improvement.





Percent of IBD Patients in Remission



Source: ImproveCareNow

### ImproveCareNow

ImproveCareNow (ICN) focuses on improving outcomes for children with inflammatory bowel disease. The network comprises 91 pediatric teams — 88 in 36 states and the District of Columbia, two in the United Kingdom and one in Qatar. The network has increased the percentage of children in remission from 48 percent to 81 percent by standardizing and improving care processes and by building patient and parent partnerships into the network infrastructure.

The ICN registry includes data on more than 26,000 patients and 170,000 patient visits. These data are used for population management, pre-visit planning, performance feedback and clinical research.

### Pediatric Rheumatology Care and Outcomes Improvement Network

The Pediatric Rheumatology Care and Outcomes Improvement Network (PR-COIN) is a network of 18 sites across the U.S. and Canada that focus on improving rheumatic conditions. The network's registry contains more than 4,700 patients and 28,000 patient encounters.

PR-COIN member teams apply quality improvement methods and approaches, such as pre-visit planning, population management, shared decision-making and self-management support, which has increased the percentage of children with inactive juvenile idiopathic arthritis and increased the reliability of many care processes critical to high quality care. Improving outcomes is difficult in any one center. However by analyzing data and sharing best practices, rates of low activity — or clinically inactive disease increased from 49 percent to 54 percent among children with juvenile idiopathic arthritis treated at PR COIN member centers. (See one family's story, page 18)

“PR-COIN member centers changed their care processes and dramatically increased the percent of patients on non-biologic disease-modifying anti-rheumatic drugs receiving toxicity lab tests from 49 to 78 percent.”

—Esi M. Morgan, MD, MSCE, Assistant Clinical Director, Division of Rheumatology and Associate Professor, University of Cincinnati Department of Pediatrics

## National Pediatric Cardiology Quality Improvement Collaborative

The National Pediatric Cardiology Quality Improvement Collaborative (NPC-QIC) is a pediatric research and quality improvement network of 60 pediatric cardiology care centers across the United States. NPC-QIC works with a parent partner organization, Sisters by Heart (SBH), to collaborate with families, clinicians and researchers to dramatically improve outcomes for infants with a complex congenital heart disease, Hypoplastic Left Heart Syndrome (HLHS). SBH focus the collaborative on changing the outcome for these infants and has helped disseminate information from the collaborative to parents through social media and other outlets. Parents serve on the NPC-QIC executive leadership team, co-lead NPC-QIC learning labs and co-produce network growth plans.

During this past year, NPC-QIC has realized several important accomplishments in Phase I of its work:

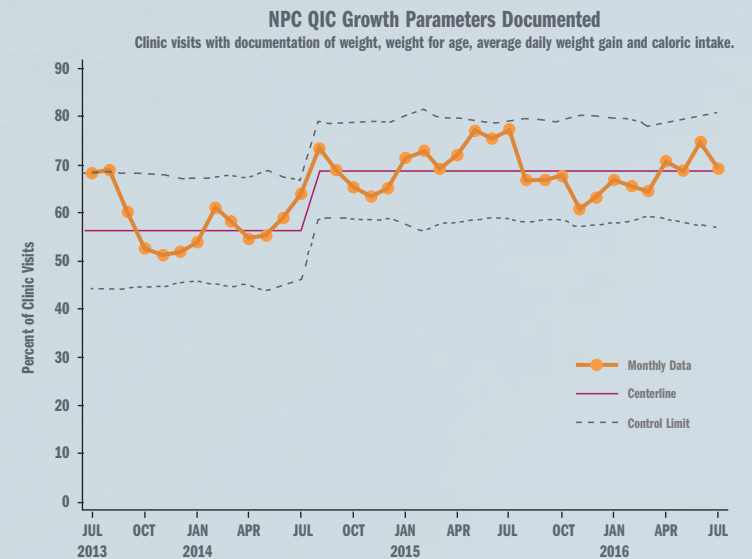
- Cumulative interstage mortality has decreased from 9.5 percent to 5.1 percent, a relative reduction of 46 percent.

- The percentage of infants experiencing growth failure has decreased from 18.6 percent to 15.8 percent, a relative reduction of 15 percent.
- The number of infants being readmitted to the hospital for serious medical problems has been significantly reduced across the collaborative.

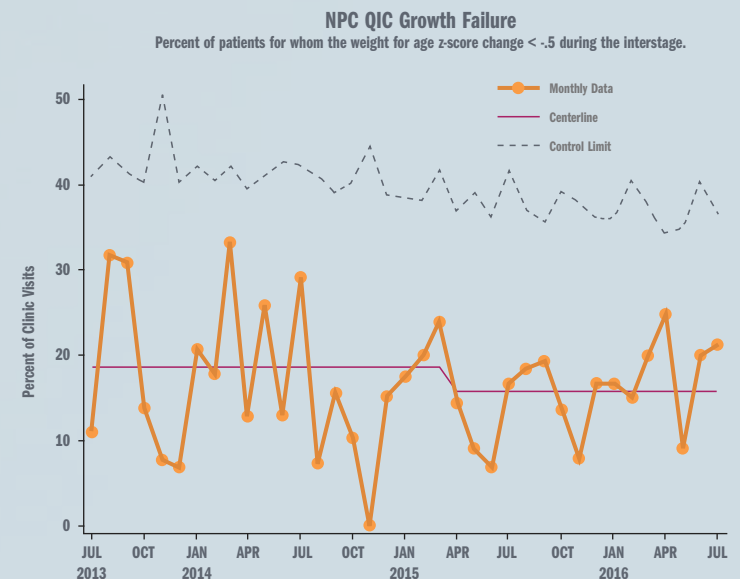
In 2016, the collaborative significantly expanded the scope of the network's work to include the time between diagnosis and first birthday. They have recruited additional team members including pediatric cardiothoracic surgeons, pediatric critical care physicians, fetal cardiologists, developmental pediatricians and their teams.

As with other learning networks, bi-annual learning sessions are the NPC-QIC's key in-person learning events, bringing participating care centers together to learn core quality improvement methodology and important clinical advances. These events also provide the opportunity for collaboration, peer coaching and mentoring and the sharing of new tools and strategies for use by other care centers.

NPC-QIC held its 13th learning session in October 2016 in Chicago in conjunction



Using standard statistical process control methods, the percent of clinic visits with growth parameters documented improved from 56.3 percent to 68.8 percent, a 22 percent relative improvement.



Using standard statistical process control methods, the percent of patients experiencing growth failure changed from 18.6 percent to 15.8 percent, a 15 percent relative improvement.

Source: National Pediatric Cardiology Quality Improvement Collaborative



with the Congenital Heart Surgeons' Society (CHSS) meeting. In attendance were 216 clinicians (including surgeons), 52 parents and family members, and two adult patients with CHD. Several NPC-QIC partner organizations attended, paving the way for collaborations as part of their Phase II work. These included CHSS, the Society of Thoracic Surgeons (STS) and the Pediatric Cardiac Critical Care Consortium. NPC-QIC was invited by CHSS leadership to hold its fall learning session immediately preceding the CHSS annual meeting to facilitate and maximize attendance from their surgical colleagues.



Zoe Lihn was diagnosed at 19 weeks' gestation with Hypoplastic Left Heart Syndrome (HLHS), which required multiple surgeries.

Now, at age 6, Zoe is thriving. Her mother, Stacey Lihn, co-founded Sisters by Heart, which provides support and information for parents of children with HLHS.





## State-Based Perinatal Collaborative Improvement Efforts

### Perinatal Quality Collaboratives

Many states have developed perinatal quality collaboratives (PQC) to improve the care and outcomes of infants, especially those born prematurely. Descriptions of the neonatal efforts of several PQCs are listed below. In addition, the national March of Dimes and the Centers for Disease Control and Prevention held a meeting in November 2016 of all 50 states to launch a Neonatal Network of Perinatal Quality Collaboratives.

#### California Perinatal Quality Care Collaborative:

The California Perinatal Quality Care

Collaborative (CPQCC) focused on optimizing

length of stay (LOS) for preterm infants

less than 31 weeks gestational age as  
their most recent neonatal quality

improvement project in 25 member

NICUs. As a portfolio provider,

CPQCC has integrated MOC

Part 4 credit into the standard

work of all CPQCC QI

initiatives. The main

components of the

initiatives included

standardizing

individual site

practices for feeding,

discharge planning,

and apnea and

bradycardia

management. Collaborative QI NICUs participated in monthly conference calls and periodic in-person meetings to share data, discuss progress and troubleshoot problems. During the 18-month intervention period, 2,586 eligible infants were cared for in collaborative QI centers, 1,222 in NICU QI centers and 3,771 in non-participant centers. For the collaborative QI NICUs, median post-menstrual age (PMA) at discharge decreased by two days ( $p = 0.003$ ) from  $37+1/7$  to  $36+6/7$ . There was not a significant decrease in non-participating NICUs.

#### Florida Perinatal Quality Collaborative

The Florida Perinatal Quality Collaborative (FPQC) was established in 2010 and has offered three projects for MOC credit. Their 2011-2012 Neonatal Catheter Associated Bloodstream Infection (NCABSI) initiative was part of a multistate effort led by the Perinatal Quality Collaborative of North Carolina. In Florida, 18 NICUs participated and reduced neonatal infections by 59 percent, avoided 150 central line infections, prevented 18 deaths and saved nearly \$8 million in health care costs. Their 2014-2015 Golden Hour Delivery Room Management initiative included nine NICUs and demonstrated that promoting teamwork (by increasing pre-delivery preparedness) was associated with improvement of thermoregulation, oxygen saturation targeting and delayed umbilical cord clamping compliance. FPQC's current initiative aims to improve the use of mother's own milk (MOM) in very low birth weight infants and involves 25 Florida Level II and III NICUs.

#### Neonatal Quality Improvement Collaborative of Massachusetts:

The Neonatal Quality Improvement Collaborative of Massachusetts (NeoQIC) launched a statewide collaborative project focused on improving safe sleep practices (SSP) in NICU infants in July 2015. All 10 Massachusetts Level III NICUs are participating in the project and have organized local teams focused on safe sleep practices. The project includes weekly audits in which NICU infants are categorized as eligible for SSP or for NICU therapeutic positioning, depending on their gestational age, weight and illness severity. Significant improvement in compliance with SSP for eligible NICU infants has been seen, with initial compliance of between 30 and 60 percent increasing to between 60 and 80 percent.

NeoQIC launched the statewide Human Milk initiative in January 2015, with 10 Level III NICUs focused on improvement in provision of mother's own milk for very low birth weight infants. The project focuses on prenatal education, early breast milk initiation, skin-to-skin care and optimizing direct breastfeeding during the transition-to-home period. The overall aim is to increase any human milk use in the 24 hours prior to discharge or transfer to more than 75 percent by December 2017.

#### Vermont Oxford Network (VON)

Vermont Oxford Network now serves more than 1,000 member centers from around the world. To date, more than 500 teams from around the world



have participated in VON QI collaboratives with the goal of moving beyond simply collecting data to transforming that data into actionable information to improve the quality, safety and value of care for infants and their families. VON offers a new simplified and streamlined mechanism to earn MOC Part 4 credit as part of the routine and standard work of the QI collaboratives. To earn MOC Part 4 credit, physicians develop a structured abstract, using the Quality Improvement / MOC Abstracts Submission Guidelines, and submit this to VON. The network also advises physicians how to turn their project into a publishable paper. Learn more at <https://public.vtoxford.org/quality-education/moc-ce/moc/>.

In 2016, more than 370 physicians received MOC Part 4 credit through the VON Portfolio Provider program by participating in VON Quality Improvement Collaboratives.

Programs sponsored by VON include:

#### **NICQ Next2 – Transforming Newborn Care**

The NICQ Next2 multi-center quality improvement collaborative has a current enrollment of 61 teams, each including a parent representative, engaged in a two-year improvement journey.

The teams participating in this collaborative are focused on the overarching goal of “transformation,” supported by the following themes:

- Embedding quality improvement methods throughout the experience;
- Achieving family centeredness and advancing family integration in care, improvement projects and co-design;
- Deepening the engagement of the local unit team in testing potentially better practices and sustaining change;
- Resourcing teams with expert consultation by engaging a mini “consulting team” including clinical experts, QI experts and family experts;
- Resourcing teams with tools, family tools, checklists, documents, virtual video visits to centers of excellence, related micro-lessons and discussion boards in the new VON Learning Management System.

#### **Internet-Based Newborn Improvement Collaborative for Quality — iNICQ 2016: Choosing Antibiotics Wisely**

In 2016, VON sponsored the 16th internet-based QI collaborative, welcoming centers from around the world, as well as partnering with statewide quality improvement collaboratives to learn, measure, improve and share. Among other activities, the iNICQ teams participate in VON Day Quality



Audits, which include both center level variables and infant level variables and serves as a gap analysis, revealing opportunities for improvement. These represent a deeper dive into auditing around a specific topic. In the past three years, VON has conducted the following:

- Largest serial audit of neonatal abstinence syndrome (NAS) to date and associated improvement outcomes;
- Large-scale order of alarm safety;
- Largest serial audit of antibiotic stewardship practices to date.

The VON Neonatal Abstinence Syndrome audit, the Universal Training and Education Program, and the statewide implementation

package are now being rolled out in collaboration with Maryland and other states. In 2015, 298 diplomates from 77 centers received MOC Part 4 credit; in 2016, 368 diplomates from 100 centers received MOC Part 4 credit.

VON is in full partnership with statewide neonatal quality improvement collaboratives in five states (Tennessee, Wisconsin, Oregon, Washington, Colorado) who enroll through their perinatal quality improvement collaboratives and who work at the local, state and national level to drive measurable improvement.

The 2016 iNICQ Choosing Antibiotics Wisely program included 186 centers from 39 states, Puerto Rico and seven other countries.





# Being a Patient Will Make Her a Better Doctor

Stockman Lecture

The third annual Stockman Lecture, a plenary address at the American Academy of Pediatrics' (AAP) National Conference & Exhibition, was not delivered by an experienced pediatrician with decades of wisdom to share. Instead, the presentation was given by a second year medical student, living with a chronic medical condition. She shared her insights from "both sides of the bed" with more than 3,000 pediatricians gathered in San Francisco on Oct. 22. Samantha "Sami" Kennedy was diagnosed at age 14 with ulcerative colitis. Her experience with doctors, hospitals and ImproveCareNow, a collaborative chronic care network of patients, parents, pediatric gastroenterologists, nurses, nutritionists, researchers and quality improvement experts, influenced her decision to go to medical school.

Her first year of medical school was filled with optimism and idealism. Her disease had been in remission for five years. Then, during her first year at Cooper Medical School of Rowan University, her symptoms re-emerged and she returned to being a patient as well as a medical student.

"I tried to think of how to ameliorate the gap between my feelings of vulnerability as a medical student with my entirely different feelings of vulnerability as a chronic illness patient," she said.

Being able to clearly understand the perspective of both patient and doctor will make her better at being both, she said. This is especially true when considering treatment regimens that may be hard for a patient to follow.

"I have been imperfectly adherent," she said. "I have disengaged in my own care when I have hit a threshold of frustration. My actions, or lack thereof, have been the root cause of at least one of my relapses... I am not the paradigm of a perfect patient. I am a real person, as are you and your patients, and it is a hard thing to be."

Reflecting on her failures to follow her treatment regimen compels her to think about the human aspects of her studies and practice, she said.

"The more I recognize my own humanity as a patient, the better I am

able to care for others in return," she said. "Being a patient is making me a better doctor. In acknowledging that I struggle to accept my own disease, to care for myself as I expect others to care for themselves, and to meet the expectations my colleagues and caregivers have set for me, I have to recognize the humanity of others beyond myself."

Kennedy also spoke fondly of and gave credit to an intern named Sara who came and talked to her after Kennedy's initial diagnosis with ulcerative colitis.

"She came after rounds and sat on the edge of my bed, and she told me her story. She made herself vulnerable to me. She took off her white coat and told me about what it was like for her to be a girl in a gown like me; to get to know a world of sickness, foreign and frustrating. I never saw Sara after that hospitalization, but nine years ago, she built a bridge that still endures."

As a physician, Sami says that she endeavors to be someone else's Sara.



*Samantha Kennedy, seen here with ABP President and CEO David G. Nichols, MD, MBA, is a second-year medical student at Cooper Medical School of Rowan University in Camden, N.J. She co-led the patient advisory board for the ImproveCareNow learning health network from 2012 through 2015. She co-developed a peer-to-peer social network, and co-created care improvements at the local and national level with patients, families and clinical teams.*

# Grace's Advocates

## The Trevey Family Story

Grace was only 11 months old when she was diagnosed with systemic juvenile arthritis.

"We were first-time parents," says Kate Trevey of Wisconsin. "Your first response is, 'my job is to care for and protect this child.' How do I do that when I know nothing about this disease?"

Over the past five years, Kate and her husband Mick have learned how to actively participate in Grace's medical care.

"We see our role as her advocate in getting the best care, asking tough questions and really being a partner alongside the doctors and nurses," Kate says. "To me, partnership implies mutual respect. A care provider should value and appreciate the input from parents as much as parents value, respect and need the input and expertise of the doctor. You have to be able to really listen to what is being said as well as what is not being said."

She feels like she's "total partners" with the health care team at Children's Hospital of Wisconsin. "It's not just the doctors, it's the whole clinic and the

whole system that really needs to be in partnership with families. They do that really well at Children's [Hospital of Wisconsin]."

Parents offer the medical team a unique perspective on the patient that could help determine the right treatment for the child.

"A diagnosis of a chronic disease is understandably life-changing for both the child and his or her parents, and the magnitude of its effect can impact all aspects of a family's life. I believe that honesty, openness and empathy can go a long way in providing much needed emotional support to patients and their families," says Julia Harris, MD, a pediatric rheumatologist at Children's Mercy Kansas City. Dr. Harris was a pediatric rheumatology fellow at Children's Hospital of Wisconsin and Grace's doctor when Grace was diagnosed. "I think it is imperative that physicians partner with parents to provide the best care possible for every patient. In my experience, this takes time — time to build a trusting relationship, educate families and recognize their



The Trevey family (from left), Mick, Grace, Kate and Anna

"We see our role as her advocate in getting the best care, asking tough questions and being really a partner alongside the doctors and nurses."





concerns. I try to make sure children and parents understand the disease process, potential symptoms and medication options, so they are empowered to take an active role in their treatment plan. I believe my patients receive improved care through collaboration and communication, and in turn, families are better able to cope, support one another and advocate for their child.”

Kate and Mick Trevey couldn't agree more. “Julia understands the important role of empathy and cares for her patients as she does for her own children,” Kate says.

Yet Kate understands that “Not all families have the same ability to advocate for their children, and not all health care providers are ready to be partners with parents in determining treatment.” For that reason, she has been part of The Pediatric Rheumatology Care and Outcomes Improvement Network (PR-COIN) since 2014.

PR-COIN is a network of rheumatologists, nurses, therapists, social workers and support staff at rheumatology centers who, in partnership with families, are working together to transform how care is delivered to children with rheumatic conditions. PR-COIN's current focus is improving the outcomes for children with Juvenile Idiopathic Arthritis (JIA). As a quality improvement collaborative, they develop and evaluate specific disease management strategies in order to improve the care of children with rheumatic conditions and determine how best to incorporate these strategies into clinical practice. Together they are working to change the way kids with arthritis live their lives and imagine a new world.

Examples of using parent contributions to transform care have included the JIA Uveitis Screening project and the Poly-JIA Flare Clinical Decision Support Treat to Target project.

“I was asked to join by one of the physicians in our clinic to be sort of the parent rep for our site at a time when the network wasn't sure what the role of the parent should be,” Kate says.

“To be honest, we're still figuring out clinic by clinic what role the parent should play. It goes back to mutual respect. Parents have experiences, thoughts, insights to share that often are not on the surface, so we need someone to ask the questions.”

PR-COIN parents have developed cards to help providers initiate conversations with parents of their patients and to help them understand more about decisions facing them and their child.

Kate is also a parent adviser to the American Board of Pediatrics and has offered her input into ways pediatricians can improve their professional practice from the perspective of a parent.

“I'm excited about the goals that the American Board of Pediatrics can put into place that will elevate the conversation about QI initiatives and thinking of this holistic care of children,” she says.

Kate shared her enthusiasm for parents partnering with physicians in May 2015 when she spoke at a PR-COIN network workshop. “I talked about the roles and perspectives that we have and how to engage parents and why it might give value.”

More than a year later, she received an email from Dr. Sandy M. Burnham, a rheumatologist who was at that meeting.

“The ‘aha’ moment for me was Kate's presentation at the learning session,” said Dr. Burnham. “Ever since then, we have worked to include a parent on all improvement teams. I typically think of a parent who may have encountered the issue targeted in the improvement project and ask if a parent has the time to discuss an issue that we think may be important for their child.”

Kate knows it's not always easy for medical providers to partner with parents or even have productive conversations with a parent whose child is ill.

“They're not only dealing with a disease, but how do they do it in a way that is thoughtful and careful for the family, their story and their needs?” she says. “Yes, it does take extra effort, but all good things usually do.”

# ADHD Conversations

## The Williams Family Story

Like most parents, Donna Williams was overwhelmed when her middle daughter, Nylah, was diagnosed with attention deficit hyperactivity disorder — ADHD.

When Nylah was in the second grade, Donna suspected something was amiss because Nylah was having trouble learning. Since Donna worked in a doctor's office, she had access to the Vanderbilt Rating Scale, a questionnaire for parents and teachers that doctors use to help diagnose ADHD. Donna filled out the section for parents and took it to her pediatrician, who prescribed medication for her daughter.

She didn't involve her daughter's teachers then, but four years later, when Nylah was in the sixth grade, Donna found that the medication alone was not enough.

"They needed to give her more time for tests and explain things better and differently, sometimes more often," Donna says. "Her teacher at that time was a little nervous about bringing it to my attention so I said it to her first — she has ADHD."

When Donna opened up about Nylah's disability, the teachers and counselors at school were able to work with her.

Looking back at her own experience, Donna realized several things:

- Parents don't know what questions to ask the doctor when their child is first diagnosed.
- Pediatricians don't always know what resources schools have to offer, or don't pass along the information to parents.

To get a diagnosis of ADHD is overwhelming, Donna says. "We all want our kids to be perfect, and when you're telling [parents] that they're not, then you need to help us. Not just kind of give me a quick, 'Well, here are some medicines and good luck.'"

So when she heard that The American Academy of Pediatrics Chapter Quality Network ADHD project wanted to involve parents of children with ADHD, she immediately volunteered to help. Donna has helped physicians provide more information to patients and caregivers. "We're making it so that parents have more input and knowledge," she says.

"I would like to see doctors have more information about the relationship with the school and make sure they are communicating with the parents... not just for the diagnosis, but also for the next steps on handling ADHD at school."







The materials developed by the ADHD project give parents an opportunity to better understand the issues and what to discuss with their pediatrician. The ADHD project also provides resources about the emotional and mental side of the diagnosis and how to better equip patients for personal challenges.

“The doctors can give this information to the parents so that they can go home and absorb it,” she says.

Donna says she “would like to see doctors have more

information about the relationship with the school and make sure they are communicating with the parents... not just for the diagnosis, but also for the next steps on handling ADHD at school.”

After Nylah turned 18 and started college, Donna became involved as a volunteer with a local Chapter Quality Network where she contributes to webinars and partners with providers to help equip children with ADHD through all the stages of their life — including preparation for college and their career to follow.

“At that point the child has to become their own advocate because they’re adults and the parents aren’t as involved,” Donna says. “Equipping your kid by the time they get to college to be able to advocate for themselves is critical.”



Donna Williams (seated) with her children (left to right), Nylah Williams, Nigel Williams and Najzma Williams

# It's More than Just the Science: Patient Safety Can Be Life or Death

The Hemmelgarn  
Family Story

Carole Hemmelgarn tells residents, medical school faculty, students, nurses — anyone who will listen at lectures and Grand Rounds — about the importance of patient safety.

To emphasize her message, she tells them the story of nine-year-old Alyssa. Back in 2007, Alyssa's family went skiing, but the usually enthusiastic girl seemed lethargic. Her mother noticed her glands were swollen and her throat was sore.

"Her mom thought she had mono," Carole tells her audiences.

But a trip to the pediatrician led to more tests, a diagnosis of leukemia and admission to a hospital.

Ten days later, Alyssa died.

"It wasn't the cancer that killed her," Carole said. "It was medical errors."

Carole speaks to medical trainees and providers on behalf of Solutions for Patient Safety (SPS), a collaborative network that strives to create a learning environment to establish the best safety practices in patient care. The SPS network includes more than 100 children's hospitals and thousands of

pediatricians. The network monitors quality metrics and shares safety successes and failures, all to protect children from harm during treatment. The SPS network creates a connection between parents and medical staff contributing to standardization of practices. They report having saved nearly 6,700 children from serious harm between 2012 and May 2016. Pediatricians participating in the SPS network are eligible for MOC Part 4 credit for participation in the SPS patient safety initiatives.


The SPS network's efforts help reassure parents about consistency of care among a continually revolving medical staff. Carole has shared her patient safety perspective to the ABP because of the ABP's mission to assure the public that pediatricians meet high standards that include interpersonal and communications skills. She hopes to encourage the ABP to consider patient safety information in initial certification and maintenance of certification requirements.

Carole provided a powerful perspective on pediatric patient safety at the US News and World Report Healthcare of Tomorrow conference, held in November in Washington, D.C.



Carole Hemmelgarn





“In health care, we typically want our physicians to be very knowledgeable, which is important,” she says. “But it’s more than just the science. It’s the human element that is so important to patients and families. It’s being able to communicate with us, but also with our children, having that bond when you come in the room.”

Poor communication was a significant problem leading to Alyssa’s death, Carole says.

Somehow, her medical team failed to realize that Alyssa had a severe hospital-acquired infection, known as C. diff. Critical lab reports went unnoticed, and the team did not respond appropriately and quickly, which lead to a classic case of failure to rescue. Her parents watched helplessly as Alyssa’s blood pressure dropped and her pulse raced. The next morning, Alyssa’s dad felt her foot — it was ice cold. Her mother asked for an attending and within minutes a code was called. Alyssa was rushed into intensive care, then into surgery.

“It wasn’t the cancer that killed her. It was medical errors.”

“They brought her out of surgery and told her parents that Alyssa would not live,” Carole says. “They had to make the decision to let her go.”

It’s only then, near the end of her talk, that Carole explains: “Alyssa was my daughter. This tragedy is my family’s story.”

And then she begins to cry.

“I don’t want it to become rote. I want it to have impact. The residents won’t remember all the statistics and bullet points on my slides, but they will remember my story.”



Alyssa

# Latoshia's Joy

## The Rouse Family Story

Latoshia Rouse's triplets are 3 years old now, but they were born at 26 weeks gestation and required more than four months of inpatient hospital care. The rotating staff, medication changes, exhausting days and draining nights were an additional strain on an anxious mom.

"If I was at home, I needed to know that at 3 in the morning, when I woke up and called to see what happened over the last couple of hours, I would hear a reassuring voice," she says.

Latoshia immediately became an active advocate in the care of her children. "I saw myself as the only constant at their bedside, because doctors change, but parents know their baby best," she says. "One doctor may do one thing that the next one is not aware of, and the only fixture is the parent."

Latoshia was determined to be part of the care required to meet the unique needs of her babies. She researched their conditions and made sure the medical staff understood what she needed. After the babies were discharged, she also relied on resources provided by the Vermont Oxford Network and the Perinatal Quality Collaborative of North Carolina to further help her communicate with medical staff.

"I asked a ton of questions," she says. "Everything I had, I gathered it all up, and whether it made sense or not, I would ask the doctor."

Latoshia's passion for obtaining the best medical care possible for her children inspired her to work toward quality improvement in the care of all children. As a current member of the two collaboratives that once supported her, she is a patient and family advisor for WakeMed Health and Hospitals in Raleigh, N.C., bringing a parent perspective to the newborn intensive care unit (NICU) and antepartum improvement committees.

"It was hard. It was very hard, but if you look at them now, no one even knows they were preemies. They are very healthy and busy. It's everything I dreamed when I was sitting there watching them beside that bed; I was dreaming of this day. So all the noise in the background is pure joy. Pure joy."

"Working with a collaborative has helped me to see how the medical staff working together with the parents can help to make health care better in general," Latoshia said. "I hope that more doctors and staff start to value parents as resources of valuable information."

She has also shared her perspective with the ABP and recently described the ABP and its quality improvement initiatives at the launch of the National Network of Perinatal Quality Collaboratives (NNPQC) in Fort Worth, Texas. The NNPQC, sponsored by the Centers for Disease Control and Prevention (CDC) and the March of Dimes, supports the development and enhances the ability of both emerging and established state perinatal quality collaboratives to make measurable improvements in maternal and infant health.

Capt. Wanda D. Barfield, MD, MPH, U.S. Public Health Service, who is director of the CDC Division of Reproductive Health, met Latoshia at the NNPQC launch.

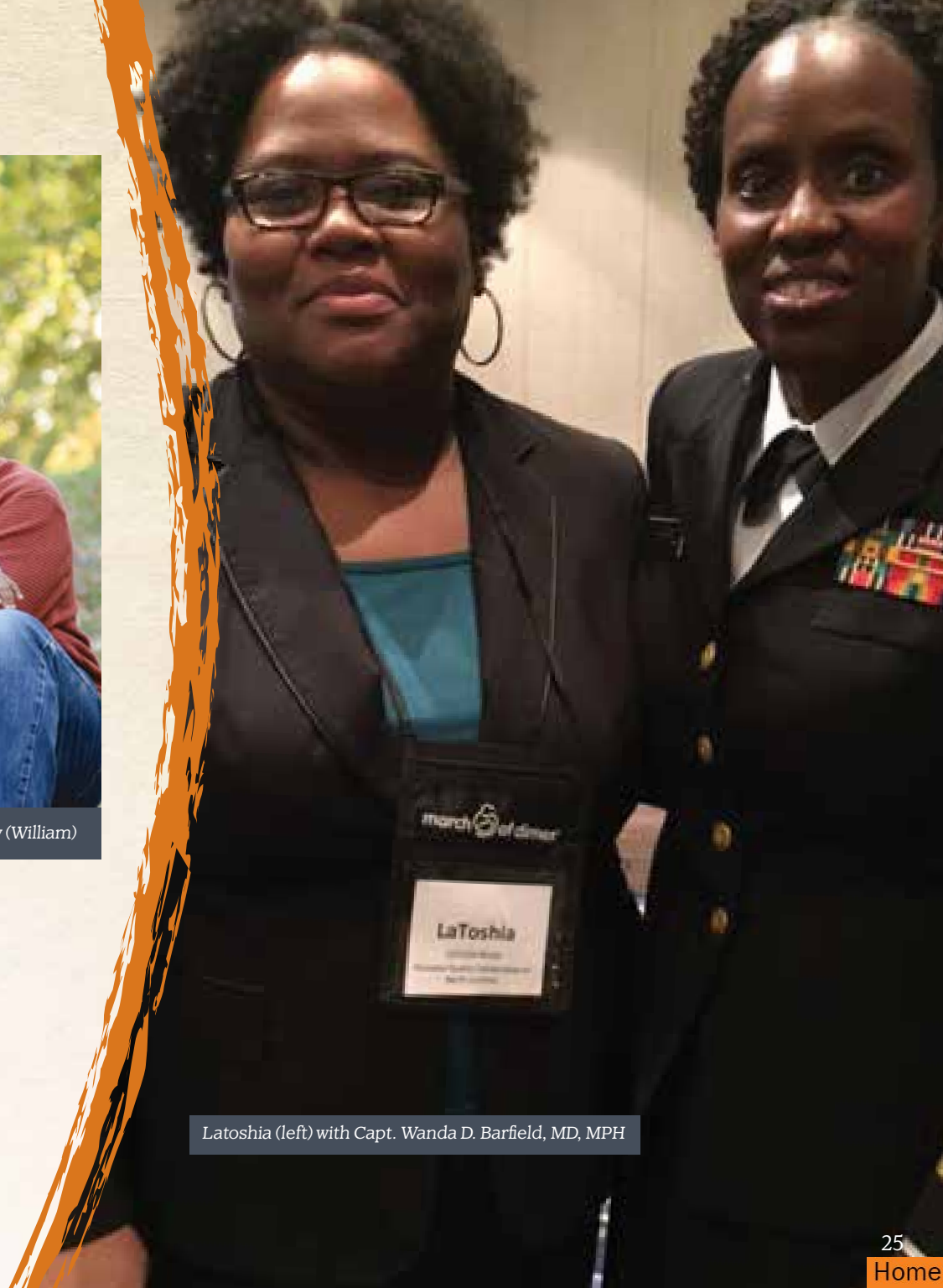
"Ms. Rouse is doing amazing work to give parents an audible voice in the Neonatal Intensive Care Unit," Capt. Barfield says. "She is improving the quality of parental involvement in the care of their critically ill newborns."





From left to right: Ava, Mommy (Latoshia), Layla, Brandon (in the back), Landon, Daddy (William)

Latoshia believes that her efforts to actively participate, stay in constant communication and ask numerous questions may serve as a model to help redefine the role parents have in the care of their children. “I hope that more doctors and staff start to value parents as resources of valuable information,” she says.



Latoshia (left) with Capt. Wanda D. Barfield, MD, MPH

# What is Certification?

## New Website Explains Certification to Parents

Certified pediatricians have completed many years of training in the medical care of children from infancy to adulthood. They demonstrate that they keep up with the latest research and best practices in their fields through Maintenance of Certification (MOC).

But do parents and other caregivers understand and appreciate the extra effort their child's certified pediatrician(s) puts into pursuing the highest levels of professionalism in patient care?

"I just assumed all pediatricians were board certified, but actually it's a choice each doctor makes," says Breck Gamel of Hewitt, Texas, the mother of three, including a six-year-old with cystic fibrosis. "Now that I know the difference between being licensed and certified, I understand the effort that goes into being a board-

certified pediatrician. Our doctor's decision to be board-certified is a gift to me as a parent. They take the time to learn and continue learning, continue to take tests and continue to push quality improvement which ultimately benefits my son with better patient outcomes, and a sense of trust that I know my doctor took the extra effort to make sure we get the best care possible."

Gamel is one of many parents who help the ABP pursue its mission to assure the public that certified pediatricians have successfully completed accredited training and fulfill continuous evaluation requirements that define the core competencies of the profession. She and other parents advised the ABP in creating a website to help pediatricians explain certification to their patients.

The site, **MyCertifiedPediatrician.org**, includes an animated video that explains how certified pediatricians differ from other health care providers. Also, parents and young adult patients share their appreciation for the impact board-certified pediatricians have had on their lives.

The site also has a list of frequently asked questions (FAQs) about qualifications and certification for general pediatricians and subspecialists. And there are links to other

resources for parents, including those offered by the American Academy of Pediatrics.

There are resources available specifically for pediatricians, too, found under "resources" at the top of the site's homepage. These include:

- An electronic "I Am Certified" logo that can be downloaded and used on websites or social media sites of certified pediatricians. The logo links to the verify certification feature on **www.abp.org**.
- News story templates for pediatricians' websites, social media, newsletters or media to be used when they achieve certification or complete an MOC cycle.
- Window clings (plastic, removable stickers) with the "I Am Certified" logo.
- Pins for a jacket, scarf or shirt bearing the "I Am Certified" logo.
- Flyers, counter cards and table tents referencing the site and the value of certification that certified pediatricians can download and print for their office.

"We have added the 'I Am Certified' icon to our website to help parents understand the value of board certification," said Robert Wiskind, MD. The website for his practice in Atlanta is **www.peachtreeparkpeds.com**.

"The physicians of Peachtree Park Pediatrics are committed to providing evidence-based



care of the highest quality,” Dr. Wiskind said. “The Quality Improvement process allows us to objectively examine our assumption that we provide great care and make the changes necessary to optimize our interactions with patients. Maintenance of Certification demonstrates our dedication to remaining current in the field of pediatrics and provides assurance to parents that we are deserving of the trust they place in us to care for their children.”



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HE IS CERTIFIABLY  
**CURIOUS**

HE DESERVES A PEDIATRICIAN WHO IS **CERTIFIED** TOO.



IS MY PEDIATRICIAN  
**CERTIFIED?**  
FIND OUT NOW

### THE MEANING OF CERTIFICATION

Graduating from medical school is just the first step, but what exactly does it mean when a pediatrician tells you she is board certified? Doctors who are certified by the American Board of Pediatrics go above and beyond basic requirements to be licensed to treat patients. Certification is a doctor's commitment to you



# MOC Credit Provides “Sweet Cookie” Incentive for Improving Implementation

“Our goal was to reduce unnecessary tests.”

Clinical practice guidelines can be a very effective mechanism for sharing best practices in the treatment of many childhood diseases. In 2006, for example, the American Academy of Pediatrics published clinical practice guidelines on the treatment of bronchiolitis, a common cause of hospitalization in children from birth to age 2.

However, pediatricians at the Department of Pediatrics at University of Texas Southwestern (UTSW) Medical Center and Children’s Health System of Texas at Dallas noted that integrating all the guidelines into practice was challenging.

Also, research suggests that guidelines are most effective when facilitated by local leaders.



Vineeta Mittal, MD, MBA, Associate Professor of Pediatrics at the Department of Pediatrics at UTSW Medical Center and Children’s Health System of Texas, worked with colleagues to discover the variation in treatment for

different children who were hospitalized in their medical center with bronchiolitis. They identified gaps between practice and evidence. As a result of their studies, they developed recommendations for institutional bronchiolitis clinical practice guidelines, which were published in *Pediatrics*. (Mittal V, *Pediatrics* 2014; 133:e730–e737.)

Their work to improve practice has earned Maintenance of Certification (MOC) Part 4 credit for Dr. Mittal and other pediatricians working on the project. Now that UTSW has become an MOC portfolio sponsor, these pediatricians can continue to earn MOC Part 4 credit through their institution

without the need for a separate application to the ABP.

“Many more pediatricians are taking time to participate in the guideline implementation since MOC credit is awarded,” Dr. Mittal said. “It’s an important and easily achievable incentive.”

In the initial study, a team of physicians — emergency department, hospitalists, general pediatricians and subspecialists in infectious disease, pulmonology and critical care medicine — as well as nurses and respiratory therapists, reviewed standards of care at Children’s Health System and at other institutions. They also reviewed the literature on treatment of bronchiolitis.

“Our goal was to reduce unnecessary tests and treatments and develop a value-based model. So we focused our interventions to reduce the number of chest X-rays we were performing and reduce the use of bronchodilators, steroids and antibiotics,” Dr. Mittal said. “We also wanted to try to reduce the length of hospital stay.”

In addition to developing clinical practice guidelines, the team used different methods



Dr. Mittal's quality improvement project team



to remind doctors to follow the guidelines. For example, they used lectures, emails, computer screen savers and laminated pocket-sized copies of key guideline recommendations.

Results from the study showed a reduction of chest X-rays from 60 percent of children in the control group (the season before the local guidelines were in place) to 45 percent the first season of the new guidelines and 39 percent the second season of the guidelines.

A control chart (below) shows a sustained reduction in chest X-ray use between pre- and post-implementation periods in the eligible patients. The horizontal black dashed line

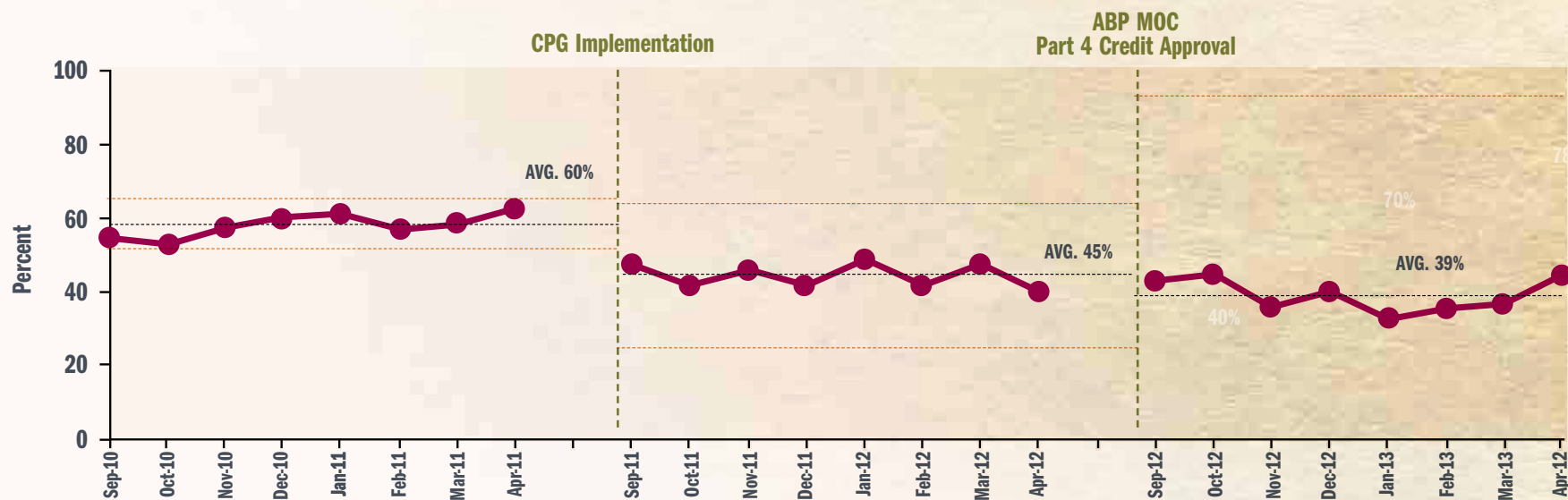
represents the average chest X-ray use during each season. Monthly run charts show a consistently sustained downward trend.

The team also found that bronchodilator use decreased from 27 percent in the control group to 20 percent in the first season and to 14 percent in the second season. Antibiotic use was reduced as well, from 37 percent in the control group to 35 percent in the first season and to 25 percent in the second season. Moreover, the average length of stay in the hospital dropped from 2.3 days for the control group to 1.8 days in the first and second seasons, with no significant change in readmission rates.

Now, based on these apparent improvements, the Department of Pediatrics at UTSW is collaborating with eight hospitals across Texas through the CHAT (Children's Hospitals Across Texas) network to implement and update the guidelines and metrics for measuring their effectiveness. The hospital has also developed and tested guidelines for musculoskeletal disorders and management of asthma in hospitalized children.

"People are motivated to make these changes because it's the right thing to do," Dr. Mittal said, "and getting MOC credit is a very sweet cookie to encourage them to participate."

## Chest X-Ray Utilization



Source: Dr. Vineeta Mittal

# EPAs, Competencies and Milestones

## How do you know when pediatric trainees are ready to practice medicine without supervision?

In recent years, researchers have been attempting to use the direct observations of trainees providing care, by members of the health care team, to develop reliable approaches to assessing competence. In order to do so, medical educators have created programs of assessment using frameworks such as Entrustable Professional Activities (EPAs), Competencies and Milestones. They have also used advances in technology to make these assessments more user friendly by making them accessible on mobile devices. These new approaches are currently being developed and refined by various groups within the pediatric community, including the American Board of Pediatrics, the Council on Pediatric Subspecialties (CoPS), Accreditation Council for Graduate Medical Education (ACGME), the Association of Pediatric Program Directors (APPD), the National Board of Medical Examiners (NBME) and others.

Research is underway to study the validity of these approaches. Recent results from two of these projects indicate that EPAs, milestones, and supervision scales are effective ways to assess whether a resident or fellow is ready to advance to the next step in training.

## What are these approaches?

EPAs are essential activities that physicians are entrusted to perform safely and effectively without supervision. Competencies are the skills a physician has to acquire in order to perform those EPAs. You might think of it this way: if riding a bicycle were an EPA, then pedaling, maintaining balance and use of the brakes would be competencies.



“We create brief narrative descriptions of behaviors at different performance levels, from novice to expert,” says Carol Carraccio, MD, MA, Vice President for Competency-Based Assessment at the American Board of Pediatrics (ABP). “They give us a shared mental image of what trainees look like delivering care at various levels of performance.”

As Dr. Carraccio explains, a trainee who needs to perform a physical exam, for example, and quickly

Milestones are narrative descriptions of behaviors for each of the competencies along a continuum of development ranging from novice — early medical student — to a master clinician who is years into practice.

takes a newborn from a mother's arms and lays the baby on a cold examining table which prompts the baby to cry would be demonstrating behaviors of a novice in the competency of performing a physical exam. A resident who is much farther along the development continuum might come into the room, establish rapport with the mother, and observe the baby in the mother's lap for rate and ease of breathing, color and use of both arms and legs before ever touching the baby.

Milestones are descriptions of the stages of development within an area of competence. As such, milestones provide a roadmap for learners who can utilize these descriptions of behaviors at each phase of their training to help reinforce and set learning goals. Integrating the behaviors of all competencies that are needed to perform an entrustable professional activity such as “providing care to a well newborn” is what trainees are called upon to do in delivering care to patients.

## What did we learn from the research?

A study led by Richard B. Mink, MD, MACM, Chief of the Division of Pediatric Critical Care, and Director of the Pediatric Critical Care Fellowship Program at Harbor-UCLA Medical Center in Torrance, Calif., and Professor of Pediatrics at the David Geffen School of Medicine at the University of California-Los Angeles (UCLA) has been presented in several formats at a number of academic medical meetings.

Dr. Mink and colleagues developed supervisory scales for EPAs. For example, a trainee who scored





a 1 on the scale was trusted only to observe a more experienced doctor, while one who scored a 5 was trusted to practice that particular professional activity unsupervised. The research, which involved more than 200 pediatric subspecialty fellowship

programs and 1,000 fellows, provided evidence for the validity of the scales as effective supervisory tools. The research also showed a correlation between levels of supervision and performance levels on milestones.

Another research project that is providing insight into the assessment of competencies and milestones is being led by Patricia J. Hicks, MD, MHPE, Professor of Clinical Pediatrics at the Perelman School of Medicine at the University of Pennsylvania and a general pediatrician at the Children's Hospital of Philadelphia. Dr. Hicks is director of the Pediatrics Milestones Assessment Collaborative (PMAC), a joint effort of the ABP, APPD and NBME.

"The collaboration of the ABP, APPD and NBME has provided an exciting opportunity for experts in assessment to work in concert with the community to develop assessment items, tools and reports," says Dr. Hicks. "The research and development work is focused on designing high-quality assessment content that provides guidance both to the learner and to those who are responsible for making decisions about learners and their competence. PMAC outcomes seek high

levels of reliability, validity, ease of use, educational value and acceptability — all at a reasonable cost."



Dr. Hicks and colleagues are assessing the validity of items and tools that can be used to inform important decisions about readiness for trainees to progress to the next level of responsibility. Because advancement from one training level to the next involves less direct

supervision and more patient care responsibility, PMAC has constructed a framework where the assessment of the learner informs the decision of readiness to advance within the training program. Additional outcomes provided to the learner and to the program include individual competency and milestone scores with narrative text feedback describing suggested recommendations for improvement. Faculty members, nurses and senior residents who work with and observe the resident complete these assessment tools on mobile devices. The researchers have found that having a variety of people assess a resident provides more thorough and specific feedback enriched by the variety of perspectives.

Current research results indicate that participants find the tools easy to use and that completion times range from four to 10 minutes. Reports, which aggregate data across tools, provided residents with insight into competency-specific performance and areas for improvement and provided program directors with data to support decisions about readiness of trainees to advance.

## Next steps

Evidence to support the value of competency-based assessment in the workplace continues to grow. To date, five papers relating to PMAC have been published in peer-reviewed journals (see ABP publications page 42), and Dr. Hicks and colleagues have committed to a number of additional publications and presentations in 2017. Data from Dr. Mink and Dr. Hicks' projects — as well as other ongoing research — is being collected in APPD LEARN (Longitudinal Educational Assessment Research Network) for management and storage within their database.

Another general pediatrics EPA study was launched in January 2016 with the goal of determining clinical competency committee expectations for levels of supervision expected at graduation from residency. The study also seeks to collect data on actual performance by following a cohort of residents over three years. We have only collected one round of data from 23 participating programs," Dr. Carraccio says. "But the partnership with APPD LEARN is leading to an amazing database that will allow the education research community to do major secondary analyses.

With the increasing recognition of the importance of these approaches has come an increase in the number of residency and fellowship programs that are using EPAs, competencies and milestones for trainee assessment and feedback. While evidence supporting their use is just emerging, Dr. Carraccio says, "It's positive enough that the message is to just keep going."

# The MOCA-Peds Pilot

## Where Are We Now?

In January 2017, the American Board of Pediatrics (ABP) launched a pilot that could revolutionize the way pediatricians are assessed throughout their career.

Currently, diplomates (certified pediatricians) must pass a four-hour Maintenance of Certification exam every 10 years at a secure, proctored testing facility. The proposed assessment approach, called MOCA-Peds (Maintenance of Certification Assessment for Pediatrics), would allow pediatricians to answer multiple-choice questions at their convenience via computer or mobile device.

Of the 6,800 diplomates eligible for the 2017 general pediatrics MOC exam, more than 5,000 diplomates — about 75 percent — enrolled in MOCA-Peds and began answering questions in January. Diplomates who participate in MOCA-Peds and meet the pilot requirements will not need to take the MOC Part 3 secure exam in 2017.

Twenty questions will be made available in a diplomate's MOCA-Peds portfolio quarterly. Once a question is opened, a diplomate will have five minutes to answer. During that time, they may use reference materials. Questions can be answered at a diplomate's convenience (but without help from others) as long as all 20 questions are answered by the end of each quarter.

## Partnering with Diplomates

The idea for a MOCA-Peds pilot grew out of the Future of Testing Conference sponsored by the ABP Foundation in May 2015. The pre-pilot planning began in earnest during the summer of 2015, and partnership with diplomates (generalists and subspecialists) has been at the forefront of the MOCA-Peds pilot during the entire planning process.

In January 2016, an open call went out to pediatricians to participate in user and focus groups. The ABP received more than 3,000 responses. Approximately 250 of the diplomates who responded were then randomly selected by RTI International, an independent, third-party research firm.

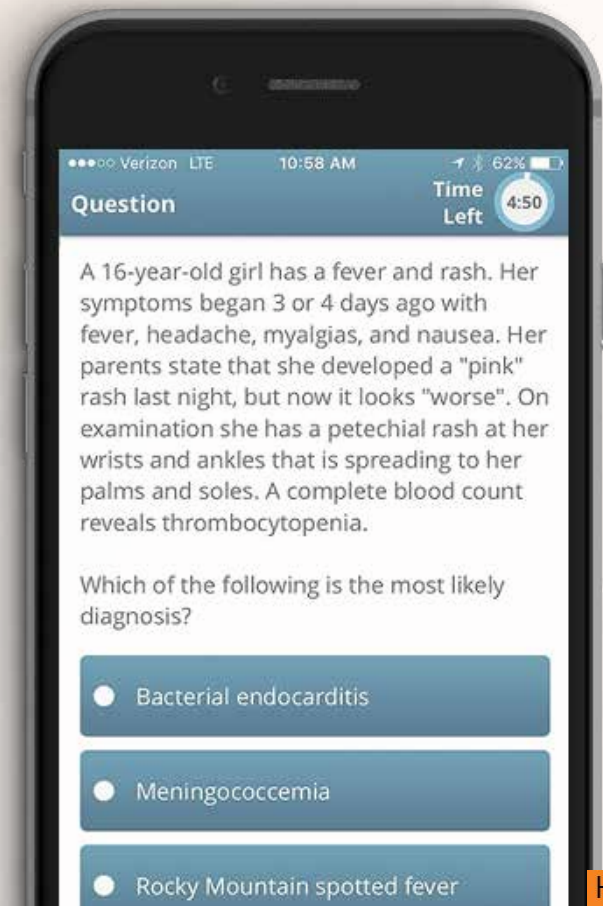
"We have been amazed by the interest the diplomate community has shown towards the pilot," Linda Althouse, PhD, Vice President of Psychometrics & Assessment Services for the ABP.

Dr. Jon Gehlbach, a general pediatrician who is completing a fellowship in critical care medicine at Duke Medical Center, participated in a meeting in September to test the MOCA-Peds platform. He commented to the staff: "I was at the Future of Testing Conference back in 2015, and it is really impressive to see how far you [the ABP] have come since that meeting."

The various groups convened on 41 separate occasions throughout 2016, providing valuable feedback in regards to feasibility, acceptability, functionality and more.

## Important Details

In the pilot development process, questions came from internal reviews and discussions, from the diplomates participating in our user and focus groups and from other interested third parties. Below are some of the key details and answers to these vital questions.





- There will be no additional fees to participate in the MOCA-Peds pilot.
- Twenty multiple-choice questions will be made available each quarter.
- Questions may be answered at any time during the quarter at the diplomate's convenience — either one at a time, in small batches or all at once.
- Immediate feedback will be provided once a question has been answered. Feedback will include whether a selected answer was correct, as well as a brief explanation and references. The goal is to foster enhanced learning.
- Diplomates could receive up to five questions a year that will cover emerging “hot topics.” For 2017, these questions will not be scored.
- Pilot participants will receive questions tailored to their individual practice profile (inpatient, outpatient or a mix).

### What About the Questions?

Questions will be based on 40 learning objectives that will be announced before questions are released. The objectives are drawn from the new General Pediatrics Content Outline, which reflects the breadth of knowledge required for practice. During the year, diplomates will receive

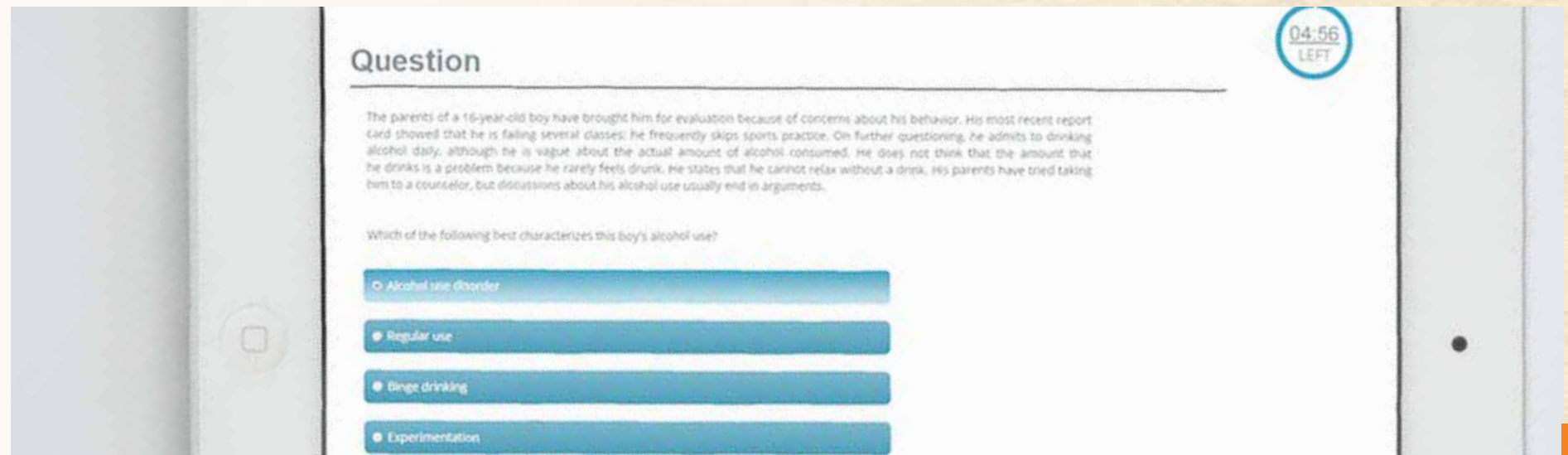
two questions associated with each learning objective. By having two questions on each objective, diplomates will have the opportunity to demonstrate they learned material they did not previously know and to reinforce information they did know.

Questions will focus on the application of fundamental knowledge used in everyday practice. This means that answering questions should not require prior studying or the use of books and online materials, even though resources may be consulted as long as the question is answered in the allotted five-minute time. Diplomates may not, however, receive assistance from others.

### The Future of MOCA-Peds

The pilot began in January of 2017 and is expected to continue into 2018. At that time, diplomates who have a general pediatrics exam due in 2018 will be eligible to join the pilot. Decisions about the future of MOCA-Peds will be based on evaluation of the pilot. If the pilot is deemed a success, MOCA-Peds will replace the 10-year secure examination and will be phased in to align with a diplomate's five-year MOC cycle. Additionally, if MOCA-Peds is successful, it will be expanded to include subspecialties.

Visit [www.abp.org/mocapeds](http://www.abp.org/mocapeds) for additional information and continued updates.



# Making the MOC Process Easier

## Lean Training

To ease the process of earning Maintenance of Certification credit for Improving Professional Practice activities (MOC Part 4), the ABP developed a system for pediatricians to apply for credit for quality improvement projects they already have completed.

But after reviewing applications for several months and answering multiple questions from pediatricians, the MOC staff realized its application process could use some quality improvement of its own.

In June, MOC staff plus other ABP colleagues and several diplomates participated in a Lean Kaizen workshop (which is a type of structured quality improvement process).

“We discovered there were questions on the application that weren’t really necessary or were redundant,” says Patience Lieno, Senior Administrator for MOC External Activities.

“We realized some of the instructions were confusing. Even the fonts and colors we used contributed to difficulty filling out the applications.”

By following the Lean Kaizen quality improvement model, the team made more improvements than they had dared hope for.

- The amount of time it takes diplomates to fill out the forms was reduced by 67 percent — from 30 minutes to 10.
- The amount of time it takes ABP staff to review the application was reduced by 58 percent — from four minutes to 1.5 minutes.
- The average number of errors per application dropped from 1.8 to zero.

“It was so rewarding to be part of a quality improvement process that made such a huge difference in our processes and saved diplomates so much time,” Patience says. “Since the Kaizen event, the number of Small Group QI Applications submitted and approved more than doubled in the following quarter (Q3) with 180 submissions and 155 approved.”

Last year’s third quarter produced 123 submissions and 90 approvals.

During 2016, more than 20 ABP staff members from MOC and other departments participated in four different Lean quality improvement sessions, which emphasized understanding processes and improving the efficiency of processes by implementing small changes systematically.

“The staff has always been enthusiastic about quality improvement, and I saw a chance to make improvements internally,” says Virginia Moyer, MD, MPH, ABP Vice President of MOC and Quality. “Our staff has taken pride in making the MOC process easier and more accessible for our physicians. It’s been rewarding to see the level of excitement when they get behind a project.”

Dr. Elizabeth Meade, a pediatrician in Seattle, Wash., participated in the June Kaizen session, helping staff identify ways to improve applications for Practice Improvement credit.



“People want to do projects that are really important and affect their clinical work,” Dr. Meade says. “I think many still think it’s a huge deal to go through the [application] process.”

But after the team applied Kaizen principles and made improvements to the application, “I was really surprised at how simple and fast it was to complete,” she says.

Dr. Meade and other diplomates who provided feedback during the Kaizen sessions say they appreciated the opportunity to work with the ABP to improve the process.

Diplomates who haven’t been involved in the ABP’s efforts to improve MOC may not realize how many positive changes have been made to make MOC and its components more valuable to diplomates, Dr. Meade notes.

“Being on the other side of it,” she says, “I see that there’s not only an interest, but there’s a drive to make this [MOC] more meaningful for people. The perception I’m getting is that the ABP has a new focus on trying to make board certification and Maintenance of Certification more relevant and meaningful for pediatricians.”

ABP staff at work improving the application process for MOC Part 4 credit



# Steal Shamelessly, Share Seamlessly

2016 PVM Fellow  
Dr. Jeffrey Anderson

Jeffrey B. Anderson, MD, MPH, MBA, refused to believe that infants born with serious heart defects could not gain weight, just one factor behind their high mortality rate.

A pediatric cardiologist at Cincinnati Children's Hospital Medical Center, Dr. Anderson began studying infants with a rare condition called hypoplastic left heart syndrome (HLHS) — a malformation of the heart — as a cardiology fellow.

Dr. Anderson is now Associate Professor of Pediatrics and Chief Quality Officer in the medical center's Heart Institute, and a faculty member in the James M. Anderson Center for Health Systems Excellence, Cincinnati Children's Hospital Medical Center. For his persistent work seeking ways to improve the care and outcomes of HLHS patients, he was named the 2016 recipient of the American Board of Pediatrics' Paul V. Miles Fellowship in Quality Improvement.

HLHS is one of the most complex forms of congenital heart disease.

Until the early 1980s, HLHS was uniformly fatal. Even in 2015, the chance of an infant with HLHS surviving until his or her first birthday was only about 75 percent. Newborns with HLHS need open-heart surgery shortly after birth, then again several months later, and a third surgery a few years later. As of a decade ago, between 10 and 15 percent of these infants did not survive to the second surgery after being discharged home following their first surgery. In addition to this unacceptable mortality rate, infants with HLHS struggle with growth during the first few months of life, often experiencing growth failure.

"The rare nature of this disorder has limited robust learning about successful strategies to improve survival undertaken by single-surgical centers," Dr. Anderson and colleagues wrote in a paper published in the July 2015 issue of *Circulation: Cardiovascular Quality and Outcomes*.

To address this gap, Dr. Anderson has been a key leader in the

National Pediatric Cardiology Quality Improvement Collaborative (NPC-QIC), a network of parents, clinical teams and cardiologists from 60 care centers across the nation with an aim to reduce growth failure and mortality among infants with HLHS. "About half of these centers treat fewer than five HLHS patients a year," he said.

When the network began, Dr. Anderson said, "We had several questions — Why do infants with congenital heart disease grow poorly, and does it matter? And can we reduce mortality for these infants between the first and second surgeries?"

Data from the NPC-QIC centers showed that growth rates matter a lot in these infants.

"Some cardiologists thought there was nothing you could do to make these infants grow," he said. Still, some cardiologists were having better success than others. Dr. Anderson determined to find out what the more successful ones were doing differently to improve

nutritional outcomes in infant heart patients, and as a result, improve the babies' chances of survival. Now, he is determined to spread ideas for successful interventions.

"We follow the mantra 'Steal Shamelessly, Share Seamlessly,'" Dr. Anderson said. "Centers shared their practices to help other centers improve their outcomes."

He recently presented this work — "Using Improvement Science to Identify Best Nutritional Practices In a Rare Condition: Improving Growth in Infants With Hypoplastic Left Heart Syndrome" — to physicians and residents at both The University of North Carolina and Duke University schools of medicine, and to the ABP staff in Chapel Hill, N.C.

Dr. Anderson praised collaborative networks such as NPC-QIC that connect health care professionals who treat specific conditions. Through this collaborative network, clinicians could pool data from their patients, gathering enough information to see trends that



individual clinics would not be able to recognize.

In addition to identifying factors that can improve growth for these infants, Dr. Anderson led a team of researchers that analyzed data for 1,163 infants from 52 surgical centers participating in NPC-QIC between 2008 and 2014. The team achieved significant improvements in interstage survival rates, despite no changes in medication or surgical strategies (see pages 12-13). The key, they suggest, was that centers learned from each other and from families as they

deployed strategies to improve nutrition, parent education, and communication between cardiologists and primary care pediatricians.

Collaborations included a variety of professionals — nurses, dietitians, respiratory therapists, cardiologists, surgeons, developmental specialists and more. Perhaps most important, he said, was involving parents.

“We found that bringing parents into the conversation changes everything,” he said. “It shifts the

focus from an independent to a collaborative practice.”

Dr. Anderson works closely with a parent support group called “Sisters by Heart.”

“Parents want to help,” Dr. Anderson said, “and they bring a different perspective to care.”

“What makes Dr. Anderson an incredible asset to the cardiac community as a whole is his dedication and willingness to work with parent partners,” said Stacey Lihn, president of Sisters

by Heart and the mother of a child born with HLHS. “He respects — and intentionally elicits — parent perspectives and proactively engages with parents.

The Paul V. Miles Fellowship was established in 2013 to honor Dr. Miles’ years of service as the ABP’s Senior Vice President for Maintenance of Certification and Quality.

The fellowship is given annually to a pediatrician who has demonstrated excellence in improving the quality of care for children.



Jeffrey B. Anderson, MD, MBA,  
with a patient and her mother

# News Roundup



David G. Nichols, MD, MBA, ABP President and CEO (far left, second row,) and Laurel Leslie, MD, MPH, ABP Vice President of Research (far right, second row), attend a luncheon sponsored by the ABP for the scholars.

## New Century Scholars

Diversity in pediatric care is critical — both for pediatricians and the communities they serve. The ABP supports the work of the Academic Pediatric Association (APA) as they continue to broaden diversity in the pediatric workforce. The APA's New Century Scholars Program connects under-represented minority pediatric residents with senior mentors who help advise and guide them in their young careers. **For more information, see [www.academicpeds.org](http://www.academicpeds.org).**

## MOC Booth at PAS and NCE

The ABP sponsored booths in the exhibit areas at two major pediatric meetings in 2016: the AAP National Conference and Exhibit (NCE), and the Pediatric Academic Societies (PAS) meetings. More than 10,000 professionals attended NCE, while over 7,000 attended the PAS meeting. Hundreds of pediatricians stopped by the ABP booth at each of the meetings, and it was a great opportunity for ABP staff members meet diplomates in person and to address their questions. Topics of interest included MOCA-Peds, Question of the Week, and how diplomates can get their required Part 2 and Part 4 points.



Pediatric nephrologists Erum Hartung, MD, (left) of Children's Hospital of Philadelphia and Jacqueline Ho, MD, (center) of Children's Hospital of Pittsburgh, discuss mentoring for junior faculty with Virginia A. Moyer, MD, MPH, ABP Vice President, Maintenance of Certification and Quality.

## ABP Extends Time To Complete Supervised Practice If Exam Eligibility Lapses

The ABP has modified the policy on time-limited eligibility for initial certification examinations. The policy change extends the amount of time a doctor can take to complete six months of supervised practice when regaining eligibility to sit for an initial certification examination.

After completing their training, candidates for certification have seven years of eligibility to pass the initial certification exam. Formerly, after seven years of eligibility lapsed, candidates had to complete a total of six months of practice under the supervision of a program director before they could sit for the initial certification exam. The six months of supervised practice had to be completed within one year.

With the recently approved modification, the ABP now allows the six months of supervised practice in an accredited training program environment to be completed in the course of *more than one year*.

All proposals for supervised practice must be approved in advance by the ABP, but proposals that span more than one year must address consistency of supervision of the individual and continuity of supervised practice experience.

For more information, contact the ABP's exam administration department at (919) 929-0461, [gpcert@abpeds.org](mailto:gpcert@abpeds.org) or [sscert@abpeds.org](mailto:sscert@abpeds.org).

## New Online Portal Makes Life Easier for Program Directors and Coordinators

Early in 2016 the ABP launched its new Program Director's Portal. The first phase of the project, now live, allows program directors and coordinators to manage their program profiles online. Features of the portal gives users the ability to change the program's contact information, add or change coordinators, provide a coordinator access to the portal and view trainee's examination results.

Additionally, program directors and coordinators can view, download and export examination results beginning with the fall 2015 examinations and 2016 Subspecialty In-Training Examination (SITE) results.

"The ABP Program Portal is a wonderful tool for residency and fellowship programs," says Ann Burke, MD, Professor of Pediatrics and Director of the Pediatric Residency Program at Wright State University in Dayton, Ohio. "Being able to manage our information online makes the process easier. I love that the exam results are posted and organized on the site. I am looking forward to having the ability to track my learners on the site in the future."

Future phases of the project include components for tracking trainees, expanded training data accessible on the portfolio and components that enhance



the process for credentialing applicants for certifying examinations.

The Program Portal is available to program directors and program coordinators at [olt.abp.org](http://olt.abp.org)

### **ABP Congratulates ImproveCareNow on Receiving 2016 Drucker Prize**

The American Board of Pediatrics (ABP) congratulates the ImproveCareNow (ICN) collaborative care network for receiving the 2016 Drucker Prize, presented by the Drucker Institute of Claremont Graduate University in Claremont, Calif.

ICN is a network of people working together to improve outcomes for children and adolescents with Crohn's disease and ulcerative colitis (Inflammatory Bowel Disease or IBD). The network has created a collaborative community where clinicians, researchers, parents and patients are empowered to learn and continuously improve to bring about more reliable, proactive IBD care for healthier children and youth.

The ABP Foundation supported the creation of ICN in 2007. Paul V. Miles, retired ABP Vice President of Maintenance of Certification, said he is proud of the success ICN has had in improving the quality of care for children with IBD.



“ImproveCareNow is a model of what quality care should be,” he said. “I’m also proud of the ABP for promoting the model among other subspecialties.”

The ICN network now includes more than 90 centers, primarily in the U.S. but also in the U.K. and Qatar. Nearly 800 pediatric gastroenterologists participate, treating 26,000 children with IBD. The overall remission rate of patients at the centers is 81 percent, up from 48 percent in 2007.

Awarded annually since 1991, The Drucker Prize is given to a social-sector organization that demonstrates Drucker's definition of innovation — “change that creates a new dimension of performance.”

Zach First, Executive Director of the Drucker Institute said that the ImproveCareNow Network is “reframing health care from a product delivered to patients to an activity that patients, care providers and researchers co-produce together. The ImproveCareNow Network has demonstrated robust results, and a rigorous commitment to continuous improvement. We are delighted to recognize them as the winner of the 2016 Drucker Prize.”

### **Pediatric Hospital Medicine Certification Approved**

In October, the American Board of Medical Specialties (ABMS) agreed to recognize a subspecialty certification in Pediatric Hospital Medicine (PHM). The ABP, a member board of the ABMS, sponsored the PHM subspecialty certification application and now will be responsible for both establishing the training and assessment criteria and awarding the certification.

“In general, children who are hospitalized today have more complex conditions than in the past,” said ABP Executive Vice President Gail McGuinness, MD. “This subspecialty certification will recognize the training that goes into preparing to care for this changing patient population. In addition, it recognizes the role of hospitalists in improving hospital systems, ensuring patient safety and striving for quality improvement.”

The ABP is finalizing eligibility requirements, including an initial pathway for PHM certification, before ACGME-accreditation can be awarded to training programs.



# At a Glance

## The ABP's Work by the Numbers

Since the ABP began:

- more than 115,000 have been certified in General Pediatrics
- more than 27,000 have been certified in a subspecialty

## Certificates

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

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

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

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

## 2016 Initial Certifying Exam Pass Rates (First-Time Test Takers)

Examination	First-Time Takers	Pass Rate (%)
General Pediatrics	3,210	80.5
Adolescent Medicine *	52	84.6
Cardiology	270	87.8
Critical Care	314	86.3
Neonatal-Perinatal Medicine	467	86.1
Nephrology	72	77.8
Pulmonology	108	80.6

\* Include 9 American Board of Internal Medicine and 3 American Board of Family Medicine candidates

## 2016 MOC Exams (All Subspecialties Combined and General Pediatrics)

Examination	First-Time Takers	Pass Rate (%)
MOC General Pediatrics	5,490	96.5
All MOC Subspecialties	1,685	95.6

Subspecialty numbers include ABP candidates and only examinations administered by ABP.



2015

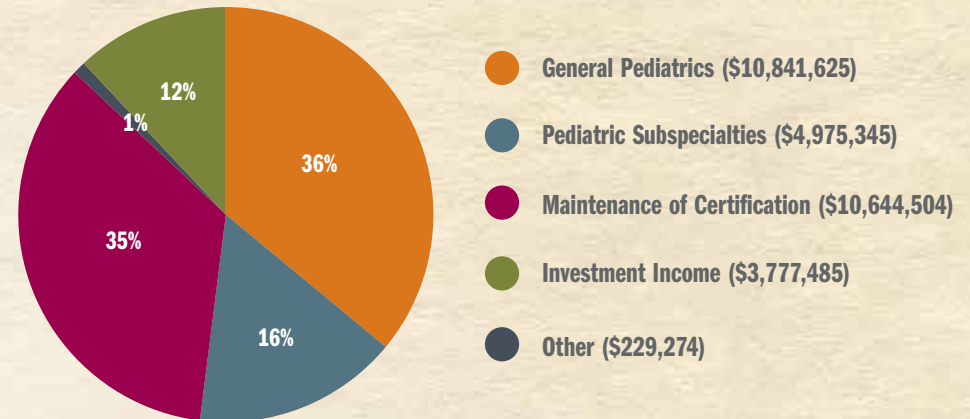
# Financials

## Gold Seal from Guidestar

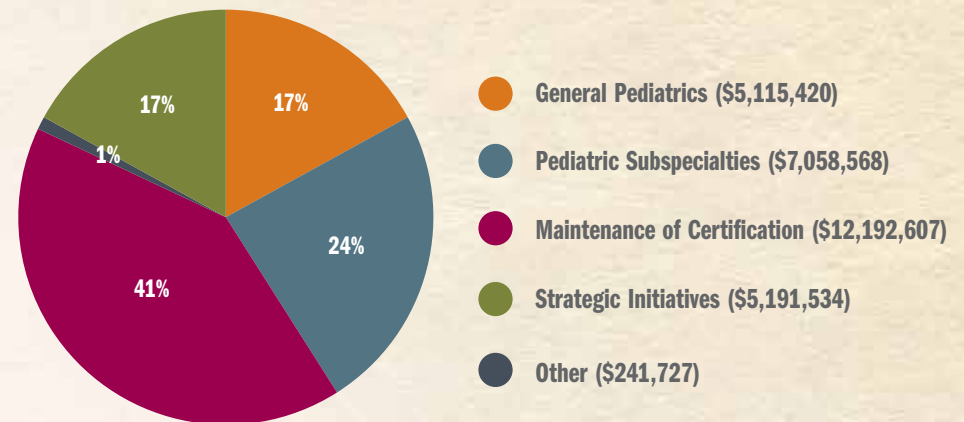
The ABP recently achieved the gold level of participation from GuideStar, a nonprofit organization that works to create a more transparent nonprofit sector and increase knowledge about tax-exempt organizations. Every IRS-registered nonprofit organization is part of GuideStar, but the gold level is reserved for organizations like ABP that increase transparency by providing additional information.

To earn the gold level, ABP provided not only basic information, such as contact information and mission statement (bronze), but also financial information including revenue, expenses, assets and liabilities (silver) and qualitative impact information about ABP's goals, strategies, capabilities, indicators and progress (gold). A gold GuideStar icon in the footer of our website takes visitors to our GuideStar information page.

## 2015 Revenue (\$30,468,233)



## 2015 Expense (\$29,799,856)



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

# 2016 Committees

Pediatricians  
Volunteer To Help



The ABP appreciates the excellent work of pediatricians who contribute their time, energy and expertise to our committees and subboards, producing examinations and providing direction for certification activities.

## Charter and Bylaws Committee

John G. Frohna, Chair  
Carolyn M. Kercksmar

## Conflict of Interest Committee

B. Keith English  
Mary Fran Hazinski, Public Member  
Rutledge Q. Hutson, Chair  
(Public Member)  
Egla C. Rabinovich

## Credentials Committee

Laura M. Brooks  
Alan R. Cohen  
Norman D. Ferrari III  
John G. Frohna  
Joseph T. Gilhooly  
David M. Jaffe, Chair  
Victoria F. Norwood

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Joseph T. Gilhooly  
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Anna R. Kuo  
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Chandy C. John  
Jonathan D. Klein  
David G. Nichols

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Christopher A. Cunha, ex officio  
Martha E. Gagliano  
Kathy J. Jenkins  
Keith J. Mann, Chair  
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Laura K. Noonan  
Greg D. Randolph  
Tara B. Rouse, Public Member

Pamela J. Simms-Mackey  
Julie K. Stamos  
David K. Stevenson  
Lindsay A. Thompson  
Brad C. Weselman  
James C. Wiley, AAP Rep  
Marshall L. Land, Jr., Consultant

## MOCA-Peds Task Force

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Terrill D. Bravender  
Laura M. Brooks, Chair  
Norman D. Ferrari III  
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*\*Dr. Yuan died in 2016. The ABP expresses sympathy to her family and colleagues.*



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2016

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A special thank you to the following ABP committee and subboard members who completed their service in 2016 (beginning service dates noted after names), and especially to those who have dedicated decades to serving the ABP. We appreciate your dedication and commitment to our mission.

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Tami D. Benton (2013)

Susan L. Bratton (2009)

Nancy C. Chescheir (2000)

Randall A. Clary (1996)

Alan R. Cohen (1989)

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Suzanne K. Woods (2009)



## Mission

The American Board of Pediatrics (ABP) certifies general pediatricians and pediatric subspecialists based on standards of excellence that lead to high quality health care during infancy, childhood, adolescence, and the transition into adulthood.

The ABP certification provides assurance to the public that a general pediatrician or pediatric subspecialist has successfully completed accredited training and fulfills the continuous evaluation requirements that encompass the six core competencies: patient care, medical knowledge, practice-based learning and improvement, interpersonal and communication skills, professionalism, and systems-based practice.

## Guiding Principles

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

# 2016 Published Works

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111 Silver Cedar Court  
Chapel Hill, NC 27514

919-929-0461  
919-929-9255 (fax)  
abpeds@abpeds.org

**For General Pediatrics Inquiries:**

In-training examinations: [ite@abpeds.org](mailto:ite@abpeds.org)  
Initial certification examinations: [gpcert@abpeds.org](mailto:gpcert@abpeds.org)  
Maintenance of Certification: [moc@abpeds.org](mailto:moc@abpeds.org)

**For Pediatric Subspecialties Inquiries:**

In-training examinations: [site@abpeds.org](mailto:site@abpeds.org)  
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