



# AMERICAN BOARD *of* PEDIATRICS

Annual Report 2018

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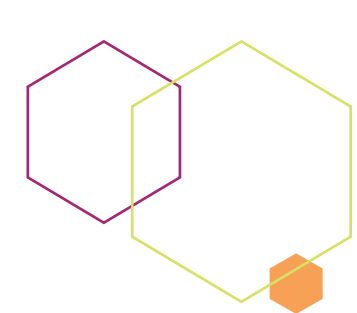
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“I consider it an honor and a privilege to work with the American Board of Pediatrics to help in its mission to improve the health of children and the quality of care we deliver. The Board relies upon and values the input of all of its volunteers because it recognizes that it cannot achieve its goals without our help. For all these reasons, it is incredibly rewarding to be a part of the ABP family.”

DEAN MINER, MD  
INTERNAL MEDICINE,  
PEDIATRICS, AND  
CLINICAL INFORMATICS  
DUKE UNIVERSITY  
HEALTH SYSTEM



COVER: DR. DEAN MINER VISITS WITH EMILIA GODRICH AT DUKE CHILDREN'S HOSPITAL. PHYSICIAN CHAMPION AND CLINICAL LEAD FOR DUKE UNIVERSITY’S ELECTRONIC HEALTH RECORDS SYSTEM, HE ALSO VOLUNTEERS ON THE ABP INFORMATICS TASK FORCE. PHOTO BY TOM FULDNER PHOTOGRAPHY

PRESIDENT'S LETTER



Dear Colleagues,

We physicians are privileged to be able to regulate our own profession. Through certification, we set standards of excellence and we decide how to measure each other against those standards. The “we” in the above sentences refers to practicing pediatricians who volunteer to do the work of setting standards and deciding how the profession should regulate itself.

As **Dr. Margaret Rosenfeld**, Professor of Pediatrics, University of Washington School of Medicine, and member of our Pediatric Pulmonology Subboard, says, “The ABP is us. The more we get involved, the better the outcomes will be for pediatricians.”

This year marks the ABP’s 85th anniversary. In that time, our profession has gone from allowing any doctor to proclaim him- or herself an expert at treating children to having more than 80,000 certified pediatricians who meet rigorous standards.

Today, more than 400 board-certified pediatricians and pediatric subspecialists volunteer countless hours to make self-regulation work. They represent a wide range of practice types, ages, genders, geographies, community resources, ethnicities, and experiences. In this issue of our annual report, they tell you about their work with the American Board of Pediatrics. Many cite the joy and camaraderie of working with others in their field. Some say it’s fulfilling to contribute to the future of their profession in a meaningful way. And more than a few say they volunteered to improve the certification process.

**Dr. Marty Gagliano**, a general pediatrician in Durham, NC, tells us, “Being a volunteer at the ABP has re-energized me. I like to think that whatever I do for the Board helps deliver better care for children everywhere and also helps my colleagues show off their unique ability to offer that care.”

My experience was similar. I began volunteering with the ABP in 1995 when I was at the Johns Hopkins University School of Medicine. I’ve written exam questions, chaired the Pediatric Critical Care Subboard and the Maintenance of Certification Subspecialties Advisory Committee, and been a member of the ABP Board of Directors. Back then, I appreciated the opportunity to interact with like-minded individuals who were interested in advancing the profession. I believe I was a better teacher and a better pediatrician because the process helped me think through the clinical problems and concepts more clearly.

Now, as one of five physicians on staff here at the Board, I have the opportunity to work with *all* of our volunteers in all fields. I am continually astounded by the willingness of these volunteers to take on challenges and shoulder the work of developing and maintaining board certification.

**Dr. Lindsay Thompson**, Associate Professor of Pediatrics at the University of Florida College of Medicine and a member of the MOC Committee, draws an analogy that resonates with me. She says, “Being involved with the ABP and an active volunteer is like voting. It is a privilege that should not be taken for granted.”

There are numerous opportunities to volunteer that don’t require hundreds of hours or multi-year commitments. You can participate in surveys, focus groups, or pilot programs that help us improve important functions. For example, more than 11,000 pediatricians helped in some way to develop MOCA-Peds, our new online assessment platform (see page 18).

If board certification is to remain relevant and provide meaningful standards for medical practice, then we need your perspectives and opinions. Please consider participating (see page 16).

And to all of our volunteers — past and present — thank you!

We are in this together to benefit children.

Sincerely,

David G. Nichols, MD, MBA  
President and CEO





DR. TONY WOODWARD, CHIEF OF THE DIVISION OF EMERGENCY MEDICINE AT SEATTLE CHILDREN'S HOSPITAL, CHAIRS THE ABP EMERGENCY MEDICINE SUBBOARD.

## WHO BETTER TO DO THE CRITICAL WORK OF BOARD CERTIFICATION?

Have you ever wondered who writes the certification exam questions for pediatricians and pediatric subspecialists? For that matter, who decides which topics are included in exams? And who decides what the passing score is?

The answer is *pediatricians themselves* who are maintaining their certification and who represent a variety of practice types, geographic locations, ages, races, and genders.

More than 400 board-certified pediatricians volunteer at the ABP. Fewer than 110 full-time staff members work for the ABP — and only five are physicians. Consequently, the responsibility for certifying that pediatricians are up to date and can competently care for children is in the hands of pediatricians themselves.



"Who better to do the critical work involved with board certification than those who have gone through the process to be certified and stay certified?" says Norman Ferrari III, MD, Vice Dean for Medical Education and Chair of the Department of Medical Education at the West Virginia University School of Medicine. He currently serves on the ABP General Pediatrics Exam Committee and on the MOCA-Peds Task Force. "Certified pediatricians can be the best critics of the process and provide the constructive feedback to make continual improvements to the process."

The ABP has more than 35 committees, subboards, task forces, and advisory groups, ranging from two to 15 members. Volunteers serve six-year terms and subsequently may be appointed to a different subboard or committee.

The 15-member Board of Directors, which is the ultimate governing body for the ABP, establishes policies, procedures, and requirements for ABP certification. This board, which includes two public members, defines the qualifications required of candidates applying for certification and determines the method, scope, and administration of the certifying examinations. It also establishes the policies for Maintenance of Certification (MOC) for pediatricians who have achieved initial certification. These directors have previously served the ABP in various capacities, giving them a clear understanding of the mission and operations of the ABP.

Five Board of Directors officers also sit on the ABP Foundation Board of Directors. They are joined by four other directors, including two public members. This Board approves the policies and priorities for research and strategic initiatives supported by the Foundation and often convenes meetings of experts to share collective expertise and promote innovation.

Other committees tend to the administrative policies of the ABP, including approval of the operating budget, auditing finances, and reviewing and revising the charter and bylaws. One committee determines whether ABP volunteers have conflicts of interest. The MOC Committee has a substantial role in evaluating requirements and approving process improvements to continuing certification. The New Subspecialties Committee reviews applications for new subspecialties, such as the newest certificate offered by the ABP: Pediatric Hospital Medicine. The Research Advisory Committee oversees research and evaluation efforts supported by the ABP Foundation. The Education and Training Committee advises and assists the ABP on initiatives related to the education and training of pediatricians from medical school throughout practice.

The Credentials Committee adjudicates appeals by pediatricians whose certification has been revoked. The committee also reviews cases of unsatisfactory evaluations for clinical competence or professionalism during residency or fellowship and approves plans for remediation. If there are requests for deviations from usual training requirements and non-standard training pathways, this committee reviews them individually.



DR. EGLA RABINOVICH, PROFESSOR OF PEDIATRICS AND CHIEF OF THE DIVISION OF PEDIATRIC RHEUMATOLOGY AT DUKE UNIVERSITY, TALKS WITH DAVID GODRICH AT THE DUKE CHILDREN'S HEALTH CENTER. DR. RABINOVICH CHAIRS THE ABP CONFLICT OF INTEREST COMMITTEE.

Tom Fuldner Photography

More than 150 pediatricians develop items for the initial certification and MOC exams. They serve on the General Pediatrics Examination Committee or one of the 15 subspecialty subboards. Subboard volunteers also serve as links between their subspecialty organizations and the ABP.

Other volunteer pediatricians help develop MOC Part 2 (Lifelong Learning and Self-Assessment) activities; participate in practice analyses that help determine test content outlines; and participate in standard-setting workshops.

“Practicing pediatricians and subspecialists are the ones who understand medical content and the obligations we have to be transparent, reliable, and consistent,” says Tony Woodward, MD, MBA, Chief of the Division of Emergency Medicine at Seattle

Children’s Hospital. Dr. Woodward chairs the ABP Emergency Medicine Subboard. “I believe it is helpful for the ABP to have national leaders and providers immersed in the process to be able to act as a conduit for information and advocate/champion for change for the large groups of diplomates [pediatricians] and students.”

In addition to the many committees and subboards, the ABP reaches out to pediatricians to get their opinions and feedback through channels that do not require years of commitment, including focus groups, surveys, pilot programs, and other opportunities.

Pediatricians can express their volunteer interests and availability using an online form (see page 16).

VOLUNTEERS SAY THE EXPERIENCE IS DEFINITELY WORTH THE EFFORT



“You will make an impact in ensuring the optimal care of our patients. You will have the opportunity to influence how all of us work to maintain our competence as pediatricians as well as influence how future generations of pediatricians will be certified. We need to hear everyone’s voice in order to do the best possible work.”

Nancy Spector, MD  
Professor of Pediatrics and Associate Dean for Faculty Development  
Executive Director of the Executive Leadership  
in Academic Medicine Program  
Drexel University College of Medicine



“I am currently on the MOC Committee and have witnessed all of the changes that make MOC less cumbersome, while still rigorous and robust. There is a lot of talk about the importance of joy in practice these days, and nothing gives pediatricians more joy than improving the care of their patients!”

Susanna McColley, MD  
Professor of Pediatrics  
Northwestern University Feinberg School of Medicine  
Associate Chief Research Officer for Clinical Trials  
Ann & Robert H. Lurie Children’s Hospital of Chicago



“It is often said among the Yoruba people of Southwest Nigeria that ‘the solid wall without a crack won’t let a lizard in.’ Having pediatricians be the gatekeepers for the specialty of pediatrics is a reassuring beacon to the profession, patients, families, and the public in general, that a tight ship is being maintained. Pediatricians who have walked the path of pediatrics can vouch for their colleagues’ integrity, competence, and professionalism.”

Folaoluwa Odetola, MD, MPH  
Associate Professor, Department of Pediatrics  
University of Michigan Medical School



“Volunteering for the ABP gives me a chance to have an impact on child health at a national level and to shape the process by which high-quality pediatric care is measured and recognized in the U.S. Also, I enjoy the opportunity to work with pediatric colleagues across the country on key pediatric issues, always learning from the knowledge and experience of these colleagues.”

Joseph St. Geme III, MD  
Physician-in-Chief and Chair of the Department of Pediatrics  
Children’s Hospital of Philadelphia



BOARD CHAIR-ELECT  
AMONG MANY WHO  
BRING GP PERSPECTIVE  
TO ABP

Anna Kuo, MD, started volunteering with the ABP nearly two decades ago when she was invited to submit two questions to be considered for the certification exam.

“A couple of months later, I received a letter from the ABP inviting me to join the Pilot Testing Committee. I guess I did OK!” laughs Dr. Kuo, a general pediatrician and Chair-Elect of the ABP Board of Directors.

Dr. Kuo is one of seven general pediatricians at Peachtree Park Pediatrics, one of the oldest pediatric practices in Atlanta. Treating children from birth to age 21, they describe their patients as “family” — fitting since some are in the second and third generations to receive treatment at Peachtree Park.

“The ABP is dedicated to the promotion of child health by setting high standards for pediatricians,” she says. “I am extremely proud of that because I know my patients would expect nothing less.”

The ABP Board of Directors tries to balance its composition with general pediatricians and subspecialists, private practitioners and academic physicians.

“I think there is a misperception that the ABP is composed solely of academicians and subspecialists who do not understand the demands of a community office practice,” she says. “On every committee I have ever sat on at the ABP, my opinions as a community generalist have been elicited and considered. In fact, I will be the third out of the most recent six Board chairs who is a general pediatrician in private practice.”

After serving on the Pilot Testing Committee, Dr. Kuo joined the General Pediatrics Examination Committee that writes questions about behavior and development, preventive pediatrics, and adolescent medicine. As a member of the MOCA-Peds (see page 18) Task Force since 2016, she helped develop the pilot and wrote many of the questions used in the MOCA-Peds pilots in 2017 and 2018.

Dr. Kuo joined the ABP Board of Directors and the ABP Foundation Board of Directors in 2014 for a six-year term. She will chair the board in 2019, and then serve another year as Immediate Past Chair. In her role on the Board, she also serves on the Finance, Long-Term Investment, Nominating, and Executive committees.

“Dr. Kuo holds herself to the same high standards for her work with the ABP that she maintains for the care of her patients,” says David A. Gremse, MD, Immediate Past Chair of the ABP Board of Directors and Professor and Chair of Pediatrics at the University of South Alabama College of Medicine. “She is a strong advocate for promoting policies that benefit pediatricians and improve the delivery of care for children.”

Dr. Kuo says her work with the ABP can be time-consuming, but the rewards are worth the effort.

“Pediatricians in private practice play a critical role at the ABP,” she says, “and I enthusiastically encourage my colleagues to consider nominating themselves to one of the ABP question-writing committees. This is a time of great change in the world of pediatrics, and we welcome fresh voices and ideas that will support the mission of the ABP.”

# ANATOMY OF AN EXAM

Volunteers and ABP Staff Work Many Hours to Ensure Board Exams Reflect Knowledge Base Necessary for Practice

For many pediatricians, *board certification* is synonymous with *examinations*. For both initial certification and continuing certification, exams are a major component of assessing whether pediatricians have the knowledge that their peers have determined is essential for the safe practice of pediatrics.

But creating valid and reliable exams for General Pediatrics and 15 subspecialties — and then scoring them — is not as simple as it might seem. The test development and scoring processes are rigorous and the underlying science is complex, but ultimately, these methods produce a fair and strong measure of a pediatrician's knowledge.



"Before I joined the ABP, I always wondered why we don't get instantaneous results after taking the computer-based exams," says Ritu Sachdeva, MD, Professor of Pediatrics in the Cardiology Division of the Department of Pediatrics, Emory University School of Medicine, and a member of the ABP Pediatric Cardiology

Subboard since 2015. "During my orientation with the Board, when I learned about all that goes on behind the scenes to validate every single question following the exam, it was truly eye-opening! Learning about the science and statistical methods behind building and grading the certification exams gave me a newfound appreciation for what the Board does for its pediatricians."

More than 300 certified pediatricians and pediatric subspecialists, supported by the ABP staff, perform the substantial job of creating exams and setting passing standards (see pages 42 to 45). Volunteers on the General Pediatrics Examination Committee and subspecialty subboards serve for terms of six years.



"It is important to keep in mind that the goal [of the certification process] is to ensure the proper medical treatment of children," says Jonathan Teitelbaum, MD, a board-certified pediatric gastroenterologist in Long Branch, NJ,

who also is maintaining his General Pediatrics certification and is a member of the General Pediatrics Examination Committee. "To that end, who better to determine the core knowledge that is needed to practice medicine than practicing pediatricians?"

## THE PROCESS BEGINS WITH PRACTICE ANALYSIS

Panels of volunteer pediatricians, certified in their areas of expertise, are heavily involved in all aspects of test development. The work of these various panels is facilitated primarily by two departments at the ABP: Psychometrics and Test Development. The first major step is to determine what topics the exams should cover — a process known as *practice analysis*.



"We [psychometrics department staff] are involved in the 'bookends' of the test development process," says Andrew Dwyer, PhD, ABP Director of Psychometrics. "At the beginning, we facilitate the practice-analysis process, and then, after the test is administered, we are responsible for scoring and score reporting."

Every five or six years, for General Pediatrics and each of the subspecialties, the ABP recruits a special practice-analysis panel of 10 to 12 pediatricians in active practice who identify the knowledge areas that are required to care for patients.

Then, the ABP sends (via online survey) the list of knowledge areas to all pediatricians certified in General Pediatrics or a subspecialty, as appropriate, asking them to rate each area based on frequency (i.e., "How frequently is knowledge in this area required in practice?") and criticality (i.e., "Would a lack of knowledge in this area result in harm?"). After the psychometrics team analyzes the survey results, the panel reviews the results to make final revisions to the list of knowledge areas and determines how many questions on the exam should be devoted to each area. Knowledge areas rated as being frequently required

and highly critical receive more questions on the exam. The information from the survey determines what is known as the **content outline** and is published on the ABP website.

Once the content outline has been approved, the practice-analysis panel's work is complete, and the annual, yearlong work of the volunteer pediatrician panels who write and review exam questions begins. A separate group of pediatricians is involved in developing test questions for each certification program (General Pediatrics and 15 subspecialties).

## QUESTION ANALYSIS AND WRITING

In addition to writing new questions, volunteers analyze questions already in the "bank" to ensure that they are still current, relevant, accurate, and align with the most current content outline. These analyses provide the ABP with additional information about gaps in the question bank and where focused item-writing may need to occur.



"The industry standard for building a good, valid, reliable exam is to have on hand three times the questions you need," says Jared Riel, MA, ABP Director of Test Development. "So, if we need five questions in a specific area or domain for an exam, then that area of the bank is not considered healthy unless it has 15 questions. If it has fewer than 15, it shows up as a need when we do our gap analysis."

The committee or subboard members are each assigned about 10 to 20 questions to draft and given two months to complete this task. The actual number varies, depending on the gap analysis and whether new areas are identified in the practice analysis, particularly as medicine evolves.

"We assign them a specific content area," Riel says. "For example, we'll say, 'We want you to write five questions on the differential diagnosis of cardiac conditions.'"

After receiving the draft questions, the ABP editorial staff edits them for consistent style before each person on the subboard reviews another member's questions and provides content edits or feedback. In particular, they are looking at questions for relevance and accuracy. The same set of questions then goes out for another review to other members of the committee or subboard.



"While I had done my very best to write questions that were unambiguous and develop evidence-based correct answers to them along with incorrect answers that could not simply be 'guessed at,' it was helpful to have a respected colleague review my work and provide me feedback so that I could do better in future

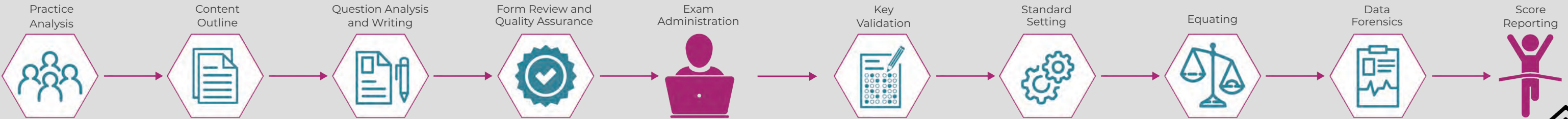
attempts," says Archana Chatterjee, MD, PhD, Professor and Chair, Department of Pediatrics and Senior Associate Dean for Faculty Development at the University of South Dakota Sanford School of Medicine.

After all this feedback, the committee or subboard meets in person to review the new questions and either approves them for use on an exam or flags them for further revisions in the future.

A final review of the questions is conducted remotely by a medical editor to ensure that all revisions or edits requested at the meeting have been made appropriately.

After a new version of an exam is built, a process, known as **form review** is conducted. In this process the entire committee or subboard reviews the collection of items and suggests which items need to be replaced on the exam. At this point, the ABP committee or subboard members have deemed the content in the exam to be ready for administration, but there are still many steps remaining for test development staff, including quality assurance reviews on the exam administration vendor's systems.

## THE LIFE CYCLE OF AN EXAM



SCORING AND SCORE REPORTING

After an exam has been administered, the scoring data is sent to the ABP psychometrics team, who then reviews and analyzes the way questions were answered. For each exam, the psychometrics team usually flags fewer than 10 questions to be re-examined.

"If, for example, an unusually large percentage of the people answered a question incorrectly," Dwyer says, "we flag that question and send it back to the committee or subboard that reviewed and approved it."

During this process, called **key validation**, the subboard or exam committee looks at each flagged question to make sure that the option identified as the correct answer really is correct and that none of the other options could also be considered correct.

"When I learned about all that goes on behind the scenes to validate every single question following the exam, it was truly eye-opening! Learning about the science and statistical methods behind building and grading the certification exams gave me a newfound appreciation for what the Board does for its pediatricians."

Ritu Sachdeva, MD  
Professor of Pediatrics  
Cardiology Division, Department of Pediatrics  
Emory University School of Medicine

Often, a question that many people get wrong points out a knowledge gap in the community. But sometimes, the subboard members agree that a question or answer is confusing or outdated. If the subboard or committee identifies questions that shouldn't count toward someone's score, Dwyer says, then the test taker isn't penalized for having received these questions.

Ensuring the fairness of each test question and computing each person's total exam score is only part of the scoring process, however. Because the exam is used to make pass or fail decisions, one of the most important aspects of scoring an exam is determining the score that is needed to pass the exam, a process referred to as **standard setting**.

During the standard-setting process, yet another independent panel of 10 to 12 practicing pediatricians participates in a two-day (or

longer) workshop where they are asked to review the questions on the exam, discuss the knowledge level needed for certification, and make a recommendation regarding the passing score. Typically, a standard-setting panel is asked to establish the passing standard for the first exam that follows a new practice analysis. As a result, the passing standard is typically revisited every five to six years, which mirrors the practice-analysis schedule.

Because each exam version (test form) may vary slightly in its overall difficulty level, the psychometrics team uses a statistical process known as **equating** to ensure that all test takers are treated fairly. "We rely on our volunteer pediatricians to identify the score that they feel reflects the level of knowledge required for board certification, and we use statistical methods to ensure that all test takers are held to that same passing standard, regardless of which test form they receive," says Dwyer.

While the scoring process is taking place, another group within the psychometrics team is conducting **data forensics** and web patrolling to ensure the security of the exam material. Statistical analysis of response data is done after every administration to identify any potential patterns of test fraud. Web patrolling allows the ABP to determine if any exam questions have been inappropriately leaked to the public. Any incident reports from the testing centers also are reviewed.

Finally, once the security process is complete, the psychometrics team can proceed with **score reporting**. They send a letter and an accompanying report to each test taker. In addition to letting pediatricians know whether they passed, the report also is designed to provide more detailed feedback that pediatricians can use to assess their strengths and weaknesses.

ABP VOLUNTEERS REFLECT ON THEIR ROLE IN EXAM PREPARATION



question writing. I am tremendously impressed with how seriously test development is taken by the ABP."

Daniel Rauch, MD  
Professor of Pediatrics and Chief of Pediatric Hospital Medicine  
Tufts University School of Medicine  
The Floating Hospital for Children at Tufts Medical Center



becomes evident that creation of a certification examination without the pediatric teams' input would be challenging."

Lisa Samson-Fang, MD  
Developmental Behavioral Pediatrics  
General Pediatrics  
Intermountain Medical Group  
Salt Lake City, Utah



"I remember my first time discussing the certification exam at one of our subboard meetings. Just seeing how much time and effort is put into making the test a high quality and fair exam was very impressive to me."

Debra Boyer, MD  
Associate Professor of Pediatrics  
Harvard University Medical School  
Pediatric Pulmonologist  
Boston Children's Hospital



positively influence and continually improve the board certification process."

Nicole Washington, MD  
Clinical Assistant Professor of Pediatrics  
Perelman School of Medicine  
Pediatric Hospitalist  
The Children's Hospital of Philadelphia



questions. Seeing how much work goes into the creation of a single question has been astonishing."

Karen Leonard, MD  
Associate Professor of Pediatrics  
University of Vermont  
Director of Inpatient Pediatrics  
University of Vermont Children's Hospital

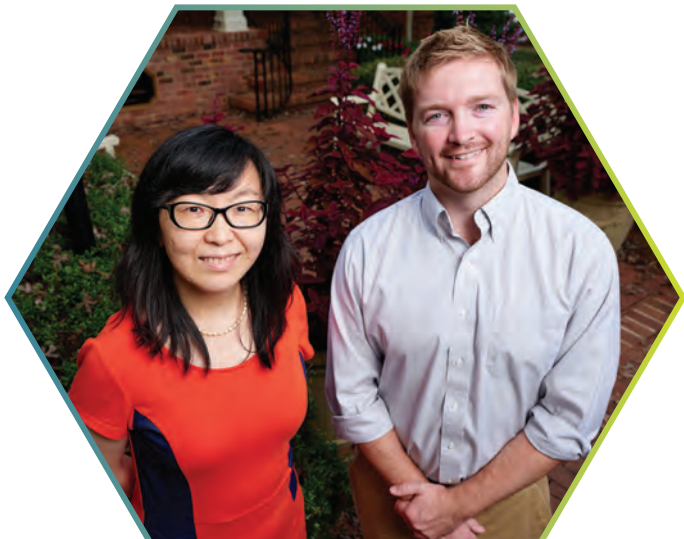


"Clearly, pediatricians not only should be, but must be involved [in developing exams and other certification activities]. It is work, a lot of work! It is also humbling to be working with other experts in my field."

Douglas Willson, MD  
The John Mickell Professor of Pediatric Critical Care  
Virginia Commonwealth University School of Medicine

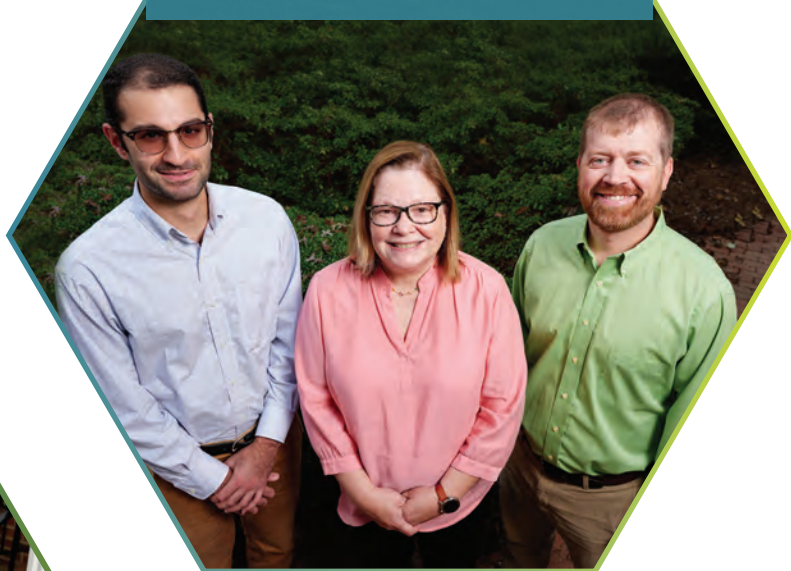


PSYCHOMETRICS AND TEST DEVELOPMENT STAFF AND THEIR YEARS OF ABP EXPERIENCE



PSYCHOMETRICS STAFF, LEFT TO RIGHT:  
YING DU (12+) ROBBIE FURTER (4+)

PSYCHOMETRICS STAFF, LEFT TO RIGHT:  
SAED QUNBAR (2+) CATHY KOENIG (9+)  
ANDREW DWYER (3+)



TEST DEVELOPMENT STAFF, LEFT TO RIGHT:  
JARED RIEL (3+) KAREN HOEVE (1+) LISA VOLK (11+)



LINDA ALTHOUSE, VICE PRESIDENT,  
PSYCHOMETRICS AND ASSESSMENT SERVICES (14+)



ASSESSMENT STAFF, LEFT TO RIGHT:  
DONNA CRISP (9 MONTHS+) VALERIE HAIG (11+) AMY OLSON (3+)



TEST DEVELOPMENT STAFF, LEFT TO RIGHT:  
TRACY LORG (3+) ROB BRUCIA (3+)

NOT PICTURED (TEST DEVELOPMENT): JEFF QUALLS (24+) BARBARA SHELDON (23+)

# DIVERSITY AMONG VOLUNTEERS BROADENS PERSPECTIVE

Pamela Simms-Mackey, MD, volunteers on both the ABP General Pediatrics Examination Committee and the Maintenance of Certification Committee.

"I think it's important for the Board to have a wide range of physicians, with respect to ethnic background, age, practice setting, and geography, on its committees," says Dr. Simms-Mackey, a general pediatrician practicing in Oakland, CA. "The diversity helps ABP volunteers create the tools that we use to assess and evaluate our physicians."

The ABP agrees, and over the past several years, has made a conscious effort to increase the number of volunteers from different backgrounds and with different perspectives.



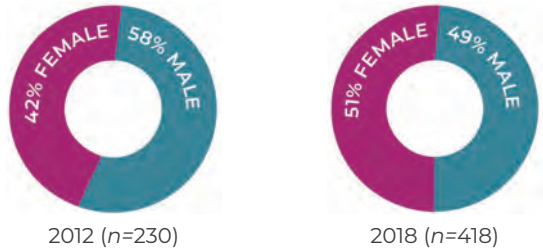
"We recognize that the demographics of pediatricians are changing over time," says Pam Moore, ABP Director of Professional Services. Moore works closely with the ABP Nominating Committee, itself made up of volunteers. "We continually work toward having the membership of our boards and committees reflect the demographics of the pediatric workforce."

Historically, ABP boards, subboards, and committees have included more male, white, and older members than the general population of pediatricians. However, over the past decade, membership has become more diverse. For example, in 2012, 42 percent of ABP volunteers were women. In 2018, 51 percent were women. The percentage of women certified in general pediatrics is 64 percent, and women now make up 73 percent of pediatric residents.

To increase volunteer opportunities, the ABP bylaws were revised in 2012 to limit committee appointments to six-year terms. The ABP works closely with other organizations to seek nominations of pediatricians from underrepresented minority groups. An online nomination tool (see page 16), developed in 2014, allows physicians to volunteer to serve on subboards and question-writing committees.

## DIVERSITY OF ABP VOLUNTEERS

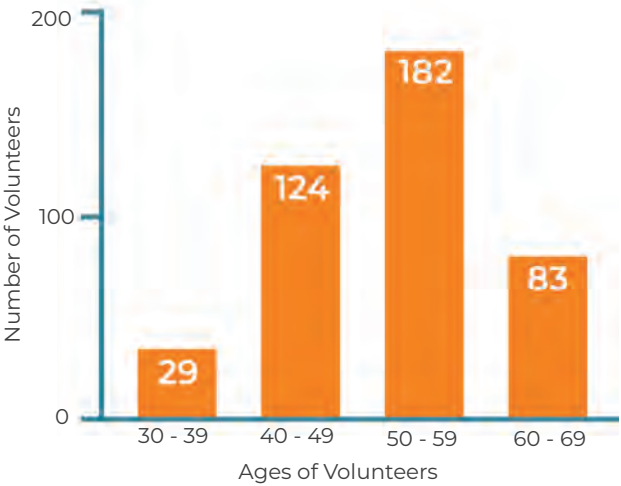
### Gender



### Race and Ethnicity



### Age



Help the ABP become more inclusive by volunteering at [www.abp.org/volunteer](http://www.abp.org/volunteer).

"I am a woman, a person of color, from the West Coast and in primary care. I feel like I help make the systems fair for all and can speak up if there is any implicit bias in questions created by the Board or in processes the Board is designing for certification or Maintenance of Certification."

"When I first started with the Board, many questions on the recertification exam started off with 'A 13-year-old African-American girl...' or 'A four-year-old Caucasian male...' I challenged my work group on why those descriptions were in the question. We are supposed to be teaching or evaluating what providers ought to know. Practicing in California, I have seen African-Americans with cystic fibrosis and Latinos with sickle cell disease. If the Board continued to produce questions like that, we would be teaching our pediatricians that certain diseases only happen in certain populations, when the world is changing and many diseases can be in a lot of populations, since race is a somewhat false construct based on what someone looks like, rather than their actual genetic makeup. Now you will see that the majority of questions we produce have cut out those descriptions, and we are evaluating our providers on how they assess the patients based on the history and facts presented to them."

Pamela Simms-Mackey, MD  
General Pediatrician, UCSF Benioff Children's Hospital Oakland  
Director, Graduate Medical Education and Pediatric Residency Program



DR. PAMELA SIMMS-MACKEY CHECKS 2-1/2-YEAR-OLD OLIVIA MAGANA-YEM DURING A CHECK-UP APPOINTMENT AT THE PRIMARY CARE CLINIC FOR UCSF BENIOFF CHILDREN'S HOSPITAL OAKLAND IN JANUARY 2018.

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# THE ABP WANTS YOU: REVAMPING VOLUNTEER RECRUITMENT

When seeking volunteers, the ABP is committed to including pediatricians from as many practice settings and types as possible so that the exams they write and policies they set will reflect the reality of modern pediatrics.

Therefore, raising awareness within the pediatric community regarding volunteer opportunities available at the ABP is a priority. To increase visibility and simplify the volunteering process, the ABP staff has enhanced the volunteer information at [www.abp.org/volunteer](http://www.abp.org/volunteer).

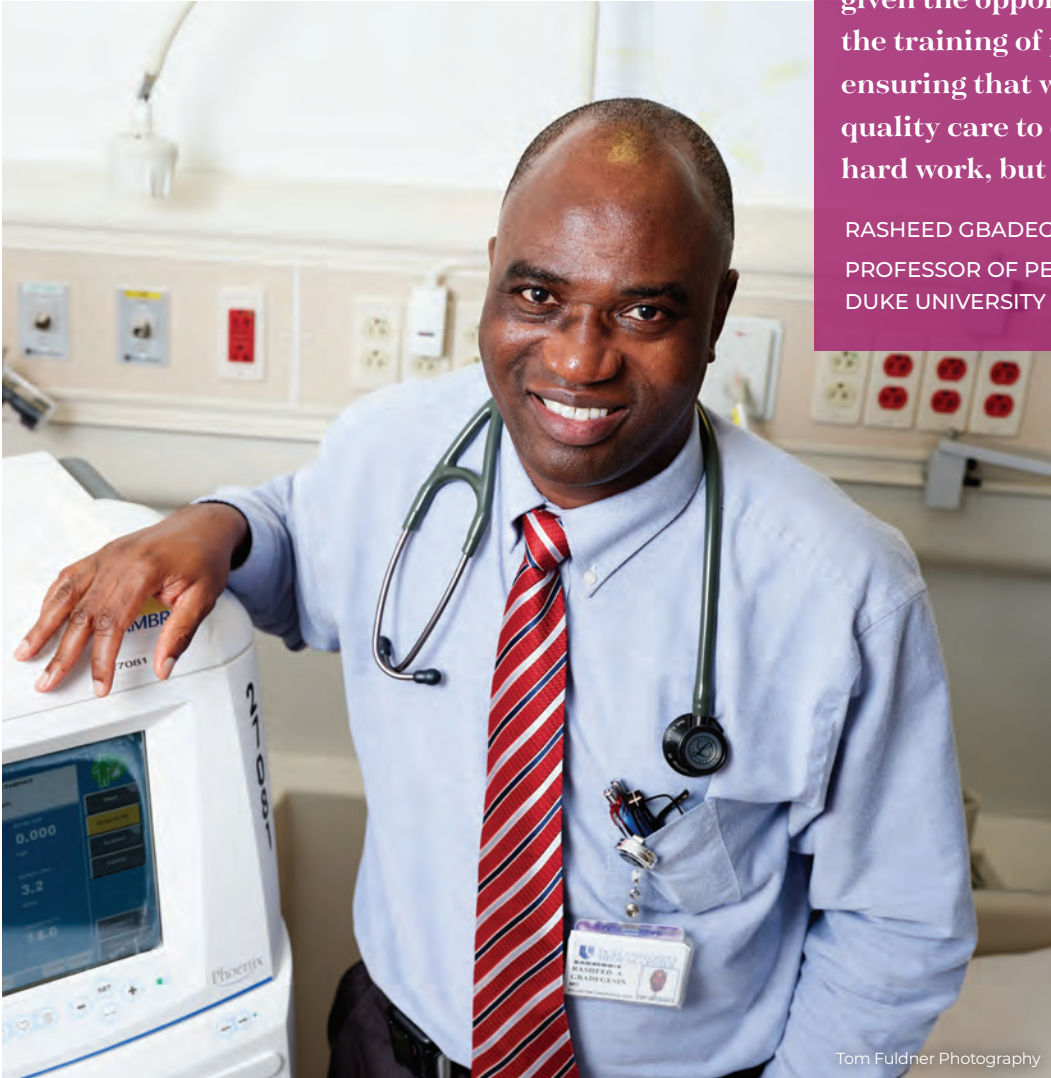
“The goal is to make the volunteer process more welcoming and informative, while also more efficient administratively,” says Kimberly Durham, Project Manager and Executive Assistant at the ABP, and a key contributor to the rebranding effort. “Our volunteer process crosses over multiple departments here at the ABP, and it’s a team effort to recruit for each position.”

ABP staff members analyzed and rebuilt the volunteer process after hearing pediatricians say they didn’t know about volunteer opportunities with the Board. The volunteer page on the ABP website was updated to provide more information about volunteer opportunities and responsibilities. The ABP hopes these actions will broaden and diversify the pool of pediatrician volunteers, while making signing up easier.

“We want pediatricians to know that we have a wide range of opportunities to get involved at the ABP,” Durham says. “A broader base of volunteers provides us with a better representation of pediatric practice across the country.”

**“I consider it a unique privilege to be given the opportunity to have a say in the training of pediatricians and in ensuring that we all are delivering high-quality care to our children. It is a lot of hard work, but the sacrifice is worth it.”**

RASHEED GBADEGESIN, MD, MBBS  
PROFESSOR OF PEDIATRICS AND MEDICINE  
DUKE UNIVERSITY AND DUKE CHILDREN’S HOSPITAL



## PEDIATRICIANS EXPLAIN WHY THEY VOLUNTEER



“It’s an honor to serve the ABP on a committee and contribute my perspective on important issues. I encourage others to volunteer because most people have an opinion on the issue of certification and serving the organization is a way to contribute in a constructive fashion.”

Elena Fuentes-Afflick, MD, MPH  
Chief of Pediatrics, Zuckerberg San Francisco General Hospital  
Professor and Vice Chair, Pediatrics  
Vice Dean for Academic Affairs  
University of California, San Francisco



“Whether you are a general pediatrician, a subspecialist in the community, or an academician, you have an important perspective to bring to the process. It’s important to have people who have experienced the challenge of pediatric health care in this century — people who are seeing kids and struggling with the complexity of health care — to be the ones overseeing the certification and Maintenance of Certification process.”

Sidney Gospe Jr., MD, PhD  
Herman and Faye Sarkowsky Endowed Chair of Child Neurology Emeritus  
Professor Emeritus, Neurology and Pediatrics  
University of Washington  
Adjunct Professor, Pediatrics, Duke University



“To me, being involved with the ABP and an active volunteer is like voting. It is a privilege that should not be taken for granted. I enjoy being a part of the process and having a better understanding of how and why decisions are made. With the current controversy over MOC across many specialties, I initially was curious to get involved to understand better the roots of the controversy. Now that I am more involved, I can easily advocate for the ABP in my home institution as I support its direction and leadership.”

Lindsay Thompson, MD, MS  
Associate Professor of Pediatrics, Health Outcomes and Biomedical Informatics  
Director, Pediatric Research Hub  
University of Florida College of Medicine



ABP STAFF MEMBERS KIMBERLY DURHAM AND ARCHANA AIDA ANALYZE THE VOLUNTEER RECRUITMENT PROCESS.



“This work could not be done without the collaboration between the exam development experts and the content experts. It is the work we do together that makes a good exam. We are all striving for the same thing: improving the health and well-being of children.”

Angela Myers, MD, MPH  
Director, Division of Infectious Diseases  
Associate Director, Pediatric Infectious Diseases Fellowship Program  
Children’s Mercy Kansas City  
Associate Professor of Pediatrics  
University of Missouri-Kansas City School of Medicine



“I would absolutely encourage others to get involved. It has been extremely rewarding intellectually, and I believe that I am a better pediatrician for having done so.”

Steven Federico, MD  
Director of General Pediatrics and School/Community Programs  
Denver Health



“We talk about having empathy with our patients and their families. But it’s also important to have empathy with our colleagues. We can learn and understand what barriers exist by listening to each other. Mixing together people who are coming at a topic from different perspectives is fundamental.”

George Lister, MD  
Jean McLean Wallace Professor of Pediatrics  
Professor of Cellular and Molecular Physiology  
Yale University



## WHY MOCA-PEDS?



MOCA-PEDS TASK FORCE MEMBERS PAUSE DURING A WORKING MEETING (LEFT TO RIGHT): DR. LISA SAMSON-FANG, DR. JEFFREY SNEDEKER, DR. JAMES BALE JR., DR. JAMES LUKEFAHR, DR. ANNA KUO, DR. LAUREN HERBERT, DR. KAREN LEONARD, DR. TERRILL BRAVENDER, AND DR. LAURA BROOKS, CHAIR. NOT PICTURED: DR. NORMAN FERRARI III

Science and medical care are advancing at previously unseen rates, with no signs of slowing anytime soon. There are also more demands on physicians' time than ever before. A web-based survey conducted in 2008 with a random sample of adults found that most believe it is important for doctors who care for children to be assessed on their quality of care (95 percent) and pass a written test at regular intervals (88 percent).<sup>1</sup>

So, how does assessment of clinical knowledge and judgment fit into the world in which we live today?

The American Board of Pediatrics began to explore new assessment options back in 2015. Three years of extensive research, building, and pilot testing later, the ABP officially launched the Maintenance of Certification Assessment for Pediatrics (MOCA-Peds) as an assessment option in January 2019.

MOCA-Peds is a web-based, non-proctored exam platform that allows test takers the flexibility to answer questions on their computers, tablets, or smartphones. They also can use resources (e.g. the internet, books, etc.) to help answer questions.

<sup>1</sup>Freed GL, Dunham KM, Clark SJ, Davis MM; Research Advisory Committee of the American Board of Pediatrics. Perspectives and preferences among the general public regarding physician selection and board certification. *J Pediatr*. 2010;156(5):841-845. doi: 10.1016/j.jpeds.2009.11.055.

## MOCA-PEDS PAPER PUBLISHED

"MOCA-Peds: Development of a New Assessment of Medical Knowledge for Continuing Certification" was published in *Pediatrics* in November 2018. It offers insight into the new platform, from details about its conception and development as a two-year pilot with thousands of pediatrician volunteers to a report on its feasibility and acceptability.

"This paper explains how the ABP worked with RTI International to engage pediatricians in the initial design and decision-making behind the MOCA-Peds model," says Laurel Leslie, MD, MPH, ABP Vice President for Research and lead author of the paper. "More than 11,000 pediatricians have participated in sharing their ideas and suggestions since February 2016, and [MOCA-Peds] is definitely better because of this."

[http://bit.ly/pediatrics\\_aappublications](http://bit.ly/pediatrics_aappublications)



"MOCA-Peds allows us to assess the most current and relevant information to pediatricians on a continuous basis rather than once every 10 years or so," says Linda Althouse, PhD, ABP Vice President for Psychometrics and Assessment Services and the executive sponsor of the platform. "It also combines learning with the assessment process."

## LISTENING TO PEDIATRICIANS

The ABP piloted MOCA-Peds for General Pediatrics for two years, beginning in January 2017. By the end of 2018, more than 11,000 pediatrician volunteers had participated in the pilot. Many of the volunteers also chose to participate in focus groups and answer surveys about their experiences. The Board found the feedback invaluable.

"Happily, we learned that pediatricians like the new platform," Althouse says.

One pilot participant noted in a survey, "MOCA-Peds is clear and straightforward." Another added, "I can do this at my own pace over time. It helps me learn." Yet another commented, "It's so much better than having to go to a testing center."

Feedback from the pilot participants also identified areas the ABP needed to enhance.

"We learned that because MOCA-Peds is continuous, we needed to build in flexibility," Althouse says. "For example, the scores from the four lowest-scoring calendar quarters [in a five-year cycle] are not counted toward the final score to allow for circumstances in

one's life where they may not be able to answer questions. We also allow those taking the assessment the flexibility to answer questions whenever they want during the quarter."

## HOW WILL IT WORK GOING FORWARD?

From 2019 on, pediatricians will not be required to take the proctored exam at a secure testing center unless they choose to or if they do not pass MOCA-Peds. Also, the MOC Part 3 (Exam) requirement is now aligned with the five-year MOC cycle.

Once pediatricians earn a passing MOCA-Peds score, they are not required to answer questions for the rest of their MOC cycle. They may *choose* to continue participating to earn five points of MOC Part 2 (Lifelong Learning and Self-Assessment) credit for each year of continued successful participation.

Participating physicians who do not pass MOCA-Peds during the first four years of the cycle will need to take the proctored exam in the fifth year. There are no penalties to pediatricians' certifications if they don't pass or if they stop doing MOCA-Peds as long as they successfully pass the proctored exam by the end of their MOC cycle.

## HOW DO PEDIATRICIANS KNOW WHEN THEY CAN BEGIN?

MOCA-Peds is now available for General Pediatrics and some subspecialties. Subspecialty exam due dates (for exams administered by the ABP only) have been postponed until MOCA-Peds is available (see chart below). Pediatricians will have the opportunity to start MOCA-Peds for their area when they enroll in their next MOC cycle. Pediatricians can log into their ABP Portfolio to find out when their specific start dates based on their MOC cycle and MOCA-Peds availability.

## ANTICIPATED MOCA-PEDS AVAILABILITY FOR GENERAL PEDIATRICS AND SUBSPECIALTIES

2019	General Pediatrics, Child Abuse Pediatrics, Pediatric Gastroenterology, Pediatric Infectious Diseases
2020	Developmental-Behavioral Pediatrics, Neonatal-Perinatal Medicine, Pediatric Nephrology, Pediatric Pulmonology
2021	Pediatric Critical Care Medicine, Pediatric Endocrinology, Pediatric Hospital Medicine, Pediatric Rheumatology
2022	Adolescent Medicine, Pediatric Cardiology, Pediatric Emergency Medicine, Pediatric Hematology-Oncology



VOLUNTEERS VALUE EXAM RELEVANCY



“Being part of the creation of an assessment for learning rather than learning for an assessment is the best way to ensure that recertification not only means you are highly qualified to care for children, but that you are up

to date and skilled in the key areas that pediatricians need to be aware of on an ongoing basis. Seeing the satisfaction metrics of those who are enrolled in MOCA-Peds in terms of how helpful this method is to improve their clinical knowledge of timely issues in child health is a particularly meaningful return on the investment of time and effort I have made as a volunteer for the ABP and its Research Advisory Committee.”

Lewis First, MD  
Professor and Chair  
Department of Pediatrics  
University of Vermont  
Larner College of Medicine  
Chief of Pediatrics  
University of Vermont Children's Hospital  
Editor-in-Chief, *Pediatrics*



“I was in the initial pilot for MOCA-Peds in 2017. Despite writing exam questions for [initial certification] the past three years, I hate taking exams! I loved the idea of having an ‘open book’ test because it was truer to what I experience in practice: if

I am unsure of something, I can look it up. The other thing I loved was that I could do a few questions at a time when I had time.

“I had previously heard about MOCA-Peds during our certifying exam committee meetings and knew members of the group who were responsible for not only writing the questions but also writing the explanations of the answers. It was great to see their hard work in action!”

Rachel Dawkins, MD  
General Pediatrician  
St. Petersburg, FL



“I think the most eye-opening event that I can recall was an ABP conference that I was invited to participate in a few years ago, called ‘The Future of Testing.’ What was truly remarkable about the meeting was that it soon

became apparent that the whole model of a 10-year test cycle was problematic and didn’t meet the needs of either the public at large or the pediatricians that the ABP serves. We came out of that conference with a completely new direction, which ultimately resulted in the MOCA-Peds model that is now being so successfully implemented. It was amazing to see the openness and willingness of this organization to fundamentally change direction so radically in such a short time.”

Jeffrey Snedeker, MD  
General Pediatrician and Infectious Disease Subspecialist  
Ithaca, NY



“Writing questions is not easy, but I’ve learned so much from the process. You learn by writing the questions and answers, and you learn even more from others on the subboard.

“The Board has thoughtfully approached the idea of a different way to assess knowledge that also promotes learning. They’ve shown that if there’s proof that an innovation will work, then they’ll make a change.”

James Callahan, MD  
Associate Medical Director, Division of Emergency Medicine  
Children's Hospital of Philadelphia



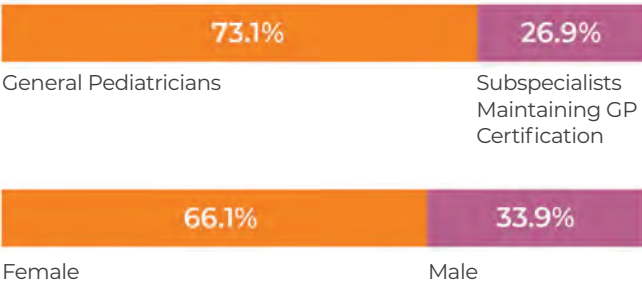
“Certification exams for pediatricians must be clinically relevant, up to date, and applicable to their practice. The only ones who can do this work are those who practice among us ... I love my profession and the peers I work with.”

Evelyn Hsu, MD  
Associate Professor of Pediatrics  
University of Washington School of Medicine  
Director of the Hepatology Fellowship  
Medical Director of the Liver Transplant Program  
Seattle Children's Hospital

2017 MOCA-PEDS PILOT RESULTS

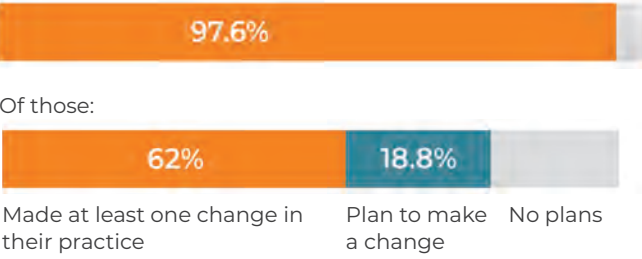
PARTICIPANTS

74.6% of the 6,814 eligible pediatricians registered to participate in the pilot. The participants were:

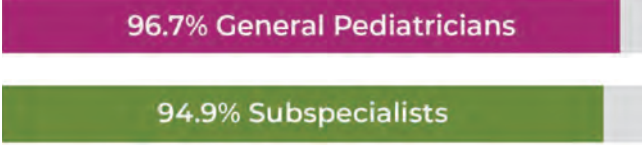


LEARNING

97.6% of end-of-pilot survey respondents said they learned, refreshed, or enhanced their medical knowledge from MOCA-Peds participation.

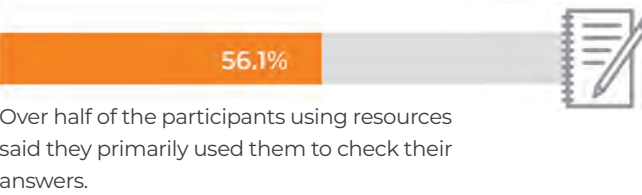
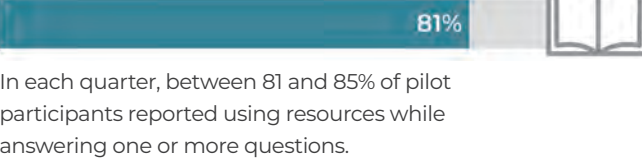


ASSESSMENT PREFERENCE



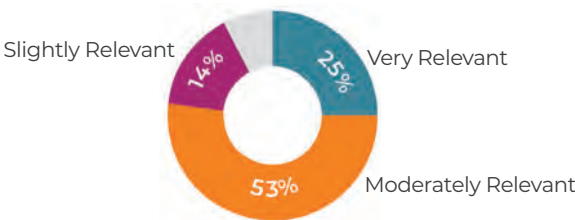
Said they would prefer using MOCA-Peds over the proctored exam for their General Pediatrics certification.

RESOURCES

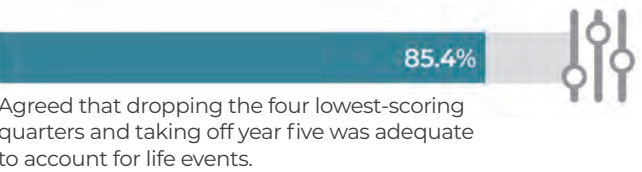
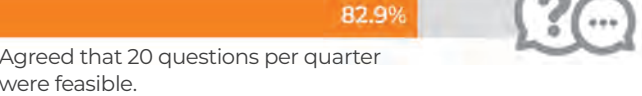


RELEVANCE

92% of the MOCA-Peds questions from the pilot were rated very, moderately, or slightly relevant.

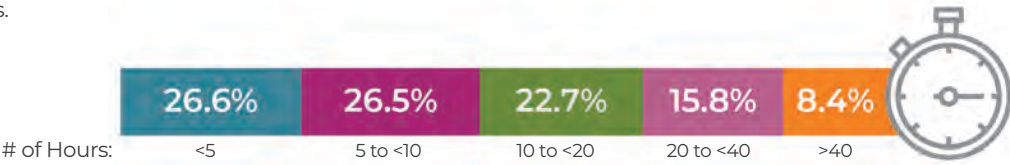


FEASIBILITY



TIME

In the end-of-pilot survey, participants reported the overall time they spent on the pilot, including studying, taking questions, and reading rationales.



Visit [www.abp.org/content/moca-peds-research-and-evaluation](http://www.abp.org/content/moca-peds-research-and-evaluation) for more information and pilot results.



## GLOBAL HEALTH TASK FORCE WRAPS UP AFTER FIVE YEARS OF SERVICE

DR. CYNTHIA KRULL, CURRENTLY A GENERAL PEDIATRICIAN AT CHILDREN'S MINNESOTA HUGO CLINIC, PARTICIPATED IN AN ELECTIVE ROTATION IN GHANA AS A SENIOR PEDIATRIC RESIDENT AT THE UNIVERSITY OF MINNESOTA.

*Global health is big these days. So, you may be asking, what is "big?"*

Geographically, it covers the entire world — including the United States. Socially, it goes well beyond working in a remote village in a low-income country for a few weeks or even years. Global health issues walk into nearly every pediatrician's office every day.

According to the U.S. Census Bureau, about one in four children under age 18 in the United States has at least one foreign-born parent<sup>1</sup>. Nearly 44 million people in the United States are immigrants, and more than 1 million arrive in the United States each year<sup>2</sup>. It is increasingly likely that a child will come to a U.S. pediatrician with an illness more commonly seen in other countries. These children also bring their own language and cultural backgrounds.

Pediatric training programs are working to respond to these demographic trends by offering cross-cultural training experiences. A survey published in 2015 revealed that more than

a quarter of pediatric residency programs have global health-specific tracks, with more than half of all programs offering global health electives<sup>3</sup>. However, opportunities to provide care for recently immigrated children, or children in international, resource-limited settings remain scarce, and there is a growing call for more formalized standards for global health training.

Enter a group of globally minded pediatricians from around the United States. The ABP brought the group together in 2013 to form the Global Health Task Force (GHTF), charged with improving the standards for global health training and working to increase opportunities for education in the field.

<sup>1</sup>U.S. Department of Health and Human Services, Health Resources and Services Administration, Maternal and Child Health Bureau. *Child Health USA 2014*. Rockville, Maryland: U.S. Department of Health and Human Services, 2014.

<sup>2</sup>Radford J, Budiman A. Facts on U.S. immigrants, 2016. Pew Research Center. <http://www.pewhispanic.org/2018/09/14/facts-on-u-s-immigrants/#fb-key-charts-arrivals>. Updated September 14, 2018. Accessed February 1, 2019.

<sup>3</sup>Butteris SM, Schubert CJ, Batra M, Collier RJ, Garfunkel LC, Montcalvo D, Moore M, Arora G, Moore MA, Condurache T, Sweet LR, Hoyos C, Suchdev PS. Global health education in US pediatric residency programs. *Pediatrics*. 2015;136(3):458-465. doi: 10.1542/peds.2015-0792.



Pennsylvania's Perelman School of Medicine.

The GHTF had five goals:

- Define what all pediatricians should know about global health;
- Improve global health knowledge, skills, and attitudes for all pediatric trainees in the United States;
- Improve the quality of global health training rotations by setting standards;
- Evaluate the potential impact of the ABP's role in global health; and
- Develop a mechanism to sustain global health awareness and education.



Education Director at the University of Wisconsin School of Medicine and Public Health.

The GHTF has published multiple articles that address key issues surrounding global health, including five articles already published in *Pediatrics*. (See references to those published before Oct. 31 on pages 38-39.)



MPH, Chair of the GHTF Publications Work Group and a Professor of Pediatrics at the University of Washington and Associate Director of the Pediatric Residency Program at Seattle Children's.

Another notable achievement of the task force was the development of *Global Health in Pediatric Education: An Implementation Guide for Program Directors*.



"The guide is a culmination of efforts by global health educators, members of the task force, and stakeholder organizations such as the Association of Pediatric Program Directors and the American Academy of Pediatrics," says Nicole St

Clair, MD, Associate Professor of Pediatrics at the University of Wisconsin School of Medicine and Public Health and Editor of the implementation guide. "We have been collaborating for many years to develop resources for global health educators. The purpose of the guide is to provide a comprehensive, practical resource for incorporating global health education into pediatric residency and fellowship training programs. In creating it, we spent several years developing, curating, and collating pertinent resources, expert opinions, and guidelines into one central resource for educators. And we've already received a lot of positive feedback on how useful it is."

Dr. St Clair says the guide, which is available at [www.abp.org/ghpdguidehome](http://www.abp.org/ghpdguidehome), can be tailored for other uses.

"Many medical schools are also integrating global health education into their framework. In developing this tool, we fully recognize that undergraduate medical educators, as well as practicing providers, may want to use these resources," she says. "There's very little in the guide that wouldn't be applicable to another specialty, so I think there is potential for other disciplines to use it."

Dr. Butteris says the task force has been successful in developing opportunities for pediatricians to learn more about global health issues, both domestically and internationally.

"People have become more keenly aware of some of the more challenging issues for our country in terms of immigrants, refugees, and the health of children who are placed in difficult situations at the border or after they enter our country," she says. "We've developed two Self-Assessment [Part 2] activities for Maintenance of Certification. One helps physicians learn more about the health issues facing immigrant and refugee children, and another covers professionalism and ethics when working in international settings."

The task force also is creating a guide that global health educators can use to enhance their global health educational programs while earning MOC Part 4 (Quality Improvement) credit.

The task force will sunset at the end of 2019, having laid a strong foundation for work that will continue.



that support pediatricians caring for children and adolescents of all backgrounds, inside and outside our borders."

"I love working with this task force," says Dr. Batra. "I know it's going to have impact. The most rewarding volunteer experience is when you have ability to see the fruit of your work. I can say with a huge smile on my face that this has been so important and so fun."

# ENGAGING PHYSICIANS IN QUALITY IMPROVEMENT

When Heather McLean, MD, was appointed Vice Chair for Quality in the Department of Pediatrics at Duke University in 2015, she was eager to expand Duke's quality efforts to improve care for pediatric patients.

However, "it seemed that only a few faculty members were excited to drive change," Dr. McLean, also Associate Professor in the Division of Pediatric Hospital Medicine, recalls. "The barrier is that everyone is busy!"

Dr. McLean's sentiment is not uncommon. It seems that everyone is busy. So how can health care leaders responsible for quality and safety break through that barrier?

The Institute for Healthcare Improvement (IHI) notes that most hospitals struggle with engaging physicians in quality and safety improvements.<sup>1</sup> To help organizations such as Duke increase engagement, IHI outlined an easy-to-follow framework with suggestions that include discovering a common purpose (e.g., improved patient outcomes), involving physicians from the beginning, making quality improvement (QI) easy, and valuing physicians' time.



Lloyd Werk, MD, MPH, Division Chief, General Academic Pediatrics at Nemours Children's Hospital in Orlando, FL, and ABP Portfolio Sponsor Manager for Nemours Children's Health System, discussed the IHI's framework during the annual ABP Pediatric Portfolio Sponsor meeting in June and provided practical

tips on its application. "For example, you might find a common purpose around reducing time wasted or reframe discussions to focus on patient outcomes instead of processes and widgets," he says. "Seek natural allies in educators and among those who can help publish findings."

Other engagement methods discussed at the meeting included embedding QI in training programs, identifying QI champions, establishing quality councils, providing coaching, making physician involvement visible, and communicating often.

To increase physician engagement with quality initiatives at Duke, the Department of Pediatrics' Quality Review Board is developing a longitudinal course to teach faculty and staff how to design and lead a quality improvement project. "Physicians in the course will be learning and doing simultaneously," Dr. McLean says. "Our goals are for each participant to have a scholarly project worth publishing and to spread quality champions across all divisions."

<sup>1</sup>Reinertsen JL, Gosfield AG, Rupp W, Whittington JW. Engaging physicians in a shared quality agenda. IHI Innovation Series white paper. Cambridge, Massachusetts: Institute for Healthcare Improvement; 2007. Available on [www.IHI.org](http://www.IHI.org). Accessed February 1, 2019.



MEMBERS OF DUKE'S QUALITY REVIEW BOARD, FROM LEFT TO RIGHT: DR. KATHLEEN BARTLETT, DR. HEATHER MCLEAN (CHAIR), DR. JANE TRINH, DR. SAMEER KAMATH, AND DR. LISA PARNELL



Doreen Toooh, Program Specialist for Medical Staff Services at Arkansas Children's Hospital, also coaches pediatricians involved in QI and encourages their engagement by giving them a Maintenance of Certification (MOC) checklist at the beginning of each year, hoping they don't wait until the last

minute to begin QI. "We coach them to keep their project small enough to be comfortable, and then they can expand later."



John Kohler, MD, MBA, Vice Chair for Quality in the Department of Pediatrics and Medical Director for Quality, Women's and Children's Services at East Carolina University, encourages engagement — and the spread of improvements to other settings — by breaking down silos. "We empower hospital-acquired condition

(HAC) champions from across the organization [to run their own projects], but they have a requirement to pull physicians and nurses from every place that the HAC touches so that ideas come from everywhere and the best practices we want to incorporate are disseminated across the organization."



When an interest in improving care is not enough motivation for physicians, some organizations institute peer recognition. Mimi Saffer, Vice President, Quality Improvement and Quality Measurement, at the Children's Hospital Association, says recognition can be at the institutional level, health system level, unit level, and

individual level. "Clearly, what the Board has done with MOC Part 4 credit is at a very personal level of recognition," she says.



Francis Rushton, MD, a private practitioner representing the South Carolina Chapter of the American Academy of Pediatrics, agrees. He uses MOC as a "carrot" to engage physicians to participate in his South Carolina Medicaid project. "MOC has been a huge boon to us," he says.

Other institutions have found that financial rewards work best. For example, Children's Mercy Kansas City gives a Patient Safety award to recognize an individual or group of individuals who have worked tirelessly to improve the safety of patients and eliminate harm. Recipients receive a plaque and a small stipend during a formal annual faculty awards event. The Children's Advisory Board at St. Luke's Children's in Idaho gives \$100,000 in quality and safety grants to at least 20 individuals annually. And Duke University's Department of Pediatrics offers a travel grant to support individuals who are invited to give a presentation at a national conference about their quality improvement project.

In the past few years, Duke's Department of Pediatrics has seen a leap in quality work and improved clinical outcomes. "We're trying very hard to get all of the incentives to line up properly," says Dr. McLean.



DR. HEATHER MCLEAN, VICE CHAIR FOR QUALITY, DUKE UNIVERSITY DEPARTMENT OF PEDIATRICS, VISITS WITH ARDEN GODRICH AT DUKE CHILDREN'S HOSPITAL.

## TACKLING BURNOUT

Research shows that physician burnout takes a toll on patient care and outcomes, and nearly half of all U.S. pediatricians surveyed in 2014 ( $n=683$ ) reported burnout — up from 35 percent for general pediatricians and 40 percent for pediatric subspecialties in 2011. Comparatively, the overall prevalence of burnout for the general U.S. working population was 28.4%.<sup>1</sup> Physician burnout has been tied to decreased productivity, lower quality of care, decreased patient satisfaction, and problems with patient safety.<sup>2</sup>



"Burnout is caused by professional, personal, and systems factors," says Laurel Leslie, MD, MPH, ABP Vice President for Research. "There are two ways we can approach this. One is we can try to decrease systems factors linked to burnout, and the other is we can try to increase professional

and personal resilience skills to be able to manage the stresses associated with work. For the most part, system-level interventions have been shown in research studies to have a greater effect than professional and personal interventions."

## RESOURCES FOR REDUCING PHYSICIAN BURNOUT

- American Medical Association: [www.stepsforward.org/modules/physician-burnout](http://www.stepsforward.org/modules/physician-burnout)
- National Academy of Medicine: [www.nam.edu/clinicianwellbeing/](http://www.nam.edu/clinicianwellbeing/)
- Executive leadership and physician well-being: nine organizational strategies to promote engagement and reduce burnout.<sup>3</sup>

<sup>1</sup>Shanafelt TD, Hasan O, Dyrbye LN, Sinsky C, Satele D, Sloan J, West CP. Changes in burnout and satisfaction with work-life balance in physicians and the general US working population between 2011 and 2014. *Mayo Clin Proc.* 2015;90(12):1600-1613. doi: 10.1016/j.mayocp.2015.08.023.

<sup>2</sup>Shanafelt TD, Goh J, Sinsky C. The business case for investing in physician well-being. *JAMA Intern Med.* 2017;177(12):1826-1832. doi: 10.1001/jamainternmed.2017.4340.

<sup>3</sup>Shanafelt TD, Noseworthy JH. Executive leadership and physician well-being: nine organizational strategies to promote engagement and reduce burnout. *Mayo Clin Proc.* 2017;92(1):129-146. doi: 10.1016/j.mayocp.2016.10.004.

# REACHING OUT TO RURAL PRACTICES IN TENNESSEE

As a Pediatric Portfolio Sponsor with the ABP, the Tennessee Chapter of the American Academy of Pediatrics (TNAAP) approves quality improvement (QI) projects for Maintenance of Certification (MOC) Part 4 credit. But unlike many Portfolio Sponsors that work solely in hospitals in large urban areas, TNAAP also focuses on primary care settings in small towns across the state through its Pediatric Healthcare Improvement Initiative for Tennessee (PHiIT) and other programs. This is the story of one such practice.

As part of her medical school training in the 1980s, Amy Evans, MD, traveled to Santiago, Chile, to examine the differences between urban and rural health care. Now a general pediatrician in a small-town private practice in Sewanee, TN, dozens of miles away from the closest medical school or large medical center, she understands firsthand the challenges of providing rural health care.

“When I first came to Sewanee in 1994, there was not a pediatric practice,” says Dr. Evans, founder of Sewanee Pediatrics and Adolescent Medicine. “And although Sewanee is a small university town, most of our patients come from rural Grundy County — the poorest county in Tennessee and one of the poorest in the United States. Sixty percent of our patients are covered by Medicaid.”

DR. AMY EVANS VISITS WITH YOUNG PATIENT ANNE CHARLTON BURNETT.



Photos by Clint Smart

DR. MARY HEATH EXAMINES REN ELROD WHILE HIS MOTHER, JULIE ELROD, LOOKS ON.

According to the U.S. Census Bureau, nearly 23 percent of the Grundy County population of 13,000 live in poverty, and the median household income in 2016 was less than \$29,000.<sup>1</sup>

To improve the care provided to her patients and distinguish the practice from nearby urgent care facilities, Dr. Evans called the TNAAP a few years ago for help. She wanted the practice to become a recognized National Committee for Quality Assurance (NCQA) Patient-Centered Medical Home (PCMH).



“At the time, PCMH standards were getting ready to change,” says Becky Brumley, MPH, PHiIT Program Director and Quality Coach. “So instead, the practice started with PHiIT, which then catapulted them into becoming a medical home because PHiIT focuses on building the QI infrastructure that is a large part of PCMH.”

“The first thing Becky did was set up our team,” says Dr. Evans. “Then they taught us how to do a PDSA [plan, do, study, act] cycle, which is so empowering. They helped us ask the right questions and collect the appropriate data.”

After on-site QI training, the practice started the early well-care project in October 2016. Subsequently, the practice completed PHiIT’s asthma project, completed a second well-child project, and started the adolescent health project.

“We had more success than we expected,” says Dr. Evans. In March 2018, 65.7 percent of their active patients were up to date on physicals. “Now when they come in sick, we try to do a well-child check, too.” By October, the percentage of patients up to date on physicals rose to 76.3 percent.

Sewanee Pediatrics and Adolescent Medicine, now an NCQA-recognized PCMH, is one of 50 practices and four residency programs across Tennessee currently enrolled in PHiIT projects, which also include breastfeeding sustainment, tobacco exposure reduction, behavioral health, and HPV vaccinations. In addition to QI training at their practice, participants receive access to educational videos approved for CME credit, coaching,



monthly support calls, aggregated data from other practices, a data collection system, personalized reports, and tools like flyers, handouts, posters, and measures tables. More than 100 pediatricians have received MOC Part 4 credit since 2015, and the number grows every year.

“The monthly support call is the best 30 minutes I spend every month,” says Dr. Evans. “We plan to stay in PHiIT for as long as it is available!”

Mary Heath, MD, MPH, also a pediatrician at Sewanee Pediatrics and Adolescent Medicine, says quality improvement has been very helpful for the practice. “It has engaged our staff in a different way and made an impact in our community as we help families, who are busy and stretched, stay on task,” she says. “QI work helps us all stay on track.”



Allen Coffman Jr., MD, concurs that one of PHiIT’s goals was to put pediatricians and parents back in the driver’s seat. As the former TNAAP President and Medical Director of PHiIT, he envisioned the program, led its development with support from the National Improvement Partnership Network (NIPN), and was instrumental in designing the projects. “Pediatricians can solve the problems and frustrations they have about primary care if they are given the right tools,” he says. “The participating practices are doing amazing work in a very short period of time.”

Dr. Evans says that beyond quality improvement in individual practices, TNAAP is trying to raise the bar about what primary care is. “Primary care is often not valued because it’s not based on medical procedures. If all AAP chapters had a project like this, it could be a way of sustaining and improving pediatric primary care across the country.”

<sup>1</sup>United States Census Bureau. QuickFacts: Grundy County, Tennessee. <https://www.census.gov/quickfacts/fact/table/grundycountytennessee/PST045217>. Accessed February 1, 2019.

## CULTIVATING A CULTURE OF QI



Cason Benton, MD, received the ABP 2018 Paul V. Miles (PVM) Fellowship Award, given annually to an accomplished mid-career pediatrician dedicated to improving the quality of health care for children. In September, she came to Chapel Hill, NC, to share her ideas, innovations, and enthusiasm for quality improvement (QI) with the ABP staff and to present grand rounds at both the University of North Carolina (canceled due to Hurricane Florence) and Duke University medical schools.

“When I trained [to become a pediatrician], there was no QI,” Dr. Benton said during her presentation to ABP staff. “We didn’t learn about QI, and it wasn’t expected of us. But as I was getting into my career, reports started coming out about how patients were not getting the care they were supposed to get, and in fact, some of them were dying.”

Later, Dr. Benton had what she calls her “aha moment” about QI at the University of Alabama at Birmingham’s Primary Care Clinic, where she has practiced since 1998 and served as medical director before becoming the founding Director of the Alabama Child Health Improvement Alliance (ACHIA) in 2013.

“We were looking at the 12-year-old well visit,” she says. “We had a number of 12-year-olds check ‘Yes’ to the question of whether they were having sex, but they came into our clinic, they left our clinic, and nobody ever addressed it with them. Thinking about preventive care, that’s kind of an important thing to tackle with children.” After the care gap was identified, the clinic worked quickly to close it.

ACHIA, a statewide alliance of public and private partners, envisions that Alabama’s children — 25 percent of whom live in poverty — receive optimal health care. Dr. Benton says that mentoring from the American Academy of Pediatrics (AAP) and the National Improvement Partnership Network (NIPN) was critical to building ACHIA.

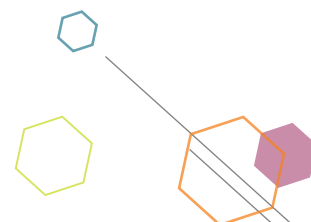
“We think one of the biggest drivers that will get us there is fostering a culture of quality improvement — not just doing QI, but really embracing the whole concept,” says Dr. Benton. “We need to do this with practitioners, payers, families, and all the organizations that are interested in children’s health.”

As ACHIA Director, Dr. Benton has developed and led five quality improvement collaboratives across Alabama, focused on healthy active living, HPV vaccinations, early developmental screening, depression screening, and asthma. ACHIA collaboratives provide content experts, QI coaching, aim statements, key drivers, measures, a data platform, monthly webinars, CME and MOC credit, billing tips, and links to community resources.

“Just under half of the practicing primary care pediatricians in Alabama have participated in one or more ACHIA projects,” she says. “We try to make it as easy to participate as possible because doctors want to be in the room with their patients. They don’t want to be sitting down at a table, and they don’t want to be the ones entering the data. If they’re going to do QI, it needs to be important and they need to feel invested and that the time they’re spending is well spent.”

“It needs to be part of the job, not something that you do after hours.”

Read more at [www.abp.org/news/benton](http://www.abp.org/news/benton).



## BREAST MILK FOR BABIES

### *Colostrum Kits Increase Early Breast Milk Feeding in Very Low Birth Weight Infants*

Infants weighing less than 1500 grams (3 lb. 5 oz.) at birth typically spend six weeks or more in neonatal intensive care units (NICUs) before going home with their families. Yet the benefits of receiving their mother’s breast milk soon after birth are well-documented and potentially lifesaving. And early expression of colostrum has been shown to increase a mother’s milk supply six weeks later.<sup>1</sup>

However, despite the short-term and long-term benefits for these very low birth weight (VLBW) infants, early and prolonged separation of mother and baby, combined with the mother’s own recovery from what may have been a complicated pregnancy or delivery, often hinders the ability of mothers to provide colostrum to their newborns or to provide it within the infant’s first day of life.

Lynn Iwamoto, MD, a neonatologist at Kapi’olani Medical Center for Women and Children and Associate Professor of Pediatrics at the University of Hawaii, found inspiration to address this issue at Kapi’olani when one of her own medical students had a VLBW infant in the NICU.



begin expressing colostrum soon after birth,” she says. “Then Dad or Grandma or a partner can bring the tubes to the NICU.”

The kits also include a link to the online Stanford Medicine Newborn Nursery, a website with videos about the importance of breast milk, including one about hand expressing milk ([www.med.stanford.edu/newborns](http://www.med.stanford.edu/newborns)).

Within three months of creating the kits and implementing the process to deliver them to mothers, the average time between birth and first feeding of VLBW infants dropped from 27 hours to 13 hours and the percentage receiving their mother’s colostrum within 12 hours of birth increased from 20 percent to 40 percent. One-hundred percent of VLBW infants at Kapi’olani Medical Center now receive their mother’s colostrum as their first food, nearly 80 percent receive it within 24 hours of

birth, and the rate of infants receiving breast milk at discharge has increased, too.

Because of their success in the NICU — and the minimal cost to create the kits — the kits are now distributed to all mothers of NICU-admitted infants and available to all new mothers throughout the medical center, regardless of the infant’s birth weight or gestational age.

“A challenge and benefit simultaneously for us was getting all the nursing units — NICU, postpartum, and labor and delivery — to participate,” says Dr. Iwamoto. “But it was one of the best things that happened because it helped get the units to collaborate together.”

<sup>1</sup>Parker LA, Sullivan S, Krueger C, Kelechi T, Mueller M. Effect of early breast milk expression on milk volume and timing of lactogenesis stage II among mothers of very low birth weight infants: a pilot study. *J Perinatol*. 2012;32(3):205-209.doi: 10.1038/jp.2011.78.



**DR. NOHEA LEATHERMAN-ARKUS, THE INSPIRATION FOR AND CO-LEAD OF THE QI PROJECT, HOLDS HER SECOND CHILD BEFORE MEDICAL SCHOOL GRADUATION FROM THE JOHN A. BURNS SCHOOL OF MEDICINE AT THE UNIVERSITY OF HAWAII. DR. LEATHERMAN-ARKUS IS NOW A FIRST-YEAR RESIDENT AT CHILDREN’S MEDICAL CENTER DALLAS.**

# DATA VISUALIZATION HIGHLIGHTS

## DISPARITIES IN PEDIATRICS,

## DRIVES DECISION-MAKING

The ABP has transformed its workforce data book into an interactive experience through digital data visualizations.

Data relating to trainees, certification areas, and more can be filtered easily by gender, age, and location, instantly generating dynamic maps, graphs, and tables.

### IDENTIFYING GEOGRAPHIC DISPARITIES

Geographic disparity is a significant problem in many subspecialties — an issue pediatric nephrologist Michelle Rheault, MD, sees in her field.

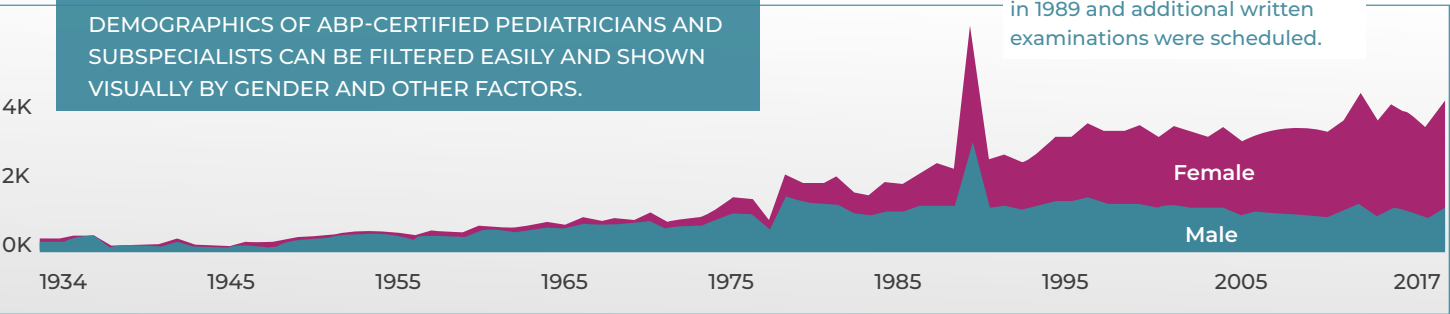


“For a small pediatric subspecialty like nephrology, the workforce is always top of mind,” says Dr. Rheault, Associate Professor of Pediatrics and Director of the Division of Pediatric Nephrology at the University of Minnesota.

She has used the ABP workforce data to look further into geographic distribution throughout the country. By simply choosing her subspecialty, Dr. Rheault can see an overview of where board-certified pediatric nephrologists are practicing — or not.

“Patients from those states [with no pediatric nephrologists] end up having to travel really far distances,” she says. “We have to create very complicated travel schedules for those patients.”

By identifying underserved areas, subspecialty practitioners can look for solutions, including possibly establishing training programs in less-populated areas or using telehealth.



### BUILDING A DIVERSE, REPRESENTATIVE WORKFORCE



Neonatologist Tamorah Lewis, MD, PhD, Assistant Professor of Pediatrics at the University of Missouri-Kansas City School of Medicine and a clinician-researcher at Children's Mercy in Kansas City, understands the correlation

between a diverse workforce and patient outcomes. She uses the ABP interactive dashboards to analyze demographic makeup (currently age, gender, and medical school graduate type) in her subspecialty and to plan for how best to prepare future pediatricians.

“One question we always ask ourselves at a big, free-standing children's hospital is, ‘What do our trainees look like in comparison to other places? What does our faculty look like in comparison to other places?’” Dr. Lewis says.

Dr. Lewis chairs a subcommittee at her hospital focused on trainee diversity, equity, and inclusion. She has used the new dashboards to review diversity trends and found she really enjoyed the ability to easily sift through the ABP data.

“When I realized I could change the age range and focus on certain places in the country, I thought, ‘This is incredible.’” says Dr. Lewis. “You were really, clearly thoughtful about the ways we could change the tables, change the figures, and even hover over things for more information. It's really well done.

“One major demographic variable lacking in the current data is race and ethnicity,” Dr. Lewis says. The ABP is working to add race and ethnicity data in the coming years.

### LEVERAGING DASHBOARD DATA FOR DECISION-MAKING



Dr. Lewis' colleague, Christopher Oermann, MD, Professor of Pediatrics and Director of the Division of Pulmonary and Sleep Medicine at the University of Missouri-Kansas City School

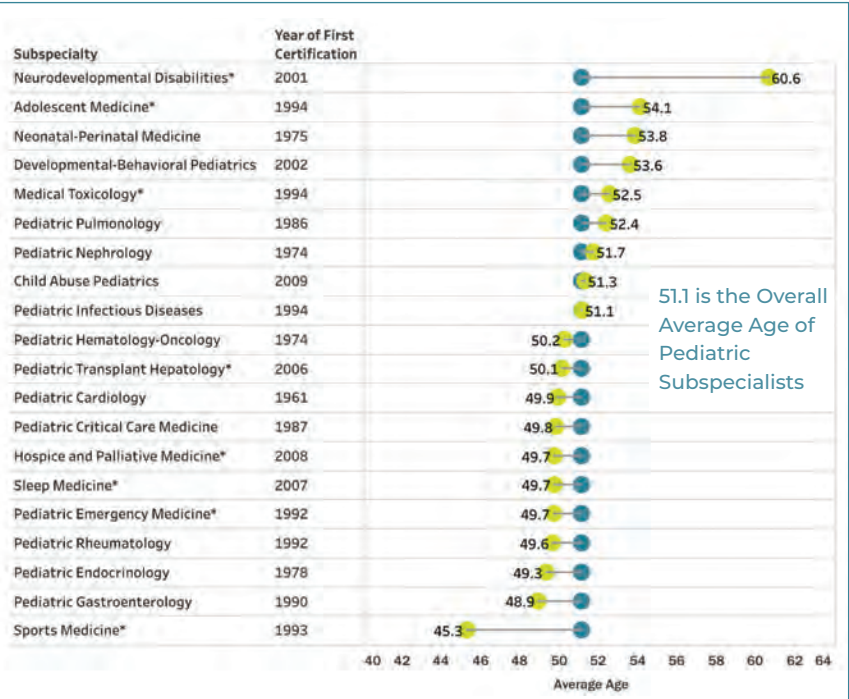
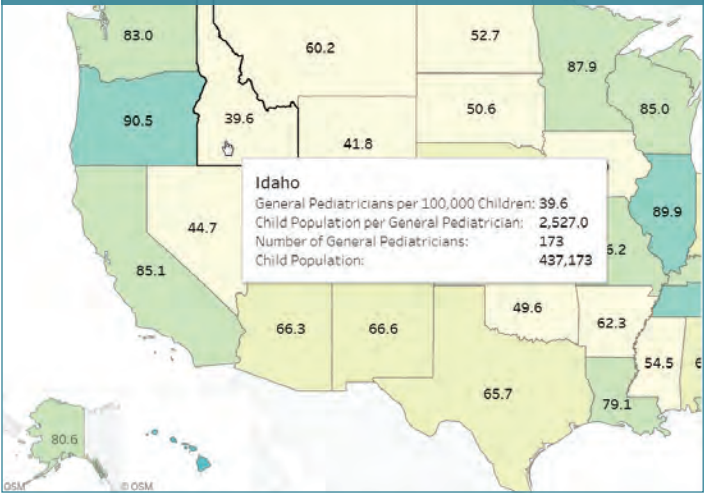
of Medicine and pulmonologist at Children's Mercy in Kansas City, also has found ways to use the data provided through the interactive dashboards to help inform key decision-makers.

As president-elect of the Pediatric Pulmonology Division Directors Association (PPDDA), Dr. Oermann is no stranger to geographic and diversity obstacles.

Dr. Oermann presented at the North American Cystic Fibrosis Conference in the fall of 2018, using the ABP dashboards to highlight specific gaps in the subspecialty.

“I used a lot of the figures from the dashboards, like geographic distribution of pediatric pulmonologists and the static nature of applications compared to other subspecialties,” he says. “It was extraordinarily helpful.”

### GEOGRAPHIC DATA ON THE WEBSITE SHOWS THE DISTRIBUTION OF GENERAL PEDIATRICIANS AND SUBSPECIALISTS AND GEOGRAPHIC DISPARITIES.



THE DATA WILL HELP TRAINING PROGRAM DIRECTORS, HOSPITAL ADMINISTRATORS, AND POLICYMAKERS IDENTIFY PEDIATRIC WORKFORCE TRENDS AND NEEDS.

Dr. Oermann says he also is looking forward to presenting data through the ABP dashboards at future conferences, including a workforce summit at the American Thoracic Society International Conference in 2019. The group, which will include executive committees from the PPDDA and the Pediatric Pulmonary Training Directors Association, plans to analyze workforce issues within the pediatric pulmonology community. The ABP dashboards will provide important data to the summit to give insight for decisions.

“The Board data are really key in understanding what's going on,” Oermann says. “What I hope to do is take these data to the summit and have the combined groups, which includes most of the stakeholders in pediatric pulmonary medicine, discuss the data and come up with a planned solution to address some of the issues that are identified. There are huge areas of the country that are just horrifically underserved, and we need to address it.”

While there are already 15 different ways to explore a number of data sets, the ABP also is pursuing even more data sets for future releases, including key survey information on the practice of pediatrics, more granular geographic distribution information, and data on race and ethnicity.

Please send us your suggestions for the ABP's workforce data dashboards by emailing [workforce@abpeds.org](mailto:workforce@abpeds.org). And visit [www.abp.org/content/workforce](http://www.abp.org/content/workforce) for these and other data visualizations.

# NEW LEADERSHIP IN CONTINUING CERTIFICATION

Keith Mann, MD, MEd, has been selected as ABP Vice President for Continuing Certification, effective Jan. 1, 2019.

He succeeds Virginia Moyer, MD, MPH, who has been Vice President for Maintenance of Certification (MOC) and Quality since 2013.

Although the title has changed, Dr. Mann will assume the same responsibilities as Dr. Moyer. He will lead the ongoing development and implementation of the ABP's continuing certification program and help keep the ABP focused on quality improvement, both for certified pediatricians and for the ABP.

As a volunteer member of the MOC Committee since 2013 — and chair since 2016 — Dr. Mann has worked closely with Dr. Moyer.



DR. KEITH MANN AND DR. VIRGINIA MOYER

"Ginny always made my job as Chair of the MOC Committee easy by walking me through changes in the external environment, sharing feedback from pediatricians, explaining the operational and implementation intricacies of the ideas that came from the committee, and sharing the work she and her team were doing in the background to make the program better," says Dr. Mann. "She did an incredible job making Maintenance of Certification credit easier to obtain for individuals while upholding the ABP standards that make certification so valuable to the public."

Formerly, Dr. Mann was Chief Medical Quality and Safety Officer and Associate Executive Medical Director at Children's Mercy in Kansas City, MO, and Professor of Pediatrics at the University of Missouri-Kansas City School of Medicine. He has been a volunteer on various ABP committees for the past 15 years.

A graduate of New Jersey Medical School, he completed his residency in internal medicine and pediatrics at the Christiana Care Health System/Al DuPont Hospital for Children, which included an additional year as Chief Resident. Additionally, he earned a master's degree in education from the University of Cincinnati.

"Dr. Mann is a great choice to lead continuing certification for the ABP as it continues to refine and improve MOC," says Dr. Moyer. "He brings extensive experience in quality and safety that will help to make our programs as accessible and useful as possible for pediatricians and maximize the efficiency of our internal processes. I am confident as I 'pass the baton' on to Dr. Mann that MOC will be in great hands going forward."

He has big shoes to fill.

During her tenure at the ABP, Dr. Moyer has worked tirelessly to broaden MOC activities to be more relevant to pediatricians' practice and to take advantage of activities pediatricians already are doing. Among her achievements:

- Expansion of ways to receive MOC Part 4 credit (Quality Improvement) for work pediatricians already are doing;
- Establishment of a collaboration between the ABP and the Accreditation Council for Continuing Medical Education (ACCME) to grant MOC credit for qualifying continuing medical education activities;
- Expansion of the Portfolio Sponsor program that allows participating institutions to approve and administer MOC activities for their physicians;
- Addition of more patient, parent, and family voices to all aspects of the work of the ABP; and
- Introduction of the "Kaizen culture" of Lean continuous improvement to ABP internal structures and processes.

"We will sorely miss Dr. Moyer's outstanding leadership at the ABP and throughout the pediatric community," says David Nichols, MD, MBA, President and CEO of the ABP. "However, we are looking forward to the new ideas and perspectives that Dr. Mann will bring to continuing certification and to our leadership team."

# A PARENT'S RX FOR PEDIATRICIANS — GET TO KNOW PATIENTS' FAMILIES



Tamela Milan-Alexander recovered from opioid addiction, regained custody of her six children, moved out of public housing, earned not only a bachelor's degree, but also a master's, and became a parent advocate, peer educator, developmental screener, community health worker, and case manager.

The changes all started, she says, because of the relationship she and her youngest child's pediatrician were able to build. Presenting the 2018 Stockman Lecture in November at the American Academy of Pediatrics' National Conference and Exhibition, she told pediatricians to have the same faith in the families of their own patients as her pediatrician had in her.

"So many people had seen my patient history and instantly judged me," she says. "He saw in me something I had yet to see in myself. When I said I couldn't, he said I could."

Her daughter's pediatrician guided her toward resources that would help her overcome her addiction and get other help she needed.

"I reflect what is possible, what can be achieved if we work together by meeting people where they are and giving them the opportunity to let you know where they want to go. That way you can create an impact on those you serve in a much more profound way," she told more than 4,000 pediatricians.

"My prescription for you is this: Get to know your clients. Meet them where they're at. You may know what's best, but often, we know better. Allow people to be authentic. And share with them just a piece of yourself. You can have boundaries, but don't have borders."

Watch her presentation at <http://bit.ly/TMilan-Alexander>.

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

# PUBLIC VOLUNTEERS CONTRIBUTE TO ABP MISSION

Rutledge Hutson is a child advocate and a mom. She also volunteers as one of two public (non-physician) members\* of the 15-member ABP Board of Directors.

“It’s important that the Board has people who are not physicians to bring a different perspective to decisions,” she says.

Public members represent parents and other members of the public who rely on certification as a way of knowing that a pediatrician has completed an accredited pediatric training program and continues to stay up to date on the latest medical knowledge and best practices.

“To parents, certification means that a doctor has made the effort to go above and beyond what’s required for a state license and that they care about high standards,” Hutson says.

Hutson, an attorney, started her career working for a commercial law firm in Atlanta. She also volunteered on a foster care review board set up to help relieve juvenile court backlogs by hearing cases and making recommendations to the judges.

“I was helping one family at a time,” she says, “but the whole system was broken.”

She then earned a Master of Public Health so she could better discuss research on factors that impact children’s well-being (including health, poverty, and maltreatment) with policymakers at the federal, state, and local levels. She worked for 15 years in Washington, DC, for the Center for Law and Social Policy and for the Children’s Defense Fund.

In 2008, Hutson was asked to participate on the ABP Long-Range Planning Committee. She was on that committee, which became the Strategic Planning Committee, until 2015. She also chaired the Conflict of Interest Committee from 2011 until 2016. In that role, she helped the ABP update its conflict of interest (COI) policy and formalize COI oversight. She was appointed to the Board of Directors in 2014 for a six-year term.

In 2016, her daughter, Khadija, was diagnosed with a chronic, debilitating condition that has required frequent appointments with specialists, weekly therapies, and trips to the hospital.

“I brought an additional perspective to the Board then, as the parent of a chronically ill child,” she says. “I know firsthand how vital it is to have confidence in the training, knowledge, professionalism, thoroughness, and teamwork of your child’s doctors. When your child is admitted to the hospital unexpectedly, you don’t have time to research the doctors caring for your child, but knowing they are board certified reassures you that they meet very rigorous standards.”



KHADIJA AND RUTLEDGE HUTSON

“Rutledge has a very analytical mind,” says Ann Burke, MD, Chair of the ABP Board of Directors and Professor of Pediatrics at Boonshoft School of Medicine at Wright State University Medical School in Ohio. “She helps us see any unintentional consequences that might be hidden in our decisions and policies. Her perspectives always enrich our discussions.”

\*Diane Pickles, a public health advocate from Massachusetts, also is a public member of the ABP Board. Six ABP committees and the ABP Foundation Board of Directors also have public members.

# PROFESSIONAL SERVICES: THE ABP ‘DREAM TEAM’

Calling them meeting planners is like calling Julia Child a cook. Technically, yes, they plan every detail to ensure that the purpose and goals of meetings are met, but they do so much more and do it with flair! For example, overseeing the interactions and relations with the ABP volunteers and other certified pediatricians and organizations also is on their bill of fare.

If you know Pam Moore, Lisa Elliott, Sheryl Thompson, Amy Green-Welsh, or Liayn McCall, then you can just imagine them blushing at this description. They personify professionalism and humility, and among them have more than 90 years’ service with the ABP.

In the course of their work, they effectively plan, oversee, and provide administrative support for more than 900 individual trips to 75 committee and subboard meetings every year, many spanning multiple days. While most meetings are held on the ABP campus in Chapel Hill, NC, the volunteers who attend come from across the country and need travel and lodging arrangements. With multiple meetings each month of the year, there are other factors to work around, like hurricanes, ice storms, and flash floods. But with a smile, they calmly address unforeseen problems and changes in plans.

They are also at the door to greet every volunteer who attends an ABP meeting.



“I can’t say enough good things about the ABP dream team of meeting planners,” says Laura Brooks, MD, a general pediatrician in Lynchburg, VA, who has been an ABP volunteer since 1999. “Their hard work and detailed planning allow volunteers to focus on the meeting agenda without needing to worry about any of the travel or administrative details.”

Their department, officially known as Professional Services, goes beyond managing the meeting experience, ensuring that ABP volunteers are well-prepared for their responsibilities and meet the rigorous policy standards that come with the role. The website for ABP volunteers is regularly updated with news and information, including meeting times and dates, meeting agendas, and other supporting materials. Working with the Conflict of Interest Committee, they ensure that volunteers disclose any associations they have that might influence, or appear to influence, their work on exams and other Board business. They also work with the Nominations Committee to oversee the appointment of volunteers to various ABP committees and subboards. A specific goal is to foster the diversity of ABP committees (based on type of practice, race, ethnicity, gender, geography, and other variables) to ensure the ABP gets ideas and feedback from all parts of the pediatric community.



PROFESSIONAL SERVICES STAFF, LEFT TO RIGHT, AND THEIR YEARS OF ABP EXPERIENCE: LISA ELLIOTT (25+) AMY GREEN-WELSH (9+) PAM MOORE (26+) SHERYL THOMPSON (29+) LIAYN MCCALL (5+)



“Their work is flawless and their patience with us as volunteers, with our never-ending questions and forgetfulness, is beyond measure,” says ABP Board of Directors Secretary-Treasurer, Victoria Norwood, MD, Professor of Pediatrics at the University of Virginia School of Medicine. She has been volunteering with the ABP since 2002. “When evil travel karma appears, they fight it off on our behalf. They feed us, house us, transport us, and care about our welfare, with never-ending smiles, grace, and calm.”



DAVID BARROW (24+ YEARS OF ABP EXPERIENCE), IS A SPECIALIST IN THE FACILITIES DEPARTMENT, BUT AN HONORARY AND ESSENTIAL MEMBER OF THE PROFESSIONAL SERVICES TEAM. HE SETS UP THE MEETING ROOMS, FROM MOVING FURNITURE TO BRINGING IN MEALS, AND ENSURES THE NEEDS OF THE ATTENDEES ARE MET. HE KEEPS THE MEETING ROOMS STOCKED WITH SUPPLIES AND REPLENISHES ITEMS AS NEEDED.

PREPARING FUTURE PEDIATRICIANS TO MEET THE BEHAVIORAL AND MENTAL HEALTH NEEDS OF CHILDREN

In April, the ABP Foundation teamed up with the National Academies of Sciences, Engineering, and Medicine (NASEM) to sponsor a conference titled “Preparing Future Pediatricians to Meet the Behavioral and Mental Health Needs of Children.” The two-day meeting brought together pediatric department chairs and program directors to engage with other critical stakeholders in discussions about advancing pediatric training in behavioral and mental health. Participants were asked to identify a commitment or change strategy that they could implement within their organization or as an individual. The agenda book, worksheets, presentations, and principles for leading change are available on the ABP website at [www.abp.org/foundation/behavioral-mental-health](http://www.abp.org/foundation/behavioral-mental-health).



SUZANNE WOODS, MD, RECEIVES TWO AWARDS IN 2018



Suzanne K. Woods, MD, Executive Vice President of the ABP, was one of nine recipients of The Parker J. Palmer Courage to Teach Award presented by the Accreditation Council for Graduate Medical Education (ACGME) in March at its Annual Educational Conference.

Also in March, Dr. Woods received MPPDA Leadership in Med-Peds Award from the Medicine-Pediatrics Program Directors Association (MPPDA).

Dr. Woods joined the ABP staff on Jan. 1, 2018. Before coming to the ABP, she was Associate Professor of Pediatrics and Medicine, Director of the Med-Peds Residency Training Program, and Section Chief for Combined Medicine Pediatrics, all at Duke University. She was the residency program director for 16 years.

ABP STAFF OFFER MOC SUPPORT AT NATIONAL CONFERENCES

ABP staff operated informational booths at two major national conferences for pediatricians this year to offer Maintenance of Certification (MOC) support and advice: the Pediatric Academic Societies (PAS) Meeting in Toronto in the spring and the AAP National Conference and Exhibition (NCE) in Orlando in the fall.

Booth size was doubled at the NCE this year to accommodate additional staff to help explain MOCA-Peds, the new ABP assessment program. Questions about MOCA-Peds, MOC requirements, and pediatricians' personal MOC status dominated the inquiries from the more than 300 pediatricians who visited the booth at PAS and 650 who visited the booth at NCE.



PATIENCE LEINO, DR. MARSHALL “BUZZ” LAND, DR. RAM CHANDRA, AND DR. VIRGINIA MOYER AT PAS

NEW PART 2 (SELF-ASSESSMENT) ACTIVITY BRINGS QI BASICS TO LIFE

More than 500 pediatricians earned Maintenance of Certification (MOC) Part 2 (Self-Assessment) credit in 2018 by participating in “A Journey of Improvement: Basics of QI.” The activity, presented as a series of animated videos, walks viewers through a step-by-step process of choosing, designing, and completing a quality improvement (QI) project. It follows the story of a general pediatrician in a community practice as she leads her team.



“We made the content more approachable for pediatricians without a lot of formal QI training,” says Daniel Schumacher, MD, MEd, Associate Professor of Pediatrics at Cincinnati Children's, who created the activity in collaboration with Carol Carraccio, MD, MA, ABP Vice President for Competency-Based Assessment.

The videos illustrate how improvement science is applied to a practice gap, how group participation and investment are a large part of QI success, and how teaching the whole team about QI principles is vital to getting everyone on the same page.

In addition to earning MOC Part 2 credit for completing the activity, pediatricians who apply what they learn by developing and completing a small-group QI project can apply for MOC Part 4 credit in their ABP Portfolio.

PEDIATRIC PORTFOLIO SPONSORS MEET TO LEARN ABOUT QUALITY IMPROVEMENT



Nearly 50 representatives from Pediatric Portfolio Sponsor organizations across the country met in Durham, NC, in June to learn and share best practices with their peers. Pediatric Portfolio Sponsors are authorized by the American Board of Pediatrics (ABP) to evaluate local and institutional QI projects against the ABP's standards and then approve QI projects for MOC credit (see story about one in Tennessee on page 26).

“Some of the portfolio managers who attended have years of quality improvement experience, while others were new to the process, and still others are in the early stages of

applying to become a sponsor,” says Kristi Gilreath, Director of MOC External Activities at the ABP. “The variety in their experience levels helps them learn from each other and build longstanding networks at these meetings.”

Attendees came from 23 states and the District of Columbia, and represented hospitals, health care organizations, professional societies, and improvement collaboratives.

Learn more about Pediatric Portfolio Sponsors and how to become one at [www.abp.org/content/sponsor-organization-activity-overview](http://www.abp.org/content/sponsor-organization-activity-overview).

# 2018 PUBLICATIONS

The following research papers, reports, and commentaries were authored by ABP staff members or supported in part or in full by the ABP or the ABP Foundation. They were published in major journals or as reports from national organizations from November 2017 through October 2018. See a complete list of publications at [www.abp.org/publications](http://www.abp.org/publications), where you now can apply filters, including keywords, author name, year, and journal name, to narrow your search.

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

## SINCE THE ABP BEGAN IN 1933

- More than 125,000\* have been certified in General Pediatrics, 3,545 newly certified in 2018
- More than 30,000\* have been certified in a pediatric subspecialty, 1,386 newly certified in 2018

\*American Board of Pediatrics. *Pediatric Physicians Workforce Data Book, 2018-2019*. Chapel Hill, NC: American Board of Pediatrics. 2019.

## CERTIFICATES AWARDED BY THE ABP

The ABP awards certificates in General Pediatrics and in 15 pediatric subspecialty areas. The pediatric subspecialties and the first exam year for each are:

- Adolescent Medicine, 1994
- Cardiology, 1961
- Child Abuse Pediatrics, 2009
- Critical Care Medicine, 1987
- Developmental-Behavioral Pediatrics, 2002
- Emergency Medicine, 1992
- Endocrinology, 1978
- Gastroenterology, 1990
- Hematology-Oncology, 1974
- Hospital Medicine, 2019
- Infectious Diseases, 1994
- Neonatal-Perinatal Medicine, 1975
- Nephrology, 1974
- Pulmonology, 1986
- Rheumatology, 1992

## CERTIFICATES AWARDED IN COLLABORATION WITH OTHER SPECIALTY BOARDS

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

## 2018 INITIAL CERTIFYING EXAMS PASS RATES (FIRST-TIME TEST TAKERS)

Note: Not all subspecialty exams are given every year.

Examination	First-Time Takers	Pass Rate (%)
General Pediatrics	3,358	91.1
Adolescent Medicine*	53	83.0
Cardiology	281	86.8
Critical Care Medicine	335	78.8
Hospice and Palliative Medicine	72	97.2
Medical Toxicology	3	100.0
Neonatal-Perinatal Medicine	478	85.1
Nephrology	64	93.8
Pediatric Transplant Hepatology	23	95.7
Pulmonology	103	91.3
Sports Medicine	14	92.9

\*Includes 10 candidates from the American Board of Internal Medicine and the American Board of Family Medicine

## 2018 MOC EXAMS (ALL SUBSPECIALTIES COMBINED AND GENERAL PEDIATRICS)

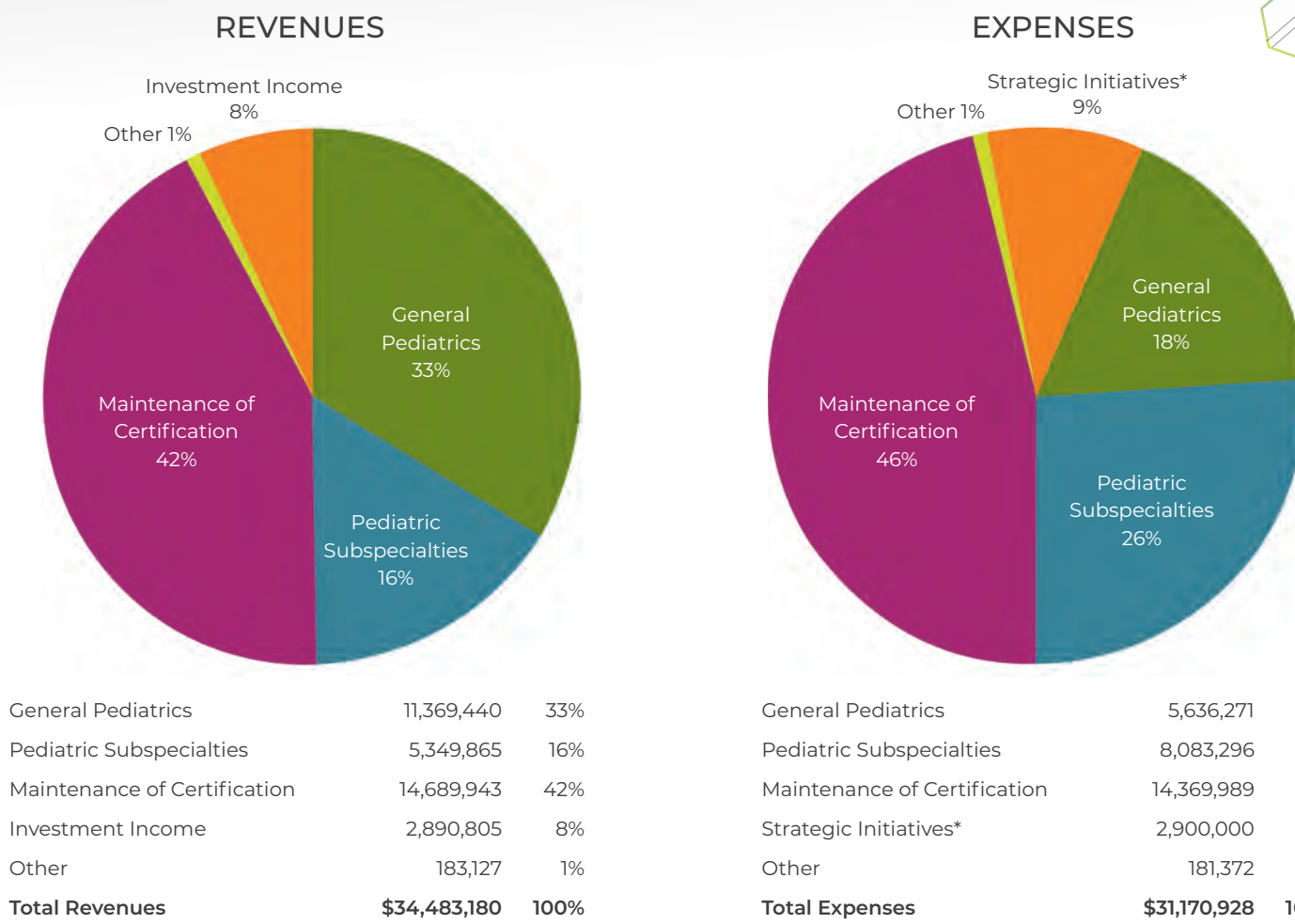
Note: Exam due dates for subspecialties have been postponed until MOCA-Peds is available for them.

Examination	First-Time Takers	Pass Rate (%)
General Pediatrics MOC Exam	997	92.4
GP MOCA-Peds Pilot	5,967	95.6
All Subspecialties MOC Exam*	75	89.3

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

# FISCAL YEAR 2017\* FINANCIALS

\*2018 financial information was not available at press time, but will be available by April 2019 through GuideStar ([www.guidestar.org](http://www.guidestar.org)).



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

## FINANCE COMMITTEES OVERSEE ABP BUDGET

Pediatricians volunteer to serve on three committees that oversee ABP finances and make recommendations to the ABP Board of Directors: the Finance Committee, the Long-Term Investment Committee, and the Audit Committee. Similar committees oversee finances of the ABP Foundation. These groups are entrusted with ensuring that the fees paid by pediatricians are used wisely for certification operations.

These committees include members who are general pediatricians and program directors, all of whom are acutely aware of the burden of student debt and average pediatric salaries, which, on average, are lower than most other specialties.

Thanks in large part to careful oversight by these committees, the ABP Board of Directors has not raised fees for the past four years. The Finance Committee monitors fees charged by specialty societies and other certifying boards, ensuring that the ABP fees compare favorably. To make improvements, including MOCA-Peds (see page 18), the Finance Committee has approved

drawing down contingency reserves. And beginning in 2018, pediatricians were able to choose an annual payment option for MOC instead of a five-year payment option. This allows them to tailor funding of their certification to their own career needs. For example, pediatricians close to retirement can pay only for the years they plan to continue to work. Newly certified pediatricians are enrolled in MOC at no additional cost for five years.

"The responsibilities for approval of the ABP budget and oversight of the long-term investments that provide support for new projects are taken very seriously by the Board of Directors," says Victoria Norwood, MD, Professor of Pediatrics at the University of Virginia School of Medicine and Secretary-Treasurer of the ABP Board of Directors. "Our philosophy is to keep fees as reasonable as we can while constantly updating systems and programs as part of our own continuous quality improvement. I am very proud that the ABP posts its financial information on GuideStar and, in fact, has achieved GuideStar's highest rating for transparency."

# VOLUNTEERING TO HELP

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

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Tom Fuldner Photography

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LEFT TO RIGHT: DR. ERIC EICHENWALD, DR. SATYAN LAKSHMINRUSIMHA, DR. CHRISTINE GLEASON, AND DR. BRENDA POINDEXTER

THANK YOU FOR YOUR SERVICE

The ABP extends a special thank you to the following volunteer committee and subboard members who completed their service in 2018 (beginning service dates noted after names), especially to those who have dedicated decades to serving the ABP.

John F. Bohnsack (2013)	Theresa W. Guilbert (2013)	Greg D. Randolph (2009)
Jennifer Bolden-Pitre (2017)	Susan H. Guttentag (2013)	J. Jack Rome (2013)
Patrick D. Brophy (2010)	James Huang (2013)	Adam A. Rosenberg (2012)
James R. Cooley (2000)	Paul T. Ishimine (2012)	Margaret Rosenfeld (2011)
John C. Duby (2011)	David M. Jaffe (1996)	Craig E. Singer (2011)
Karen J. Farst (2013)	Marcia C. Levetown (2001)	James C. Wiley (2013)
James D. Fortenberry (2011)	Gary S. Marshall (2013)	Susan E. Wiley (2013)
Martha E. Gagliano (2011)	Karen F. Murray (2007)	Yolanda H. Wimberly (2012)
William T. Gerson (2000)	Kim E. Nichols (2013)	Manisha B. Witmans (2010)
Denise M. Goodman (2013)	Laura K. Noonan (2009)	
Sidney M. Gospe Jr. (1998)	Maria M. Oliva-Hemker (2013)	

The ABP also extends a special thank you to the volunteers who served on the Content Development Teams (CDT) and Subspecialty Self-Assessment Teams who completed their service in 2018.

We appreciate the dedication and commitment to our mission of all ABP volunteers.



ABP VOLUNTEERS REVIEW EXAM QUESTIONS AT A NEONATAL-PERINATAL SUBBOARD MEETING.

Tom Fuldner Photography

# 2018 LEADERSHIP

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# MISSION

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

# VISION

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

# GUIDING PRINCIPLES

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



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