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President’s Letter

Dear Colleagues,

Today is December 24, and my wife and I are flying to Baltimore to celebrate Christmas with our grandchildren, the youngest of whom arrived just six months ago. They remind me of how passionate we pediatricians are about trying to contribute to a healthy future for everyone’s children and grandchildren. The 2019 ABP Annual Report highlights how the ABP volunteers and staff have attempted to do our part.

NEW VISION AND MISSION STATEMENTS

In 2019, the ABP Board of Directors approved more concise vision and mission statements:

Vision: Inspiring a lifetime pursuit of learning to improve child health

Mission: Advancing child health by certifying pediatricians who meet standards of excellence and are committed to continuous learning and improvement

While the words we use have changed, the ultimate vision and mission of the ABP have remained the same since the Board’s founding in 1933.

LEARNING AND ASSESSMENT

The word “learning” now features prominently. One challenge for any certifying board is to assess whether a resident has learned and can apply the competencies needed in a rapidly changing health care landscape. The parents and other public members on our committees regularly report that competencies in communication and managing the health care system are as critical to them as medical knowledge. Therefore, the annual report describes ongoing collaborative research with pediatric training programs to determine if entrustable professional activities (EPAs) provide a more meaningful framework to assess resident performance. EPAs focus on what really matters—the impact of the care on the patient.

The ABP also has prioritized enhancing learning for practicing pediatricians. MOCA-Peds and Question of the Week (QOW) remain popular as online tools to enhance learning. QOW

Sincerely,

David G. Nichols, MD, MBA
President and CEO

Anyone who has stepped onto a train, subway, or airplane has noticed the space between the platform and the transport, in the London Underground, prominent signs warn subway passengers to “Mind the Gap.” Pediatricians face gaps, too—in their own knowledge and medical practice. But through their commitment to continuous learning and improvement, these dedicated physicians also strive to “mind the gap.”

Certification activities can help.

A major goal of the American Board of Pediatrics (ABP) is to help identify and fill gaps faced by pediatric trainees, faculty, practitioners, programs, and the profession as a whole. Over the past few years, the ABP has made significant changes to its certification process. The ABP works with numerous organizations, including the Association of Pediatric Program Directors (APPD), the Accreditation Council for Graduate Medical Education (ACGME), and the Council of Pediatric Subspecialties (CoPS), to identify areas where there are gaps in knowledge and medical practice. But through their commitment to continuous learning and improvement, these dedicated physicians also strive to “mind the gap.”

This issue of the annual report focuses on ways the ABP is helping mind the gap in pediatric practice on numerous levels.

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ARE THERE GAPS FACED BY THE WHOLE PROFESSION? The ABP also partners with many groups, including the American Academy of Pediatrics (AAP), to consider what those gaps might be and how to fill them. For example, the ABP, the AAP, and many other groups have identified gaps in pediatric mental health care. Some are in access to care, while others are in pediatricians’ confidence in recognizing mental health conditions and then treating and/or referring patients.

Routinely, the ABP reaches out to pediatricians and specialists to determine what topics ABP exams should cover. Every five to six years, for General Pediatrics and for 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 for care for patients. Then, the ABP sends (via online survey) the list of knowledge areas to all pediatricians certified in the appropriate area to rate each area based on how frequently the knowledge is required in their practice and whether a gap could occur if the knowledge is lacking. This way, all pediatricians can contribute to keeping exams relevant to practice.

Periodically, pediatricians see gaps encompassing an expanding field and ask for new certifications. The newest is Pediatric Hospital Medicine. The first certifying exam for this sub specialty was administered in November (see page 16).

Each year, the ABP shares data on the pediatric workforce across the United States at www.abp.org/content/workforce. The data show where there are gaps in access to general pediatric and pediatric subspecialty care, among other demographics.

Certification is recognition of the commitment of pediatricians and pediatric subspecialists to continuous learning and improvement to meet the highest standards of care—from residency to retirement. The ABP aspires to support and nurture a lifetime of learning, practice improvement, and adherence to high standards of care.

Together, we can see the gaps and ensure that no one—physician or patient—falls through them.
Study Identifies Gaps in Training

Pediatricians routinely monitor a child’s growth and development at well-child visits. Similar checks are part of a pediatrician’s training. The traditional way to track a resident is through knowledge tests and studying competency-based medical education for almost two decades.

But pediatric program directors, among others, have been searching for a better measure of readiness for unsupervised practice.

“We have to think about the essential activities residents need to perform safely and effectively by the end of training and then make a judgment about whether they are ready to practice unsupervised.”

—CAROL CARRACCIO, MD

The ultimate goal, he says, is to know “what residents can be allowed to do with minimal supervision, what they need more supervision for, and how that changes as they go through residency and eventually graduate.” The study followed nearly 2,000 trainees throughout their three years of training. The study found that two of the lowest-performing EPAs were treating behavioral and mental health and understanding the science behind quality improvement (QI).

“Training programs are really struggling with how they are going to teach this,” Dr. Carraccio adds. “They say, ‘We need resources to help us do a better job.’”

“Program directors [involved in APPD LEARN] are really interested in the assessment of residents,” says Alan Schwartz, PhD, director of APPD LEARN. “They want to understand how to know what residents are good at and what they need to get better at.”

Dr. Carraccio says several factors might have contributed to the gap in training for the treatment of behavioral and mental health. The number of children with behavioral and mental health problems is escalating, and most pediatric faculty members are not well-equipped to teach students and residents in this area because they themselves were not trained to diagnose and treat these conditions. To make the problem worse, there are not enough child psychiatrists to care for all the patients who need them.

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The other gap identified in the study is the trainees’ understanding of QI science. After pediatricians pass their initial board certification examination, one requirement for continuing certification is to engage in ongoing practice improvement.

“If you don’t know how to do a quality improvement project, it [the QI requirement] becomes a real problem,” says Dr. Carraccio.

Now that the data has shown gaps in training, Dr. Carraccio says the next step is to disseminate the findings to all the programs.

Some program directors who participated in the study are beginning to address these gaps (see page 10). They have begun to present their ideas at national meetings, sponsored by groups such as the APPD and Pediatric Academic Societies, to share their progress and lessons learned with other training programs.

“Our hope is to partner with even more pediatric organizations to create learning activities for trainees and faculty,” says Dr. Carraccio. “Then we’ll disseminate the learning activities that have been created and look at the impact of those learning activities on performance over time.”

Read what training programs and health organizations are doing for residents and primary care providers to fill mental health training gaps on pages 8 through 13.
As behavioral and mental health problems become more prevalent among children and adolescents, pediatricians have an increasing responsibility to meet their needs, say the authors of “Preparing Future Pediatricians to Meet the Behavioral and Mental Health Needs of Children,” a special article in the December issue of Pediatrics.*

“The wide array of commitments coming out of this meeting was inspiring,” says Marshall Land Jr., MD, a general pediatrician in South Burlington, VT, and a co-author of the article. “They reflect the passion, dedication, and determination that training programs, national organizations, parents, patients, and trainees have to work collaboratively to help improve the behavioral and mental health care of children and adolescents.”

Here are just a few of the projects being pursued.

**Michigan State University:** MSU works to improve behavioral and mental health competencies along the continuum from medical students and residents to practicing physicians.

The pediatric residency program in Lansing has begun training residents in Mental Health First Aid (MHFA), a national program managed by the National Council for Behavioral Health. Residents were enthusiastic about the training and asked that it be added to the curriculum as mandatory training.

In Grand Rapids, the program optimized training in behavioral and mental health with a number of programs and initiatives. For example, they set up an immersive primary care rotation for interns in their first or second month that focuses on well-child care and anticipatory guidance, using the Keystones of Development curriculum. They also developed a new senior rotation that combines developmental–behavioral pediatrics (DBP) and child psychiatry components. This rotation is in addition to the required DBP rotation and electives in DBP and child psychiatry.

To help practicing pediatricians, pediatrics trainees, and family medicine trainees in the Upper Peninsula of Michigan, MSU child psychiatrists provide virtual office hours for physicians based in Marquette.

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**Children’s Hospital of Colorado:** The Children’s Hospital of Colorado teaches residents about common behavioral issues through a longitudinal thread over the three years of training. A formal curriculum on adolescent behavior and mental health issues is built into the adolescent rotation in the first year and in one of their inpatient rotations (primarily patients with eating disorders) during years one and three. Initial exposure to psychiatry intakes takes place in the DBP rotation in the first year of training. Mental health providers have been embedded into the clinics, giving residents frequent exposure through consultation on patients in their panels as well as dedicated time with the mental health providers during years one and two. Residents are exposed to behavioral and mental health screening tools in the clinics. This past summer, the pediatric residency program began an elective with the Child Psychiatry Department of a one- or two-week consolidation experience for all third-year residents.

**American Board of Pediatrics (ABP):** To help improve the behavioral and mental health care of children and adolescents, ABP has embarked on a comprehensive strategic plan. ABP has convened a national meeting of leaders, trainees, and patients to discuss the current state of behavioral and mental health training in the residency program. This meeting will be held in the spring of 2020, and the recommendations will be published in the fall of 2020.

**Weill Cornell Medical College:** Weill Cornell teams have embedded psychologists both in ambulatory and inpatient settings. The new addition to the inpatient setting helps each team address issues such as anxiety and adjustment disorder in patients with chronic illness. Additionally, they have developed a buddy system that pairs a pilot group of pediatric residents with child and adolescent psychiatry (CAP) fellows. Each CAP trainee is assigned to four or five pediatric trainees. Buddies are available to each other for informal consultations, handoffs for shared patients, shadowing experiences, and leading collaborative case conferences. Ten collaborative case conferences, facilitated by general pediatrics and CAP trainees, have been held or scheduled during the year.

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At any given time in the United States, about one in seven children has a mood or anxiety disorder—or both—that could be improved with medical intervention and treatment. Yet, with only 8,300 practicing child psychiatrists in the country, it can take months for these children to get an appointment and their families.

Better address routine psychosocial issues for children “Collaborative office rounds,” the trainees learn ways to address these issues; for a larger discussion of the case for the remainder of the time. At least one representative from each small group summarizes the points discussed and offers any recommendations or resources for the presenter to consider for ongoing care of the patient.

“A patient with a behavioral or mental health complaint is like any other patient. You just talk about their presenting symptoms. You take a thorough history. You make a plan, and then you follow up and see how things are going.”

— Emily Borman-Shoap, MD

We’d like to get to a point where all pediatricians who graduate from our program and other programs can recognize and diagnose common behavioral health and mental health concerns and initiate the first next steps.

“The pediatric residency program at the University of Minnesota School of Medicine. Pediatric residents, local pediatrics, and mental health professionals participate in these monthly collaborative office rounds to understand the impact of mental health issues on their patients and to learn how to spot mental health problems, if they cannot attend in person, they can participate in a nationwide program, funded by the U.S. Department of Health and Human Services’ Maternal and Child Health Bureau, that strives to fill the gaps in mental health training for primary care providers. Through “collaborative office rounds,” the trainees learn ways to better address routine psychosocial issues for children and their families.

“Collaborative office rounds is a concept that’s been in place for about 10 years, and the intent [of ours] is to create opportunities for residents and pediatricians in practice to come together with mental health professionals to discuss some of the cases they’re seeing and get ideas for how to best help their patients,” says Emily Borman-Shoap, MD, Assistant Professor, Director of the Pediatric Residency Program, and Vice Chair for Education in the Department of Pediatrics at the University of Minnesota School of Medicine.

Dr. Borman-Shoap says, “We’re trying to get them thinking about behavioral and mental health concerns through that same rhythm that they would think about any other medical problem.”

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New Jersey Minds the Gap Between Symptom Onset and Intervention

ABOVE: NJAAP staff attend a collaborative learning session. From left to right: Kyle Shupp, Harriet Lazarus, Marcela Betzer, Krista DeFilipo, Lindsay Caporino, and Bethany Kondawaty. Photo by Andrew Miller Images.

When behavioral and mental health treatment is delayed for children and adolescents, disorders become more difficult and costly to handle. Yet, the average delay between the onset of symptoms and intervention is eight to 10 years, in part because of a national shortage of child and adolescent psychiatrists.¹

To increase early identification and close the intervention gap, New Jersey is one of many states working to integrate mental health services with primary care. “Our state, depending on which county you look at, has either a high shortage, or no child and adolescent psychiatrists,” says Harriet Lazarus, MBA, Chief Operating Officer of the New Jersey Chapter of the American Academy of Pediatrics (NAAP). “This problem is not going away anytime soon.”

With support from the New Jersey Department of Children and Families, the NJAAP collaborated with Hackensack Meridian Health, Cooper University Health Care, Atlantic Health Systems, and other partner hospitals to build the Pediatric Psychiatry Collaborative (PPC). The collaborative aims to:

* Increase mental/behavioral health screening in primary care settings;
* Provide pediatricians with quick access to psychiatric consultation and evaluations for patients when needed;
* Assist pediatricians with care coordination; and
* Refer families to community services as needed.

“Pediatricians might not have the resources, time, or comfort level to screen or treat behavioral and mental health issues,” says Marcella Betzer, MPH, Program Director of NJAAP’s Mental Health Collaborative MOC Part 4 Program. “It’s often not something they learned in medical school. And many practices don’t have the ability to hire a child psychologist or a social worker.”

To implement the goals of the PPC, the partners established eight regional mental health “hubs” in 20 counties. A ninth hub, located in Essex County and managed by Rutgers University Behavioral Health Care, means that every county in New Jersey has access to an integrated child mental health delivery system.

“Hubs have two purposes,” says Lazarus. “They provide a direct service to children who have immediate behavioral or mental health needs, and they coordinate care for other children by connecting their families to appropriate community services.”

For example, a hub psychiatrist might provide a one-time evaluation of a child at no charge to the patient or assist a primary care pediatrician with diagnostic clarification or medication management.

To increase behavioral and mental health screening in primary care settings, clinicians who participate in a regional hub agree to conduct behavioral and mental health and substance use screenings at all well visits, submit a weekly screening log, and complete demographic surveys. They also are encouraged to view monthly webinars and participate in an optional, ABP-approved, Quality Improvement (QI) Maintenance of Certification (MOC) Part 4 program to support their continuing certification (see below).

“The PPC offers an efficient pathway for children to receive the behavioral or mental health services they need,” says Lazarus. “PPC participation increases the capacity of practices to provide care, and then families feel their primary care office is a trusted place where they can share their concerns.”

In the last four years, more than 900 pediatricians or pediatric clinics have participated in the PPC by screening about 146,000 patients. Nearly 9,000 of those screened needed support from one of the hubs.

The six-month MOC activity is available to hub participants in all New Jersey counties. In four years, 56 practices with about 150 pediatricians or pediatric practices received MOC Part 4 credit by participating.

“The Part 4 activity helps them develop a system in their practice,” says Harriet Lazarus, MBA, Chief Operating Officer of the New Jersey Chapter of the AAP (NAAP). “They look at the data, reflect on their success or shortcomings, and then determine how they can improve. It meets the practices where they are, both figuratively and literly.”

Like the PPC, the NJAAP’s Mental Health Collaborative MOC Part 4 Program aims to increase behavioral and mental health screening, referrals, and care coordination in primary care settings.

But the program also provides educational and training opportunities for pediatricians. “Those who join the MOC Part 4 program participate in collaborative learning sessions and receive technical assistance office visits and calls,” says Marcella Betzer, MPH, Program Director of NJAAP’s Mental Health Collaborative MOC Part 4 Program.

The learning sessions and technical assistance activities offer participants additional tools and resources and opportunities to network with mental health experts and other clinicians.

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The six-month MOC activity is available to hub participants in all New Jersey counties. In four years, 76 practices with about 150 pediatricians received MOC Part 4 credit by participating.

“Seeing monthly success throughout the MOC project really helped to reduce staff hesitancy and even resulted in them wanting to make larger screening goals,” says Theresa Giannattasio, DO, a general pediatrician at the Pediatric and Adolescent Center in Ledgewood, NJ, and a former program participant.
WINNING IN WISCONSIN: Advancing Family-Centered Care

Nearly one in five children in Wisconsin has a chronic physical, developmental, behavioral, or emotional illness or condition, such as ADHD, autism, cancer, diabetes, or heart disease.

But less than half of those children consistently receive care in a “medical home” that focuses on all aspects of their physical and mental health care needs, ensures that they and their families make informed decisions about their health, and coordinates the child’s care across disciplines and health care systems.1

The Children’s Health Alliance of Wisconsin aims to do something about it. The Alliance wants to improve child health outcomes for children and youth with special health care needs (CYSHCN) by increasing the number who receive care in medical homes, increasing the use of developmental and mental health screenings, and supporting families as partners in their children’s care.

“This year we have 54 different pediatric primary care practices and tribal health centers from across the state working to advance family-centered care by developing shared health care plans,” says Arianna Keil, MD, Quality Improvement Director, Children’s Health Alliance of Wisconsin and Wisconsin Department of Health Services’ Family Health Section. “The plans are living documents, developed jointly and shared among families and medical teams.”2

Survey respondents chose their top three benefits of family engagement: heightened understanding of family issues and needs, increased family–professional partnerships and communication, and more services directly responsive to family needs.2

“It’s been satisfying to see intentional representations of family voices within the project teams,” adds Dr. Keil.

The Wisconsin teams must identify a specific patient population when they apply to participate in the shared plan of care project.

“We have some teams who are focusing on kids with medical complexity, others focusing on kids with behavioral or mental health challenges, and others focusing on kids with ADHD,” says Dr. Keil. “Our aim in 2019 was that 85% of the families served by those 14 practices say the shared plan of care assured that more of their child’s needs were met.”

In Dr. Keil’s joint role with the Children’s Health Alliance of Wisconsin and the Wisconsin Department of Health Services’ Family Health Section, she provides QI support to her colleagues by helping them use QI methods to accelerate learning. Although the Alliance has been providing health care improvement services for more than 25 years, the shared plan of care project is the first to offer Maintenance of Certification (MOC) Part 4 credit.

Dr. Keil was inspired to apply for MOC Part 4 credit on behalf of the Alliance after hearing David Nichols, MD, MBA, President and CEO of the ABP, speak in 2016 at the Wisconsin American Academy of Pediatrics Chapter Open Forum about the ways the ABP had expanded what kinds of projects qualify for MOC Part 4 credit.

“When I heard him speak, I thought this might be an opportunity for us to partner with the ABP to offer MOC Part 4 credit to Wisconsin pediatricians who are already engaged in this work,” says Dr. Keil. “Giving MOC credit is a way to tell clinicians that we value the time and effort they put in to improve their practice. It’s an important way to acknowledge the additional work they do to ensure high-quality care.”

The shared plan of care project in Wisconsin began in 2016 and was approved by the ABP for MOC credit in 2018. Pediatricians who participate in the project can receive 25 points of Part 4 credit.

Other Alliance projects focus on asthma, early literacy, emergency care, grief and bereavement, injury prevention and child death review, medical homes, and oral health. Common threads among the projects include managing health instead of illness, an emphasis on quality of life, and family-centered care. The Alliance hopes to pursue another MOC Part 4 project this year.

“The MOC Part 4 application process was straightforward and not onerous at all,” says Dr. Keil. “It’s a valuable partnership that benefits all involved.”


“This new subspecialty sets standards for training and recognizes the expertise of pediatricians working primarily in hospital settings.” — Suzanne Woods, MD

Establishing a new subspecialty is an involved process. Interest in PHM certification started more than seven years ago. In 2014, a group from the Joint Council on Pediatric Hospital Medicine petitioned the ABP for a subspecialty certification in their field. After it was approved by the ABP Board of Directors and then by the American Board of Medical Specialties (ABMS), the ABP appointed a PHM subboard (a committee of subspecialists in a particular field). The pediatricians on the new subboard established eligibility criteria for three pathways (practice, training, and a combination). The Accreditation Council for Graduate Medical Education (ACGME) then approved the PHM training program requirements. And finally, the PHM subboard wrote questions for the initial PHM certifying exam.

In February 2019, the ABP started accepting applications for the first PHM exam. Pediatricians certified in general pediatrics who currently work in a hospital as a general pediatric hospital medicine specialist may qualify to take the exam through a practice pathway. After the PHM exam in 2023, however, all pediatricians taking the PHM certifying exam must meet the requirements for the training pathway, which includes completion of a fellowship in a PHM program.

“My field of hospital medicine requires skill in certain areas, including quality improvement, system administration, and leadership,” she says. “These are all areas of expertise that set our subspecialty apart. It’s important to have these skills when you are in a hospital setting, especially as an educator, researcher, or administrator.”

She doesn’t think every pediatrician working in a hospital needs the PHM certification, though.

“The field of hospital medicine requires skill in certain areas, including quality improvement, system administration, and leadership. These are all areas of expertise that set our subspecialty apart.” — Sara Horstmann, MD

“There’s a tremendous amount of hospital medicine work that needs to be done,” she says. “You can be an excellent clinician without having hospitalist training.”

PHM Application Concerns Addressed by the ABP

In the summer of 2019, a group of pediatricians working as hospitalists shared concerns about the experience requirements for taking the exam. They petitioned the ABP for additional information regarding the practice pathway criteria. The petitioners said they had collected anecdotal reports that might indicate the practice pathway criteria disadvantaged women.

In its response, the ABP explained that it had approved 93% of the 1,627 applicants by that time. About 70% of applications were from women, which mirrors the demographics of the pediatric workforce. A careful analysis of the preliminary numbers showed that applications from 4% of women and 3.7% of men were denied — a statistically insignificant difference. The ABP also acknowledged that the petitioners did not find the guidance on the ABP website sufficiently transparent and revised the language for greater clarity. That guidance may be found at http://bit.ly/PHM-cert. The ABP’s response to the petition may be found on the ABP website. The ABP also addressed concerns about the practice pathway criteria. The ABP explained that it had approved 61% of the 323 applications that petitioners said they had collected anecdotal reports about. The ABP also addressed concerns about the experience requirements for the training pathway. The ABP explained that it had approved 93% of the 1,627 applications by that time. About 70% of applications were from women, which mirrors the demographics of the pediatric workforce. A careful analysis of the preliminary numbers showed that applications from 4% of women and 3.7% of men were denied — a statistically insignificant difference. The ABP also acknowledged that the petitioners did not find the guidance on the ABP website sufficiently transparent and revised the language for greater clarity. That guidance may be found at http://bit.ly/PHM-cert. The ABP’s response to the petition may be found on the ABP website.
From the beginning, the ABP hoped that MOCA-Peds, its new online assessment platform, would not only satisfy a pediatrician’s continuing certification examination requirements, but would also foster learning. It was to be “assessment for learning” instead of only “assessment of learning.” The questions would help pediatricians identify gaps in their knowledge, and the rationales that accompany the answers would help pediatricians identify gaps in their professional knowledge. When participants assess their own learning needs, they are more likely to change their practice.

The hope is that as more pediatricians gain access to the platform and participate, they will leverage MOCA-Peds as a tool to keep up with the ever-changing world of medicine. ‘I think the best aspect of MOCA-Peds is the ongoing nature [of it],’ says Dr. Althouse. ‘For general pediatrics [and subspecialties], there is great value in touching up on skills quarterly.’

The ABP recommends participants review learning objectives before starting MOCA-Peds each year, access resources while taking questions, and review the rationale and references supporting the correct answers.

Also, Althouse encourages pediatricians to visit the ‘Question History’ page within MOCA-Peds, where they can get detailed information about the questions and answers, including rationales on which the answer is based. This information may help pediatricians identify and fill gaps in their knowledge.

As one pediatrician noted, it’s about “keeping up to date in real time rather than cramming for a test.”

‘I think MOCA-Peds is great,’ says Sinda Althoen, MD, a board-certified pediatrician at Providence St. Joseph Health in Santa Ana, CA. Her experience with the platform began in 2019 when MOCA-Peds became available for General Pediatrics, Child Abuse Pediatrics, Pediatric Gastroenterology, and Pediatric Infectious Diseases for pediatricians who enrolled in a Maintenance of Certification (MOC) cycle in 2018.

‘The number of questions is reasonable,’ adds Dr. Althoen. ‘The time allotted is reasonable and five minutes [per question] is easy to find in my day.’

MOCA-Peds allows the pediatrician to be more of an active participant in their learning,” says Althouse. “By participating in MOCA-Peds, pediatricians are able to continually obtain feedback on how they are performing in a number of content domains. These data are stored within the platform and accessible to the pediatrician. When participants assess their own learning needs, they are more likely to change their practice.”

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Dr. Althoen also credits MOCA-Peds with refreshing her knowledge was one of the primary goals of the new platform. ‘MOCA-Peds allows the pediatrician to be more of an active participant in their learning,” says Althouse. “By participating in MOCA-Peds, pediatricians are able to continually obtain feedback on how they are performing in a number of content domains. These data are stored within the platform and accessible to the pediatrician. When participants assess their own learning needs, they are more likely to change their practice.”

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MOCA-PEDS FOR SUBSPECIALTIES: ANTICIPATED AVAILABILITY

In 2019, MOCA-Peds was available for pediatricians in General Pediatrics, Child Abuse Pediatrics, Pediatric Gastroenterology, and Pediatric Infectious Diseases. Exam due dates for all subspecialties have been postponed until MOCA-Peds is available in those areas.

Other pediatric subspecialties certified by the ABP

• 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

From anonymous survey responses:

“MOCA-Peds helps you realize what has changed in medicine and put it into practice.”

“It’s really just refreshing general knowledge about things and in reinforcing things that I maybe haven’t thought about in a while. I am a subspecialist, and so there are many [General Pediatrics] items I don’t really look back on. However, I feel like refreshing my [General Pediatrics] knowledge makes me a better physician in general.”

“[Now] I routinely access clinical guidelines during chart review for conditions that I see less frequently, because the MOCA-Peds pilot highlighted areas of practice where my knowledge was not as strong.”

“By not studying endless hours of minutiae for a sit-down exam, I was able to [answer] these questions faster and immediately learn from the discussions and focus my extra time on practical continuing education for my patients.”

“I had gotten out of the habit of reading to stay current and MOCA-Peds was a great jump start to get going again.”

was not on the list,” she said. “I thought everything I had to everyone else, and I found that I gave... months in the hospital.

When Brandon was 3, Rouse gave birth to triplets. Born at 26-weeks’ gestation, the babies had a gastrostomy tube in their stomach. And in the pediatrician’s office, Brandon was mimicking the beeping of a machine in the room.

Rouse said she felt near the breaking point — until the pediatrician stopped and asked, “How are you doing?”

“No one had asked me that before,” she told the audience. “My pediatrician helped make me feel like I was not alone … I had a teammate.”

So, Rouse made an appointment with her pediatrician and arrived pushing two babies in a double stroller, holding one in a carrier on her chest, and holding Brandon’s hand. One of the babies had a gastrostomy tube in place to deliver nutrition directly to his stomach. And in the pediatrician’s office, Brandon was mimicking the beeping of a machine in the room.

When Brandon was 3, Rouse gave birth to triplets. Born at 26-weeks’ gestation, the babies spent more than four months in the hospital.

“I personally found that I gave everything I had to everyone else, and I was not on the list,” she said. “I thought eventually I would break, but I couldn’t.”

Shortly after that, Brandon was diagnosed with mild to moderate autism, while the whole family received the support they needed.

“When I don’t expect you to solve all our problems,” Rouse told the pediatricians at the AAP meeting, “But just having a conversation is supportive. Even if resources are not available, listening helps.”

ABP’s Lean Way to Quality

While board-certified pediatricians work to improve the care they provide children, the ABP also seeks to improve the certification process for pediatricians. The ABP staff uses a systematic, yet rapid-change, approach called lean. Lean activities—such as process mapping exercises, root-cause analysis, and standardization of work—help identify and eliminate wasteful steps in any process and maximize value for the pediatricians the ABP serves.

“As the Board transforms to a lean culture, we are making a fundamental change in the way we think, what we value, and how we complete our work,” says Keith Mann, MD, MEd, ABP Vice President for Continuing Certification.

“Following the spirit of the ABP mission, the staff is committed to continuous learning and improvement, knowing the approach will help improve the certification process for pediatricians, which can positively impact the health outcomes for children, adolescents, and young adults.”

In 2019 the ABP held lean workshops to improve the following processes:
• Orienting volunteers who are new to writing examination questions
• Reviewing, revising, and approving potential exam questions
• Sending customized, informational emails to candidates and pediatricians
• Promoting volunteer opportunities and efficiently collecting and synthesizing application information

Each workshop is a four-day immersive experience with cross-functional teams dedicated to improving a given process with the idea of eliminating unnecessary or redundant steps and maximizing both the efficiency and the quality of what we are setting out to improve. Most teams accomplish in four days what would usually take a year or more of monthly meetings. More than half of the ABP staff has participated in at least one workshop.

“In each workshop, we work on making our processes more efficient and effective,” says Travis Dodson, MBA, ABP Operations Manager and lean facilitator. “By equipping our staff members to identify problems and inefficiencies in the way we do things, we can provide a better certification experience for pediatricians.” Dodson and Amy Hodak, ABP Director of MOC Administration, have led the lean effort at the ABP since 2016.

This year, an additional 15 ABP staff members were trained as lean facilitators, demonstrating the priority the ABP places on process improvement.

Vision Commission Report: A Watershed for ABMS Boards

For the 24 member boards of the American Board of Medical Specialties (ABMS), 2019 was a watershed year. In February, after a year of study, the Continuing Board Certification: Vision for the Future Commission released its final report, which outlined recommendations for improvements to certification that should be made by all boards.

Some of the main themes of the report are:
• Boards need to bring value to physicians in supporting their relevant learning and improvement needs.
• Boards need to bring value to the profession (and other stakeholders) by offering a meaningful credential.
• Meaningful self-regulation requires a system of engaged stakeholders to ensure a collaborative solution to concerns about certification.

After reviewing the Commission’s report, the Federation of Pediatric Organizations (FOPO) released a statement, confirming that, “The conclusions of this Commission align closely with the work that FOPO conducted four years ago and which has allowed the ABP (American Board of Pediatrics) to have an early start in improving continuing certification. These events illustrate the importance of all pediatric organizations working together through FOPO to advance child health.”

As FOPO stated, many changes that aligned with the Commission report were already underway. The ABP reported to the Vision Commission that its alternative continuing certification assessment for General Pediatrics and three subspecialties, replacing the proctored examination, had been launched. The new assessment, called MOCA-Peds (Maintenance of Certification Assessment for Pediatrics), is an online longitudinal assessment platform that allows test takers the flexibility to answer questions on their personal computers, tablets, or smartphones. The ABP is on track to make MOCA-Peds available for all 15 pediatric subspecialties by 2022 (see page 19).

The ABP also is working on ways to follow other recommendations, including an exploration of ways to integrate the various parts of continuing certification and to provide more ways for pediatricians and pediatric subspecialists to participate as volunteers in the work of the ABP.

The 27 commissioners represented various groups with a stake in certification, including practicing physicians; health care leaders; representatives of state and national medical associations, specialty societies, and health advocacy groups; and the public. For more than a year, they gathered feedback through surveys and oral and written testimony, before making their recommendations. Their work led to a consensus on the future direction to collaboratively improve certification for the benefit of patients and physicians.
2019 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 2018 through December 2019.


Publications continued on page 25
2019 Committees

The ABP appreciates the excellent work of pediatricians and members of the public who volunteer their time, energy, and expertise to our committees and subcommittees that provide direction for certification activities and produce examinations. We also thank the volunteers who served as subspecialty content development experts or on practice-analysis panels, standard-setting panels, and other user panels in 2019. We appreciate the dedication and commitment of all ABP volunteers to the ABP vision and mission.

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VISION
Inspiring a lifetime pursuit of learning to improve child health

MISSION
Advancing child health by certifying pediatricians who meet standards of excellence and are committed to continuous learning and improvement

VALUES
- Consistency: Making unbiased decisions based on published ABP policies
- Excellence: Striving to do our best work
- Reliability: Living up to responsibilities and commitment
- Transparency: Sharing non-confidential information openly

GUIDING PRINCIPLES
Overarching Principle: The “North Star” for the ABP is and will remain the improvement of health outcomes for children, adolescents, and young adults.
- The ABP is primarily accountable to children, from infants to young adults, and their families as it guides professional self-regulation and certifies pediatricians.
- ABP certification recognizes pediatricians who meet rigorous standards for competencies essential to improving child health.
- The ABP supports best practices for the assessments of all core competencies using tools that are fair, valid, reliable, and contribute to lifelong professional development.
- The ABP prioritizes work that the organization is uniquely positioned to do.
- The ABP strives to align opportunities for continuing certification with pediatricians’ professional practice.
- The ABP continually evaluates and improves its work based on changing trends in child health, stakeholder feedback, and advances in knowledge, assessment, technology, and care delivery.
- The ABP engages in open dialog with pediatricians, patients and families, and other members of the public.
- The ABP seeks out and respects diverse backgrounds, experiences, and perspectives to inform its work.
- The ABP collaborates with other regulatory bodies, medical organizations, and professional societies to align accreditation and certification across the continuum from training through practice.