CoPS Fall Council Meeting Revised Agenda
November 16-17, 2017
Sheraton Chicago O'Hare Airport Hotel (6501 North Mannheim Road, Rosemont, IL)
Main Meeting Room: O'Hare East

DAY ONE: Thursday, November 16, 2017 from 9am-5:00pm

8:00-9:00am Networking Breakfast - Myrick’s Atrium I

9:00-9:45am Welcome & Introductions (45 min) - Dr. Melvin Heyman
• Please introduce yourselves, your role, your organization, how you got chosen/elected to be your organization’s representative, and what you want to get out of this meeting

9:45-10:15am CoPS History/Update (30 min) - Dr. Melvin Heyman and Ms. Laura Degnon

10:15-12:00pm Liaison Presentations
• Academic Pediatric Association (APA) - Dr. Terri Turner
• American Academy of Pediatrics (AAP) - Dr. Anne Edwards
• Association of Medical School Pediatric Department Chairs (AMSPDC) - Drs. Alice Ackerman & John Barnard
• Association of Pediatric Program Directors (APPD) - Drs. Franklin Trimm & Pnina Weiss
• American Board of Pediatrics (ABP) - Dr. Gail McGuinness

12:00-1:00pm Lunch – Myrick’s Atrium I

1:00-2:30pm Workforce – (1.5 hours) Drs. Debra Boyer (CoPS), Pnina Weiss (APPD), Laurel Leslie (ABP), Gary Freed (ABP), and Anne Edwards (AAP)

2:30-2:40pm Relocate to breakout rooms (10 min)

2:40-3:30pm Workforce Breakout Sessions (50 min)
  1. Recruitment issues/pipeline  (Drs. Diane Stafford & Lisa Imundo - Room: Gateway)
  2. Funding of training  (Dr. Pnina Weiss - Room: 306A)
  3. Job distribution/jobs after fellowship  (Dr. Rob Ross - Room: 406A)
  4. Scholarship/research during fellowship & beyond  (Dr. Christiane Dammann - Room: 506A)

3:30-3:45pm Break (15 min)

3:50-5:00pm Report outs from Workforce Breakout Sessions (70 min)

DAY TWO: Friday, November 17, 2017: 7:30am–11:40am

7:30-8:00am Breakfast - Myrick’s Atrium I

8:00-8:10am Welcome / Recap of Day 1 - Dr. Melvin Heyman

8:10-8:55am 2 year fellowship (45 min) – Dr. Melvin Heyman

8:55-9:00am Reflections by Gail (5 min) – Dr. Gail McGuinness

9:00-9:05am Financial report (5 min) - Dr. Tandy Aye

9:05-9:10am Membership / Membership committee development (5 min) - Dr. Tandy Aye

9:10-9:15am Milestones 2.0 ACGME update (5 min) - Dr. Debra Boyer

9:15-9:35am New transition action team (20 min) - Dr. Melvin Heyman

9:35-9:45am SPIN update (10 min) - Dr. Jill Fussell

9:45-10:10am Communications Committee / How to use Twitter (25 min) - Drs Jill Fussell, Alice Ackerman and Mark Atlas

10:10-10:30am Break / Check Out (20 min)

10:30-11:30am Action Plan for Workforce Initiative (1 hour) – Dr. Debra Boyer

11:30am-11:40pm Action Plan: CoPS Focus for next 3-4 years (10 min) - Executive Committee

Next Face to Face Meeting:
The CoPS Spring meeting will take place in conjunction with the APPD meeting in Atlanta, Georgia March 20-23, 2018. Exact day/time of the CoPS meeting is March 20, 2018 from 2-5pm.
Welcome to the CoPS Fall Meeting

Wifi: Meeting Room
Password: wonderland
November 16-17, 2017
Chicago, IL
MISSION
The Council of Pediatric Subspecialties advances child health through communication and collaboration within its network of pediatric subspecialties and liaison organizations.

VISION
All pediatric subspecialties working together for optimal child health.

VALUES
As an organization, we embrace:
• Collaboration
• Responsiveness
• Diversity
• Transparency
Agenda

Today:
Networking Breakfast
Welcome & Introductions
CoPS History / Update
Liaison Presentations
2 year fellowship
Lunch
Workforce & Breakouts; Report Back

Tomorrow:
Welcome / Recap of Today
Financial report
Milestones 2.0 ACGME update
Membership / Membership committee development
SPIN update
Communications Committee / How to use Twitter
Break / Check Out
New transition action team
Fellowship Start Date survey
Action Plan: CoPS Focus for next 3-4 years
Thanks for your attendance and participation in CoPS.

Introductions:
- Introduce yourself / role / organization.
- How many CoPS meetings have you attended?
- State how you got here / involved in CoPS.
- What do you want to get out of this meeting?
CoPS Fall Meeting
CoPS Fall Meeting

Laura Degnon, CAE, Executive Director

History of CoPS

November 16, 2017
CoPS History


• In August 2012, CoPS published a paper in Pediatrics entitled Council of Pediatric Subspecialties (CoPS): The First Five Years. This article summarized CoPS' accomplishments over its first five years of existence and is available at http://pediatrics.aappublications.org/content/130/2/335.full.pdf+html
CoPS History

Authors on first article @ how/why CoPS got started:

- Ted Sectish: APPD
- Bill Schnaper: PAS Meeting (AAP, APA, APS, SPR)
- Bruder Stapleton: AMSPDC
- Dick Behrman: FOPO
- Laura Degnon: Association Management

Trying to sort through where pediatric subspecialists were, our first discussions literally started out like this:
<table>
<thead>
<tr>
<th>Subspeciality</th>
<th>Subboard</th>
<th>Society</th>
<th>Training Prog</th>
<th>AAP Section &amp; Committee</th>
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Authors: Drs. Dick Behrman, Bruder Stapleton, Ted Sectish, Bill Schnaper and Ms. Laura Degnon
CoPS History

• Became more and more evident there was not a single organization that spoke for all subspecialties

• Apparent there was a real need for communication across subspecialties

• Discussions with Association of Specialty Professors (internal medicine)

• Subspecialties plus FOPO organizations = Membership

• “I’m here representing ___ Specialty” to “I’m here on behalf of ____ org/sec representing ___ Specialty”
Overview

- Action teams
- Web site
- Fellowship funding
- MOC
- ACGME
- Milestones/EPAs
- AMSPDC pages in J Pediatr
- SWOT revisited
CoPS Update

ACTION TEAMS

• Workforce
• Communications
• Social Media
• Fellowship Match Date
• Fellowship Start Date
CoPS Update - website

Pediatric Subspecialty Descriptions (resource for residents and med students) – UPDATE yours if not already done!

http://pedsubs.org/SubDes/index.cfm
CoPS Update

• Fellowship Funding
  – CoPS is working with APPD to begin an assessment of issues surrounding fellowship funding
  – AMSPDC particularly interested in mandate for FPD support (15-35%)

• Subspecialty Pediatrics Investigator Network (SPIN)
  Rich Mink
CoPS Update

• MOC:
  – CoPS coordinating communication between Subspecialties and ABP (David Nichols)
  – Discussion points:
    • Point system – single QI project to reach 60 or 100 points
    • Peer review publications for MOC 4 credit
    • Further options now on ABP website
  – MOCA-PEDS implemented this year, subs in 2019
CoPS Update re ACGME

• ACGME Subspecialty Program Requirements:
  – Response from CoPS reps regarding ACGME requirements for Duty Hours
    • ‘One size does not fit all’
  – Response from CoPS reps regarding Program Requirements, Section VI, specifically regarding documentation of on-call clinical time at home
    • Problematic for subspecialties
    • Documentation left to programs
  – Protected time for Program Directors
    • 15%-35% current recommendation, related to program size (now a funding issue)
CoPS Update

CoPS meetings, 2017:
- Monthly EC conf calls
- Spring Meeting: Webinar June 1
- Executive Committee Meeting: Aug 3-4
- PEEAC Dinner Meeting with AMSPDC, APA, APPD, and COMSEP: Sept 28 (Wash DC)
- ABP Mental Health Roadmap – Oct 13
- Fall Council Meeting: Nov 16-17 (Chicago)
- AMSPDC webinar – CoPS to lead, review initiatives: Jan 2018
- Spring meeting at APPD Mar 20, 2018 (Atlanta)
CoPS Update

Milestones for subspecialty EPAs

- Educational resources on CoPS website

www.pedsubs.org
Milestones for subspecialty EPAs

• Participation in Milestones 2.0 discussions
  – Individual subspecialties can have their own milestones if they desire
  – Some subs using additional milestones, developing other tools
AMSPDC pages in J Peds

• SPIN (Mink et al) has been accepted

• Other manuscripts in preparation
  – Fellowship Funding
    • for Mar 2018 - Heyman, Weiss
  – Pediatric Subspecialty Workforce Issues
  – CoPS - last 10 years
SWOT ANALYSIS (adapted from R Spicer 2015)

- **Strengths**
  - Advantages
  - Capabilities
  - Resources, Assets, People
  - Marketing - reach, distribution, awareness

- **Weaknesses**
  - Lack of competitive strength
  - Financials
  - Our vulnerabilities
  - Timescales, deadlines and pressures
  - Continuity, supply chain robustness

- **Opportunities**
  - Market developments
  - Business and product development

- **Threats**
  - Environmental effects
  - Market demand
  - Obstacles
Weaknesses

• Lack of understanding of CoPS’ value to member organizations and their members
• Lack of a Shared Vision of the member organizations (some splintering)
• Minimal Involvement in Social Media
Threats

- Competing Interests of Members
- Transitioning of Dr. Mink SPICER
- Leadership “FTE” commitment
- Overextending
Opportunities

• Coordinate Workforce Efforts
• SPIN Research Network Expansion
• Expand Partnerships with Allied Organizations
• Expand Partnerships with Partner Organizations
• Workforce issue with AAP, ABP
• Fellowship funding action with APPD, AMSPDC
• Additional subspecialty memberships
Strengths

• Individual Council Membership
• Executive Committee Dedication
• Degnon Assoc.
• Allied Organization Support
• Number of Subsp Organizations represented
• Respected Ped Sub Organization
  – Requests for responses from ACGME (duty hours, FPDs FTE)
• Action Teams
• Focused – ‘less is more’
Accomplishments

Participation in Meetings of Import (2017)

• APPD (April – SF; Sept – Wash DC)
• MOC
• Milestones 2.0
• AMSPDC collaborative meeting Sept
• ABP Mental Health Roadmap Oct
Accomplishments

Successful Project Development

• Journal of Pediatrics Pages
• Creation of EPAs for the subspecialties
• Expansion of Website, Social Media
• The Common Match Date
• Fellowship Start Date
• Workforce task force
Accomplishments

Ongoing/Upcoming Collaborations

- Subspecialty Program Requirements Revision; ACGME – feedback on subspecialty requirements, support for FPDs
- ABP – MOC, EPA development
- APA – Fellowship Core Curriculum
- SPIN – Subsp Ped Invest Network
2018 Slate

• Jill Fussell – Vice Chair
• Need nominees for one At Large (3 year)

• Deb Boyer – Chair
• Tandy Aye – Secretary-Treasurer
• Mel Heyman – Past Chair
• Lisa Imundo – At Large
The CoPS Spring meeting will take place in conjunction with the APPD meeting in Atlanta, Georgia March 20-23, 2018. CoPS meeting is scheduled for March 20, 2018 from 2-5pm.
Gail McGuinness, MD

Thank you!!
2-Year Fellowship

• Issue triggered by Hospitalist subboard accreditation

• 3-year (and 4-year) fellowships offered to encourage scholarship, academic career development

• 2-year fellowship may be preferred for those seeking clinical training

• ABP: entire subspecialty must agree to same length of fellowship
2-Year Fellowship

• Next steps?
  – Discuss with your training programs, societies/subspecialty orgs
  – Review paper on the issue?
  – Wait for ACGME and ABP?
Recap Day 1
Action Team Reports

ACTION TEAMS

• Workforce – yesterday (Deb Boyer)
• Communications/Social Media – Jill Fussell (next)

• Fellowship Match Date
• Fellowship Start Date
ACTION TEAM Reports

ACTION TEAMS

Fellowship Start Date

- Fellows survey:
  - ABP sent survey to first year fellows: 240/698 responses (34%)
  - Resending to rest of first year fellows by mid Dec
Fellowship Start Date

- **FPD survey** (Rich Mink, David Wininger, Elaine Muchmore and Dena Hofkosh):
  - As of this week: 312/802 (39%) responses

**Preliminary results:**

- 75% of respondents have a single Designated Institutional Official (DIO) that manages pediatric and adult programs
- Of the 312 respondents, 273 had first year fellows starting in June or July
- 66% indicated delayed start date (fellows DID NOT begin training ON or BEFORE July 1)
- These are programs, not institutions, but FPDs from multiple institutions responded
Transition Action Team

GotTransition

• Is this an issue for CoPS?
Transition Action Team
Exemplary Pediatric Education

ASSOCIATION OF PEDIATRIC PROGRAM DIRECTORS

MISSION

- APPD serves pediatric programs by leading the advancement of education to ensure the health and well-being of children.

PEDIATRIC PROGRAMS

- 200 Residency Programs
- 800 Associated Fellowship Programs

MEMBERS

- 3300 individual members
  - Program Directors (Residency and Fellowship)
  - Associate Program Directors
  - Coordinators
  - Chief Residents
### Vision 2020

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<th>MISSION</th>
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<tr>
<td>APPD serves pediatric programs by leading the advancement of education to ensure the health and well-being of children.</td>
<td>Exemplary pediatric education.</td>
<td>The leadership is governed by these principles: ✓ Leadership ✓ Innovation ✓ Collaboration ✓ Scholarship ✓ Engagement</td>
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Leadership Structure

Mission Driven – Member Focused

Board of Directors

- Associate Program Directors’ Executive Committee
  - Associate Program Directors Section
- Fellowship Program Directors’ Executive Committee
  - Fellowship Program Directors Section
- Coordinators’ Executive Committee
  - Coordinators Section
Leadership Structure

Mission Driven – Member Focused

Board of Directors

Learning Communities
- Members

APPD LEAD
- LEAD Chair, Council, Cohorts

APPD LEARN
- Director, Committees

Spring Annual Meeting
- Chairs, Committee

Fall Annual Meeting
- Chair, Committee

Other Projects
- Share Warehouse, Liaisons, Special Projects, Journal pages

Leadership Structure

- Mission Driven – Member Focused
- Board of Directors
- Learning Communities
  - Members
- APPD LEAD
  - LEAD Chair, Council, Cohorts
- APPD LEARN
  - Director, Committees
- Spring Annual Meeting
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- Other Projects
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<td><strong>Development of Programs &amp; Members</strong></td>
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<td><strong>Organizational Excellence</strong></td>
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<td><strong>Leadership &amp; Collaboration</strong></td>
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<td><strong>Research &amp; Scholarship</strong></td>
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VISION 2020

Development of Programs & Members
- Engagement of Members
- Wellness & Resilience
- Enhance Mentoring
- Enhance Leadership
- Diversity & Inclusion

Organizational Excellence
- Future Pediatric GME Training
- Optimize Organizational Structure
- Technology

Leadership & Collaboration
- APPD Influence & Representation
- Business Model

Research & Scholarship
- Research Priorities
- Development of Research Capabilities
Spring Annual Meeting

APPD 2018 Spring Meeting Schedule

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<tr>
<th>Pre-Conference Day</th>
<th>Day 1</th>
<th>Day 2</th>
<th>Day 3</th>
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<td>9 am Plenary</td>
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<td>8 am Plenary</td>
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<td>10 am Grassroots</td>
<td>10 am “Table to Able”</td>
<td>9 am Platform Presentations</td>
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<td>12 pm Networking Lunch</td>
<td>12 pm Regional Lunch Meetings</td>
<td>10:15 am Expanded Learning</td>
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<td>1:30 pm Expanded Learning</td>
<td>1:30 pm Learning Communities</td>
<td>11:45 am Networking Lunch</td>
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<td>3:30 pm Expanded Learning</td>
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<td>5 pm Networking Reception</td>
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<td>8:30 am — 5:30 pm Forum for</td>
<td>9 am Networking Lunch (on your</td>
<td>12 pm Regional Lunch Meetings</td>
<td>8 am Plenary</td>
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<td>10 am — 5:30 pm Coordinators’</td>
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<td>12 pm Learning Communities</td>
<td>9 am Platform Presentations</td>
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<td>5 pm Networking Reception</td>
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APPD 2017 Annual Fall Meeting ~ September 27-29, Arlington, VA ~ www.appd.org

Council of Pediatric Subspecialties ~ November 16-17, 2017, Chicago, IL ~ APPD.ORG

www.company.com
Spring Annual Meeting

• **Goals** for Redesigned Spring Meeting
  – 1. Address concerns about length and content..
  – 2. Promote interactions of members..

• **Highest priorities** of our members are::
  – A. Learning important new GME and educational concepts and information
  – B. Learning best practices and innovative educational approaches
  – C. Enhanced networking opportunities for the members

• **Innovative elements** will include::
  – • Concurrent sessions (workshops, panel discussions,, debates,, etc.)
  – • A new ‘Table to Able” Session .
  – • Specific networking sessions..
  – • New Learning Communities centered around themes//projects..
  – • An initial Plenary Session each day that sets the framework for the day..
Evolving Organizational Structure

- **APPD Learning Communities**
  - Formerly known as Task Forces and Pediatric Education Groups
  - Groups of members
    - Share learning interests
    - Communicate regularly to collaborate on learning and projects
  - **APPD Learning Communities**
    - Curriculum
    - Learning Technology
    - Faculty and Professional Development
    - Research and Scholarship
    - Assessment
    - Global Health
    - LGBTQA+
    - Under-Represented Minorities
    - Simulation
    - Child Advocacy/Community Health
CoPS + APPD

- Synergy and uniqueness of our organizations is good for Pediatrics and children.
- Shared meeting time
  - Spring APPD meeting time
  - Pre-conference meeting time
  - Possibility of increased shared synergy during APPD meeting
Fellowship Directors Exec Committee

- Pnina Weiss, Chair
- Kammy McGann, Chair-Elect
- Angie Myers, Immediate Past Chair
- Kathy Mason
- Jennifer Kesselheim
- Christine Barron

- Past members
- Geoffrey Fleming
- Bruce Herman
- Michael Brooks
# Fellowship Directors Exec Committee

## Development of Programs & Members
- Workshops at Fall, Spring APPD meetings
- Forum for FPDs at PAS
- PAS Core Curriculum for Fellows
- Quarterly newsletter
- Discussion group for superfellowship directors/Vice Chairs of Education
- FPD guide on program administration

## Organizational Excellence
- Grassroots sessions for FPDs at Fall, Spring APPD meetings
- Fee structure supporting FPDs

## Leadership & Collaboration
- Collaboration with CoPS, ABP, ACGME
- ACGME Milestones 2.0
- CoPS workforce

## Research & Scholarship
- FPD Protected Time Study
- Fellowship Funding Study
- Collaboration with SPIN
- Collaboration with CoPS, APPD LEARN, ABP, AMSPDC
ABP Update
COPS FALL MEETING – NOVEMBER 16, 2017
CHICAGO, IL
Update from the ABP

1. MOC Update and Improvements
   - MOCA-Peds Pilot and Plans for Subspecialties
   - MOC for Fellows

2. Content Outline Revision for Subspecialty Exams

3. Miscellaneous Updates: Hospital Medicine, Resources for PDs, Fees, Diversity, New VP for Exam Admin and Credentialing
Part 1 - Professionalism

• Current standard is unrestricted licensure
  ▪ A low bar for professionalism

• Significant effort in the training space
  ▪ *Teaching, Promoting and Assessing Professionalism Across the Continuum: A MEDICAL EDUCATOR’S GUIDE* – from the ETC

• Part 2 Self-assessment in development

• Will be the subject of the annual ABMS MOC review for 2017-18
Part 2 – Self Assessment

• Learning activities that incorporate individual learning with individual assessment and feedback.

• ABP-developed activities (N=53) include subspecialty self assessments, topic specific self assessments, Decision Skills, GPKSA, QOW
  ▪ No charge for access or for CME

• Activities developed by other organizations (ex: AAP PREP), (N=72 listed on ABP website)
  ▪ Outside organizations may charge for access and/or for CME

• New in 2017: ACCME collaboration
ACCME COLLABORATION

• CME providers apply for MOC credit for their activities on ACCME’s website at the same time they register the activity for CME

• No fee at this time

• CME providers attest to meeting ABP’s revised standards and submitting completion data online within 30 days

• 474 new activities registered as of last week, 216 currently available

• Credit transmitted to ABP daily, appears in diplomate portfolio immediately upon transmittal

• Diplomates received information in February 21 Diplomate “ABP Check Up” Newsletter
QOW Enhancements

- CME (!) As of January 2017
- 10 MOC points + 10 CME hours per 20 correct QOW answers
- Pearl available to all (even if you get the answer wrong)
- Archiving of retired items
Part 3: Knowledge Assessment

- Secure exam every 10 years → MOCA-Peds
- Pilot in progress
- Go Live planned for 2019 for General Peds and 3 subspecialties
MOCA-Peds Pilot

• Shorter, more frequent physician assessment called MOCA-Peds
  *(Maintenance of Certification Assessment for Pediatrics)*

• Test Questions delivered by computer and mobile device
  - Multiple-choice questions quarterly based on the General Pediatrics Content Outline
  - To be answered anytime during quarter at diplomate’s convenience
  - Immediate feedback with references, with brief explanation of correct answer to enhance learning
MOCA-Peds Pilot

- Questions focus on application of fundamental knowledge used in everyday practice
- Resources may be used, excluding assistance from others, but questions must be answered in allotted five minutes
- Will incorporate questions about practice guidelines and articles in the future
- MOC-Peds will replace 10 year secure exam and align with diplomate’s 5 year MOC cycle
Scoring for Summative Assessment

• Pass-fail decision made **every 5 years** (aligns w/ MOC cycle)

• Final summative score at **end of Year 4**

• The **four lowest quarters will be dropped** from scoring

• **No questions in Year 5**

• If passing standard not met, must take secure exam in Year 5
MOC Cycle Alignment and Life Circumstances

Scoring process will drop the lowest 4 quarters of performance in a 5 year MOC cycle

- Reduces burden
- Eliminates the appeal process
- Accounts for –
  - Extenuating circumstances
  - Technical issues (eg, slow internet, dropped questions)
Five-year MOC Cycle (once live in 2019)

<table>
<thead>
<tr>
<th>Year 1</th>
<th>Year 2</th>
<th>Year 3</th>
<th>Year 4</th>
<th>Year 5</th>
</tr>
</thead>
<tbody>
<tr>
<td>80 questions</td>
<td>80 questions</td>
<td>80 questions</td>
<td>80 questions</td>
<td>Proctored exam (if needed)</td>
</tr>
</tbody>
</table>

Because of the 4 lowest quarters rule, those performing well enough may be able to stop at end of Year 3

Am I meeting the performance standard at the end of Year 4?

No

Yes

You do not have to participate in MOCA-Peds until your next MOC 5-year cycle
## Part 3 Options (once MOCA-Peds adopted)

<table>
<thead>
<tr>
<th>MOCA-Peds</th>
<th>Proctored Exam</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Default with enrollment</td>
<td>• Every 5-years at proctored site</td>
</tr>
<tr>
<td>• No additional fees</td>
<td>• Additional fee to cover cost of seat fee and processing</td>
</tr>
<tr>
<td>• Earn Part 2 points</td>
<td>• No Part 2 credit</td>
</tr>
</tbody>
</table>
General Phase-in Plan

Diplomates will enter MOCA-Peds at the start of the 5-year MOC cycle during which their next exam due date falls.

Individual dates will be posted to personal Physician Portfolio page.
Subspecialty Model Current Plan

- Hope to mirror General Pediatrics as much as possible
- First subspecialty model release date 2019
- Straight to live - no pilot
- Goal – complete rollout by 2022

2019
Child Abuse Peds
Gastroenterology
Infectious Diseases
### Subspecialty Rollout Schedule

<table>
<thead>
<tr>
<th>Year</th>
<th>Subspecialties</th>
</tr>
</thead>
<tbody>
<tr>
<td>2019</td>
<td>CHAB, GAST, IDIS</td>
</tr>
<tr>
<td>2020</td>
<td>DBEH, NEON, NEPH, PULM</td>
</tr>
<tr>
<td>2021</td>
<td>CRIT, ENDO, HMED, RHEU</td>
</tr>
<tr>
<td>2022</td>
<td>ADOL, CARD, EMER, HEMO</td>
</tr>
</tbody>
</table>
Starting in 2018, subspecialists who have their Part 3 requirement due, but do not have MOCA-Peds available to them will get an extension to allow them to wait for MOCA-Peds.
Maintaining Multiple Certificates

Regardless of the number of certifications held, diplomates will need to answer the same number of questions for a given discipline/area to maintain the certification for that area.
ABP Part 4 credit – the early days

**Presumption**: few were doing QI so ABP needed to be prescriptive

- The options were: Online modules (PIMs or EQIPP), a long, complex and expensive application, or be a part of an organizational portfolio
- PIMs and EQIPP focused only on primary care pediatric offices
  - So everyone chose handwashing because it was quick and easy, but often not very meaningful
- Application for independent projects was long and expensive – only large hospitals with a QI staff could manage it
- Only a few organizations had “portfolio” status to award Part 4 credit
- No repeat credit for ongoing participation in large projects
What has changed?

- QI has become part of daily work in many settings
- ABP wants to recognize QI work already being done by diplomates
- New pathways for Part 4 credit were created starting in 2015
- Part 4 credit can be awarded for the “application of QI science and methods to any process that is intended to improve the health of children”
  - Clinical care, clinical outcomes, medical education and research processes
10,392 ABP diplomates received MOC Part 4 credit for QI projects initiated by the individual, team, network, or institution (ie, not online modules) in 2016.
Annual Fee Option

• At the time of MOC re-enrollment, pay the full 5-year fee, or can opt to pay annually

• Full fee=$1304 ($261/yr); Annual fee=$275/yr, subject to change

• Annual fee option is in force for the entire 5-year MOC cycle (there is no 2- or 3-year option)

• At re-enrollment into the next cycle at the end of 5 years, choose either the full 5-year fee or the annual fee option
MOC for Residents / Fellows

- Trainees not yet certified will be able to **earn Part 4 MOC credit** for meaningful participation in QI activities (just like a diplomate)
  - Practice Improvement Modules (PIMs)
  - Approved QI projects in institutions and organizations
  - Authorship of qualifying QI articles or posters

- **MOC credit** will be “in the bank” for when they become certified and enter their first MOC cycle

- Trainees will be able to **access many other ABP Part 2** (self assessments and QOW) activities, but will not receive bankable credit
MOC Credit During Fellowship

- MOC credit depends on a fellow’s certification status *(Have they passed the GP exam?)*

- Fellows who have not yet passed their general pediatrics examination may earn **MOC credit for ABP approved QI Projects** and apply credit to their first MOC cycle.

- Fellows already certified in general pediatrics get credit in **2 ways:**
  - 20 points of MOC credit automatically awarded per year for fellowship
  - ABP Approved QI activities earn additional MOC credit
Summary of What Fellows Need to Know

➢ BEFORE the Fellow passes the GP exam: Bankable Part 4 MOC credit can be earned

➢ When the Fellow passes the GP exam, they are enrolled in the first 5-year cycle of MOC, need 100 points just like any other diplomate
  ▪ Any already banked credit goes live
  ▪ 10 Part 2 and 10 Part 4 points are automatically awarded for each year of fellowship training after the fellow achieves initial GP certification

➢ When the Fellow passes the subspecialty exam, the MOC cycle is extended by 1 year
  ▪ There is only 1 MOC cycle no matter how many certifications
  ▪ Diplomates will enter MOCA-Peds at start of next 5-year MOC cycle. If MOCA-Peds is not yet available exam is deferred
Exam Content Outline

- Content Outline serves as blueprint for initial certification, MOC and In-training exams

- Outline identifies for all stakeholders the knowledge areas being measured by these exams

- General Pediatrics updated in 2016 and now posted on ABP website: https://www.abp.org/content/general-pediatrics-content-outline
General Pediatrics Practice Analysis

Practice Analysis
- The systematic study of a role or profession.
- Used by certifying organizations to establish content outlines for exams.

Goal: To ensure exam is relevant to practice.

Practice Analysis for General Pediatrics

Phase 1 – Draft Content Outline. Identified critical tasks performed by general pediatricians and the knowledge required to perform those tasks.

Phase 2 – Validation Survey. Validated the panel’s work through a large-scale survey of all board certified general pediatricians (N ≈ 70,000).

Phase 3 – Weighted Content Outline. Used survey results to make final revisions to the outline and establish exam weights.
# New Structure of Content Outline

<table>
<thead>
<tr>
<th>Content Domains</th>
<th>Universal Tasks</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Basic Science and Pathophysiology</td>
<td>1. Preventive Pediatrics/Well Child Care</td>
</tr>
<tr>
<td>2. Epidemiology and Risk Assessment</td>
<td>2. Fetal and Neonatal Care</td>
</tr>
<tr>
<td>3. Diagnosis</td>
<td>3. Adolescent Care</td>
</tr>
<tr>
<td>4. Management and Treatment</td>
<td>4. Genetics, Dysmorphology, and Metabolic Disorders</td>
</tr>
<tr>
<td>…</td>
<td>25. Research Methods, Patient Safety, and Quality Improvement</td>
</tr>
</tbody>
</table>

The American Board of Pediatrics
The tables below indicate exam weights (i.e.: the percentage of test questions that fall within each content domain and each universal task) for all three General Pediatrics examinations (initial certification, maintenance of certification, and in-training).

### Content Domain

<table>
<thead>
<tr>
<th>Content Domain</th>
<th>Exam Weight</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Preventive Pediatrics/Well Child Care</td>
<td>8%</td>
</tr>
<tr>
<td>2. Fetal and Neonatal Care</td>
<td>5%</td>
</tr>
<tr>
<td>3. Adolescent Care</td>
<td>5%</td>
</tr>
<tr>
<td>.....</td>
<td></td>
</tr>
<tr>
<td>25. Research Methods, Patient Safety, and Quality Improvement</td>
<td>2%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>100%</strong></td>
</tr>
</tbody>
</table>

### Universal Task

<table>
<thead>
<tr>
<th>Universal Task</th>
<th>Exam Weight</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Basic Science and Pathophysiology</td>
<td>20%</td>
</tr>
<tr>
<td>2. Epidemiology and Risk Assessment</td>
<td>10%</td>
</tr>
<tr>
<td>3. Diagnosis</td>
<td>35%</td>
</tr>
<tr>
<td>4. Management and Treatment</td>
<td>35%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>100%</strong></td>
</tr>
</tbody>
</table>
Things to Note About New Outline

1. Content Outline (Blueprint) is **not** a curriculum. Curriculum is broader and includes elements that cannot be assessed on a multiple choice exam.

2. Purpose is to assist in building an exam that reflects **knowledge** needed for practice. Detailed knowledge changes quickly and falls outside scope of outline.

3. ABP is testing the same general knowledge as previous exams and using the same question pool.
Revision of Content Outline for Subspecialty Exams

- Practice Analysis and Content Outline (Exam Blueprint) Revision underway for subspecialties
- Timeline: Began in 2016 with expected completion for all subspecialties in 2020
- Peds Nephrology revision is now posted on website for exam in 2018. Previous version still available online for comparison

- Similar to changes in GP outline:
  - Content domains will be reorganized and reweighted with less granularity
  - Outline will be 2 dimensional, incorporating “Universal Tasks” as well as content domains

- Scholarly Activity Knowledge Content will be revised for all subspecialties with a lower weight than in past. Elimination of teaching and learning and addition of QI to content
Pediatric Hospital Medicine (PHM)

- Petition for subspecialty certification in PHM approved by ABP & ABMS
- Two years of training with scholarly activity required
- ACGME approval to accredit fellowship programs received
- Manuscript published in Pediatrics (Mar 2017) outlining ABP process, current training and practice of PHM, and rationale for decision
- Subboard appointed
- First exam: Fall 2019
Pediatric Hospital Medicine – Eligibility Criteria

**Practice:** Temporary period (first three exams 2019, 2021, 2023)

- Most recent 4 years of full-time practice consisting of 50% time in professional activities (clinical care, teaching, research, administration) in care of hospitalized children

- 25% of full time practice must be devoted to direct patient care of children

- For Med-Peds practitioners, non-patient care professional time related to adults may qualify, but time devoted to direct patient care for children must be 25%
Pediatric Hospital Medicine – Eligibility Criteria

**Training:**
• 2 years of fellowship (non-accredited) associated with ACGME accredited pediatrics residency program

• ABP will determine and publish dates after which fellows must enter accredited training to be eligible for certification

**Training and Practice:**
• Less than 2 years of fellowship requires an additional 2 years of practice that meets requirements as outlined

**FINALIZED ELIGIBILITY CRITERIA ARE POSTED ON WEBSITE WITH AN FAQ DOCUMENT**
Revision of **Professionalism Guide for PDs**

- Expanded to address needs of continuum of learners
- On-line electronic format as well as PDF
- Reflects competency-based assessment
- Ability to search for milestones and linked content
- Updated vignettes and cases
- New chapters on e-professionalism and humanism

[https://www.abp.org/professionalism-guide](https://www.abp.org/professionalism-guide)
Subspecialty Fellowship Orientation Slide Deck

• Annotated slide deck that provides information about the ABP targeted for entering first-year fellows:
  ▪ Evaluation and tracking
    ▪ Data reported annually to the ABP and implications of marginal or unsat evaluations
  ▪ Scholarly Activity
  ▪ SITE and exam security
  ▪ Certification
  ▪ MOC during fellowship and beyond
Subspecialty PD Guide to the ABP

Guide for subspecialty program directors to the ABP includes:

- ABP Schedule of Communications and Important Events
- ABP Program Directors Portal and Staff Contact Info
- Certification and MOC
- Training for Subspecialty Certification
- Synopsis Of Training Pathways
- FAQs
- ABP Relevant Forms

Can be found under the program directors tab
https://www.abp.org/content/program-directors

The ABP strives to keep its fees as low as possible

Fees for the initial certifying exams (general pediatrics and subspecialties) have remained unchanged since 2014 (i.e.: 2014, 2015, 2016, 2017)

Fees cover exam development and administration including:

- Meeting for question writers
- Development of test items
- Work of medical editors
- Credentialing of applicants for exam
- Psychometric analysis of results
- Administration of computer-based exam
Exam Fees

• Subspecialty exams do not generate sufficient revenues to cover expenses due to small numbers of candidates, so there is cost sharing to prevent fees from being prohibitive.

• GP exam fee is one of the lowest among 24 ABMS boards. ABIM and ABFM do have lower fees because they examine far more candidates generating significant economies of scale.

2018 exam fees will remain unchanged!
ABP Efforts to Increase Diversity on Committees/Subboards

2012
Access
Revised ABP bylaws limiting all committee appointments to a 6-year term

2013
Recruitment
Contacted organizations seeking nominations of pediatricians from under-represented minority groups

2014
Access
Developed an online nomination tool for physicians interested in serving on subboard and general pediatrics item writing committees to self-nominate

2014
Pipeline
Initiated support for Academic Pediatric Association’s New Century Scholars Program

2016
Pipeline
Formed Content Development Teams as an opportunity to select a younger and more diverse set of pediatricians to assist subboards/GP committee in item-writing
Racial and Ethnic Distribution: 2012 & 2017 ABP Appointees

- **2012**
  - White: 89%
  - People of Color: [VALUE]%

- **2017**
  - White: 77%
  - People of Color: [VALUE]%

N=230 vs. N=356
The ABP WELCOMES Suzanne Woods to join The ABP Staff as VP for Exam Administration and Credentialing In January 2018!!
Online tool can be found @ www.abpeds.org
Nominate Yourself or Someone Else
Appointees serve a six-year term
Must be board certified in the area of interest

Seeking candidates who represent:

Diversity of pediatric practice: everything from rural, private practices to medical centers in major metropolitan areas

Reflection of today's trends in pediatric practice: well-seasoned pediatricians, new practitioners, part-time providers
ABP Web Site

www.abp.org

- Eligibility and training requirements for general pediatrics and all subspecialties, PD information, ABP policies, etc.

- 2016–2017 Workforce Data available for viewing and downloading from ABP Web site

- Resources for Program Directors
  - www.abp.org
  - Click the Program Directors button
Who is Providing Care to America’s Children? Understanding the Pediatric Workforce

Gary L. Freed, MD, MPH
ALL FUNDING PROVIDED BY THE AMERICAN BOARD OF PEDIATRICS FOUNDATION
Lots of Workforce Data

- Multiple publications on many topics
- Presentation limited to topics of specific interest
- More studies if interested
LIMITATIONS IN WORKFORCE STUDIES

- Denominator issues/data sources
  - Accuracy of studies
  - Advocacy vs. science

- Distribution
  - Patterns
  - Variation among subspecialties

- Location/ownership of practice
  - Not all work in academic centers
  - Private practice is growing

- Effective workforce—headcount vs. actual
How Many You Have
Depends On Who You Ask!

- AMA Masterfile
- American Board of Pediatrics
- American Academy of Pediatrics
- Sub-specialty Societies
- State licensure files
Comparison of AMA Masterfile and ABP Certified Diplomate Database for Select Pediatric Medical Subspecialists

Source: AMA Physician Masterfile and ABP Pediatric Subspecialty Certified Diplomates Database
Do you have those budget numbers from last month?

They’re totally inaccurate.

I know, but those are the only numbers we have.

Actually, we have infinite inaccurate numbers to choose from.

Let’s keep those in our back pocket in case we need them.

I’ll encrypt them so no one else can use them.
Certified and Eligible Pediatric Cardiologists per 1,000 Children under 18 years
ABP Data

# of Ped Card per 1000 Children

- 0 - 1.2
- 1.3 - 2.0
- 2.1 - 2.9
- 3.0 - 4.6
Pediatric Cardiologists per 1,000 Children under 18 years
AMA data

# of Ped Card per 1000 Children
0 - 1.2
1.3 - 2.0
2.1 - 2.9
3.0 - 10
"I just feel fortunate to live in a world with so much disinformation at my fingertips."
Who Are the Non-matched and What Are They Doing?

- Adult cardiologists with pediatric patients
  - Markets without pediatric cardiologists
  - Deliberate marketing efforts
  - Managed care contracts

- Pediatricians who did not complete fellowship training

- Does it matter?
SUBSPECIALTY DISTRIBUTION
Relative Distribution of ABP Neonatal-Perinatal Medicine Diplomates by State
(Total Diplomates ever certified as of 12/31/12)

Pediatric Specialist-to-Child Ratio
- No certified specialists
- 1:30,000+
- 1:22,000-29,999
- 1:19,000-21,999
- 1:15,000-18,999
- 1:11,000-14,999
- 1:1-14,999
Relative Distribution of ABP Rheumatology Diplomates by State
(Total Diplomates ever certified as of 12/31/12)

Pediatric Specialist-to-Child Ratio
- No certified specialists
- 1:500,000+
- 1:300,000-499,999
- 1:200,000-299,999
- 1:125,000-199,999
- 1:1-124,999
Child Population to Pediatrician
Demography
Population of the United States
Children Aged 0-18 Years
1963-2008

Source: U.S. Census Bureau
Pediatric Medical Generalist and Subspecialist Physicians

Source: AMA Physician Masterfile
Pediatric Medical Generalist and Subspecialist Physicians Per Child (Aged 0-14 Years)

Sources: AMA Physician Masterfile and U.S. Census Bureau
THE SUBSPECIALTY PIPELINE
THE INFORMED PATIENT

By LAURA LANDRO

As Specialists Grow Scarcer, Families Turn to Telemedicine

When her daughter Kolbie was still refusing solid food at the age of four, Jeannette Davis tried in vain to find a pediatric specialist near her home in Oklahoma City. "No one here knew what to do," says Mrs. Davis.

Amid all the alarming statistics about shortages in health-care workers, one of the real worries for parents is the declining numbers of pediatric subspecialists -- the doctors who focus on the medical problems of kids, from gastroenterologists to cardiologists and orthopedic surgeons.
Pediatric Fellows

Note: Data prior to 1998 are not included because full tracking data were not available. The total values include 14 subspecialties. In addition, only the first three years of training are included.
Fellows by Gender

Pediatric Subspecialty Tracking
Percentage of Fellows in Training
Trends in Gender

Note: Data prior to 1998 are not included because full tracking data were not available. The total values include 14 subspecialties. In addition, only the first three years of training are included.
Market Share Changes
Distribution of Visits for Children 0 to 17 Years of Age

Source: National Ambulatory Medical Care Survey
Distribution of Visits for Children 11 to 17 Years of Age

Source: National Ambulatory Medical Care Survey
Implications

• Increased market share results in increased workforce needs
  – Primary care
  – Subspecialty care

• Increased survival of children with chronic illness creates greater demand
  – Primary care
  – Subspecialty care
Subspecialists

PRACTICE OWNERSHIP & LOCATION OF PRACTICE
<table>
<thead>
<tr>
<th>Ownership of Primary Practice Setting</th>
<th>Overall (N=218)</th>
<th>Card Care (N=231)</th>
<th>Crit Care (N=198)</th>
<th>GI (N=197)</th>
<th>Hem-onc (N=197)</th>
<th>Neonat (N=239)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Academic hospital/outpatient clinic</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>65 (705)</td>
<td>64 (140)</td>
<td>71 (163)</td>
<td>67 (132)</td>
<td>77 (152)</td>
<td>49 (118)</td>
<td></td>
</tr>
<tr>
<td>Community hospital</td>
<td>16 (170)</td>
<td>5 (10)</td>
<td>19 (44)</td>
<td>4 (7)</td>
<td>9 (17)</td>
<td>38 (92)</td>
</tr>
<tr>
<td>Private outpatient practice</td>
<td>12 (129)</td>
<td>27 (58)</td>
<td>0 (1)</td>
<td>24 (47)</td>
<td>10 (19)</td>
<td>2 (4)</td>
</tr>
<tr>
<td>Other</td>
<td>5 (49)</td>
<td>2 (4)</td>
<td>9 (21)</td>
<td>2 (3)</td>
<td>2 (3)</td>
<td>8 (18)</td>
</tr>
<tr>
<td>Managed care organization</td>
<td>2 (25)</td>
<td>3 (6)</td>
<td>0 (1)</td>
<td>4 (8)</td>
<td>2 (4)</td>
<td>3 (6)</td>
</tr>
<tr>
<td>Public health clinic/community health center</td>
<td>0 (5)</td>
<td>0 (0)</td>
<td>0 (1)</td>
<td>1 (1)</td>
<td>1 (2)</td>
<td>0 (1)</td>
</tr>
</tbody>
</table>
Subspecialists

CLINICAL ACTIVITY
## Clinical Care

### Do you currently provide direct or consultative pediatric subspecialty patient care? (N=3624)

<table>
<thead>
<tr>
<th></th>
<th>Overall (N=3624)</th>
<th>Recent Graduates (N=1932)</th>
<th>Mid-Career (N=1692)</th>
<th>P-Value</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Yes, the primary focus of my clinical practice is subspecialty care</strong></td>
<td>86 (3111)</td>
<td>90 (1746)</td>
<td>81 (1365)</td>
<td>&lt;.0001</td>
</tr>
<tr>
<td><strong>Yes, my clinical practice is a relatively even mix of primary and subspecialty care</strong></td>
<td>6 (201)</td>
<td>5 (102)</td>
<td>6 (99)</td>
<td></td>
</tr>
<tr>
<td><strong>No, the primary focus of my clinical practice is primary care</strong></td>
<td>4 (164)</td>
<td>2 (42)</td>
<td>7 (122)</td>
<td></td>
</tr>
<tr>
<td><strong>No, I am not currently engaged in direct or consultative patient care</strong></td>
<td>4 (148)</td>
<td>2 (42)</td>
<td>6 (106)</td>
<td></td>
</tr>
</tbody>
</table>
## Prevalence of Clinical Inactivity of ≥ 12 Months

<table>
<thead>
<tr>
<th>Variable</th>
<th>% (N)</th>
<th>P</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Overall</strong></td>
<td>12 (554)</td>
<td>NA</td>
</tr>
<tr>
<td><strong>Gender</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male (N=2117)</td>
<td>7 (155)</td>
<td>&lt;.0001a</td>
</tr>
<tr>
<td>Female (N=2529)</td>
<td>16 (399)</td>
<td></td>
</tr>
<tr>
<td><strong>Female Physicians</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Generalist (N=2075)</td>
<td>16 (339)</td>
<td>.0984</td>
</tr>
<tr>
<td>Subspecialist (N=454)</td>
<td>13 (60)</td>
<td></td>
</tr>
<tr>
<td><strong>Male Physicians</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Generalist (N=1495)</td>
<td>7 (112)</td>
<td>.6416</td>
</tr>
<tr>
<td>Subspecialists (N=622)</td>
<td>7 (43)</td>
<td></td>
</tr>
<tr>
<td><strong>Faculty Status</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Full-time faculty (N=999)</td>
<td>8 (76)</td>
<td>&lt;.0001a</td>
</tr>
<tr>
<td>Part-time, adjunct and non-faculty (N=3632)</td>
<td>13 (472)</td>
<td></td>
</tr>
</tbody>
</table>

NA indicates not applicable

a P<.05 for male versus female pediatricians and full-time faculty versus part-time, adjunct and non-faculty
Part Time Status (2016)

General Pediatricians  25%#
Subspecialists  10%**#

*varies markedly by subspecialty from 3%-23%
#varies markedly by gender
Possible Explanations for Shortage Perception

• Prolonged survival
  – Chronic disease
  – Premature infants
• Change in work hours for subspecialists
• More subspecialties
• Change in primary care practice
  – More referrals?
  – Less care for common diagnoses?
  – Implications for pediatric education?
SUBSPECIALTY SATISFACTION AND RESEARCH ENGAGEMENT
Proportion of subspecialists satisfied with their professional time allocation

<table>
<thead>
<tr>
<th>Year</th>
<th>Satisfaction Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>2013</td>
<td>82.8%</td>
</tr>
<tr>
<td>2014</td>
<td>83.6%</td>
</tr>
<tr>
<td>2015</td>
<td>81.4%</td>
</tr>
<tr>
<td>2016</td>
<td>81.3%</td>
</tr>
</tbody>
</table>
Proportion of subspecialists with academic appointments
Proportion of subspecialists spending at least 25% of their time in research
Proportion of subspecialists spending at least 50% of their time in research

- 100.0%
- 90.0%
- 80.0%
- 70.0%
- 60.0%
- 50.0%
- 40.0%
- 30.0%
- 20.0%
- 10.0%
- 0.0%

Proportion of pediatric residents who plan to conduct research at some point during their career

- First year residents
- Third year residents

NURSE PRACTITIONERS
Common Perceptions*

- Nurse practitioners will help alleviate perceived pediatric (primary care & subspecialty) shortages
- Nurse practitioners will help to alleviate future resident effort changes
- There is a growing number of nurse practitioners
- There is a growing number of pediatric nurse practitioners

*Did anyone bother to check?
Number NP Graduates by Clinical Track: 1996-2008

Number NP Graduates by Clinical Track: 1996-2008

Graduates

Year

Pediatric NP
Neonatal NP
Pediatric Acute Care NP
School NP
Family NP
All Other NPs
Where Do We Go From Here?

• Be skeptical – very skeptical of workforce data

• Landscape is changing

• Impact of health reform is unclear

• Constant challenge to provide the best care to children
Bonus Slides (if time)

- Additional data/surprises
  - PNP workforce and pipeline
  - PA workforce and pipeline
  - Referral patterns of primary care pediatricians
  - Primary care shortage? Perception vs. reality
Data Sources

• Association of Pediatric Nurse Practitioners
• Pediatric Nursing Certification Board
• American Nurses Credentialing Center
• American Association of Colleges of Nursing
• 2008 US Census Bureau estimates
How Many NPs Are There?

• NPs: 125,000 (AANP)

• PNP: 13,384 (NAPNAP)

• PNP: 11,750 (AANP)
FNP Implications

- FNPs provide little care to children
- Few work in pediatric practices
- Demographics of the US pushing new FNPs into adult care
- Unlikely to have a significant impact on the primary care or subspecialty pediatric workforce
PHYSICIAN ASSISTANTS
Current National Estimates of PAs are Imprecise

- 68,100 practicing PAs in the United States (January 2009)
- American Academy of Physician Assistants report 2114 Pediatric PAs (June 2009)
Pediatric PA Distribution, June 2009

Legend

Pediatric PAs per 100,000 children
- 0 - <=1
- >1 - <=2
- >2 - <=4
- >4

Pediatric PAs per State
- <=50 Pediatric PAs

Sources: AAPA, U.S. Census Bureau 2008 Estimates
Physician Assistant
Summary

- Will not have a strong impact on the pediatric workforce in near future

- Likely competition in recruitment from adult providers will increase in near term

- Scope of work in pediatric care is unknown
Distribution of Visits for Children < 1 Year of Age

Source: National Ambulatory Medical Care Survey
How can something seem so plausible at the time and so idiotic in retrospect?
<table>
<thead>
<tr>
<th>Time</th>
<th>Event Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>8:00-8:10am</td>
<td>Welcome / Recap of Day 1</td>
</tr>
<tr>
<td>8:10-8:55am</td>
<td>2 year fellowship</td>
</tr>
<tr>
<td>8:55-9:00am</td>
<td>Reflections by Dr. Gail McGuinness</td>
</tr>
<tr>
<td>9:00-9:05am</td>
<td>Financial report</td>
</tr>
<tr>
<td>9:05-9:10am</td>
<td>Membership/Membership Committee</td>
</tr>
<tr>
<td>9:10-9:15am</td>
<td>Milestones 2.0 ACGME update</td>
</tr>
<tr>
<td>9:15-9:35am</td>
<td>New transition action team</td>
</tr>
<tr>
<td>9:35-9:45am</td>
<td>SPIN update</td>
</tr>
<tr>
<td>9:45-10:10am</td>
<td>Communications Committee/ How to use Twitter</td>
</tr>
<tr>
<td>10:10-10:30am</td>
<td>Break / Check Out</td>
</tr>
<tr>
<td>10:30-11:30am</td>
<td>Action Plan for Workforce Initiative</td>
</tr>
<tr>
<td>11:30am-11:40am</td>
<td>Action Plan: CoPS Focus for next 3-4 years</td>
</tr>
</tbody>
</table>
Recap Day 1

History – Laura

Liaison Organization reports:

APA – Teri Turner

– Striving to train academic pediatricians
– Struggle with funding, want to be part of match (all academic pediatric fellowships)
– Fellowship online curriculum
– Increasing involvement for children requiring chronic care
Recap Day 1

Liaison Organization reports:

AAP: Anne Edwards

- AAP developed 5-yr strategic plan in 2016
  - includes focus on medical and surgical subspecialists
- Agenda for Children – focus of AAP
  - Bias and discrimination impact on health
  - Physician health and wellness – determine factors related to burnout
- Advocacy
  - large effort supporting Federal funding
  - Advocate for subspecialty referral, shortage – loan repayment (is ‘access to health’)
  - Military spending for training
  - Impact of travel bans on IMG
Recap Day 1

Liaison Organization reports:

AMSPDC: Alice Ackerman, John Barnard

- Issue of match frenzy
- Incorporating Behavioral and Mental Health into training programs
- Surveys of chairs about to go out:
  1. Global health – how implement into education of residents
  2. Unfunded mandate for FPD protected time (what is the current gap?)
  3. Mission-based budgeting (Chairs concerned that hospital-based support will be going away)
Recap Day 1

Liaison Organization reports:

AMSPDC: Alice Ackerman, John Barnard

– Clinical Care Committee of AMSPDC

March annual AMSPDC meeting – three topics for discussion:

1) Overview of Pediatric Workforce issues
2) Opportunities and Challenges for women in pediatric workforce
3) Issues related to Chair turnover rate
Recap Day 1

Liaison Organization reports:
APPD: Franklin Trimm, Pnina Weiss

• Vision 20/20 – current strategic plan
  – Emphasis on wellness and resilience (of trainees and trainers)
  – Diversity, equity and inclusion

• Research and scholarship (longitudinal program at spring meeting)

• Welcome CoPS for meeting in March

• Med Ed Portal – Jennifer Kesselheim “Humanism and Professionalism”
Recap Day 1

Liaison Organization reports:

**ABP: Gail McGuinness**

- MOC update
  - ACCME facilitating credit for CME activities
  - MOCA-Peds-Subspecialty starting in 2019

- Content Outline Revision (in next year)
  - Practice analysis will be done for each subspecialty (already done for Gen Peds)
  - Will be completed for all subs by 2020 – started in 2016; peds nephrology completed, posted
Recap Day 1

• **Workforce: Deb Boyer**
  – Presentations from Gary Freed, Laurel Leslie, Anne Edwards, Lynn Olson
  – Breakouts
  – Further discussion this morning
2018 Slate

- Jill Fussell – Vice Chair
- Need nominees for one At Large (3 year)

- Deb Boyer – Chair
- Tandy Aye – Secretary-Treasurer
- Mel Heyman – Past Chair
- Lisa Imundo – At Large
2-Year Fellowship

• Issue triggered by Hospitalist subboard accreditation
• 3-year (and 4-year) fellowships offered to encourage scholarship, academic career development
• 2-year fellowship may be preferred for those seeking clinical training
• ABP: entire subspecialty must agree to same length of fellowship
2-Year Fellowship

• Next steps?
  – Discuss with/Survey your training programs, societies/subspecialty orgs
  – Review paper on the issue?
Thank you!!
ACTION TEAM REPORTS

ACTION TEAMS

Fellowship Start Date

- Fellows survey:
  - ABP sent survey to first year fellows:
    240/698 responses (34%)
  - Resending to rest of first year fellows by mid Dec
Fellowship Start Date

• **FPD survey** (Rich Mink, David Wininger, Elaine Muchmore and Dena Hofkosh):
  – As of this week: 312/802 (39%) responses

**Preliminary results:**

– 75% of respondents have a single Designated Institutional Official (DIO) that manages pediatric and adult programs

– Of the 312 respondents, 273 had first year fellows starting in June or July

– **66% indicated delayed start date** (fellows DID NOT begin training ON or BEFORE July 1)

– These are programs, not institutions, but FPDs from multiple institutions responded
Transition Action Team?

• Is this an issue for CoPS?
About Got Transition

Got Transition/Center for Health Care Transition Improvement is a cooperative agreement between the Maternal and Child Health Bureau and The National Alliance to Advance Adolescent Health. Our aim is to improve transition from pediatric to adult health care through the use of new and innovative strategies for health professionals and youth and families. With a broad range of partners, we are working to:

- Expand the use of the Six Core Elements of Health Care Transition in pediatric, family medicine, and internal medicine practices;
- Partner with health professional training programs to improve knowledge and competencies in providing effective health care transition supports to youth, young adults, and families;
- Develop youth and parent leadership in advocating for needed transition supports and participating in transition quality improvement efforts;
- Promote health system measurement, performance, and payment policies aligned with the Six Core Elements of Health Care Transition; and
- Serve as a clearinghouse for current transition information, tools, and resources.

Contact Information

Got Transition
1615 M Street NW, Suite 290
Washington, DC 20036
Phone: 202-223-1500
Fax: 202-429-3957
info@GotTransition.org

http://www.gottransition.org/about/index.cfm
About Got Transition

Got Transition/Center for Health Care Transition Improvement is a cooperative agreement between the Maternal and Child Health Bureau and The National Alliance to Advance Adolescent Health. Our aim is to improve transition from pediatric to adult health care through the use of new and innovative strategies for health professionals and youth and families.
Transition Care

Six Core Elements of Health Care Transition:

• transition policy
• transition tracking and monitoring
• transition readiness assessment
• transition planning
• transfer of care
• transfer completion
Transitioning a Patient With IBD From Pediatric to Adult Care

Transitioning to adulthood with IBD

The majority of adolescents with inflammatory bowel disease (IBD) will transition from a pediatric to an adult specialist. This transition can be challenging if they are not prepared to take ownership of their healthcare. Even those who remain with their pediatric specialist should be transitioning from dependence on their parents to independent self-management. A successful transition to an adult specialist requires collaboration among the patient, family and healthcare team.

It is critically important to educate the patient as much as possible about their disease and healthcare needs. In addition, it is important to encourage the patient do to as much as they can on their own. The patient should be encouraged to ask questions and participate actively in their care. Some key areas for successful transition are listed below.

Key areas for successful self-management and transition:

**KNOWLEDGE**
- Disease
- Medications (name, dose, purpose, side effects, interactions)
- Tests

**INDEPENDENCE AND ASSERTIVENESS**
- Independent health behaviors
  - Responsible for medications, doctor’s visits (scheduling and self-reporting at visit)
- Self-advocacy
  - School, work
- Insurance issues

**HEALTH AND LIFESTYLE**
- Effect of drugs, smoking
- Consequences of nonadherence
- Fertility/sexuality

The precise age at which children and adolescents assume these tasks and responsibilities may vary.
# Transition Care

## Healthcare Provider Transitioning Checklist

<table>
<thead>
<tr>
<th>AGE</th>
<th>PATIENT</th>
<th>HEALTH CARE TEAM</th>
</tr>
</thead>
</table>
| 12-14     | **EARLY ADOLESCENCE**

*New knowledge and responsibilities*

- [ ] I can describe my GI condition
- [ ] I can name my medications, the amount and times I take them
- [ ] I can describe the common side effects of my medications
- [ ] I know my doctors’ and nurses’ names and roles
- [ ] I can use and read a thermometer
- [ ] I can answer at least one question during my health care visit
- [ ] I can manage my regular medical tasks at school
- [ ] I can call my doctor’s office to make or change an appointment
- [ ] I can describe how my GI condition affects me on a daily basis

| 14-17     | **MID ADOLESCENCE**

*Building knowledge and practicing independence*

- [ ] I know the names and purposes of the tests that are done
- [ ] I know what can trigger a flare of my disease
- [ ] I know my medical history
- [ ] I know if I need to transition to an adult gastroenterologist
- [ ] I reorder my medications and call my doctor for refills
- [ ] I answer many questions during a health care visit
- [ ] I spend most of my time alone with the doctor during visit
- [ ] I understand the risk of medical nonadherence
- [ ] I understand the impact of drugs and alcohol on my condition
- [ ] I understand the impact of my GI condition on my sexuality

- [ ] Discuss the idea of visiting the office without parents or guardians in the future
- [ ] Encourage independence by performing part of the exam with the parents or guardians out of the examining room
- [ ] Begin to provide information about drugs, alcohol, sexuality and fitness
- [ ] Establish specific self-management goals during office visit

- [ ] Always focus on the patient instead of the parents or guardians when providing any explanations and
- [ ] Allow the patient to select when the parent or guardian is in the room for the exam
- [ ] Inform the patient of what the parent or guardian must legally be informed about with regards to the patient condition
- [ ] Discuss the importance of preparing the patient for independent status with the parents or guardian and address any anxiety they may have
- [ ] Continue to set specific goals which should include:
  - Filling prescriptions and scheduling appointments
  - Keeping a list of medications and medical team appointments
Find an adult IBD doctor and get prepared for your first visit

- Checklist for preparedness
- List of local IBD physicians
Transition Action Team?

• Is this an issue for CoPS?

• Charge of team?
  – To provide resources for pediatric subspecialties (web-based?)
Action Plans – next steps

- **Membership Committee**: in addition to other subspecialties, approach CHA for Allied Membership
Action Plans – next steps
Pediatric Subspecialty Descriptions (resource for residents and med students) – UPDATE yours if not already done!
http://pedsubs.org/SubDes/index.cfm
CoPS Update

CoPS web site (www.pedsubs.org):
• Milestones for subspecialty EPAs
• MOC options (Handout from ABP)
• Promote with Twitter

• Transition care?
• Resource: Subspecialty jobs
Action Plans – next steps

• *J Pediatr* manuscripts in preparation thru AMSPDC:
  – Fellowship Funding
    • for Mar 2018 - Heyman, Weiss
  – Pediatric Subspecialty Workforce Issues
  – CoPS - last 10 years
Action Plans – next steps

- **Fellowship Funding**
  - Continue to work with APPD, AMSPDC, and liaison organizations to help problem solve
  - Survey of Pediatric Chairs re gap analysis pending from AMSPDC
Funding Sources and Financial Insecurity in Pediatric Fellowship Programs

APPD FD EC & CoPS

Pnina Weiss, MD, Angela L. Myers, MD, MPH, Kathleen A. McGann, MD, Katherine E. Mason, MD, Jennifer C. Kesselheim, MD, Med, Geoffrey M. Fleming, MD, Christine Barron, MD, Ann Klasner, MD, MPH, Melvin B. Heyman, MD, Doria L. Weiss, Elizabeth Mauer, MS, Linda M. Gerber, PhD, Erika L. Abramson, MD
Background

- Critical shortages in pediatric subspecialties
  - Many areas lack pediatric subspecialties
  - Pediatricians report inadequate access to subspecialists
- In many subspecialties, inadequate recruitment of new fellows to replace the retiring physician population
- Challenges to development of pediatric physician scientists

“The current system of funding graduate medical education (GME)....provides insufficient financial support to address the current and future pediatrician workforce needs of the nation’s infants, children, adolescents and young adults”

Financing Graduate Medical Education to Meet the Needs of Children and the Future Pediatrician Workforce. *Pediatrics.* 2016;137
Funding for fellowships

• Centers for Medicare and Medicaid Services (CMS)
  – Funds fellows at 50%
  – Research time does not count

• Children’s Hospital Graduate Medical Education (CHGME) Payment Program
  – Must be approved by Congress annually

• NIH- T32
  – Decreasing

• Pediatric Department
• Section/Division
• Extramural
• Institutional
AIMS

• Characterize the sources of funding for trainee salary and educational expenses
• Describe the effects of limited funding on programs
• Determine insecurity of FPDs re: funding of programs
  – Characteristics of programs that are more insecure
Methods

- Survey to FPDs
- APPD and CoPS listserves
- Nov 1, 2016 - Feb 9, 2017
- Multivariate analysis
## Results

<table>
<thead>
<tr>
<th>Program</th>
<th>Responded</th>
<th>Total ABP</th>
<th>% Total programs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adolescent Medicine</td>
<td>19</td>
<td>28</td>
<td>68</td>
</tr>
<tr>
<td>Cardiology</td>
<td>39</td>
<td>59</td>
<td>66</td>
</tr>
<tr>
<td>Child Abuse</td>
<td>20</td>
<td>29</td>
<td>69</td>
</tr>
<tr>
<td>Critical Care</td>
<td>46</td>
<td>67</td>
<td>69</td>
</tr>
<tr>
<td>Developmental Behavioral</td>
<td>20</td>
<td>39</td>
<td>51</td>
</tr>
<tr>
<td>Emergency Medicine</td>
<td>30</td>
<td>77</td>
<td>39</td>
</tr>
<tr>
<td>Endocrinology</td>
<td>55</td>
<td>70</td>
<td>79</td>
</tr>
<tr>
<td>Gastroenterology</td>
<td>46</td>
<td>62</td>
<td>74</td>
</tr>
<tr>
<td>Hematology- Oncology</td>
<td>58</td>
<td>73</td>
<td>79</td>
</tr>
<tr>
<td>Infectious Disease</td>
<td>44</td>
<td>64</td>
<td>69</td>
</tr>
<tr>
<td>Neonatal- Perinatal</td>
<td>66</td>
<td>99</td>
<td>67</td>
</tr>
<tr>
<td>Nephrology</td>
<td>13</td>
<td>45</td>
<td>29</td>
</tr>
<tr>
<td>Pulmonology</td>
<td>48</td>
<td>54</td>
<td>89</td>
</tr>
<tr>
<td>Rheumatology</td>
<td>15</td>
<td>36</td>
<td>42</td>
</tr>
<tr>
<td>Total</td>
<td>519</td>
<td>802</td>
<td>65</td>
</tr>
</tbody>
</table>
## Geographic regions

<table>
<thead>
<tr>
<th>Region</th>
<th>N</th>
<th>% total programs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Midwest</td>
<td>153</td>
<td>29</td>
</tr>
<tr>
<td>Northeast</td>
<td>136</td>
<td>26</td>
</tr>
<tr>
<td>Southeast</td>
<td>107</td>
<td>21</td>
</tr>
<tr>
<td>Southwest</td>
<td>42</td>
<td>8</td>
</tr>
<tr>
<td>West</td>
<td>81</td>
<td>16</td>
</tr>
</tbody>
</table>
How many total fellows do you have for academic year 2016-2017

<table>
<thead>
<tr>
<th>Total fellows</th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-3</td>
<td>204</td>
<td>39</td>
</tr>
<tr>
<td>4-6</td>
<td>162</td>
<td>31</td>
</tr>
<tr>
<td>7-9</td>
<td>83</td>
<td>16</td>
</tr>
<tr>
<td>&gt;9</td>
<td>70</td>
<td>13</td>
</tr>
</tbody>
</table>
What is the funding source of your fellows’ salary?
How do you pay for the following fellowship expenses?
Over the last two years, have concerns about insufficient funding had an impact on the number of fellows that you have in your program?

- Yes - 23%
  - 7% had to decrease the # of fellows
  - 16% couldn’t increase the # of fellows
In what other ways has insufficient funding impact your program?

- Recruitment
- Scholarly activity
- Educational resources
- Statistical support for research
- Travel to conferences
- Limited 4th year fellows
- Increased reliance on international fellows
- Increased time and energy devoted to obtaining the funds
What do you see as the biggest threat to continuing financial support of fellows?

• Cuts in
  – external, government and institutional training grants, extramural funding, philanthropy, federal GME
• Decreased clinical revenues
• Decreased support from department, division and hospital
• Present political climate
• Threats to dissolve the ACA/cuts to CMS
Insecurity/Security

Indicate how secure you feel about funding for fellow salary this year and future years

<table>
<thead>
<tr>
<th>Year</th>
<th>n</th>
<th>% insecure</th>
</tr>
</thead>
<tbody>
<tr>
<td>2016-2017</td>
<td>33</td>
<td>6</td>
</tr>
<tr>
<td>2017-2018</td>
<td>67</td>
<td>13</td>
</tr>
<tr>
<td>2018 and later</td>
<td>98</td>
<td>19</td>
</tr>
</tbody>
</table>
Security 2018 and later by Program

Key
1 Adolescent Medicine
2 Cardiology
3 Child abuse
4 Critical Care
5 DBP
6 EM
7 Endocrinology
8 GI
9 Heme/Onc
10 ID
11 Neonatology
12 Nephrology
13 Pulm
14 Rheum
Security 2018 and later by type of Program

<table>
<thead>
<tr>
<th></th>
<th>Insecure N(% total)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital</td>
<td>17 (13%)</td>
</tr>
<tr>
<td>Non-hospital</td>
<td>81 (22%)*</td>
</tr>
</tbody>
</table>

* p = 0.02

Hospital-based
Neonatology
Emergency Medicine
Critical Care
### Characteristics of hospital vs non-hospital based programs

<table>
<thead>
<tr>
<th>Source of Salary</th>
<th>% of Hospital-based Programs</th>
<th>% of Nonhospital-based Programs</th>
<th>P value</th>
</tr>
</thead>
<tbody>
<tr>
<td>≥ 7 fellows</td>
<td>58%</td>
<td>19%</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Hospital</td>
<td>73%</td>
<td>57%</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>T32</td>
<td>11%</td>
<td>25%</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Pediatric dept</td>
<td>27%</td>
<td>37%</td>
<td>0.04</td>
</tr>
<tr>
<td>Extramural</td>
<td>8%</td>
<td>24%</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Division</td>
<td>35%</td>
<td>30%</td>
<td>NS</td>
</tr>
</tbody>
</table>
### Security 2018 and later by number of fellows

<table>
<thead>
<tr>
<th>Number of fellows</th>
<th>Insecure N (%total)</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-3</td>
<td>51 (26%)</td>
</tr>
<tr>
<td>4-6</td>
<td>30 (20%)</td>
</tr>
<tr>
<td>7-9</td>
<td>10 (13%)</td>
</tr>
<tr>
<td>&gt; 9</td>
<td>7 (10%)</td>
</tr>
</tbody>
</table>

* p = 0.04
### Predictors for insecurity (multivariate analysis)

<table>
<thead>
<tr>
<th>Predictor</th>
<th>OR</th>
<th>Confidence Intervals</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>≥7 fellows</td>
<td>0.44</td>
<td>0.24-0.77</td>
<td>0.01</td>
</tr>
<tr>
<td>Hospital or GME/CHGME (in yrs 2,3)</td>
<td>0.54</td>
<td>0.32-0.89</td>
<td>0.02</td>
</tr>
<tr>
<td>Extramural/Other</td>
<td>1.86</td>
<td>1.16-3.0</td>
<td>0.01</td>
</tr>
<tr>
<td>Division*</td>
<td>1.80</td>
<td>1.11-2.89</td>
<td>0.016</td>
</tr>
</tbody>
</table>

Not department, T32, program type

Security- type of program
Conclusions

- Insufficient funding limited positions in 23% of programs
- Many programs had insufficient funds for educational expenses
- Insecurity about future funding was common
- Characteristics of programs that were insecure
  - Small (≤ 6 fellows)
  - Not funded by Hospital/CHGME in yrs 2,3
  - Funded by extramural or division
  - Non-hospital based*
Discussion
How long have you been a program director?

<table>
<thead>
<tr>
<th>Variable</th>
<th>n</th>
<th>mean</th>
<th>sd</th>
<th>median</th>
<th>min</th>
<th>max</th>
</tr>
</thead>
<tbody>
<tr>
<td>How long as a fellowship director?</td>
<td>507</td>
<td>7.14</td>
<td>6.28</td>
<td>5</td>
<td>0</td>
<td>30</td>
</tr>
</tbody>
</table>
Predictors for security ($\geq 2.5$)

<table>
<thead>
<tr>
<th></th>
<th>OR</th>
<th>Confidence intervals</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>$\geq 7$ fellows</td>
<td>2.13</td>
<td>1.32-3.46</td>
<td>0.002</td>
</tr>
<tr>
<td>Hospital or GME/CHGME (in yrs 2,3)</td>
<td>1.97</td>
<td>1.32-2.95</td>
<td>0.001</td>
</tr>
<tr>
<td>Extramural/Other</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Division</td>
<td>0.49</td>
<td>0.32-0.77</td>
<td>0.002</td>
</tr>
<tr>
<td>Non-hospital</td>
<td>0.57</td>
<td>0.35-0.93</td>
<td>0.03</td>
</tr>
</tbody>
</table>
## Funding by T32

<table>
<thead>
<tr>
<th>Program</th>
<th>No</th>
<th>Yes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adolescent Medicine</td>
<td>14.74%</td>
<td>5.26%</td>
</tr>
<tr>
<td>Cardiology</td>
<td>34.87%</td>
<td>5.13%</td>
</tr>
<tr>
<td>Child Abuse Pediatrics</td>
<td>20.00%</td>
<td>0.00%</td>
</tr>
<tr>
<td>Critical Care Medicine</td>
<td>40.87%</td>
<td>6.13%</td>
</tr>
<tr>
<td>Developmental-Behavior</td>
<td>20.00%</td>
<td>0.00%</td>
</tr>
<tr>
<td>Emergency Medicine</td>
<td>29.97%</td>
<td>1.33%</td>
</tr>
<tr>
<td>Endocrinology</td>
<td>37.67%</td>
<td>18.33%</td>
</tr>
<tr>
<td>Gastroenterology</td>
<td>34.74%</td>
<td>12.26%</td>
</tr>
<tr>
<td>Hematology-Oncology</td>
<td>45.78%</td>
<td>13.22%</td>
</tr>
<tr>
<td>Infectious Disease</td>
<td>32.73%</td>
<td>12.27%</td>
</tr>
<tr>
<td>Neonatal-Perinatal</td>
<td>57.86%</td>
<td>9.14%</td>
</tr>
<tr>
<td>Nephrology</td>
<td>5.38%</td>
<td>8.62%</td>
</tr>
<tr>
<td>Pulmonology</td>
<td>34.71%</td>
<td>14.29%</td>
</tr>
<tr>
<td>Rheumatology</td>
<td>9.60%</td>
<td>6.40%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Program</th>
<th>No</th>
<th>Yes</th>
<th>P</th>
</tr>
</thead>
<tbody>
<tr>
<td>Neonatal/Critical Care/ Emergency Medicine</td>
<td>126.89%</td>
<td>16.11%</td>
<td>0.00128</td>
</tr>
<tr>
<td>Other</td>
<td>284.75%</td>
<td>93.25%</td>
<td></td>
</tr>
</tbody>
</table>

P-value from Chi-square test
Indicate how secure you feel about funding for fellow salary

<table>
<thead>
<tr>
<th></th>
<th>n</th>
<th>mean</th>
<th>SD</th>
<th>median</th>
<th>% insecure</th>
</tr>
</thead>
<tbody>
<tr>
<td>2016-2017</td>
<td>439</td>
<td>3.33</td>
<td>0.97</td>
<td>4</td>
<td>6</td>
</tr>
<tr>
<td>2017-2018</td>
<td>498</td>
<td>2.92</td>
<td>1.03</td>
<td>3.1</td>
<td>13</td>
</tr>
<tr>
<td>2018 and later</td>
<td>493</td>
<td>2.6</td>
<td>1.1</td>
<td>3</td>
<td>19</td>
</tr>
</tbody>
</table>
Security 2018 and later by type of Program

<table>
<thead>
<tr>
<th>Insecure</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital</td>
<td>17 (13%)</td>
</tr>
<tr>
<td>Non-hospital</td>
<td>81 (22%)*</td>
</tr>
</tbody>
</table>

* p = 0.02
Security 2018 and later by number of fellows

<table>
<thead>
<tr>
<th>Number of fellows</th>
<th>Insecure</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-3</td>
<td>51 (26%)</td>
</tr>
<tr>
<td>4-6</td>
<td>30 (26%)</td>
</tr>
<tr>
<td>7-9</td>
<td>10 (13%)</td>
</tr>
<tr>
<td>&gt; 9</td>
<td>7 (10%)</td>
</tr>
</tbody>
</table>

* p = 0.04
CoPS Financial Update
Secretary-Treasurer Report

Tandy Aye, MD
November 17, 2017
Chicago, IL
## Council of Pediatric Subspecialties
### STATEMENTS OF ACTIVITIES
for Years Ended June 30

<table>
<thead>
<tr>
<th></th>
<th>2017</th>
<th>2016</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Support and revenue:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Member dues income</td>
<td>$ 75,500</td>
<td>$ 72,000</td>
</tr>
<tr>
<td>Meeting income</td>
<td>8,525</td>
<td>9,892</td>
</tr>
<tr>
<td>SPIN network contribution</td>
<td>18,700</td>
<td>0</td>
</tr>
<tr>
<td>Interest income</td>
<td>46</td>
<td>84</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>102,771</strong></td>
<td><strong>81,976</strong></td>
</tr>
<tr>
<td><strong>Expenses:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Program service - meeting expenses</td>
<td>21,194</td>
<td>21,580</td>
</tr>
<tr>
<td>Program service - membership services</td>
<td>4,368</td>
<td>4,287</td>
</tr>
<tr>
<td>SPIN network expenses</td>
<td>18,700</td>
<td>0</td>
</tr>
<tr>
<td>Admin, operating, management</td>
<td>50,173</td>
<td>46,774</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>94,435</strong></td>
<td><strong>72,641</strong></td>
</tr>
<tr>
<td><strong>INCREASE IN NET ASSETS</strong></td>
<td><strong>8,336</strong></td>
<td><strong>9,335</strong></td>
</tr>
</tbody>
</table>
### CoPS FY18 Approved Budget

**Support and revenue:**
- Member dues income: $74,000
- Meeting income: 7,975
- SPIN network contribution: 18,700
- Interest income: 40
**Total:** 100,715

**Expenses**
- Program service - meeting expenses: 23,000
- Program service - membership services: 8,500
- SPIN network expenses: 18,700
- Admin, operating, management: 49,910
**Total:** 100,110

**INCREASE IN NET ASSETS**
605
Overall financial status:
June 30, 2013 net assets: $22,785
June 30, 2014 net assets: $28,404
June 30, 2015 net assets: $30,934
June 30, 2016 net assets: $40,269
June 30, 2017 net assets: $48,605

Independent CPA reviews our finances
The Council of Pediatric Subspecialties advances child health through communication and collaboration within its network of pediatric subspecialties and liaison organizations.
OUR VISION

- All pediatric subspecialties working together for optimal child health.
OUR VALUES

VALUES
As an organization, we embrace:
- Collaboration
- Responsiveness
- Diversity
- Transparency
ALLIED PEDIATRIC ORGANIZATIONS

- Academic Pediatric Association (APA)
- American Academy of Pediatrics (AAP)
- American Board of Pediatrics (ABP)
- American Pediatric Society (APS)
- Association of Medical School Pediatric Department Chairs (AMSPDC)
- Association of Pediatric Program Directors (APPD)
SUBSPECIALTIES

- Academic Generalists
- Adolescent Medicine
- Allergy and Immunology
- Cardiology
- Child Abuse
- Critical Care
- Developmental Pediatrics and Behavior Medicine
- Emergency Medicine

- Endocrinology
- Gastroenterology
- Hematology and Oncology
- Hospitalist Medicine
- Infectious Disease
- Neonatology
- Neurology
- Nephrology
- Pulmonary Medicine
- Rheumatology
- When we worked together...all subs benefitted.
- Later July Start date
- Letter for J1 visas
- Common Match Date
- Formation of SPIN
THE PROPOSAL

- Other subspecialties not currently present
  - Dermatology
  - Psychiatry/Psychology
  - Palliative Care Medicine
  - Medical Genetics
  - Sports Medicine

- Should we expand our membership?
  - What would we gain?
  - Can we advocate better for pediatric providers?
WHAT ABOUT OUR SURGICAL COLLEAGUES?

- Pediatric Anesthesia
- Urology
- General Surgery
- Orthopedics
- Plastic Surgery
OTHER ADMINISTRATIVE REPS

- Children’s Hospital Association: Even as an Allied Member?
WHAT ARE OUR NEXT STEPS?

- Formation of a Membership Committee
- Begin dialogues with Societies/Organizations etc
  - Palliative Care
  - Medical Genetics
A Short Intro to Twitter

Mark Atlas (@MarkPAtlasMD)
Alice Ackerman (@CloseToHomeMD)
What is Twitter?

• Rapid fire social media platform
• Since beginning was limited to 140 characters per message
  • Starting last week new limit is 280 characters
• Allows for instantaneous interactions
• You can “follow” anyone and anyone can follow you unless you block or lock your account
Twitter Lexicon

• Tweet
• Retweet
• Twittersphere
• Twitter handle
  • @_pedsubs
  • @MarkPAtlasMD; @CloseToHomeMD
• Twitter Display Name
  • Council of Ped Subs;
  • Mark P Atlas, MD; Alice Ackerman, MD

• @Mention
• Hashtag (#)
• DM (direct message)
• Bots
• Trolls
Evolution of Twitter uses over the years

- Micro blogging
- Social interactions
- Advocacy
- Medical Education
- Politics
Multiple Uses for Twitter in Medical Education

• Tweet chats such as #meded, #HCLDR
• Twitter journal clubs
• Informal mentoring of students/ residents/ fellows and junior faculty
• Specialty specific, such as @AmerAcadPeds, @HumanPathology
Participants in #CCC45 via Symplur
Academic outcomes
Online Social Networking by Age Group

Results of this poll, conducted by Princeton Survey Research Associates International for the Pew Research Center
Social Media & Health Care

• **40%** - consumers say info found on social media has impacted how they deal with their health

• **90%** - ages 18-24 trust medical info shared by others on social networks

• **41%** - social media would affect their choice of a specific doctor, hospital or medical facility

Sources: Mediabistro; Demi & Cooper Advertising and DC Interactive Group
Rise of online health/patient communities

• Started with web-site based
  • (www.patientslikeme.com)
• Now many are Twitter or Facebook based
• Rare diseases
• Share information
• Connect with providers
Dynamics and Centrality of Twitter Patient/Community Network

https://www.youtube.com/watch?v=CHmqsqnUp8Q
SOME TWITTER DO’S AND DON’TS
Getting Started on Twitter

• Choose your twitter handle and display name
  • Can be same or different
  • Display name can change over time; handle cannot

• Write a short bio
  • List major interests, use hashtags if warranted

• Upload a photo

• Get involved
Mayo Clinic Social Media Policy

Don’t Lie, Don’t Pry,
Don’t Cheat, Can’t Delete,
Don’t Steal, Don’t Reveal
Next Step-Goals

- Make sure your goals for being on Twitter are clear (to you at least)
  - Networking
  - Teaching
  - Learning
  - Marketing
  - Mentoring
Do Be *DELIBERATE* and
Do use your *FILTER*

- Too many health care providers make SMALL MISTAKES
  - that come back to haunt them days, weeks, months or years later
- Tweeting or posting under your OWN NAME
  - will keep you HONEST, and
  - help you remember your manners

No such thing as “just this once”
Don’t Be An Egg-head

- Default “photo” on Twitter
- Usually associated with an empty bio screen, too
- When you look like this only your mother will follow you (maybe)
Don’t Expect To See Everything That Happens On Twitter

• Twitter moves fast
• You can’t see everything
• It’s like going in and out of a movie marathon
  • You will miss some of the key scenes but it’s OK
• Use lists
• Use hashtag searches
• Focus your attention on important people and information
Develop Your Network

- Search for people who are interesting to you
- Follow them so you see their content
- Make lists to group those you are following
- Expand your horizons
- Stop following if they annoy you

- Don’t follow everyone
  - Even if they follow you first
- Don’t follow “bots”
  - Report spammers
- Consider following those listed in #FF tweets (Friday follow)
- Consider following those on lists of folks you respect/like
Who to Follow? Just a few to get you started

• @_Pedsubs
• @AmerAcadPeds
• @healthychildren
• @medicalaxioms (Mark Reid, MD)
• @BostonChildrens
• @peds_id_doc (Nick Bennett)
• @DrJenGunter (Jennifer Gunter)
• @MtnMD (Dr. Kelly Sennholz)
• @Doctor_V (Bryan Bartabedian)

• @SCCM
• @MayoClinic
• @NPRHealth
• @davhill (David L. Hill, MD)
• @ChrisCarrollMD
• @NASPGHAN
• @RyanMadanickMD
• @MedEdChat
• @MarkPAAtlas
• @CloseToHomeMD
Be Helpful/Engaged

• Do create content
• Do engage
• Do offer of yourself
• Do reply to @mentions
• Do say thank you
• Share others’ content at least twice as much as you share your own

• Don’t just sit there
• Don’t expect favors
  • But you will get them
• Don’t be mean, cruel, or rude
• Don’t YELL
Tweet Chats/ Twitter Chats

- Do join a tweet chat
- Examples
  - #hscm
  - #hcldr
  - #meded
- Do introduce yourself
- Do contribute
- Do ask questions

- Do not *just* lurk
- Do not pretend to be someone you are not
- Do not be afraid to voice your opinion on the topic
- Do not stray from the topic unless permitted by the moderator

Search for a Tweet Chat at Symplur.com
Common Sense Always Applies

• You NEVER stop being a healthcare provider
• There is no real anonymity
• Professional behavior ALWAYS wise
• Hard to make jokes without seeming rude
  • Context is difficult in 140 characters (¿ Less so in 280)