CoPS Fall Meeting 2013
October 17-18 2013
Sheraton Chicago O'Hare

In attendance: Alice Ackerman, Sue Aucott, Coura Badiane, Jim Bale, Bruce Boston, Debra Boyer, Michael Brook, Carol Carraccio, Nicole Christin, Gary Crouch, Paul Darden, Annabelle de St Maurice, Raye-Ann deRegneir, Bill Dolan, Jean Emans, Hayley Gans, Chris Harris, Bruce Herman, Mel Heyman, Patty Hicks, Pam High, Kim Horii, Lisa Imundo, David Jaffe, Chris Kennedy, Pat Leavey, B Li, Gail McGuinness, Rich Mink, Mary Ottolini, Marilyn Punaro, Michael Somers, Rob Spicer, Maria Trent, Linda Van Marter, Carol Weitzman
Management: Laura Degnon, Amy Schull

To see a detailed list of attendees with which subspecialty and organization they represent, please see Attachment 1

Introductions

Review of CoPS Activities
Dr Mink briefly reviewed the list of the CoPS accomplishments, see Attachment 2

Financial Report
Dr Heyman gave a brief overview of finances. It was noted that the CoPS finances are reviewed by an independent CPA at the end of the fiscal year. He produces a set of complete Financial Statements for the Executive Committee's review/approval. In concert with management, he also submits the required Form 990 to the IRS on behalf of CoPS.

Proposed ByLaws
Ms Degnon reviewed the proposed ByLaws changes to extend the Secretary-Treasurer term from 2 to 3 years. A vote will be required to make this change to the Bylaws, which will be forthcoming to the Council soon via email.

Action Teams
Subspecialty Clinical Training and Certification Initiative (SCTC) final report – Spicer and McGuinness
Rob Spicer

Dr Spicer provided on overview of the SCTC initiative that is now complete. Many people collaborated to put together the priorities and timeline. It was gratifying to see CoPS be a part of this important initiative.

See slides, Attachment 3

Dr McGuinness thanked the leaders of CoPS who have done everything they could to be certain the word got out regarding the SCTC and that CoPS role was so important in the effort. The recommendations are not ones that are going to get a lot of pushback. There were deliberations around many critical issues and the ABP listened carefully.

Some examples of the critical issues debated:

- Should training be shortened

- Should criteria for scholarship requirement be changed/removed
- Should training be 100% clinical

The subspecialties are going to be responsible for defining the things that an individual subspecialist performs. EPAs are one potential framework to do this. This discussion is going on around the world. The ABP is aware that the methodologies are not in place but they are committed to assist program directors in methodology. Dr McGuinness wanted to emphasize that this is not an overnight process.

Flexibility was another recommendation. The ABP has allowed flexibility to develop individual training. They are not asking for specific reporting but are encouraging you to identify individual career paths. It is the Program Director that has the responsibility to report to the ABP; they are not changing that but it should be done in a clinical competency frame.

The ABP asked CoPS how can they get this conversation going within the individual subspecialties.

The presentation was followed by conversation and Q&A from the group. The general consensus was the increased flexibility is very positive. It was also pointed out that this puts the pressure on the Program Director's to know their trainees and individualize the training. There was also some concern that Fellowship and Categorical Program Directors have no idea about this flexibility.

Dr McGuinness addressed the question of what is meant at the ABP regarding competency based training. She indicated that the physician scientist track is the way of the past. The concept about scholarly activity was so that people could bring that to the bed side. When the EPAs group got together, scholarly activity came up. EPAs = clinical professional activities.

Dr Carraccio: scholarship was critically important but was a broad view in that it's critical that every subspecialist be able to read and apply that to patients as well as teach. There was an EPA that was developed around scholarship that is in the common EPA. There is not one that addresses discovery of knowledge. Milestones around discovery are being developed.

Dr Mink reviewed the EPA section of the CoPS website: http://www.pedsubs.org/issues/EPAs.cfm.

Pediatric Educational Excellence Across the Continuum PEEAC Update
Jim Bale

Dr Bale gave an update on the PEEAC meeting. It was a very successful meeting. The next meeting will presumably take place in 2015. It was suggested that CoPS remain a partner.

Fellowship Match
Chris Kennedy

Dr Kennedy gave an update.
See slides, Attachment 4

There are 20 overall subspecialties on the list. The Action Team's approach was to raise awareness of the available process and benefits. Goals were to create a common match process and a common date. All but one subspecialty is now using ERAS.

Another accomplishment is that the subspecialty descriptions are on the CoPS web site, including a list of fellowship match dates that has become a good resource.

The final challenge is common dates.

- Now focus on two match dates – spring/fall (5 in each)
- Other 10 programs have varied dates

The Section on Medical Students, Residents and Fellowship Trainees (SOMSRFT) pointed out that they prefer a later date.

The Action Team asked if CoPS should now push for one match date or are things at a good point? Some potential stumbling blocks are a few grants that have specific guidelines, e.g., CF foundation grants, NIH T32 grants; and adolescent medicine, allergy/immunology and, heme-onc are separate from match dates.

One idea that was brought up is to possibly approach the issue through AMSPDC who could develop a statement of the issues and potential solutions. After some discussion, it was decided that CoPS, APPD and SOMSRFT would submit a joint letter to AMSPDC asking for support for moving all fellowship matches to the fall. Dr Kennedy will write the initial draft. .

Dr Kennedy encouraged everyone to look at the NRMP website, if they haven't done so recently. They have completely redesigned things to be much more user friendly and easier to navigate.

Communication Update
Rich Mink

Dr Mink gave a brief update of the Communications Action Team. It currently consists of three people, but one them, Kim Horii, MD, will no longer be the CoPS representative for dermatology after this meeting so they are looking for a replacement.

See slides, Attachment 5

There was a suggestion to have a regular electronic update (newsletter, eblast) of issues that CoPS is working on, something to highlight a particular subject area. Dr Mink pointed out that additional people are needed to help with content but the focus lately has been more on quick updates every couple of months through the website and listserv.

Some highlights from the presentation:

- 149,802 page views (vs about 100,000 last year)
- Subspecialty description views up 124% this year compared with last year
- Trying to drive views of subspecialty descriptions to medical students – this would be accomplished through a collaboration with the Council on Medical Student Education in Pediatrics (COMSEP)
- IMPORTANT: Need to keep the subspecialty descriptions up to date (verify links, etc) – suggest at least every two years. It was requested that the CoPS representatives ensure their subspecialty description is accurate.

We will also explore obtaining feedback from viewers of the subspecialty descriptions

Fellowship Readiness – final report
Debra Boyer and Mel Heyman
See slides, Attachment 6

Dr Carraccio commented on the self directive learning piece. There needs to be a shared vision of what that means. Other labels to describe self plan learning are independent, autonomous. The problem with most of these labels also implies isolation. Self directed learning should involve mentors and tutors.

Final recommendations:
1. Train competent general pediatricians
2. Research methodology
    - Some exposure to basic principles
    - Principles of use of evidence based medicine
3. Specialty-Specific knowledge is not required/expected – they will learn in the program (but some specialty time is important to confirm interest in field)
    - Adjunctive areas of exposure might be helpful
4. Procedural training: not required, but might be helpful to learn basic procedural proficiency
5. Mentorship essential (career guidance, design of individualized time, etc. – as combined advice from both residency and subspecialty mentors – maybe using CoPS as resource of mentors)
6. Teaching exposure (role as senior, teacher)
    - Faculty development is critical
7. Leadership – supplementary supervisory rotations
8. Self-directed learning (difficult; teach learning skills)
9. Other: longitudinal clinic experiences; training in consultative process; volume --- increase exposure/care of sick patients!!

- One size will not fit all
- Recommendations cannot be prescriptive
- CoPS and APPD can play critical role

Dr Hicks recommended putting the PowerPoint slides on the "what's new" scrolling on the home page of APPD for additional visibility and to help communicate with the categorical PDs. The Action Team will send a draft of the report to the CoPS Executive Committee and the APPD Board for comments. Once the comments are compiled, it should be sent to the CoPS Executive Committee for acceptance.

To complete the project, the group needs assistance with the statistics. Dr Mink will secure statistical help.

FOPO Initiative report
Patrick Leavey

Dr Leavey reported on the activities of the FOPO Visioning Summit. Four workgroups were formed to cover different subjects, although there was some overlap. It was a very well thought out, pre-planned endeavor. All the workgroups' work and ideas were compiled into a list of 5 Megatrends:

1. Aligning Training To The Emerging Needs Of Children & Families
2. Uncertain Future Of Support For Training & Research
3. The Continuing Drive Toward Mastery Within the Profession
4. Aligning and Optimizing Pediatrics to a Changing Health Care Delivery System

5. The Changing Nature of the Pediatric Workforce

See slides, Attachment 7

There were others that participated that also shared their thoughts. Overall the results were very positive – it was well-designed but it was a LOT to cover in a limited amount of time. What's going to matter are next steps and whether or not anything is done with all of the ideas raised.

Legislative affairs Update
Chris Harris

See Slides, Attachment 8

- Oct 1 enrollment for ACA began
- Pediatric specialty loan repayment program in place
- CoPS signed letter in January thanking the White House for loan repayment; followed in June with Senate letter
- Budget still pending (Senate okay, House no action)
- Letter regarding gun control in response to Newtown, CT massacre
- FDA Safety and Innovation Act (FDASIA) of 2012 to provide FDA authority to act on drug shortages
- Working with AAP Dept of Federal Affairs to keep abreast of pertinent issues

Social Media Report
Alice Ackerman

See Slides, Attachment 9

Dr Ackerman reviewed with the group the charge of the Social Media Action Team: to determine if CoPS should be involved in social media? (With the focus on medical students and residents in initial charge.) If so, which platforms and at what cost (not just financial but time, as well)?

Overall recommendations:

- CoPS should be involved
- Focus on Twitter and a blog
- Once established, can be maintained with approximately 20-30 minutes/day
  Repurpose current content on the web

Dr Ackerman addressed the issue of resources and pointed out, it's going to take someone that has a real passion for it, realistically, it would probably need 2 or 3 people working jointly to successfully manage the project.

The next step is to decide if CoPS wants to be involved in Social Media, and if so:

- What message(s) do we want to send/communicate?
- Whom should we focus on: med studs, residents, fellows, lay public, adult subspecialists
- Specific goals: how define success, failure?

- Content sources – who will do this? (The key is we will need someone that is willing to participate)

Dr Mink thanked Dr Ackerman and her Action Team for their work. The CoPS Executive Committee will review the material and make a decision as to the next step.

Fellowship Start Date
Rich Mink and Jim Bale

Drs Mink and Bale indicated group members have now been identified and formally agreed to participate. The group will begin meeting on a regular basis and things should begin to move forward.

Other Updates
Transfer of Leadership
Dr Mink informed the representatives that CoPS is formalizing when officers transition into/out of their positions. The new chair will assume his/her role after PAS in the spring.

Presentation at AMSPDC workforce session
This was an invited presentation that Dr Mink gave during the last PAS meeting.

See Slides, Attachment 10

Dr Mink highlighted that some subspecialties have more openings than applicants and vice versa.

Strategic Plan Discussion: where things stand currently and looking at the potential need for revision
Rich Mink

Dr Mink asked the group for feedback with the direction that CoPS is taking. Should the Strategic Plan be revised by just a little tweaking? Does it need to be revamped? Scratched and started fresh?

GOALS:
1. Network of Subspecialty Organizations
2. Source of Expertise
3. Workforce Development Focus
4. Sustainability and Strength of CoPS

Sustainability and strength of CoPS
Who do we need to connect? Who do we serve? In what areas can we improve?
Groups all have choices on where to spend their money and things get tighter and tighter. Being able to provide value is of utmost importance.

Workforce Development Focus
It was mentioned that it's important to make sure all relevant people know about CoPS. We need an abbreviated version of the minutes, a PR piece that is shorter than what is currently circulated.

This was followed by a brief discussion on whether a warehouse/resource center is still a relevant goal. Sometimes there are leadership courses that are hard for people to find. Would it be a good resource to have them all in one place to connect all of the organizations. Would that be of value? The consensus was "perhaps", and that it could possibly even help the perception of "return on investment" for some of the organizations.

Dr High brought up the issue that there were a few things that are related to her subspecialty that are missing in the document. Just merely getting funding is an issue and that is not an isolated issue. Instead of looking at the match statistics regarding number of positions available vs the number filled…What about the children – what kind of specialists do they need? The funding and positions should come from the where the need originates, not the other way around.

Summarizing the discussion, some of the potential projects that CoPS could pursue include a conference center, a method to provide career guidance to trainees and a fellowship PD white paper.

ACGME NAS
Leih-Lai and Fischer
See Slides, Attachment 11

Ten Year Self-Study Visit
It's important to remember, you should still do the annual program evaluation in preparation.

What is a focused site Visit?
It assesses selected aspects of a program. There is a 30 day minimum notification.

MOC
Virginia Moyer
See Slides, Attachment 12

Certification is the duty of the ABP as a "service to the public."

MOC Part II
The ABP will be rolling out a "Question of the Week" in January. People have to sign up for it, it won't be automatic. Once the question is answered, it will immediately show the results of how everyone else has answered. Then there will be additional information, articles, etc., and a second opportunity to answer the question – the second time is the one that counts. If all 50 questions are answered during the year, 20 MOC points will be awarded.

There is no charge for activities in Part II that are developed at the ABP (and one often gets CME with the activity, as well).

MOC Part IV

The ABP has chosen to use a Quality Improvement approach as opposed to a standards approach.

Important note that many don't realize, if you do a project, you can get credit for either doing the project OR publishing it – not both.

Dr Moyer also discussed the current list of PIMS and ones that are in development. They expect that the Medication adherence PIM will be popular.

The ABP wants to encourage institutions to become Pediatric Portfolios – the fee is the same ($500). Once an institution is an approved Portfolio, it can approve any number of projects within the institution (rather than paying $500/project). Chief QI officers can sponsor projects and may involve multiple specialties (Multi-specialty portfolio sponsor). All QI projects need to be approved by an institutional QI officer or by the ABP (this is an advantage of the multispecialty portfolio model). In order to apply, an institution must have 3 projects to show they have the history/knowledge to approve and manage the project. There is an application on the website that is hard to find. The ABP is happy to help walk you through it.

Workplace QI projects have been rising but the ABP would like them to be the majority of the projects. You don't have to show improvement to get credit – just that you tried. And you may actually learn more from one that doesn't. QIPA: Quality Improvement Project Approval Programs are becoming more popular. Everyone is required to do QI projects, so ABP is giving credit to all involved in same project.

Why does this cost so much?
Fees from exams and MOC must cover all core ABP operations:

Exam development, production and administration
50 exams – more than any other Board
Staff

The entire staff at ABP did a training program this year. Over 80 people at each session where they learned about QI projects. Everyone had to do the same thing that they are asking you to do so they are well equipped to answer questions. If you do have projects that you think qualify – call the ABP, that's your best bet.

Future of Part IV

- Multi-Specialty Portfolio programs are where we need to be pushing the hardest.
- Access to activities from other Boards through the HUB
- Leadership points (for leading others thru QI projects)
- (already get leadership credits for leading a QI project)

MOC going forward

- Approved successful single site and multisite QI
- Redesign Part II

- Continue to elevate Part III
- Add patient focused feedback
- Add system focused activities (teamwork survey)
- MOC credit during residency, residents and fellows can get credit for Part IV MOC. They can bank those credits until their first exam.
- Continue to assess and improve the process

Virginia Moyer is available by phone, please feel free to contact her with any questions.

Q&A

The presentation was followed by a period of questions and answers.

Dr Moyer clarified that leading a QI project already provides points to the leader. The Leadership points referred to earlier are meant for the person ensuring that the whole hospital is engaged. If you lead a project for your fellows, you do already get credit.

It was brought up that ABMS had sent out an email asking for comment. Dr Moyer explained there is a public comment period for ABMS. Please look at the comments if you get an email because we will have to live by those when they are finalized.

Dr Moyer explained that no matter how many certifications someone may have, they only have one MOC schedule. Because of this, fellows get credit for their subspecialties as it all counts toward their MOC. She gave an example of someone who has 4 certifications, 1 general and 3 subspecialties, but only has one MOC schedule.

Dr Moyer addressed the issue of QI projects that are repeated. She clarified that it is acceptable to now get repeat credit if a person is meaningfully involved and the project continues to evolve. However, the ABP does not offer repeat credit for PIMs, although they are going to open up several of the PIMS to people that have already done them to get a second set of data to analyze.

Dr Hicks briefly reviewed the Motivational Interviewing PIM that is being developed. It is a technique that is used to encourage change in the patient and family. The technique is a set of deliberate questions followed by listening for barriers to adherence and/or change. PIM offers part IV and II credits.

Dr Kennedy shared that his hospital is a portfolio sponsor and it has been a great experience. They have more people than ever involved. It's been a very effective strategy – they've also included their nursing department. People seem to be living it and he encourages others to look into becoming one.

It was suggested that a FAQ about other ways to meet Part IV requirements would be helpful. Dr Mink will work with Dr Moyer to develop these. Dr Moyer responded she's happy to provide any answers to any questions.

EPA presentation
Carol Carraccio
See Slides, Attachment 13 (this is also available to watch on the CoPS website at http://www.pedsubs.org/video/carolpresentation.cfm)

Standardizing the Language
- Domain of competence: pt care, professionalism

Competency
- Complex task that involves knowledge, skills, attitudes
- Addresses the actual activities to do something
  - Gather essential and accurate information
  - Perform a complete and accurate PE
  - Develop and carry out management plans

Milestones:
- Markers or performance levels along a developmental continuum for each competency (novice to master in pediatrics)
- What behaviors does a novice demonstrate when gathering essential and accurate information?
- What behaviors does an advanced beginner demonstrate

Why do we need EPAs?
- Have Domains of Competence, Competencies, and Milestones
- EPAs makes assessment practical and meaningful
- Competencies are context independent (does not give information about patient on which info is being collected)
- Entrustment implies competence but uses a lens of supervision that is a more intuitive framework for clinicians

Competency focuses on the ability of the individual, whereas, EPA focuses on the essential tasks of the profession. Embedded in a clinical context making assessment meaningful.

EPAs may be the basis to provide evidence to request change in the number of years required for training.

EPA worksheet
- Mapping (judiciously) to domains of competence
  - Need to consider what competency(ies) are critically important to carry out EPA
  - List KSA that are needed to execute the EPA

Accomplishments to date:
- Chose EPAs from generalist list that cross generalist/specialist role
- Identified and mapped common subspecialty EPAs

Work in Progress
- Finalizing drafts of subspecialty-specific EPAs

Next steps:

- Vetting
- Mapping

The ABP hopes that as this evolves, what will have to be reported will not be a huge amount of material. The subset will hopefully be what is reported. There are concerns dealing with ACGME, the Board doesn't have a receptor piece for what they're collecting right now.

Subspecialties should go ahead and start thinking about mapping, although it will most likely just be word-smithing. There may be some feedback will involve more changes to a particular EPA but don't anticipate that it will affect the majority of them.

CoPS is hosting its first webinar on October 30, at 12:00noon EASTERN. Carol Carraccio will be leading. Joe Gilhooly will be participating, as well. Questions can be submitted ahead of time. We're anticipating that there will also be questions around the Milestones. Would this format meet the community needs? This is CoPS First segue into this medium.

ACTION: email announcement for the EPA/Milestones webinar to go out October 21.

One suggestion was to put together a fact sheet or some sort of converted classroom sheet that would highlight the basics.

Cost of Pediatric Subspecialty Certifying Examination
B. Li

Dr Li, representing NASPGHAN, gave a presentation on the costs of the Pediatric Subspecialty Certifying Exams and how it can be a burden.

See Slides, Attachment 14

NASPGHAN's final thoughts/suggestions:

- Share concerns with and seek support from CoPS
- Ask the ABP to reduce cost of boards or disperse to later stage
- Educate fellows regarding costs
- Help fellows negotiate with future employers
- Unlikely current training programs will be able to afford to take on additional costs

Dr McGuinness shared that the costs to develop a test are the same regardless of how many people are taking it. It costs over $2,000/question. The Board subsidizes the costs, so each exam costs the same per person regardless of the subspecialty (if they charged per the number of participants, some subspeciatlies would be much more affordable and conversely, some would be exorbitant). Another factor is the type of exam for MOC should be very different. If they could use it as the same, the cost would be considerably less but they feel it should not be the same. Those monies come from the

strategic reserves. It's from those reserves that they have some income they are able to utilize for the good of pediatrics. If they didn't have those, they couldn't do those things, like MOC. They are trying to identify collaborative opportunities, as well as things that cross over.

Dr McGuinness addressed the possibility of not having to pay it all upfront but deferring some of it. She wasn't sure if that is feasible but something to consider.

Dr Kennedy suggested having a brief video available highlighting the things that Dr McGuinness shared.

End of Meeting Suggestions:

- Distribute minutes
  - Executive Summary might be helpful, something that boils things down into a much briefer, more quickly accessible promotional/educational piece.
- Check that AAP Sections and subspecialty organizations have link to CoPS website
- PAS meeting (2 hours on Sunday morning)