CoPS Fall Council Meeting  
October 2-3, 2014  
Embassy Suites, Rosemont, IL

Thursday, October 2, 2014: 8am – 4:30pm

In attendance: Drs. Rob Spicer, Chris Kennedy, Alice Ackerman, Gail McGuinness, Christopher Harris, Meridith Bone, Gary Crouch, Ildy Katona, Debra Boyer, Franklin Trimm, Paul Darden, Diane Stafford, Amy Wilson, Teresa Wright, Marcus Renno, Mary Ottolini, Pam High, Michael Somers, Kristina Bryant, Michael Brook, Lisa Imundo, Marilyn Punaro, Bruce Herman, Angie Myers, Linda Van Marter, Kara Shah, Jean Emans, Christianne Dammann, Mark Atlas, Dena Hofkosh, Patrick Leavey, Rich Mink, Mel Heyman  
Management: Ms Laura Degnon and Ms Amy Schull

Welcome and Introductions
Dr. Spicer opened the meeting at 8:05 with brief introductions

Introductions finished ahead of schedule so Dr. Spicer thought it would be interesting to have a few of the people that have been involved with CoPS reflect on the origins and past activities.

Dr. Mink spoke about the paper “The five years of CoPS”. It was noted that without the support of APPD, AMSPDC and ABP, CoPS wouldn’t exist. All three organizations were instrumental in the founding of CoPS.

Update on CoPS Exec Cmte July 2014 mtg
See Attachment 1  
Dr Spicer transitioned to reviewing his slides for the Executive Committee meeting from July and the “review of activities”.

Financial Report
See attachment 2  
Dr. Leavey talked about the organization being a small one with very limited funds so we have to be very cognizant with regards to our resources and how many activities we take on each year.

The meeting registration from the fall meeting was increased from $225 to $275. With further consideration, we’ve agreed to raise the dues for subspecialty orgs from $500 to $750 beginning July 1, 2015. It was noted that CoPS has increased activities that the organization has been involved, webinars, etc so there is tremendous value for the dues. It was shared that the CoPS website has valuable information on it that can’t be found elsewhere.

Action Team/Other Reports
See attachment 3  
Fellowship Start Date Recommendations
The group was given a handout with the Action Team’s recommendations and Dr Mink reviewed his slides with the data.

**Recommendation #1:** Beginning with the 2017 appointment year, Pediatric Subspecialty Fellowships should start no earlier than July 7

**Recommendation #2:** Orientation shouldn’t start before July 5

**Recommendation #3:** Implementation should involve an aggressive educational campaign aimed at fellowship program directors to make them more aware of the problem and to clearly communicate the desires of the trainees.

Dr Mink then opened up the room for discussion.

The first point that was brought up is that the Fellowship PD’s don’t see this as a problem and educating them is going to important.

It was mentioned that the Insurance/COBRA issue is not an insignificant issue. A lot of residents are moving with families and this may create a gap. Dr Mink indicated it is a federal law that COBRA must be offered and is a possible, easily accessible solution.

It was noted that this may not be that different than when trying to get people to transition to ERAS. It was suggested that talking points be created by CoPS to help people communicate why this is important. The residents really want this delay. They (the residents) communicated this in an open-ended question in the survey.

*Topic for Friday: Although there will be challenges with implementation would you be in favor of moving the date of the ABP Gen Peds Certifying Exam to July if the exam was administered before the start of the fellowship training?*

**Legislative Affairs**
Dr. Harris gave an update on Legislative Affairs

The Loan repayment program has still not been appropriated and funded. It was in the 2014 budget but currently is not in the President’s 2015 budget. Hopefully one day, the $5 million we hope to see will be funded by the legislative branch, it would provide 64, 2-year fellowships.

Another issue is the Medicaid to medicare bump. It was a very difficult rollout. The states were very slow in getting the program out. The goal was to increase access to children. One of the big problems was the government wanted/expected to see the effects at the same time the states were having a hard time rolling things out. There is no guarantee this will be authorized in 2015.

There was a brief discussion regarding the residency match this year and that the number of people entering is up. There is an increased number of medical grads not obtaining positions. Gail McGuinness mentioned the IOM report addresses this.

**ACTION:** Ms. Degnon to post/share with the group the 5-page summary of the IOM report.

**Communications**
See attachment 4
Dr Mink reviewed his slides including a handout with subspecialty description web page visits. SOMSRFT offered to promote the subspecialty descriptions in their newsletter.

The Communications Action Team needs more involvement. Dr. Van Marter has volunteered to help but will need additional help, as well. The Action Team re-organized the website last year, at this point, help is needed to keep everything updated.

**ACTION:** Management should send out Subspecialty descriptions with the dues renewals/reminders in the future.

**ACTION:** Management to put subspecialty descriptions form online for members to access.

**ACTION:** Management to investigate getting unique users for the web stats report.

Dr. Marcus Renno from SOMSRFT told the group that each year at the AAP’s NCE, there is a “speed dating” session with all the subspecialties for Med Students. He estimated that approx 1000 people attend. He asked if there is some way to have CoPS involved and/or additional information for all the subspecialties available?

**ACTION:** Dr. Renno to investigate this further and get back to Dr. Spicer.

**Fellowship Readiness**
(See attachment 5)
Dr. Debra Boyer discussed that CoPS is trying to put together a resource for people researching particular subspecialties; a place where they can go to get answers from actual people. Below is what would be included:

- List of career advisors for each subspecialty - this is not a mentoring position, it’s a brief “advising” for people curious about specific subspecialties to get answers.
- List of suggested rotations for residents entering each subspecialty.

Dr Boyer asked if there were any concerns and if the representatives were willing to go back to their organizations to identify people for this role. It was suggested that “advisor” be changed to “resource” and the guidelines should be included so people really understand what they are committing to – it’s too easy to say “no” because they think it’s too big of a commitment. In other words, it’s important to make sure the “ask” is correct/accurate.

**ACTION:** With Dr. Boyer’s help, management to send out to everyone the request for career advisors and rotations for residents.

**Fellowship Match**
See attachment 6
Dr. Chris Kennedy presented slides from the Fellowship Match Action Team.

Dr Kennedy presented the data from the survey the action team did in conjunction with SOMSRFT.

What are the challenges remaining for one match date?

- Discuss with constituencies to understand the remaining issues for spring match?
  - GI, Cardiology and Heme/Onc
- What is the best way to engage in discussion or provide help?
• Should CoPS attempt to focus a survey to these groups of trainees? Consider the SITE exams?
• Should we seek to pursue subs with stand alone matches?

Dr Leavey voiced his observations from the Heme/Onc perspective – there is a sense that we’re training more physicians than needed. Heme/Onc numbers have more than doubled. Some of the large programs will drive how we see things; if they can’t “play” it’s going to shape how the rest think about it. He suggested that ASPHO will look at this again and do their due diligence but these are some of the concerns that will be raised.

AMSPDC hasn’t been engaged in this conversation but there are several other issues they are focusing on. Dr Ackerman’s impression is that this issue will most likely be deferred to the PD’s, but she will bring this up again at the Spring AMSPDC meeting.

Endocrinology shared that they we were surprised once we presented the PD’s with the “it’s not about us, it’s about them” which makes it a much easier issue to tackle.

**ACTION:** Dr Kennedy has created a historical document on the Fellowship Match that he will share.

**PEEAC Meeting**

See attachment 7

Dr Spicer reviewed the overall purpose of the PEEAC meeting – collaboration of 4 organizations (APPD, COMSEP, CoPS and APA). He reviewed the objectives of the meeting.

Dr Spicer asked Drs. Mary Ottolini and Dena Hofkosh to weigh in on their experiences as being part of the planning committees in the past. Dr Ottolini has been involved in all three meetings and thinks the opportunity for collaboration across the continuum is huge. Dr Hofkosh thinks it’s a wonderful opportunity for education, and APPD is interested continuing it. Those involved in the planning have told us it’s a very complex process. It was noted that we’re a little behind in the planning process so if we’re going to do this, we really need to move quickly. It was noted that people should share ideas for workshops.

Someone asked if PEEAC could it be a standalone meeting that was more centrally located? It was shared that the dates for 2015 are set and will be in conjunction with the APPD meeting but going forward this is something that can/will be explored.

Dr Spicer asked for volunteers for the planning committee for the 2015 meeting.
The Fellowship Program Directors group committed to helping (Drs. Bruce Herman and Angie Myers) and Dr. Mel Heyman said he would help, as well.

**Journal affiliation**

See attachment 8

Dr. Spicer noted that CoPS was approached by *Pediatrics* and we were asked to consider having a regular publication in their journal. It was shared that the fact we were approached illustrates how important an organization CoPS has become and validates the great work we do. He told the group the first opening to be included in the journal will be Feb/March 2015 and the project needs a leader. It was agreed that this “Notes from CoPS” could be a lot of work so the commitment shouldn’t be more than twice a year.
Dr Mink volunteered to be the author of the first paper as he thought this would be a good opportunity to talk about the start date.

Another topic idea that was mentioned was workforce issues.

Dr Mink pointed out that the action team doesn’t need to be very big – they aren’t necessarily the ones who will do the writing, they can simply facilitate the topics. Dr Mink suggested that he and Dr. Boyer could facilitate the topics.

**ACGME**
See attachment 9
Dr Spicer introduced Dr Eric Holmboe; who then went through his powerpoint presentation.

Dr Holmboe opened up the room for questions when he finished his presentation.
Q: Where does the patient family decision making model fit in with this?
A: There are public members on the ACGME Board now. There has been a fair amount of work with the competencies and work will continue with those. In faculty development, how do you do that in a patient centered way? That is a big thread in the CLER visits.

Q: With more and more prescribing rules – is there a sense that we don’t have to do “this or that” any more because they aren’t outlined and the outcome-based things are finished being outlined?
A: We are trying to look at data to create a composite that would signal a concern.

Dr McGuinness mentioned she sits on the ACGME RC as an ex-oficio. In these early stages, there are a lot of triggers for them to look at programs with depth. They are also relying on residents in their surveys to help identify things.

Q: Based on a book on brain research, in the current situation, we are focusing our attention too much/long – we need time to daydream, take breaks to “reset” the brain. How can we help make simple solutions to make it more manageable rather than create an even more complex solution?
A: Based on research, there is good evidence that you can only go full-on for about 5 hours then you need a break. We don’t create enough space for that. We’re talking to the AMA. What does the environment look like around fatigue? The Council of Residents is taking this issue forward and focusing on well-being.

**ABP Update**
**Update on the Time Limited Eligibility Policy**
See attachment 10

Dr. McGuiness shared that the ABP is trying to consider how to deal with the needs of the 14 different subspecialties – is every one so different we have to separate requirements? Can we lump them all together? If not, can we cluster some of the subspecialties together into “like” groups? This is not to help people **pass** the Boards, it’s simply to ensure they are eligible to **sit** for the boards. If our goal is to assess if they are competent to sit for the exam, we can probably do that in a relatively quick time. It doesn’t take long to see if someone is competent. In the ideal world you develop the idea of what makes a successful clinical physician – what experiences do you need to see over what period of time to know that someone is competent?

One concern was raised regarding the legal ramifications of saying someone is “competent” even though they have not passed or may have failed the Boards making them eligible to see patients.
Moving onto Mental Health Crisis
See attachment 11
Dr. David Nichols has a blog where he recently posted two entries about mental health. There have been many interesting comments on that blog as follow up.

Dr Trimm shared why the non-prescriptive method is useful – there are 10 cycles. If we knew what we had to do with each of the 36 months, we wouldn’t be able to innovate and/or address individual crises that come up that allow some flexibility.

Friday, October 3, 2014: 8am – 12:00pm

Welcome; Recap of Day 1
Dr. Spicer indicated that he was excited about all the new faces and how engaged everyone was yesterday. The energy level in the room was high; noting that CoPS had an incredibly productive year.

ABP Update Continued
See attachment 12
Not originally on the agenda, but Dr Spicer asked Dr. Gail McGuinness to give a presentation on MOC.
Of note is Slide 10 - Part 2 MOC: part 4 points are awarded (general academics don’t count); and the clock doesn’t start ticking until the individual is certified. If the individual engages in activity before they are certified, it’s going to into the “bank” which the person can then get credit for once certified.

APPD Fellowship Directors Exec Cmte
Dr Myers summarized some of the projects that they’ve been working on:
The group has helped CoPS to move EPAs forward.
They’ve tried to help clarify the cooperative goals of APPD and CoPS.
They developed a survey around FTEs for FPDs that had a low response rate so they are redesigning it to get to Department chairs as well and are hoping to develop some sort of mandate to ensure adequate time is protected for FPDs. Dr Herman added that the group’s goal is to get hard data; they want to increase categorical PD’s networking back to the fellowship PD’s.

Dr Trimm responded that timing is vital. There are several layers of ACGME accreditation requirements. There are Common Program Requirements (CPR) that apply to all training programs in all disciplines. The current CPR include duty hour rules, patient safety, learning environment and NAS requirements. For Pediatrics specifically, there is a set of Common Pediatric Subspecialty Requirements that are in addition to the CPRs. This is the target for addressing required support for Fellowship Program Director support. Requirements in this set would apply to all pediatric fellowships. Beyond these two layers of requirements, there are discipline specific related to each subspecialty. The Common Pediatric Subspecialty Requirements and discipline-specific requirements are due for an update. The process to develop these updates will likely be established within the next year by the Pediatric RC. Therefore, data collection about FPD needed support and organizing the results into a formal request is timely, and should move forward rapidly.

Dr Ackerman shared that from the Chairs perspective, the financial issue is a big one. There are things that take up faculty time for which there is no funding, so it would be great to come to AMSPDC with recommendations that also have the dollar mechanism of how they can be supported.
Dr Herman clarified that they don’t want this to become a mandate where things are eliminated, they agree the financial component is an important one. Perhaps they could develop metrics. It will be important to show that there is more value than just RVUs.

APPD LEARN / EPA Project
See attachment13 (APPD LEARN) and 14 (EPA Project)
PMAC: Pediatric Milestones Assessment Collaborative is a collaborative project with the National Board of Medical Examiners (NBME), APPD and the ABP to validate tools for learner assessment. There are a number of workgroups that are functioning. One is learning about how we determine when residents are able to work without supervision at the point of care.

The group then discussed this project on a broader scale, it was agreed that it would be beneficial to reach out to the FPDs and get them involved. There was some concern about how this would continue to move forward with CoPS, if it continues to build. How would CoPS continue to administratively support it? This should be discussed further on the EC level, how would proposals be entertained for additional funding?

ACTION: The EC to further discuss CoPS role in research projects given the required resources.

Introduction of Goals for the Year
See attachment15
Strategic Plan
Dr Spicer reviewed CoPS goals from the Strategic Plan:
1. Network of Subspecialties – our goal is to recognize CoPS as an effective and efficient pediatric subspecialty network for communications and issues development.
Dr Spicer briefly went through line by line the first goal and highlighted the many areas that CoPS has made progress.

2. Source of Expertise – position CoPS as a resource for sharing and developing expertise among pediatric subspecialties
Dr Spicer acknowledged that CoPS has continued to take on more than one important issue each year. With limited resources (people and money), we have to be cognizant of what and how much we take on.

3. Workforce Development – Focus on issues of workforce development, curriculum and job satisfaction
The ABP has data on how many people are entering the pipeline, compared over time, some subspecialties have doubled, some have remained flat, and some have dipped. There is also the issue of what’s needed where (geographically). To get at what is needed and where is not an easy task. There will be additional information as people enroll in MOC. It was noted that this takes all organizations to their mission: to make healthcare accessible and available to all patients. How can we use workforce to think about the goals of training?

4. Sustainable CoPS Organization – Create and maintain an effective Council with sustainable resources and leadership

The CoPS 2014-2015 Goals are as follows:

• Establish common match date
• Work on fellowship start date and fellowship readiness
• Collaborate, coordinate and begin EPA research project
• Develop, Incorporate, and Link EPA’s
• Create & disseminate Milestones educational resources
• Address Fellowship funding issue
• Webinar/s on topics of interest
• Development of MOC FAQ’s with ABP

MOC and CLER visits
AMSPDC Educational Committee is exploring MOC with interest and activity. Not sure there will be a specific ask of CoPS other than transfer of information.

Is this important enough that this is something that CoPS needs to be positioned to take on? If one program has developed a plan that works, CoPS is a good way to connect the other programs. It would help people at the institutional level to provide appropriate and accurate communications.

Next CoPS Meeting
The next CoPS meeting will take place during PAS; more details to follow.

Everyone thanked Dr. Spicer for running an excellent meeting.

The meeting adjourned.
WELCOME!

Who are you?
Are you new to CoPS?
Where do you work? What is your position there?
What CoPS member organization do you represent?
What are your organization’s expectations for your membership in CoPS?

2013-14 Accomplishments

• Subspecialty Clinical Training and Certification Initiative
  Published in Pediatrics May 2014
  ABP acknowledged the “essential partnership with CoPS”
• Pediatric Educational Excellence Across the Continuum, October 2013
  Partnership with APA, APPD, COMSEP, and CoPS
• Webinars
  “Understanding EPA’s” October 2013
  “CCC’s & Milestones” February 2014
  Partnering with representatives from ABP and ACGME
2013-14 Accomplishments

- **The Unification Process aka: Common Match Date**
  - survey data collection
  - partnership with SOMSRFT and APPD

- **The Preparation Process aka: Fellowship Readiness**
  - survey data collection
  - partnership with APPD
  - poster presentations @ APPD and @ PAS

- **The Matriculation Process aka: Fellowship Start Date**
  - partnership with the entire GME community

2013-14 Accomplishments

- **Website growth & development**
  - subspecialty descriptions
  - reorganization and additional information
  - informational resource for Milestones and EPA’s

- **EPA educational research project**
  - partnership with ABP, APPD fellowship committee and APPD LEARN
  - the beginnings of a research network
2013-14 Accomplishments

• **CoPS is now a sustainable organization**
  support from sustaining organizations
  (ABP, AMSPDC, APPD)
  and contributing organizations
  (APA, APS, SPR)
• **Governance structure ensures organizational memory**
  election and transition of E.C. members
• **A productive and valuable year**

2014 Executive Committee
July 9 & 10, Chicago

• **New EC member Boot Camp** including the remarkable
  origins and growth of Degnon Associates
• **Financials**
  management fees
  cost of CoPS meeting at PAS
  deficit planning nixed and reg. fee increase to $275
  retention of sustaining, supporting and contributing
  organizations
2014 Executive Committee  
July 9 & 10, Chicago

- CBME and CoPS role in education/dissemination of info.
- Action Team Reports & Updates
- Potential Projects
  - Fellowship Funding
  - Fellowship P.D. Job Descriptions and Support
  - M.O.C.
  - Journal of Pediatrics
- New Members/invited guests
  - Surgicals, Anesthesia, COMSEP, SOMSRFT

2014 Executive Committee  
July 9 & 10, Chicago

- Annual Meeting Planning
  - Agenda
  - Goals & Objectives
  - Strategic Plan revision
  - Engage Council membership
    - What are our most important issues?
    - What do we want to accomplish?
    - What are the limitations and constraints?
    - Open forum, small groups, breakout
2014 Executive Committee
July 9 & 10, Chicago

- **Reflections**
  
  Legacy of Vicky, Jim, and Rich and others is huge
  Strength going forward
  Enthuse and empower Council members
  Don’t lose sight of our mission (the two C’s)
  Don’t take on too much
  Continue to strengthen our partnerships
  Laura and her team are an invaluable asset
  Have a great fall meeting
## Council of Pediatric Subspecialties (CoPS) 2014-15 Budget ~ Income

<table>
<thead>
<tr>
<th>Dues</th>
<th>Per Member Organization ($)</th>
<th>Total ($)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Sustaining Member</strong></td>
<td>10,000</td>
<td>40,000</td>
</tr>
<tr>
<td><strong>Contributing Member</strong></td>
<td>2,500</td>
<td>10,000</td>
</tr>
<tr>
<td><strong>Regular Dues</strong></td>
<td>500</td>
<td>17,500</td>
</tr>
<tr>
<td><strong>TOTAL Dues</strong></td>
<td></td>
<td><strong>67,500</strong></td>
</tr>
<tr>
<td>Annual Meeting Registration</td>
<td></td>
<td>7,150</td>
</tr>
<tr>
<td>PEEAC profit share</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Interest</td>
<td>100</td>
<td></td>
</tr>
<tr>
<td><strong>TOTAL income</strong></td>
<td></td>
<td><strong>74,750</strong></td>
</tr>
</tbody>
</table>
### Council of Pediatric Subspecialties (CoPS)
#### 2014-15 Budget ~ Expenses

<table>
<thead>
<tr>
<th>Administrative</th>
<th>Total ($)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Management Fees</td>
<td>32,000</td>
</tr>
<tr>
<td>• Rent</td>
<td>4,000</td>
</tr>
<tr>
<td>• Insurance</td>
<td>1,200</td>
</tr>
<tr>
<td>• Filing / Legal fees</td>
<td>210</td>
</tr>
<tr>
<td>• Accounting services</td>
<td>3,630</td>
</tr>
<tr>
<td>Operating Expenses</td>
<td></td>
</tr>
<tr>
<td>• Printing / Postage / Design</td>
<td>700</td>
</tr>
<tr>
<td>• Phone / Fax / Email</td>
<td>1,500</td>
</tr>
<tr>
<td>• Supplies / Plaques</td>
<td>850</td>
</tr>
<tr>
<td>Web page / IT</td>
<td>12,000</td>
</tr>
<tr>
<td>PAS meeting</td>
<td>3,000</td>
</tr>
<tr>
<td>Annual meeting</td>
<td>11,000</td>
</tr>
<tr>
<td>Liaison to other organizations</td>
<td>1,500</td>
</tr>
<tr>
<td>Exec committee meeting</td>
<td>5,000</td>
</tr>
<tr>
<td><strong>Total Expense</strong></td>
<td>76,590</td>
</tr>
<tr>
<td><strong>Net Income</strong></td>
<td>(1,840)</td>
</tr>
</tbody>
</table>

**Overall financial status:**

- June 30, 2013 net assets: $22,785
- June 30, 2014 net assets: $28,404

**Independent CPA reviewed our finances**

**Form 990 soon being submitted to IRS (501c3 requirement)**
Issues/Questions?
Fellowship Start Date

Charge

• to examine the current start date for fellowship training and to make specific recommendations as to how this transition could be improved
• propose a strategy to accomplish this
• submit recommendations by October 2014
Members

• PD and FPD representatives from surgery, IM & pediatrics, & DIOs
  – Council of Pediatric Subspecialties
    • James Bale, Jr., MD, Co-Chair
    • Richard Mink, MD, MACM, Co-Chair
  – Association of Pediatric Program Directors
    • Grace L. Caputo, MD, MPH
    • (alternate Dena Hofkosh, MD, MEd)
  – Association of Program Directors in Internal Medicine
    • Ethan D. Fried, MD
  – Association of Specialty Professors
    • Elaine Muchmore, MD

Members

• PD and FPD representatives from surgery, IM & pediatrics, & DIOs
  – Association of Program Directors in Surgery
    • Daniel Vargo, MD
  – Fellowship Council (Surgery)
    • Aurora Pryor, MD
  – Designated Institutional Officials
    • Khanh-Van Le-Bucklin, MD
    • Julia McMillian, MD
Action Plan

• Monthly calls
• Surgery and IM conducted surveys
• Surgery announcement in February
  – moving start date to August 1
  – moving General Surgery qualifying (written) exam to July
• Internal Medicine still deciding what to do
• Focused on Pediatrics

Pediatrics Fellowship Start Date

• Conducted two surveys
  – Graduating pediatric residents entering fellowship
    • 439 residents
  – Fellowship Program Directors
    • 495 FPDs
When do you expect to complete your residency training?
(3rd year residents entering fellowship)

<table>
<thead>
<tr>
<th>Date</th>
<th>Number of Respondents</th>
</tr>
</thead>
<tbody>
<tr>
<td>June 30</td>
<td>450</td>
</tr>
<tr>
<td>July 7</td>
<td>0.7%</td>
</tr>
<tr>
<td>July 15</td>
<td>0%</td>
</tr>
<tr>
<td>July 31</td>
<td>2.5%</td>
</tr>
</tbody>
</table>

Will it be necessary for you to move to a new place of residence in another city for your fellowship?

<table>
<thead>
<tr>
<th>Answer</th>
<th>Number of Respondents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>300</td>
</tr>
<tr>
<td>No</td>
<td>314</td>
</tr>
</tbody>
</table>
If yes, will other family members be moving with you?

- Yes: 59.2%
- No: 40.8%

In preparation for your fellowship, are you required to attend an orientation session?

- Yes: 94.8%
- No: 5.2%
If yes, what is/are the date(s) of the orientation?

If the pediatric fellowship start date were delayed until "X," would a gap in income for this period be acceptable to allow for the increased flexibility this delay would provide?
Considering what would be ideal (and not what is currently done), which of the following would be your preferred start date for pediatric fellowship training?

- July 1: 6.4%
- July 7: 38.3%
- July 15: 38.5%
- August 1: 16.9%

Fellowship PDs
Do you think that the current start date for fellowship programs poses a problem for incoming fellows and/or general pediatrics residency programs?

Number of respondents

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>49.9%</td>
<td>50.1%</td>
</tr>
</tbody>
</table>

Are you aware that the APPD has recently issued a statement that strongly supports a delay in the start date of pediatric fellowships until July 7 or later?

Number of respondents

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>33.0%</td>
<td>67.0%</td>
</tr>
</tbody>
</table>
Did any of your fellows that began training in July 2014 move from another city for their fellowship?

- Yes: 79.8%
- No: 20.2%

In preparation for their fellowship, were your fellows that began training in July 2014 required to attend an orientation session?

- Yes: 89.0%
- No: 11.0%
If yes, what is/are the date(s) of the orientation?

- Before June 30: 33.2%
- July 1: 59.5%
- July 2: 29.1%
- July 7: 7.1%

Taking into account that residency is not officially completed until June 30, which of the following would be your preferred start date for pediatric fellowship training?

- July 1: 28.7%
- July 7: 33.3%
- July 15: 25.5%
- August 1: 16.0%
“The Council of Pediatric Subspecialties and the Association of Pediatric Program Directors recently surveyed graduating program directors who were pursuing fellowship training about the fellowship start date. Four hundred and thirty-nine individuals completed the survey. When asked about their preferred start date for fellowship training, 6% responded July 1, 38% July 7, 39% July 15 and 17% August 1.”

Knowing these data, which of the following would be your preferred start data for pediatric fellowship training?
Action Team Recommendation #1

Beginning with the 2017 appointment year, Pediatric Subspecialty Fellowships should start no earlier than July 7.

Rationale

• Health benefits
  – COBRA available 30 days retroactively
• J-1 Visa
  – allowed 30 days in between educational programs
• Residents favored both July 7 and 15
  – increased financial hardship with 2 week delay
• Fellowship PDs preferred July 7
  – 82% said July 7 or later
• Transition easily accomplished
Action Team Recommendation #2

Orientation should not be scheduled before July 5.

Rationale

• counterproductive to delay the start date until July 7 but allow orientation to occur before July 1
• large number of trainees required to attend orientation before June 30 – some paid
Action Team Recommendation #3

Implementation should involve an aggressive educational campaign aimed at fellowship program directors to make them more aware of the problem and to clearly communicate the desires of the trainees.

Rationale

• no single organization controls the date on which fellowships start
  – voluntary
• many institutions already have multiple orientation sessions
• FPDs unaware of problem
• changed their opinion when advised of resident preferences
  • 38% reduction in choice of July 7
• 100% compliance not required
Educational Opportunities

• grass-roots discussions at meetings
• newsletters
• presentation of data at national meetings
• assistance from the categorical PDs
• publication of data
Communication Action Team:
Richard Mink
Pat Leavey

CoPS Website Activity
August 2013-July 2014
• total page views: 284,734
  – compared with 149,802 last year (90% increase)
CoPS Website Activity

August 2013-July 2014

• average number of views per day: 780
  – 453 last year
• peak activity: October (8.8%)
  – July last year
  – consistent throughout the year
Subspecialty Descriptions Activity

- page views: 172,419
  - 75,696 last year
  - 128% increase
Subspecialty Descriptions Activity

Without introductory page
• average of views per day: 435
  – 184 last year
• peak activity: April (13.9%)
• average time each page viewed:
  – 0’59” (GI) to 2’03” (cardiology)
  – shorter view times

Individual Subspecialties
• Increased views in all subspecialties
  – greatest % increase in cardiology (246%)
  – introductory page increased 82%
    • same as last year
• Top three subspecialties viewed
  – neonatology
  – hematology-oncology
  – cardiology
Webinars

- October: “Understanding EPAs”
  - participants: ~95
  - views: 1191
  - peak in January
- February: “CCCs and Milestones”
  - participants: ~135
  - views: 361
  - peak in March
  - slides: 725 visits

**EPAs**

<table>
<thead>
<tr>
<th>Common EPA</th>
<th>Visits</th>
</tr>
</thead>
<tbody>
<tr>
<td>Scholarly Activity</td>
<td>382</td>
</tr>
<tr>
<td>Apply Public Health Principles</td>
<td>382</td>
</tr>
<tr>
<td>Lead Within the Subspecialty</td>
<td>319</td>
</tr>
<tr>
<td>Consultation</td>
<td>278</td>
</tr>
<tr>
<td>Practice Management</td>
<td>266</td>
</tr>
<tr>
<td>Teams</td>
<td>286</td>
</tr>
<tr>
<td>Handovers</td>
<td>301</td>
</tr>
<tr>
<td>TOTAL</td>
<td>2214</td>
</tr>
</tbody>
</table>
CoPS Website

- More involvement
- Continue to “market” Subspecialty Descriptions
  - Council on Medical Student Education in Pediatrics (COMSEP)
- Link EPAs to descriptions
- Revise subspecialty descriptions next year
  - date of last revision now on website page
  - PEM not updated
  - update content (match)
  - verify links

CoPS LISTSERV

- intended as an internal method for bidirectional communication
- has had very limited use
- type:
  “COPS_REPRESENTATIVES@LISTSERV.PEDSUBS.ORG”
  in “To” box
- etiquette rules posted on website under organizational structure
Fellowship Readiness Action Team

Debra Boyer, Mel Heyman, Christine Barron, Michael Brook, Suzanne Lavoie, Adam Rosenberg, Rick Mink

Action Team

• Christine Barron
• Michael Brook
• Suzanne Lavoie
• Adam Rosenberg
• Rich Mink
We need your help

- List of career advisors for each subspecialty
- List of suggested rotations for residents entering each subspecialty
- By Nov. 3
Fellowship Match 2014

Goal- Simplify the application process

- Create a common match process
- Create a common match date
### Subspecialties in Peds

<table>
<thead>
<tr>
<th>Endocrinology</th>
<th>Academic Generalist (Pediatrics)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gastroenterology</td>
<td>Adolescent Medicine</td>
</tr>
<tr>
<td>Hematology-Oncology</td>
<td>Allergy and Immunology</td>
</tr>
<tr>
<td>Infectious Diseases</td>
<td>Cardiology</td>
</tr>
<tr>
<td>Neonatology</td>
<td>Child Abuse</td>
</tr>
<tr>
<td>Nephrology</td>
<td>Child/Adolescent Psychiatry</td>
</tr>
<tr>
<td>Rehabilitation Medicine</td>
<td>Critical Care</td>
</tr>
<tr>
<td>Sports Medicine</td>
<td>Child Neurology</td>
</tr>
<tr>
<td>Pulmonary Medicine</td>
<td>Dermatology</td>
</tr>
<tr>
<td>Rheumatology</td>
<td>Developmental-Behavioral</td>
</tr>
<tr>
<td></td>
<td>Emergency Medicine</td>
</tr>
</tbody>
</table>
The Process

- Historically
  - individual programs
    - Each applicant applied to each program
  - Individual applications
    - Each program received and processed applications

CoPS approach

- Raised awareness of the available process and benefits (NRMP and ERAs)
- Developed talking points
- Found the common ground through paired surveys of trainees and programs
- Negotiated dates that worked
- Worked to build consensus
Application process
What has changed?

- Gradually increasing use of the electronic resource - ERAs
  - Of the 20 Subs tracked 2012-15/20.
  - 2013 increased by 4 19/20.
- ERAs 2013 Piloted a web-based application process with remote downloading
- Improved consistency across subs
  - One stop/one fee for residents
  - Residents already familiar with the process
- Easier to view applications for programs

NRMP match process

- Residents and programs wanted a clear unified and secure process
- PEM started in late 1990’s with the match
- Now 18/20 use the NRMP process
Common Match Date/process

- Initially disparate dates and very confusing 17 different dates
- Now two common dates
  - PSFM fall match – 2013- 5 subs
  - 5 subs stand alone
  - PSSM spring match 2013- 5 programs
  - The other 10 programs on different dates
    2014 – 8 subs PSFMatch
    hospitalists join in 2014

Fellowship Match Overview July 2014-16

<table>
<thead>
<tr>
<th>subspecialty</th>
<th>ERAS</th>
<th>Match</th>
<th>Match Day</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pediatric Generalist Pediatrics</td>
<td>No</td>
<td>No coordinated match</td>
<td>N/A</td>
<td>Contact each program</td>
</tr>
<tr>
<td>Adolescent Medicine</td>
<td>Yes</td>
<td>NRMP</td>
<td>Mar</td>
<td>Match launched 2012</td>
</tr>
<tr>
<td>Emergency Medicine</td>
<td></td>
<td>NRMP</td>
<td>Mar</td>
<td>Considered neurology sub-specialty</td>
</tr>
<tr>
<td>Current: All Programs</td>
<td></td>
<td>NRMP</td>
<td>Mar</td>
<td>Considered neurology sub-specialty</td>
</tr>
<tr>
<td>Other 10 programs</td>
<td></td>
<td>NRMP</td>
<td>Mar</td>
<td>Considered neurology sub-specialty</td>
</tr>
</tbody>
</table>

Available for possible Common Fall Date...

3rd year Fall Match-9
- Child Abuse
- Critical Care
- Developmental-Behavioral
- Emergency Medicine
- Hospitalist Medicine
- Infectious Disease
- Nephrology
- Neonatology
- Rheumatology

Spring Match-5
- Cardiology
- Endocrinology (until 2016)
- Gastroenterology
- Hematology/Oncology
- Pulmonary Medicine (until 2016?)

The Stand Alone Matches-potential alignment?

- Academic Generalists
- Allergy
- Adolescent Medicine
- Child/Adolescent Psychiatry
- Child Neurology
- Dermatology
- Rehabilitation Medicine
- Sports Medicine

- No really a match
- Combined program IM/Peds
- Applicants from FP/Peds/IM
- Considered Psych Subspecialty
- Considered Neuro Subspecialty
- San Francisco Match
- Stand Alone
- Combined
Actions this year...

- Built Consensus
  - Presented @APPD Spring Meeting (Mike Brook, Chris, and Rich)
  - Surveyed SOMRFT members (Annabelle, Rich, Chris)

Barriers/opportunities

- Spring 2014
  - Concerns related to a common match date and possible move of Cardiology to the fall match in resulted in active discussion and raised concerns about a common match day
  - “Categorical Program directors will be upset because they will not be able to provide coverage for all the residents interviewing at the same time”
Building Consensus APPD Results

- Presented this issue to the APPD grassroots session for PDs (Mike B., Chris, Rich)
- Virtually unanimous support for a fall (3rd year common match)
  - Simpler to keep track of timing
  - No concerns about coverage
- The result
  - A letter of support from APPD (thanks Dena!)

Where do the candidates stand..

- Surveyed SOMSRFT summer 2014 (Thanks Annabelle de St. Maurice)
- Asked simple questions about where they stand related to the decision and application process
- 1117 respondents
## SOMSRFT Survey 2014 Results

### 1. Are you a....?

<table>
<thead>
<tr>
<th>Category</th>
<th>Count</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Resident</td>
<td>905</td>
<td>81.0%</td>
</tr>
<tr>
<td>Fellow</td>
<td>210</td>
<td>18.8%</td>
</tr>
<tr>
<td>Unspecified</td>
<td>2</td>
<td>0.2%</td>
</tr>
</tbody>
</table>

**Total** 1117

### 2. When would you prefer a fellowship match date?

<table>
<thead>
<tr>
<th>Option</th>
<th>Count</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. In December of 3rd year?</td>
<td>1000</td>
<td>89.5%</td>
</tr>
<tr>
<td>b. In June of 2nd year?</td>
<td>82</td>
<td>7.3%</td>
</tr>
<tr>
<td>c. Neither?</td>
<td>35</td>
<td>3.1%</td>
</tr>
</tbody>
</table>

**Total** 1117
### 3. Do you support having a common fellowship match date for all pediatric subspecialties?

<table>
<thead>
<tr>
<th></th>
<th>Votes</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>933</td>
<td>90.1%</td>
</tr>
<tr>
<td>No</td>
<td>102</td>
<td>9.9%</td>
</tr>
<tr>
<td>Total</td>
<td>1035</td>
<td></td>
</tr>
</tbody>
</table>

### 4. Do you think you would be more likely to join a subspecialty if you had more time during residency to make your decision about whether or not to pursue a fellowship?

<table>
<thead>
<tr>
<th></th>
<th>Votes</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>858</td>
<td>77.8%</td>
</tr>
<tr>
<td>No</td>
<td>245</td>
<td>22.2%</td>
</tr>
<tr>
<td>Total</td>
<td>1103</td>
<td></td>
</tr>
</tbody>
</table>
The later the better—Continues to be a priority for residents

With duty hours restriction many residents may not get exposure until the 3rd year.
Depends on the core program and 6 individualized month design
Matches on the same day can use couples match

Challenges remaining for one match date?

- Discuss with constituencies to understand the remaining issues for spring match?
  - GI, Cardiology and Heme/Onc
- Best way to engage in discussions or provide help?
- Should we attempt to focus a survey to these groups of trainees? Consider the SITE exams?
- Should we seek to pursue subs with stand alone matches?
Challenges remaining for one match date?

- Issue identified include- NIH training and foundation grants (such as CF foundation) deadlines before match.
- Pulmonary progress (Dr. Boyer)
- GI reps any progress?
- Only 75% of programs must participate in the match
- What percent of candidates are funded by NIH training grants?
- How many fellows proceed with the accelerated research pathway- 2 years residency and 4 years of fellowship funding

Results-from CoPS

- Develop a report about the match process? 1st draft done but will adjust based on CoPS meeting input Dr Kennedy will submit to CoPS EC for review

- Will they be supportive?
  - ACTION items:
    - SOMSRFT(Annabelle de St. Maurice annabelle.dest.maurice@vanderbilt.edu
    - NRMP issues to be negotiated date selection heme/onc and adolescent and add CoPS links to the NRMP sites.
    - Support obtained from APPD 2014
    - Ways to gain the support of change for Cardiology and Heme/onc
    - Advantages and exposure the couples, the streamlining
      - Scheduling not a challenge
      - Survey only programs through the NRMP process not in the fall.
      - Explore and decide if all the dates can align.
PEDIATRIC EDUCATIONAL EXCELLENCE ACROSS THE CONTINUUM (PEEAC)

Pronounced: Peace or Pee-akh

3 previous meetings: ‘09, ‘11, ‘13

CoPS partnership: COMSEP, APA, and APPD

Mission:

To provide exemplary teaching, mentoring, and leadership preparation to students and residents through a national network of educational programs, centers, and collaborations.

Vision:

To create a better world for children and families through the delivery of high-quality health care and a strong commitment to the provision of educational services.

Values:

- Excellence
- Innovation
- Collaboration
- Diversity
- Integrity
- Respect for all
- Equity
- Learning
- Sharing
- Community

Meeting Information

Targeted Audience:

The meeting is designed for pediatricians, pediatric subspecialists, pediatric residents, and allied health professionals.

FELAC Meeting Objectives:

- To provide an opportunity for attendees to engage in meaningful discussions and learning experiences.
- To foster a collaborative environment for the exchange of ideas and new approaches in pediatric education.
- To provide a platform for the dissemination of research and best practices in pediatric education.
- To offer networking opportunities for attendees.

Program Overview:

The program includes a variety of sessions, including workshops, panel discussions, and keynote presentations.

Accreditation Statement:

This meeting is accredited by the Accreditation Council for Continuing Medical Education (ACCME) for physicians and by the American Academy of Pediatrics (AAP) for pediatricians.

Disclosure Policy:

All attendees are required to disclose any potential conflicts of interest related to the content of the meeting. Any commercial support received will be disclosed.

Content:

The content of the meeting includes presentations on the latest research and educational strategies in pediatrics. The sessions are designed to provide attendees with valuable insights and tools to enhance their practice.
PEEAC 2015

- Latha Chandran, Chair of APA Education Committee
  Should we have the meeting again?
- Conference calls
- APPD and APA commitment
- Communication with COMSEP, Jim Bale & AMSPDC

PEEAC 2015

- Significant work commitment
- Complexity of the Workshops
- Target audience?
- Strategic & operational planning will be needed
- Networking opportunities are great
- Importance of CoPS and our relative contribution
- CoPS E.C. favors continued involvement
Journal of Pediatrics
Notes from the AMSPDC

Table of Contents

The Journal of Pediatrics
July 2014 • Volume 165 • Number 1

The Editors' Perspectives

This Month in The Journal of Pediatrics

Notes from the Association of Medical School Pediatrics Department Chairs, Inc.

Pediatric Research Impacts and Benefits from All of Biomedical Science
Susan R. Shatz, MD, and Valerie F. Clark, MD
Journal of Pediatrics

Notes from the AMSPDC

• April 2014
  Communication from Balistreri to gauge interest

• July 2014
  Presented to EC

• July 2014
  Discussions with Balistreri & Wilmot

• October 2014
  Presentation to Council for discussion and gauge interest
Journal of Pediatrics

- Share/alternate with AMSPDC
- Publication Feb.-March 2015
- Dec. 1st submission deadline
- 1300 words/1100 with figures
- 4-6 pages double-spaced
- Topics: Introduction to CoPS, History of CoPS, Goals & Mission of CoPS, Match, EPAs/Milestones

Journal of Pediatrics

- Commitment of time and personnel?
- Leadership of project
- Action Team creation
- Next Steps (Council interest and volunteers)
Accreditation Council for Graduate Medical Education

Assessment in the NAS Era

Why CBME: System Needs

Frenk J. Health professionals for a new century: transforming education to strengthen health systems in an interdependent world. Lancet. 2010

© 2014 Accreditation Council for Graduate Medical Education
What Are The Outcomes?

- A competent (at a minimum) practitioner aligned with the CMS Triple Aim

The IHI Triple Aim

Better care for individuals, better health for populations, lower per capita costs

U.S. Lags Other Countries: Mortality Amenable to Health Care

Deaths per 100,000 population

* Countries age-standardized death rates before age 75, including ischemic heart disease, diabetes, stroke, and bacterial infections. Analysis of World Health Organization mortality files and CDC mortality data for U.S.

Source: Adapted from E. Nolte and M. McKee, “Variations in Amenable Mortality—Trends in 16 High-Income Nations.” Health Policy. published online Sept. 12, 2011
Decade of Rising Concern

- Institute of Medicine (2003)
  - Educating Health Professionals
- Institute of Medicine (2008)
  - Resident Duty Hours: Enhancing Sleep, Supervision, and Safety
  - Retooling for an Aging America
- Congress (2011-12)
  - Reductions in GME funding
  - Request to IOM to review GME regulation
- MedPAC (2009-2010)
  - June 2010 Report influenced reform legislation
- Institute of Medicine (2014)
  - More accountability for GME funding
  - Innovation fund
The NAS in a Nutshell

• A Continuous Accreditation Model based on assessment of annual data – this list is not all encompassing and is subject to change
  • Annual program data (resident/faculty information, major program changes, citation responses, program characteristics, scholarly activity, curriculum)
  • Aggregate board pass rate
  • Resident clinical experience
  • Resident survey and faculty survey (latter is new)
• Semi-annual resident Milestone evaluations
• 10 year Self-Study and Self-Study Visit
• Clinical Learning Environment Review (CLER) Visits

What is a “System?”

• Deming:
  • “Two or more parts that work together to accomplish a shared aim.”
• Key concepts:
  • Working together, interactional and interdependent.
  • CBME as a system is not simply the sum or average of the curricular and assessment components, but the product of all the interactions among the components.
The Assessment “System”

Residents

Assessments within Program:
- Direct observations
- Audit and performance data
- Multi-source FB
- Simulation
- ITExams

Qual/Quant “Data” Synthesis: Committee

JUDGMENT

Faculty, PDs and others

FB

FB

Unit of Analysis: Program

Accreditation

Certification and Credentialing

Unit of Analysis: Individual

Milestones and EPAs as Guiding Framework and Blueprint

Community Goes Wild Over Milestones

Milestones Oh Yeah!

Milestones? Is that a beer?

Milestones? Is that a beer?

Milestones the bestest!

Ugh, Milestones my Millstone!
**Milestone**

1. A stone marker set up on a roadside to indicate the distance in miles from a given point.
2. An important event, as in a person's career, the history of a nation, or the advancement of knowledge in a field; a turning point.
3. A significant point in the development of a trainee which helps to define the appropriate developmental trajectory of a trainee.

---

**PC1. History (Appropriate for age and impairment)**

<table>
<thead>
<tr>
<th>Competency</th>
<th>Sub-competency</th>
<th>Developmental Progression or Set of Milestones</th>
</tr>
</thead>
<tbody>
<tr>
<td>PC1.</td>
<td>History</td>
<td>Competency</td>
</tr>
<tr>
<td>Level 1</td>
<td>Acquires a general medical history</td>
<td></td>
</tr>
<tr>
<td>Level 2</td>
<td>Acquires a basic physiatric history including medical, functional, and psychosocial elements</td>
<td></td>
</tr>
<tr>
<td>Level 3</td>
<td>Acquires a comprehensive physiatric history integrating medical, functional, and psychosocial elements</td>
<td></td>
</tr>
<tr>
<td>Level 4</td>
<td>Efficiently acquires and presents a relevant history in a prioritized and hypothesis driven fashion across a wide spectrum of ages and impairments</td>
<td></td>
</tr>
<tr>
<td>Level 5</td>
<td>Gathers and synthesizes information in a highly efficient manner</td>
<td></td>
</tr>
</tbody>
</table>

- **Specific Milestone:**
  - Seeks and obtains data from secondary sources when needed
  - Elicits subtleties and information that may not be readily volunteered by the patient
  - Models the gathering of subtle and difficult information from the patient

© 2014 Accreditation Council for Graduate Medical Education
Entrustable Professional Activities

- EPAs represent the routine professional-life activities of physicians based on their specialty and subspecialty
- The concept of “entrustable” means:
  - “a practitioner has demonstrated the necessary knowledge, skills and attitudes to be trusted to perform this activity [unsupervised].”¹


Milestones and EPAs as Roadmap

Observations:
1) Journey not a straight line
2) More than one path (but not infinite)
3) “If you don’t know where you are going, any road will get you there”
Competencies, Milestones and EPAs

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Competencies</th>
<th>Milestones</th>
<th>EPAs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Granularity</td>
<td>Low</td>
<td>Moderate to High</td>
<td>Low to Moderate</td>
</tr>
<tr>
<td>Synthetic/Integrated</td>
<td>Moderate</td>
<td>Low to Moderate</td>
<td>High</td>
</tr>
<tr>
<td>Practicality (application)</td>
<td>Low</td>
<td>Moderate</td>
<td>High</td>
</tr>
<tr>
<td>Conceptual</td>
<td>High</td>
<td>Low</td>
<td>Low to Moderate</td>
</tr>
</tbody>
</table>

Dreyfus & Dreyfus Development Model

- Novice
- Advanced Beginner
- Competent
- Proficient
- Expert/Master

Dreyfus SE and Dreyfus HL. 1980
Carraccio CL et al. Acad Med 2008;83:761-7
Criteria for “Good” Assessment

• Validity or Coherence
• Reproducibility or Consistency
• Equivalence
• Feasibility
• Educational effect
  • Learning that occurs in preparation for an assessment (e.g. certification exam; MRCP)
• Catalytic effect
  • Assessment resulting in feedback that “drives future learning forward.”
• Acceptability

\(^1\)Ottawa Conference Working Group 2010

The Reality of Assessment Methods

There is NO HOLY GRAIL of Assessment:

George Box: “All models are wrong, some are useful”
Effective Assessment Process

- Clarity on right outcomes linked to curriculum
- Right combination and synthesis of assessment methods
- Critical importance of shared understanding & mental models of competence
  - Competencies, milestones, entrustable professional activities (EPAs)

Features of Effective Clinical Performance Assessment System

- Direct observation of performance
- Broad systematic sampling
- Multiple “raters”
- Competency framework
- Formative feedback
- Encourages weekly assessment
- Naturalistic setting
- Limited rating choices per item
- Specifies meaning of ratings

Adapted from: Baker K. Determining Resident Clinical Performance: Getting Beyond the Noise. Anesthesiology. 2011; 115: 862-78

© 2014 Accreditation Council for Graduate Medical Education
System “Structure”

**Clinical Competency Committee**
- Periodic review – professional growth opportunities for all
- Early warning systems

**Structured Portfolio**
- ITE (formative only)
- Monthly Evaluations
- miniCEX
- Medical record audit/QI project
- Clinical question log
- Multisource feedback
- Trainee contributions (personal portfolio)
  - Research project

**Advisor**
- Review portfolio
- Reflect on contents
- Contribute to portfolio

**Trainee**
- Review portfolio
- Reflect on contents
- Contribute to portfolio

**Program Leaders**
- Review portfolio periodically and systematically
- Develop early warning system
- Encourage reflection and self-assessment

**Program Summative Assessment Process**

**Licensing and Certification**

© 2014 Accreditation Council for Graduate Medical Education
Model For Programmatic Assessment
(With permission from CPM van der Vleuten)

Kirkpatrick Model:
Medical Program Perspective

National Health Service – UK.
http://www.wipp.nhs.uk/tools_gpn/unit6_education.php
© 2014 Accreditation Council for Graduate Medical Education
Group Decision Making

• Key Issues
  • What is the environment in which the committee performs its work?
    • What is the local culture?
      • Groups within groups
      • What is the local medical culture?
  • What are the effects of hierarchy on group decision making?
    • Berg: Medicine one of the most hierarchical of all professions
  • Single variable of effectiveness: extent to which people are willing to say “positive” and “negative” comments and observations in a group
The Wisdom of Crowds

- The wisdom of many is often better than the wisdom of the few
- To maximize the probability of good judgments:
  - Sample
  - “Independence”
  - Diversity are important...

Basic Committee Principles

- Evidence-based versus verdict-based “jury”
  - Start and review all evidence before a decision
    - Do not start with a conclusion/decision
  - Confirmation bias
- Be careful not to emphasize consensus over dissent
  - Minority opinions, even if “wrong”, still helpful
  - Be sure all voices are “heard” and watch carefully for negative effects of hierarchy
Committees are *Not Inquisitions*

“Wisdom of the Crowd”

- Hemmer (2001) – Group conversations more likely to uncover deficiencies in professionalism among students

  - 18% of resident deficiencies requiring active remediation became apparent only via group discussion.
    - Average discussion 5 minutes/resident (range 1 – 30 minutes)
Narratives and Judgments

- Pangaro (1999) – matching students to a “synthetic” descriptive framework (RIME) reliable and valid across multiple clerkships
  - Key component: good process with facilitation

- Regehr (2012) – Faculty created narrative “profiles” (16 in all) found to produce consistent rankings of excellent, competent and problematic performance.

Milestone Journey:
Revised Conceptual Model of Rapid Cycle Change

© 2014 Accreditation Council for Graduate Medical Education

Thank You and Questions

eholmboe@acgme.org
Update from the ABP

1. Time-Limited Eligibility Policy
2. MOC for Residents / Fellows
3. Nomination Tool for GP Exam Committees & Subboards
4. Mental Health Crisis – ABP Blog
**Time-limited Eligibility Policy**

- A residency or fellowship graduate has 7 years to pass board certification exam

- Purpose: disallow claims of unlimited “board eligibility” as an achievement. Time limit is consistent with continuous evaluation of competencies and tightens the connection between training and certification.

- Policy applies to all 24 specialty boards in the U.S.

- ABP detailed policy and FAQ available on website.

---

**Time-Limited Eligibility Policy**

- If certification is not achieved within the time limit an additional period of supervised practice within an accredited training program is required to regain eligibility.

- The ABP does not require an individual to have a specific title; it is acceptable for the individual to have an appointment and salary as a practitioner or faculty member.

- Supervision and evaluation by faculty is critical.
Time-Limited Eligibility Policy

- The candidate must obtain a position on her/his own. The ABP does not place candidates.
- Part-time positions are acceptable as long as the supervised practice role is clearly delineated.
- PD in an accredited program must verify competence to practice unsupervised upon completion of additional training.

ABP Approval of Proposed Training Program

- General pediatrics training:
  - Preapproval of training program by ABP is required to insure 1 year training is broadly constructed. (PD should send an outline of the training to the ABP for review)

- Subspecialty training:
  - Clinical training must conform to the usual ACGME clinical training requirements, but pre-approval not required at present time.
Important Points About Time-Limit Policy

1. NOT an ACGME Issue:
   - No entry into webAds
   - No resident survey
   - No milestones report
   - No Board scores reported to ACGME by ABP
   - No increase in resident/fellowship complement

2. Programs **not** obligated to take trainees.

---

Important Points About Time-Limit Policy

1. ABP cares about accredited training environment, faculty supervision, and competency assessment.

2. Purpose of retraining is not to ensure certification but to assure the ABP that an individual still possesses competencies verified at conclusion of residency or fellowship.

3. Credentialing bodies and institutions can make exceptions to their BC/BE policy.
Time-limited Eligibility Policy

Special Considerations for Subspecialties

- “Time-limit clock” begins upon completion of training
- Completion of fellowship before general pediatrics residency by IMGs may be risky
- Fewer opportunities to take exam available for those who train out of sequence
- Training beyond three years required for certification will not re-set the clock (eg: chief residency, advanced subspecialty, and research)

ACGME Eligibility Requirements: Fellowships

- All required clinical education for entry into ACGME-accredited fellowship programs must be completed in an ACGME-accredited residency program, or in an RCPSC-accredited residency program located in Canada.

- An ACGME-accredited fellowship program may accept an exceptionally qualified applicant, who does not satisfy the eligibility requirements but who does meet additional qualifications and conditions.
CAUTION

- ACGME eligibility exception should NOT be used for IMGs who wish to seek ABP certification since fewer opportunities to take examination are available for those who train out of sequence (“reverse training”)

- Alternate training pathway for IMGs that is not formal ACGME accredited training and tracked by ABP will not confer eligibility for certification - NO EXCEPTIONS

Concerns about the TLE Policy

- **Confusion about the intent of retraining:**
  False perception that one year period is to teach candidates how to pass the exam

- **Confusion about the proper design of training program:**
  Some candidates designed programs that did not follow ACGME requirements or meet ABP policy.

- **Inadequate access:**
  Insufficient training programs willing to accept candidates

- **Undue hardship:**
  Need to give up job and relocate
Planned Changes to the Policy & FAQs  (anticipated late 2014)

• Replace “retraining” with “supervised practice” in the policy language to clarify that the purpose is to afford an opportunity for observation and supervision of candidates to assure ABP of competence.

• Require pre-approval by ABP of all supervised practice proposals (general pediatrics and subspecialties)

• ABP will explore ways to allow greater flexibility in the proposed plan for supervised practice in the accredited training program to accommodate personal circumstances.

Concerns about the TLE Policy (Subspecialties)

- **IMG Reverse Training:**
  Unintended consequences may be that these trainees have no opportunity to take a subspecialty exam if delayed in certification in general pediatrics

- **Planned Changes to Policy:**
  Allow one attempt at initial subspecialty certification exam for those who have lost eligibility, provided no more than 7 years have elapsed since completion of general pediatrics training and no more than 10 years since completion of fellowship.
MOC for Residents

- Residents will be able to earn Part 4 MOC credit during residency 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

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

- Residents will be able to access many other ABP Part 2 (self assessments and QOW) activities, but will not receive bankable credit.

MOC for Fellows

- BEFORE the Fellow passes his/her GP exam (and thus becomes a certified diplomate of the ABP):
  - As long as an individual has a “training line” in the ABP system (eg is enrolled in an ACGME approved program), bankable credit can be earned.

- When the Fellow passes his/her GP exam, he/she is enrolled in the first 5-year cycle of MOC, needs 100 points just like any other diplomate
  - Any already banked credit goes live
  - 10 Part 2 and 10 Part 4 points are awarded for each year of Fellowship training, once the fellow is certified
  - The subspecialty exam does not change the MOC cycle.
Motivational Interviewing PIM

- Designed for use in dyads of learners/observers
  - Ideally, dyad includes a resident & a faculty preceptor, learning together
- Utilizes surveys of patient/parent and observer
- Designed to allow assessment of specific Milestones in Communication
- Will “go live” soon, but no credit before 2015

MOC can be fun!
Question of the Week

A scenario every week with a single question

- Recent abstract plus commentary
- Answer the question twice, once for practice, once for real
- See what everyone else has answered
- Bonus clinical pearl
- Available to residents in 2015, but no MOC credit
Published Quality Improvement Projects

- Requirements similar to all QI projects
  - Must tell the story of a QI project, must present data over time
  - Must be peer-reviewed
  - Adhere to SQUIRE reporting guidelines
  - Be published during the diplomate’s current MOC cycle
  - Residents will be eligible for banked credit

- Over 160 Diplomates have received MOC credit for publishing an article describing a QI project
- NEW: Credit for peer-reviewed posters presented at national meetings
  - Retroactive to 2010
  - MOC staff viewed PAS posters in Vancouver and found 50 good candidates
  - 5 applications received within a week of PAS

Nominating Tool: GP Committees and Subboards

- New 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
Mental Health Crisis – ABP Blog

Mental Health Crisis among America’s Children — What Should We Do?

1. Why?
   - Mental health crisis and behavioral health services are consistently cited as the highest priority in primary care.
   - Mental health services are used for most chronic health conditions and management of medical conditions.
   - Mental health is now the second leading killer of children.

2. What?
   - Pediatricians and Family Physicians are more involved in the treatment of mental health issues than ever before.
   - However, many pediatricians and other health care providers are unprepared to meet the needs of these patients.

3. How?
   - The ABP will encourage training programs to enhance the preparedness of the graduates in mental health.
   - The ABP will work with advocacy groups to develop new initiatives.

Responding to the Mental Health Crisis among America’s Children

The big question is, what should we be doing about it?

The American Board of Pediatrics

Mental Health Crisis

- Developmental, behavioral, and mental health disorders are major chronic diseases seen in primary care practices.

- Many pediatricians feel unprepared to meet the needs of these patients.

- What should “we” be doing about it?
  The ABP, general pediatricians, subspecialists, and others?

The American Board of Pediatrics
What is ABP’s Role?

- ABP and AAP are actively engaged in an Institute of Medicine Forum (round table to explore the topic and assess capacity to implement effective programs in communities and institutions)

- ABP can be a powerful driver for competency development and assessment through content of certifying examinations and MOC activities (Part 2 self-assessment & Part 4 quality improvement)

- Dialogue and collaboration with training programs and ACGME to enhance preparation of graduates in mental health

- Work of the ABP: Strategic Planning Committee – focus on role of the general pediatrician and competencies needed
Longitudinal Educational Assessment Research Network

A collaborative research network of pediatric residency programs

- Alan Schwartz - current director
- Robin Young - Full time project manager
APPD LEARN

- 137 programs
- Wide geographic and size distribution

Current Studies

- Assessing the Association between Entrustable Professional Activities (EPAs), Competencies, and Milestones in the Pediatric Subspecialties – CoPS, APPD
- Pediatrics Milestones Assessment Collaborative (PMAC) - Module 1
- Striving for the Optimal Balance Between Service and Education (Boyer, Kesselheim)
- Validity of resident self-assessment using Pediatrics Milestones
Submitting a proposal

- Application instructions online
- Review cycles: January 1-April 30, May 1-August 31, and September 1-December 31
- Review committee

APPD LEARN support

- Recruitment
- Assistance with IRB kits
- Administration of study
- Collection of data
- Analysis of data
Questions?
Assessing the Association between EPAs, Competencies and Milestones in the Pediatric Subspecialties

Collaborative Project

- APPD Fellowship Executive Committee
  - Co-leader: Bruce Herman, MD
- CoPS
  - Co-leader: Richard Mink, MD, MACM
- ABP
  - Carol Carraccio, MD
- APPD LEARN
  - Alan Schwartz, PhD
Focus on Common Subspecialty EPAs

• Total of 7
  – 5 included in categorical program
  – 2 subspecialties only
• Project will evaluate 6
  – scholarship EPA will not be included
• Specific competencies map to each EPA
  – milestones used to assess each competency

Specific Aims

For each of the 6 common EPAs being evaluated:
1. to determine if there is a specific milestone level at which a fellow is deemed entrustable
2. to compare the milestone level at which fellows are deemed entrustable across the pediatric subspecialties and to determine if any specific competencies are more influential in the entrustment decision than others.
Study Goals

3. to compare the initial overall impression of fellow level of entrustment made by the Fellowship PD with that determined by the CCC after the milestone levels are assigned.
Participants

Pediatric subspecialty networks
- > 20% of programs in the subspecialty must participate (30% preferred)
  - commitment of all 14 ABP subspecialties
- each subspecialty responsible for recruitment within its subspecialty
- identified leaders supervise subspecialty participation
- leaders comprise the Project Steering Committee

Basic Outline of Methods

- Before CCC meeting, Fellowship PD records his/her impression of the level of entrustment for each fellow for the 6 EPAs
- CCC meets and assigns milestone levels for all competencies mapped from EPAs
  - 10 additional competencies to be evaluated
- At end of session, CCC records their impression of the level of entrustment for each fellow for the 6 EPAs
Entrustment Scales

<table>
<thead>
<tr>
<th>Apply public health principles and methodology to improve care for populations, communities, and systems</th>
<th>Provide for and obtain consultation from other health care providers caring for children</th>
<th>Contribute to the scientifically sound and ethically acceptable conduct of a practice (e.g., through testing, scheduling, coding, and regulatory billing documentation)</th>
<th>Facilitate handovers to another healthcare provider</th>
<th>Lead an interprofessional healthcare team</th>
<th>Lead within the subspecialty profession</th>
</tr>
</thead>
<tbody>
<tr>
<td>Trusted to observe, act in a manner that demonstrates a collaborative effort to improve care at the institutional level</td>
<td>Trusted to contribute as a member of a collaborative effort to improve care at the institutional level</td>
<td>Trusted to lead a collaborative effort to improve care for populations and patients at the community level</td>
<td>Trusted to lead a collaborative effort to improve care for populations and systems at the regional and/or national level</td>
<td>Trusted to observe, act in a manner that demonstrates a collaborative effort to improve care at the institutional level</td>
<td>Trusted to contribute as a member of a collaborative effort to improve care at the institutional level</td>
</tr>
<tr>
<td>Trusted to observe, act in a manner that demonstrates a collaborative effort to improve care at the institutional level</td>
<td>Trusted to contribute as a member of a collaborative effort to improve care at the institutional level</td>
<td>Trusted to lead a collaborative effort to improve care for populations and patients at the institutional level</td>
<td>Trusted to lead a collaborative effort to improve care for populations and systems at the regional and/or national level</td>
<td>Trusted to observe, act in a manner that demonstrates a collaborative effort to improve care at the institutional level</td>
<td>Trusted to contribute as a member of a collaborative effort to improve care at the institutional level</td>
</tr>
</tbody>
</table>

Specific Roles

- **APPD LEARN**
  - provide data management and statistical analysis
  - assist with IRB submission
  - will NOT recruit programs

- **APPD Fellowship Committee**
  - institutional IRB approval
  - recruitment
Specific Roles

• ABP
  – financial support
  – content expertise

• CoPS
  – study coordination
  – recruitment

Where are We?

• “deadline” to recruit programs—September 22
  – all PDs who participate acknowledged as contributor
  – 14 subspecialties participating
    • > 250 programs
    • 92 institutions
    • > 1000 trainees

• IRB submission
  – only ONE per institution
  – IRB packet developed
    • should be exempt
  – created master list grouped by institution
<table>
<thead>
<tr>
<th>Participating Institution</th>
<th>P3 Institution</th>
<th>Subspecialty</th>
<th>ACGME Program Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Advocate Children's Hospital</td>
<td>CRITICAL CARE</td>
<td>3232162046</td>
<td></td>
</tr>
<tr>
<td>Albany Medical Center</td>
<td>NEONATOLOGY</td>
<td>3232162060</td>
<td></td>
</tr>
<tr>
<td>Albert Einstein College - Children's Hospital at Mount Sinai</td>
<td>ASSISTANT</td>
<td>3232162003</td>
<td></td>
</tr>
<tr>
<td>Albert Einstein College of Medicine/Children's Hospital at Montefiore</td>
<td>RHEUMATOLOGY</td>
<td>3332162032</td>
<td></td>
</tr>
<tr>
<td>Albert Einstein College of Medicine/Children's Hospital at Montefiore</td>
<td>CRITICAL CARE</td>
<td>3232162044</td>
<td></td>
</tr>
<tr>
<td>Baylor College of Medicine</td>
<td>CRITICAL CARE</td>
<td>3232162010</td>
<td></td>
</tr>
<tr>
<td>Baylor College of Medicine</td>
<td>ASSISTANT</td>
<td>3212162016</td>
<td></td>
</tr>
<tr>
<td>Baylor College of Medicine</td>
<td>CRITICAL CARE</td>
<td>3232162061</td>
<td></td>
</tr>
<tr>
<td>Baylor College of Medicine</td>
<td>NEONATOLOGY</td>
<td>3232162044</td>
<td></td>
</tr>
<tr>
<td>Baylor College of Medicine/Texas Children's</td>
<td>NEONATOLOGY</td>
<td>3232162032</td>
<td></td>
</tr>
<tr>
<td>Boston Children's Hospital</td>
<td>CRITICAL CARE</td>
<td>3232162003</td>
<td></td>
</tr>
<tr>
<td>Boston Children's Hospital</td>
<td>EMERGENCY MEDICINE</td>
<td>3232162032</td>
<td></td>
</tr>
<tr>
<td>Boston Children's Hospital</td>
<td>INFECTIOUS DISEASES</td>
<td>3232162010</td>
<td></td>
</tr>
<tr>
<td>Boston Children's Hospital</td>
<td>HEMATOLOGY - ONCOLOGY</td>
<td>3232162010</td>
<td></td>
</tr>
<tr>
<td>Brown University/Rhode Island Hospital - Lifespan</td>
<td>INFECTIOUS DISEASES</td>
<td>3232162010</td>
<td></td>
</tr>
<tr>
<td>Case Western Reserve University/MetroHealth</td>
<td>CRITICAL CARE</td>
<td>3232162044</td>
<td></td>
</tr>
<tr>
<td>Case Western Reserve University/Rainbow Babies and Children's Hospital</td>
<td>CRITICAL CARE</td>
<td>3212162010</td>
<td></td>
</tr>
<tr>
<td>Children's National Medical Center/George Washington University</td>
<td>CRITICAL CARE</td>
<td>3212162044</td>
<td></td>
</tr>
</tbody>
</table>

**Where are We?**

- finalize entrustment scales
- develop data collection tools
  - web-based
  - similar to ACGME
Several Opportunities

- evaluate the value of the milestones in determining the level of entrustment for the pediatric subspecialty EPAs
- collaboration among several pediatric organizations
- develop a Network of Pediatric Subspecialty Investigators (NOPSi)
  – future studies

PLEASE Encourage Participation!
Strategic Plan

Council of Pediatric Subspecialties (CoPS)

www.pedsubs.org

Strategic Direction
2011 – 2015

Goals
Four goals were set to deliver value to subspecialty societies and pediatric organizations. The intent being to distinguish the Council from other organizations - and not overlap in their own areas of competencies - while delivering a forum of expertise and a ready network of collaboration.

The goals areas include:

I. Network of Subspeciality Organizations
II. Source of Expertise
III. Workforce Development Focus
IV. Sustainability and Strength of CoPS

I. Network of Subspecialties – Recognize CoPS as an effective and efficient pediatric subspecialty network for communications and issues development.

| Establish relationships and lines of communications that create an integrated network | 2011 (ongoing) |
| Benefits of membership for groups delineated in Summer 2011 | 2011 (ongoing) |
| ListServ created in Spring 2012 | 2011 (completed) |
| Newsletters/updates every two months | 2011 (completed) |

Determine process for vetting issues

| Process for vetting and responding to issues developed | 2012 (ongoing) |

Outline the issues that CoPS and its integrated network can best address

<table>
<thead>
<tr>
<th>Action items:</th>
<th>2012 (ongoing)</th>
</tr>
</thead>
<tbody>
<tr>
<td>o SCTC: Created Summer 2011; completed Summer 2013</td>
<td></td>
</tr>
<tr>
<td>o PEEAC: 3rd biannual meeting, CoPS joined co-sponsorship spring 2011; expanded in 2012, recent meeting held Fall 2013 with success</td>
<td></td>
</tr>
<tr>
<td>o Fellowship Readiness: Created Spring 2012</td>
<td></td>
</tr>
<tr>
<td>o Fellowship Start Date: Created Spring 2013</td>
<td></td>
</tr>
<tr>
<td>o EPAs</td>
<td></td>
</tr>
<tr>
<td>o MOC</td>
<td></td>
</tr>
<tr>
<td>o ACGME subspecialty program requirements – reviewed and commented</td>
<td></td>
</tr>
</tbody>
</table>
# Strategic Plan

## A. Establish a Network Designed to Serve Pediatric Subspecialties (Cont.)

<table>
<thead>
<tr>
<th>Identify CoPS's relationships to other (i.e. NEW) pediatric subspecialty organizations' goals and activities</th>
<th>2012 (ongoing)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Invite to be a member of Co-PS (June 2013): Council on Medical Student Education in Pediatrics (COMSEP)</td>
<td></td>
</tr>
<tr>
<td>Invite to annual meeting (2014)</td>
<td></td>
</tr>
<tr>
<td>Pediatric Anesthesia Consider inviting to be a member of CoPS (2014)</td>
<td></td>
</tr>
<tr>
<td>Pediatric Urology</td>
<td></td>
</tr>
<tr>
<td>Pediatric Orthopedics</td>
<td></td>
</tr>
<tr>
<td>Pediatric ENT</td>
<td></td>
</tr>
<tr>
<td>Pediatric Neurosurgery PM&amp;R</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Develop functional model for effective, efficient communications amongst the pediatric organizations' community</th>
<th>2011 (ongoing)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Benefits of membership delineated (Summer 2011)</td>
<td></td>
</tr>
<tr>
<td>CoPS ListServ (Spring 2012)</td>
<td></td>
</tr>
<tr>
<td>Consider creating ListServ of ListServs (2013)-work with administrators</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Provide a rapid response to facilitate communications within the profession</th>
<th>2011 (completed)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Process for vetting and responding to issues developed</td>
<td></td>
</tr>
</tbody>
</table>

## B. Develop a Portfolio of Consulting Areas in Which CoPS can Provide a Consultant/Service

<table>
<thead>
<tr>
<th>Create a record of past successes and areas for future endeavors</th>
<th>2011 (ongoing)</th>
</tr>
</thead>
<tbody>
<tr>
<td>First 5 years paper (Summer 2012)</td>
<td></td>
</tr>
<tr>
<td>Newsletters/Updates</td>
<td></td>
</tr>
<tr>
<td>PEEAC (2011, 2013)</td>
<td></td>
</tr>
<tr>
<td>Strategic planning document</td>
<td></td>
</tr>
<tr>
<td>Action Team Reports</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Multiple interests where CoPS can serve as a forum and or use its network</th>
<th>2012 (ongoing)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Collaboration with other organizations</td>
<td></td>
</tr>
<tr>
<td>ABP, SCTC, EPA, MOC</td>
<td></td>
</tr>
<tr>
<td>ACGME: Milestones</td>
<td></td>
</tr>
<tr>
<td>APDSM, ASP, APDS: Fellowship Start Date</td>
<td></td>
</tr>
<tr>
<td>APPD: Fellowship Readiness and Fellowship Start Date</td>
<td></td>
</tr>
<tr>
<td>FSPO: Peds Training</td>
<td></td>
</tr>
<tr>
<td>NRMP: match</td>
<td></td>
</tr>
<tr>
<td>AMSPDC: Education Committee</td>
<td></td>
</tr>
<tr>
<td>COMSEP: Career Guidance</td>
<td></td>
</tr>
</tbody>
</table>
Strategic Plan

B. Develop a Portfolio of Consulting Areas in Which CoPS can Provide a Consultant/Service (Cont.)

Serve as a communications network to help subspecialty organizations market their education and issues
- Develop a process/guidelines for
  - Determine criteria whether the issue has multi-specialty appeal
  - Submission form: include start/end date for duration of posting
  - Method of dissemination
    - CoPS ListServ
    - Updates
    - Calendar of events on website
    - ListServ of Listservs
  - Fees: members free? Charge for non-members?
  - Examples: leadership conferences, content of cross discipline interest

2012 (initiated)

C. Promote the value of CoPS among pediatric colleagues

Promote the value (services) of CoPS
- Disseminate a portfolio of accomplishments
  - Updates
  - First Five Years Paper
  - Presentations at APPD/PAS/PEEAC

2012 (ongoing)

D. Effective Communication Strategies: External and Internal

Social Media
- Evaluate practicality and value
- Maintain and enhance website
  - Communications Committee assignment: consider restoring bulletin board for responses and examining website functionality to enhance bidirectional communication.

2012 (initiated)

Maintain and enhance website
- (ongoing)

Develop a comprehensive database
- Pediatric e-mail addresses from ACGME; updated twice a year; all CoPS subs
- Leaders of organizations (include sub-board chairs, if applicable): office calls to obtain e-mail addresses; update 6-12 months; go to reps as secondary resource. Also obtain url address, if there is one. Consider resurveying reps.
- Fellows: consider as task for later
- Subspecialists: tabled. Not an element of the current strategic plan

2011 (completed except for fellows)

Improve brand identity of CoPS in the pediatric community
- CoPS ListServ

2012 (completed)
### Strategic Plan

#### II. Source of Expertise – Position CoPS as a resource for sharing and developing expertise among pediatric subspecialties.

**A. Identify the important issues (i.e. health care system reform, medical home, subspecialist referrals, reimbursement, fellowship training, etc.).**

<table>
<thead>
<tr>
<th>Approach collaborating organizations to identify how CoPS processes can assist in achieving their goals</th>
<th>2013 (ongoing)</th>
</tr>
</thead>
<tbody>
<tr>
<td>- AAP disseminate information about legislative affairs</td>
<td></td>
</tr>
<tr>
<td>- Internal Medicine: APPDIM/ASP (start date)</td>
<td></td>
</tr>
<tr>
<td>- Surgery</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Select at least one issue annually that positions CoPS as a leader in expertise and collaboration</th>
<th>2011 (ongoing)</th>
</tr>
</thead>
<tbody>
<tr>
<td>- ABP Subspecialty Clinical Training and Certification Initiative (2011-2013)</td>
<td></td>
</tr>
<tr>
<td>- Fellowship Readiness (2012-2013)</td>
<td></td>
</tr>
<tr>
<td>- Fellowship Start date (2013-2015)</td>
<td></td>
</tr>
<tr>
<td>- EPAs (2013-)</td>
<td></td>
</tr>
<tr>
<td>- Common Match Date (ongoing)</td>
<td></td>
</tr>
<tr>
<td>- Subspecialty Descriptions (ongoing)</td>
<td></td>
</tr>
<tr>
<td>- Resource Center (central location on web to post leadership programs) - ?</td>
<td></td>
</tr>
<tr>
<td>- Social Media TF - ?</td>
<td></td>
</tr>
<tr>
<td>- ABP Part IV MOC: Cost of Boards - ?</td>
<td></td>
</tr>
<tr>
<td>- COMSEP career pathways - ?</td>
<td></td>
</tr>
</tbody>
</table>

#### (Cont.)

**B. Develop functional process and model for expert collaboration.**

<table>
<thead>
<tr>
<th>Identify issues that CoPS can optimally manage as a third party, reflecting its work product expertise</th>
<th>2013 (ongoing)</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Fellowship start date</td>
<td></td>
</tr>
<tr>
<td>- EPAs dissemination, promoting discussion and feedback</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>External collaboration – Relationships with other organizations and subspecialty societies</th>
<th>2011 (ongoing)</th>
</tr>
</thead>
<tbody>
<tr>
<td>- First step – Process for vetting issues developed (Summer 2011)</td>
<td></td>
</tr>
<tr>
<td>- Building collaborations with other groups</td>
<td></td>
</tr>
<tr>
<td>- ACGME</td>
<td></td>
</tr>
<tr>
<td>- NRMP</td>
<td></td>
</tr>
<tr>
<td>- ERAS</td>
<td></td>
</tr>
<tr>
<td>- PPC</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Internal collaboration mechanisms</th>
<th>2012 (ongoing)</th>
</tr>
</thead>
<tbody>
<tr>
<td>- CoPS Listserv</td>
<td></td>
</tr>
</tbody>
</table>
Strategic Plan

II. Source of Expertise – Position CoPS as a resource for sharing and developing expertise among pediatric subspecialties. (Cont.)

| C. Promote, sustain, and enhance partnerships and synergize with others in the pediatric community. |
| Identify and establish CoPS network of experts |
| • EPA Preliminary meeting |
| • ACGME at Annual Meeting |
| Identify and utilize appropriate venues to demonstrate and expand the role and activities of CoPS |
| • PEEAC |
| • Posters & presentations |
| • Webinars |

III. Workforce Development Goal – Focus on issues of workforce development, curriculum and job satisfaction.

| A. Be the pediatric subspecialties program knowledge center. |
| Form working groups to explore existing resources and establish new programs |
| • Collaboration with FOPO on future education of trainees |
| • Fellowship readiness Action Team |
| • Process to disseminate information from subspecialties |

| Develop regional hubs of subspecialty education |
| • Possibilities for webinars: |
| o Creating EPAs/milestones |
| o Giving feedback |

<table>
<thead>
<tr>
<th>Stage</th>
<th>Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>Collaboration with FOPO on future education of trainees</td>
<td>2012 (initiated)</td>
</tr>
<tr>
<td>Fellowship readiness Action Team</td>
<td>2012 (initiated)</td>
</tr>
<tr>
<td>Process to disseminate information from subspecialties</td>
<td>2013</td>
</tr>
<tr>
<td>Develop regional hubs of subspecialty education</td>
<td>2013</td>
</tr>
</tbody>
</table>
Strategic Plan

B. Serve as a pediatric subspecialty recruitment source.

<table>
<thead>
<tr>
<th>Task</th>
<th>Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>Improve Recruitment Strategies by raising awareness of CoPS resources among trainees, subspecialty organizations and subspecialists</td>
<td>2013</td>
</tr>
<tr>
<td>- Work with APPD, AAMC, AMSPDC, and COMSEP to promote subspecialty descriptions on website</td>
<td></td>
</tr>
<tr>
<td>Promote and track utilization of CoPS website</td>
<td></td>
</tr>
<tr>
<td>- APPD poster</td>
<td>2012</td>
</tr>
<tr>
<td>- Website data</td>
<td></td>
</tr>
<tr>
<td>Increase medical student/resident research with pediatric subspecialists</td>
<td>L</td>
</tr>
<tr>
<td>Promote scholarships for medical students and residents to attend subspecialty meetings</td>
<td>L</td>
</tr>
<tr>
<td>Increase subspecialty visibility at national meetings</td>
<td>L</td>
</tr>
<tr>
<td>Potentially use social networking sites to reach medical students and trainees</td>
<td>2013</td>
</tr>
<tr>
<td>Create and promote job boards</td>
<td></td>
</tr>
<tr>
<td>- Consider for non-subspecialty specific jobs, i.e. chair, DIO, Dean</td>
<td></td>
</tr>
<tr>
<td>Solicit disease based organizations (parents) for support of subspecialty training to meet children’s needs</td>
<td>L</td>
</tr>
</tbody>
</table>

C. Be a pediatric subspecialty professional development resource

<table>
<thead>
<tr>
<th>Task</th>
<th>Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>Partner with existing leadership training programs and identify gaps in existing resources</td>
<td>2013</td>
</tr>
<tr>
<td>Survey and catalog leadership training programs/boot camps for trainees, subspecialists and program directors</td>
<td>2013</td>
</tr>
<tr>
<td>Include listing and URL link to leadership courses on CoPS website</td>
<td>2013</td>
</tr>
<tr>
<td>Partner with organizations to fill gaps in leadership training/professional development</td>
<td>2013</td>
</tr>
<tr>
<td>Emphasize the importance of professional development</td>
<td>L</td>
</tr>
</tbody>
</table>

D. Be the quality-of-life resource for the pediatric subspecialties.

<table>
<thead>
<tr>
<th>Task</th>
<th>Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>Identify issues with reimbursement, loan repayment and life balance that influence recruitment and retention</td>
<td>L</td>
</tr>
<tr>
<td>Partner with other organizations to improve reimbursement / loan repayment for the pediatric subspecialties</td>
<td>2012</td>
</tr>
<tr>
<td>- Cosign letters</td>
<td></td>
</tr>
<tr>
<td>Conduct focus group(s) with medical students and trainees to gain a better understanding of the current work life balance, the future vision of such balance, and the barriers to subspecialty careers</td>
<td>L</td>
</tr>
</tbody>
</table>
## Strategic Plan

### IV. Sustainable CoPS Organization – Create and maintain an effective Council with sustainable resources and leadership

#### A. Short-term sustainability

<table>
<thead>
<tr>
<th>Task</th>
<th>Year</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>Develop a budget identifying costs of programs and services and necessary income; appoint a treasurer and/or finance committee</td>
<td>2011</td>
<td>(completed)</td>
</tr>
<tr>
<td>- Budget developed</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Initial treasurer to be appointed</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Role of treasurer determined</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prepare a dues schedule immediately to fund 2011 operations and identify support from subspecialty societies and sections</td>
<td>2013</td>
<td>(completed)</td>
</tr>
<tr>
<td>- Dues structure reviewed</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Initial mailing to PAS societies completed in spring 2011</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Dues letter to the remainder of Societies. For AAP sections, invoice may be sent out through reps pending further discussion with AAP leadership</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Updated letter for invoices (add ABP initiative)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Basic dues category for subspecialty societies</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Registration included for up to two reps if dues categories above basic; For Basic, need to pay for registration</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- “Pay to play” mandatory July 2012</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Advise Council of pay to play at annual meeting in October</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Can have more than one rep but only two votes per subspecialty</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- “Liaison” changed to “Allied Pediatric Organization”</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- FOPO invited guest through July 1, 2013; invited to become a member</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- By-laws will need to be updated to reflect changes</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

#### B. Short-term sustainability

<table>
<thead>
<tr>
<th>Task</th>
<th>Year</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>Advise supporting organizations of the repositioning of CoPS and of the services that CoPS can provide</td>
<td>2011</td>
<td>(completed; ongoing)</td>
</tr>
<tr>
<td>- CoPS Chair (or designee) to attend meetings of supporting organizations (ongoing)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Distribute copies of strategic plan to organizations (ongoing)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Consider brief paper detailing strategic plan</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Approach AAP to discuss areas of common interest and where CoPS unique structure can benefit each organization</td>
<td>2011</td>
<td>(ongoing)</td>
</tr>
<tr>
<td>- Discussions ongoing</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Finalize the selection process of Council representatives to optimize continuity</td>
<td>2012</td>
<td>(completed)</td>
</tr>
<tr>
<td>- Responsibility of member organizations/societies</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ensure Executive Committee leaders involvement in governance and Council informed</td>
<td>2011</td>
<td>(ongoing)</td>
</tr>
<tr>
<td>- Involvement of Council in task forces</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Monthly calls of Executive Committee</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Bi-Monthly e-mails (brief updates/progress)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Process for responding to issues delineated which addresses this issue</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Strategic Plan

B. Long-term sustainability (Cont.)

<table>
<thead>
<tr>
<th>Activity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anually review financial commitments to ensure long-term sustainability</td>
</tr>
<tr>
<td>Consider establishing financial relationships with other organizations/groups of common interest</td>
</tr>
<tr>
<td>Explore feasibility and legality of leasing database</td>
</tr>
<tr>
<td>• Discussed: not feasible</td>
</tr>
</tbody>
</table>

Strategic Plan

Goals For The Year 2014-15 (as published)

• Establish common match date
• Work on fellowship start date and fellowship readiness
• Collaborate, coordinate and begin EPA research project
• Develop, Incorporate, and Link EPA’s
• Create & disseminate Milestones educational resources
• Address Fellowship funding issue
• Webinar/s on topics of interest
• Development of MOC FAQ’s with ABP
Strategic Plan

MOC and CLER visits

• AMSPDC Educational Committee exploring MOC with interest and activity

• Initial CLER visit report from ACGME
  (the 6 focus areas: Safety, QI, Transitions, Supervision, Duty Hours & Fatigue management, & Professionalism)

• Potential opportunity & challenge for CoPS

• Invitation to MOC webinar

Break-out Sessions

• Goals for the year…and beyond

• Action Team creation

• Create a CoPS philosophy
  – how much?
  – how well?
  – with whom?
  – for whom?

• Limited resources
  – financial
  – personnel
  – time