Program Directors' Meeting

14 September 2017

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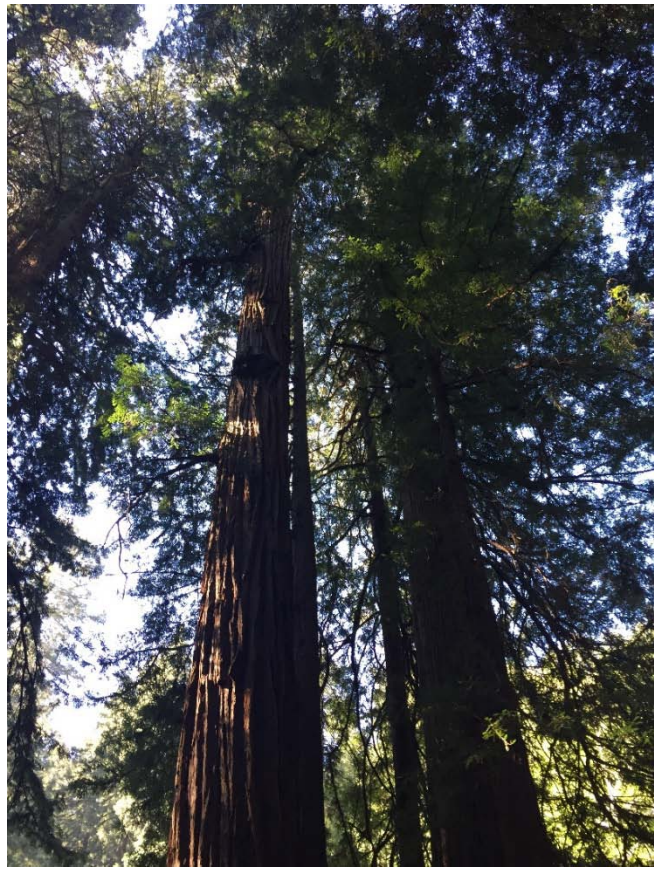
Agenda



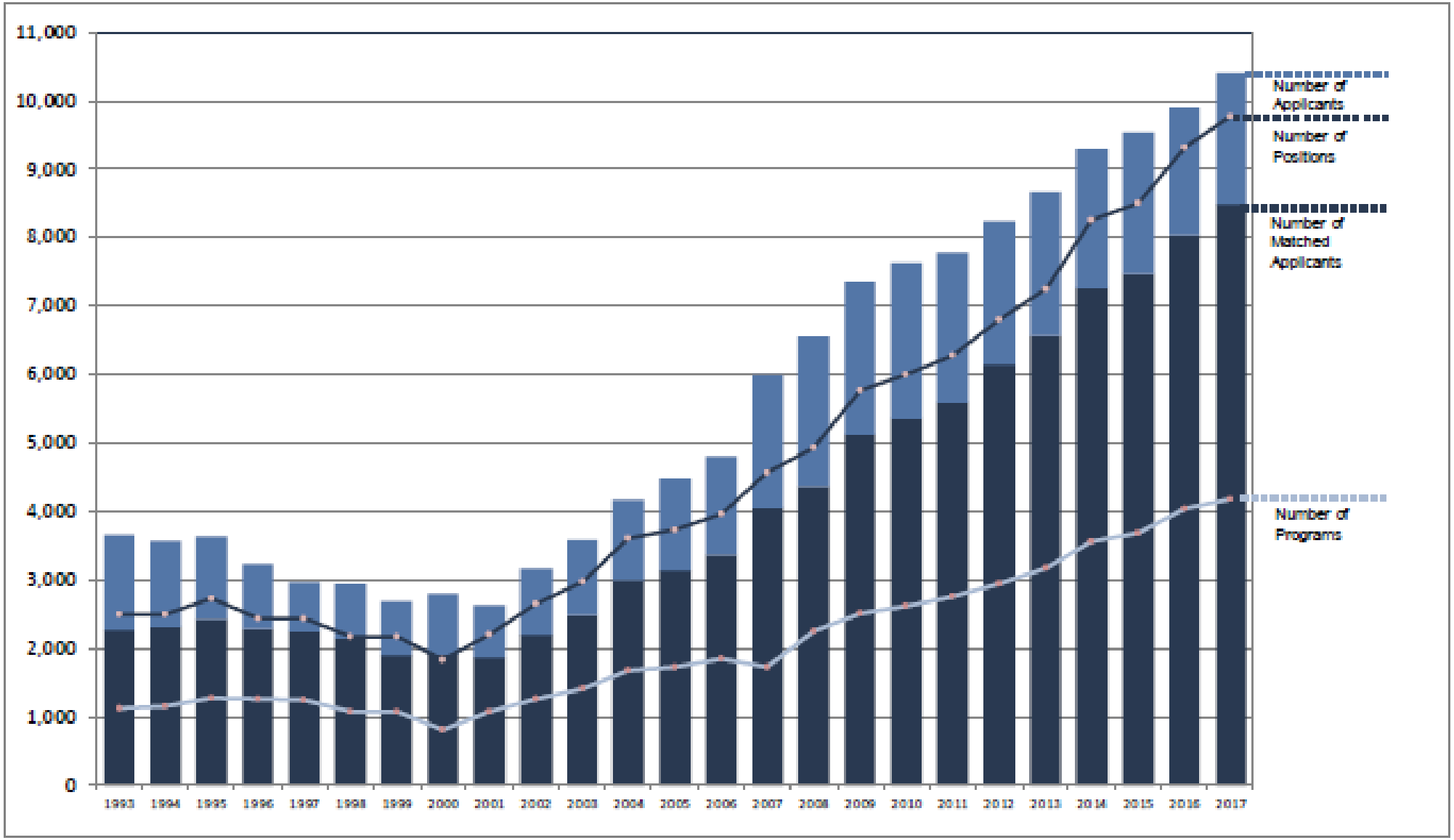
Part One

- Match Data from Fall 2016
- Workforce
- Training length
- New start date
- Protected time for PDs

Part Two

- Changes in ACGME fellowship training requirements
- Future of Entrustable Professional Activities
- Strategic Plan Charge for Training Council

Figure 2 Numbers of Applicants and Programs Participating in the Specialties Matching Service© (SMS©) by Appointment Year, 1993-2017



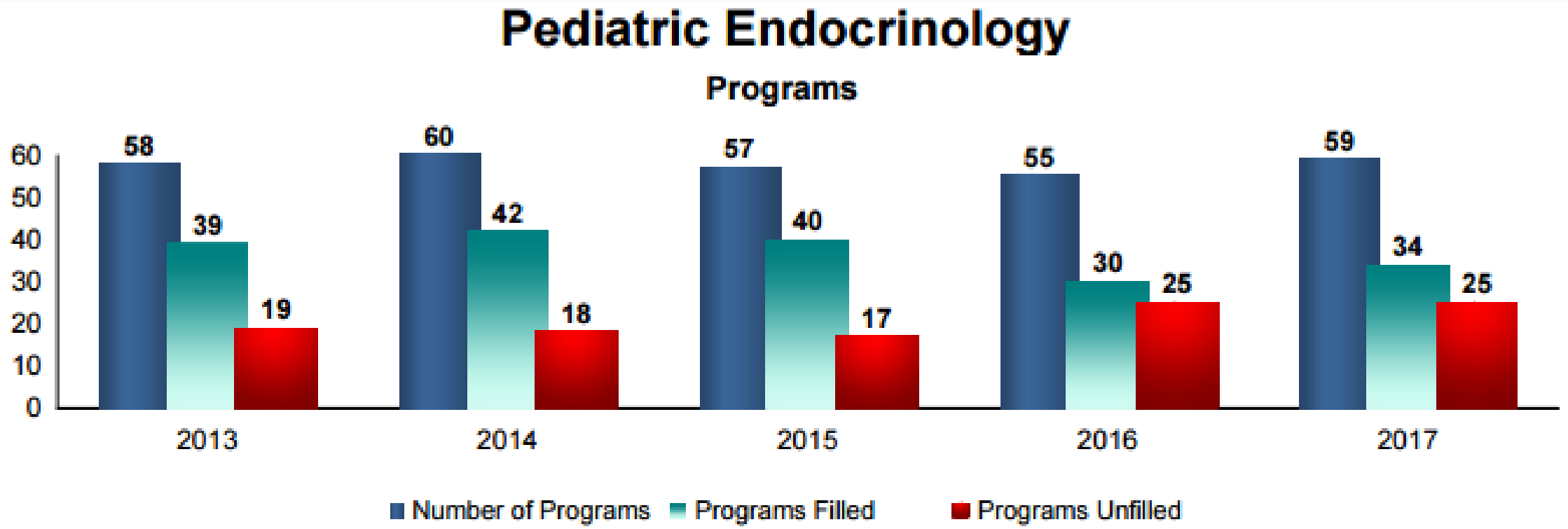
The statistics from the past Match

	2017	2016	2015	2014
No of positions	88 (59 programs)	83	85	84
% Filled in Total	69	65	76.5	73.8
% Filled by US grads	39.8	55.5	49.4	38.1

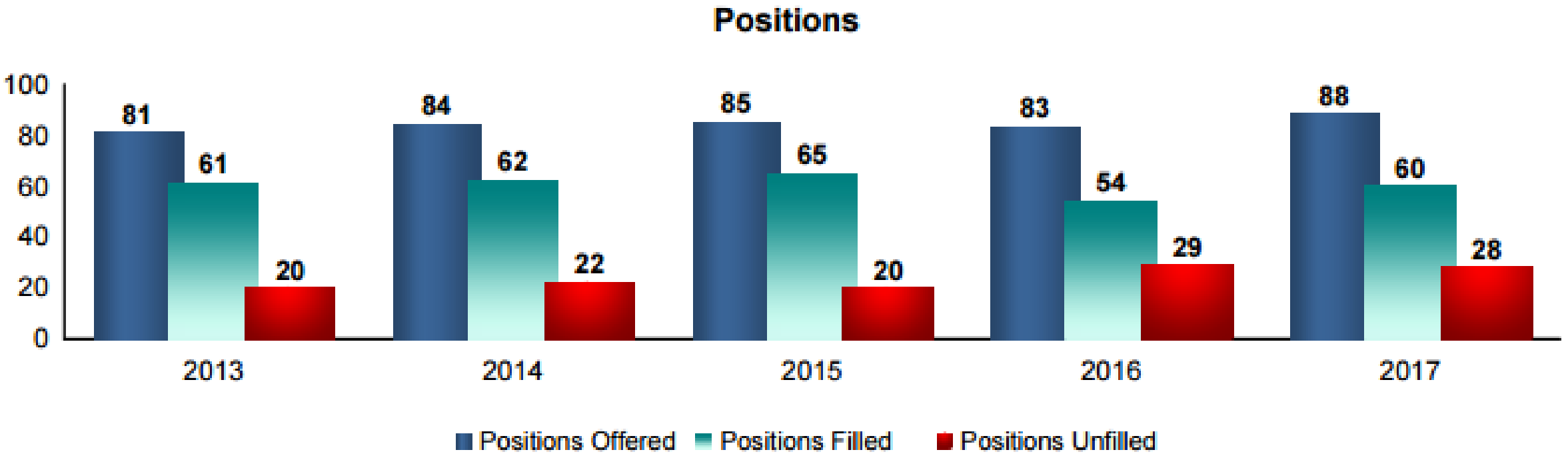
Table 5 Fellowship Matches by Specialty and Applicant Choice, 2017 Appointments

Specialty	Number of Applicants Ranking Specialty		Number Matched		Matches by Rank Choice								Matched in Another Specialty		Unmatched	
	Total	Preferred Specialty	Total	Preferred Specialty	1st Choice		2nd Choice		3rd Choice		Greater Than 3rd Choice					
Pediatrics																
Child Abuse	14	13	12	12	12	85.7	0	0.0	0	0.0	0	0.0	1	7.1	1	7.1
Developmental and Behavioral Pediatrics	32	32	31	31	26	81.3	1	3.1	2	6.3	2	6.3	0	0.0	1	3.1
Neonatal-Perinatal Medicine	248	248	234	234	128	51.6	51	20.6	26	10.5	29	11.7	0	0.0	14	5.6
Pediatric Cardiology	165	165	139	139	74	44.8	21	12.7	17	10.3	27	16.4	0	0.0	26	15.8
Pediatric Critical Care Medicine	188	187	179	178	102	54.3	29	15.4	18	9.6	30	16.0	1	0.5	8	4.3
Pediatric Emergency Medicine*	214	213	177	157	95	44.4	33	15.4	22	10.3	27	12.6	2	0.9	35	16.4
Pediatric Endocrinology	61	61	60	60	43	70.5	9	14.8	6	9.8	2	3.3	1	1.6	0	.0
Pediatric Gastroenterology	102	102	86	86	37	36.3	27	26.5	5	4.9	17	16.7	0	0.0	16	15.7
Pediatric Hematology/Oncology	188	188	163	163	83	44.1	38	20.2	18	9.6	24	12.8	0	0.0	25	13.3

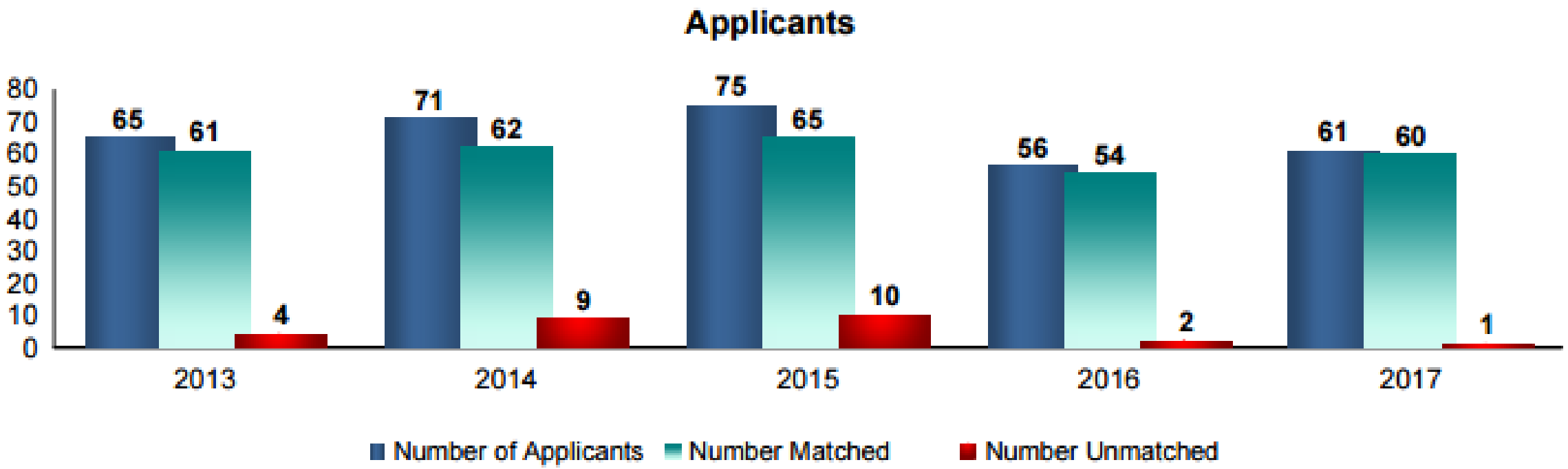
Since the match….by program

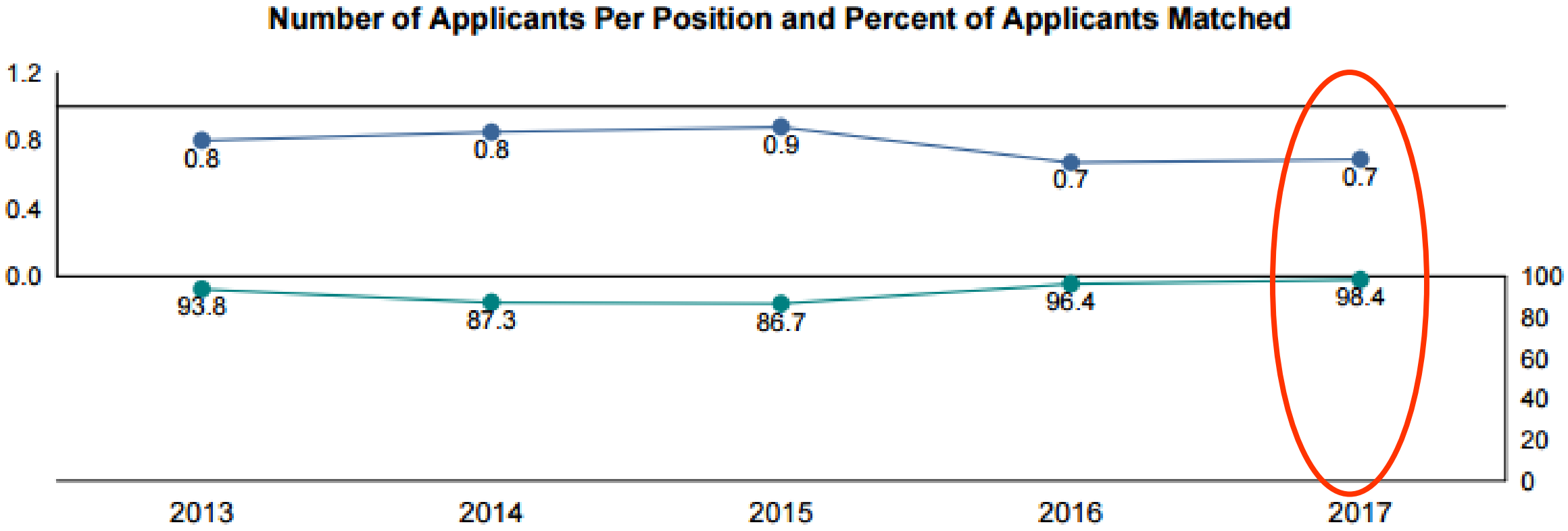


Since the match….by position



Since the match…by applicants




Number of Applicants Per Position and Percent of Applicants Matched
1.2
0.8
0.4
0.0
0.8
0.8
0.9
0.7
0.7
93.8
87.3
86.7
96.4
98.4
100
80
60
40
20
0
2013
2014
2015
2016
2017

	# positions	% filled TOTAL	% filled US
Adolescence	32	81.6	76.9
Child Abuse	26	46.2	83.3
Dev and Behavior	44	70.5	67.7
NICU	254	92.1	58.1
Cardiology	142	97.9	77.0
Critical Care	187	95.7	65.9
Emergency	180	98.3	67.2
Endocrine	88	68.2	58.3
Gastroenterology	92	93.5	59.3
Hematology/Oncology	166	98.2	69.3
Hospital Medicine	44	86.4	86.8
Infectious Disease	77	62.3	58.3
Nephrology	59	54.2	56.3
Pulmonology	67	70.1	44.7
Rheumatology	40	72.5	69.0
Sports Medicine	25	92.0	69.5

Where were spots still left after Match Day?

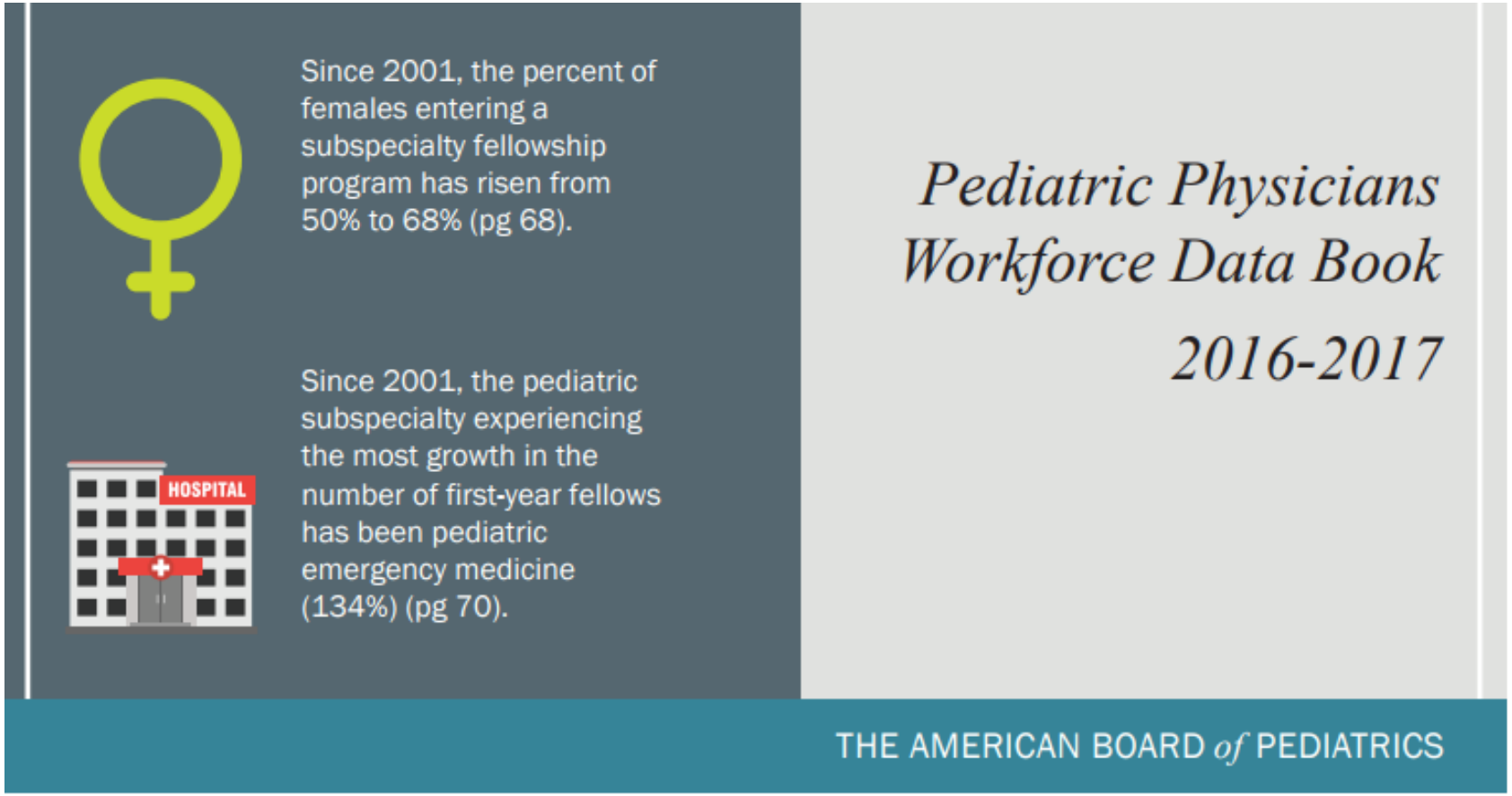
Alabama (*)
Phoenix
Stanford (*)
UC Davis
UCLA
Emory (*)
U of Chicago (*)
LSU
Hopkins
U Mass Bay State
Mayo
U Minnesota (*)
Mercy
SUNY Brooklyn
SUNY Buffalo
SUNY Stony Brook
SUNY Winthrop
Case
St. Christopher’s
Brown

- Vanderbilt
- U Utah (*)
- U Texas

(*) =partial fill

Pediatric Endocrinology
Training Level Tracking Data

Year Starting July 1	Training Level 1	2	3	Total
2000	49	32	38	119
2001	53	51	33	137
2002	73	47	50	170
2003	79	61	48	188
2004	71	72	57	200
2005	76	72	65	213
2006	89	75	66	230
2007	77	80	68	225
2008	93	81	76	250
2009	86	89	75	250
2010	98	79	84	261
2011	94	94	73	261
2012	94	85	93	272
2013	91	90	82	263
2014	90	80	88	258
2015	90	81	76	247



- Tracked since start of Pediatric Residency
- Board Certification is Voluntary
  (ACGME accredited program, sign off from program director and unrestricted license)
- Each ITE, Certification exam and beginning of MOC cycle q 5 years

Table 1.2. All Multi-Certified Pediatric Diplomates Ever Certified

(as of December 31, 2016)

Certification type	General Pediatrics	Adolescent Medicine	Pediatric Cardiology	Child Abuse Pediatrics	Pediatric Critical Care Medicine	Developmental-Behavioral Pediatrics	Pediatric Emergency Medicine	Pediatric Endocrinology	Pediatric Gastroenterology	Pediatric Hematology-Oncology	Pediatric Infectious Diseases	Neonatal-Perinatal Medicine	Pediatric Nephrology	Pediatric Pulmonology	Pediatric Rheumatology	Hospice and Palliative Medicine	Medical Toxicology	Neurodevelopmental Disabilities	Sleep Medicine	Sports Medicine	Transplant Hepatology
General Pediatrics	118,292	692	3,218	352	2,693	775	2,242	1,781	1,649	3,027	1,553	6,408	996	1,301	407	277	44	255	274	287	114
Adolescent Medicine	692	–	0	2	0	2	2	5	0	1	1	1	0	0	2	1	0	1	1	9	0
Pediatric Cardiology	3,218	0	–	0	128	0	1	0	0	0	0	40	0	0	0	0	0	0	1	0	0
Child Abuse Pediatrics	352	2	0	–	2	2	23	0	0	1	2	1	0	0	0	0	0	0	0	0	0
Pediatric Critical Care Medicine	2,693	0	128	2	–	0	18	1	2	4	10	49	9	68	1	50	2	0	8	0	0
Developmental-Behavioral Pediatrics	775	2	0	2	0	–	0	0	0	0	0	8	0	0	0	2	0	85	3	1	0
Pediatric Emergency Medicine	2,242	2	1	23	18	0	–	1	0	3	15	2	0	1	0	2	23	0	0	8	0
Pediatric Endocrinology	1,781	5	0	0	1	0	1	–	2	2	0	4	5	0	0	0	0	0	0	0	0
Pediatric Gastroenterology	1,649	0	0	0	2	0	0	2	–	0	0	3	0	0	0	0	0	1	0	0	114

Table 1.3. All Multi-Certified Pediatric Diplomates Ever Certified, Age 70 and Under

(as of December 31, 2016)

General Pediatrics	93,727	630	2,633	329	2,629	709	2,185	1,475	1,554	2,497	1,401	5,450	725	1,199	380	272	39	222	269	278	109
Adolescent Medicine	630	–	0	1	0	1	2	2	0	0	0	0	0	0	2	1	0	1	1	9	0
Pediatric Cardiology	2,633	0	–	0	118	0	1	0	0	0	0	22	0	0	0	0	0	0	1	0	0
Child Abuse Pediatrics	329	1	0	–	2	2	21	0	0	1	1	1	0	0	0	0	0	0	0	0	0
Pediatric Critical Care Medicine	2,629	0	118	2	–	0	16	1	1	4	7	38	7	58	1	50	2	0	8	0	0
Developmental-Behavioral Pediatrics	709	1	0	2	0	–	0	0	0	0	0	7	0	0	0	2	0	77	3	1	0
Pediatric Emergency Medicine	2,185	2	1	21	16	0	–	1	0	1	14	1	0	1	0	2	22	0	0	8	0
Pediatric Endocrinology	1,475	2	0	0	1	0	1	–	2	2	0	2	1	0	0	0	0	0	0	0	0

306 certifications held by above Age 70 years.

Table 5.7.1. All Pediatric Endocrinology Diplomates Ever Certified: Distribution of Certificate Status by Demographics

(as of December 31, 2016)

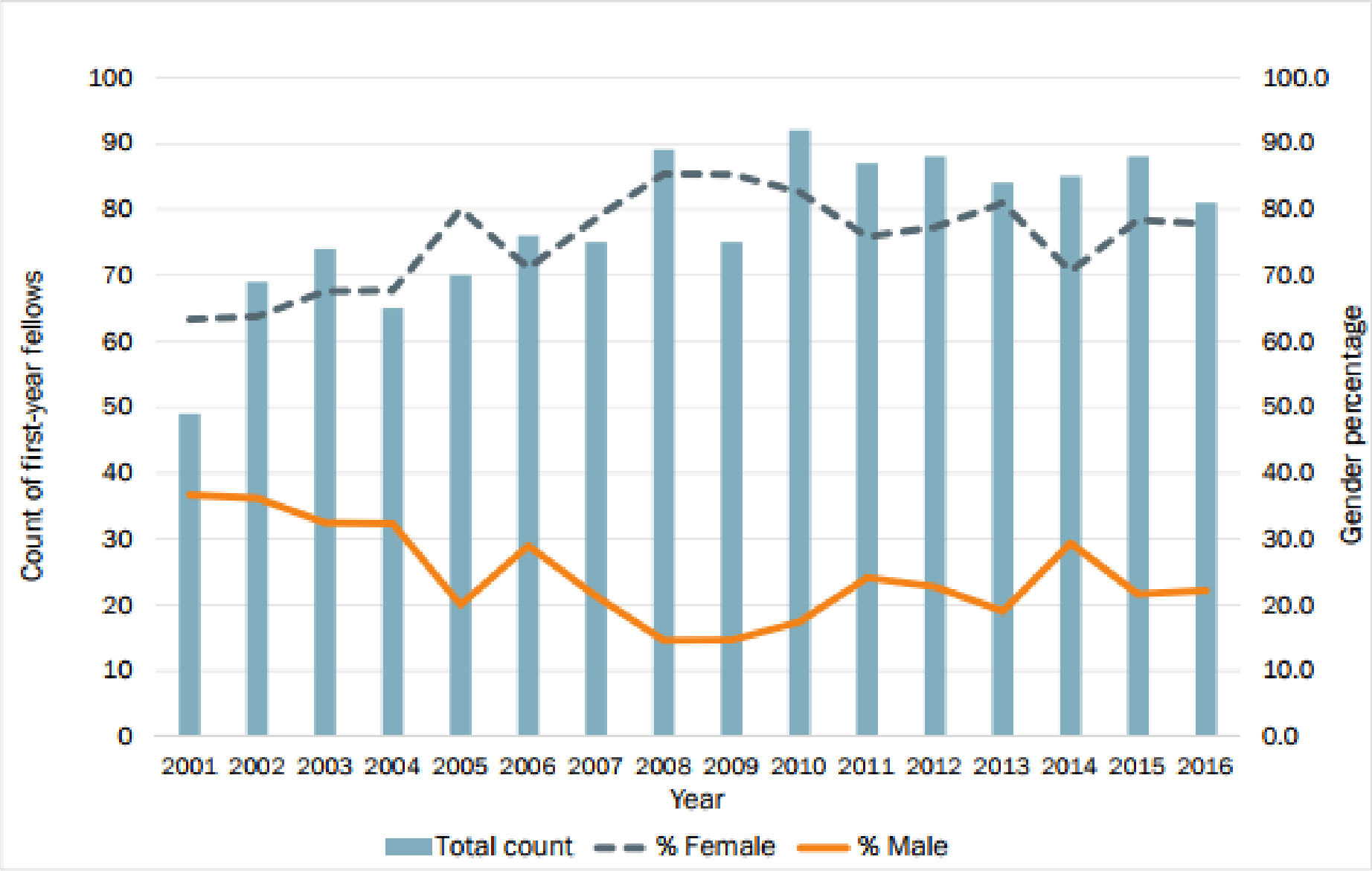
	Certificate status									
	Permanent (n=489)		Time-limited/ no end date (n=1,099)		Lapsed (n=187)		Revoked (n=6)		Total (n=1,781)	
Variables	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**
Age										
31 to 40	0	0.0	326	29.7	20	10.7	0	0.0	346	19.4
41 to 50	0	0.0	431	39.2	38	20.3	0	0.0	469	26.3
51 to 60	1	0.2	259	23.6	57	30.5	1	16.7	318	17.9
61 to 70	199	40.7	77	7.0	64	34.2	2	33.3	342	19.2
71 to 80	173	35.4	6	0.5	7	3.7	2	33.3	188	10.6
81 to 90	64	13.1	0	0.0	1	0.5	1	16.7	66	3.7
≥ 90	16	3.3	0	0.0	0	0.0	0	0.0	16	0.9
No birth year available	36	7.4	0	0.0	0	0.0	0	0.0	36	2.0
Gender										
Female	149	30.5	763	69.4	109	58.3	0	0.0	1,021	57.3
Male	340	69.5	336	30.6	78	41.7	6	100.0	760	42.7
Medical school graduate type										
AMG	337	68.9	752	68.4	124	66.3	5	83.3	1,218	68.4
IMG	152	31.1	347	31.6	63	33.7	1	16.7	563	31.6

Table 5.7.2. All Pediatric Endocrinology Diplomates Ever Certified, Age 70 and Under: Distribution of Certificate Status by Demographics

(as of December 31, 2016)

	Certificate status									
	Permanent (n=200)		Time-limited/ no end date (n=1,093)		Lapsed (n=179)		Revoked (n=3)		Total (n=1,475)	
Variables	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**
Age										
31 to 40	0	0.0	326	29.8	20	11.2	0	0.0	346	23.5
41 to 50	0	0.0	431	39.4	38	21.2	0	0.0	469	31.8
51 to 60	1	0.5	259	23.7	57	31.8	1	33.3	318	21.6
61 to 70	199	99.5	77	7.0	64	35.8	2	66.7	342	23.2
Gender										
Female	79	39.5	761	69.6	105	58.7	0	0.0	945	64.1
Male	121	60.5	332	30.4	74	41.3	3	100.0	530	35.9
Medical School										
AMG	161	80.5	749	68.5	122	68.2	2	66.7	1,034	70.1
IMG	39	19.5	344	31.5	57	31.8	1	33.3	441	29.9

Figure 5.7.2. Yearly Count of First-Year (Level 1) Fellows in Pediatric Endocrinology Programs Since 2001 by Gender



Data that is available

Certification by:

- Age
- Gender
- Medical School Type
- State
- Number of hours worked
- Responsibility
- Research

Workforce still remains an issue….

- Can we do it on our own?
- Do we partner with other subspecialties etc.

Controversies and Discussions

Length of Fellowship training

- Hospitalist Medicine has been approved as a 2 year fellowship
- Still requires the research component
- Will we need to head that way?

PDs need protected time

- How have Chairs accepted this?
- Are fellowship positions at risk?

Start date delayed to July 7, 2017

- Can all fellowships do this?

ACGME Clinical Education and Experience FAQS

The new requirements specify that clinical work done from home must count toward the 80-hour weekly maximum, averaged over four weeks. Why was this change made?

The requirements acknowledge the changes in medicine, including electronic health records, and the increase in the amount of work residents and fellows choose to do from home. Resident decisions to complete work at home should be made in consultation with the resident's/fellows' supervisor. In such circumstances, residents/fellows should be mindful of their professional responsibility to complete work in a timely manner and to maintain patient confidentiality. The requirement provides flexibility for residents/fellows to do this while ensuring that the time spent completing clinical work from home is accomplished within the 80-hour weekly maximum.

What is included in the definition of clinical and educational work hours under the requirement limiting them to 80 hours per week?

- All clinical and educational work activities related to the training program
  - Inpatient/Outpatient Care
  - In-House Call /Short Call/Night Float
  - Day Float
  - Transfer of patient care
  - Administrative activities related to patient care- completing medical records, signing orders, ordering and reviewing tests, etc., whether done in the institution or at home
  - Time spent taking calls from home
  - Time spent in the hospital after being called in from home call
  - Activities such as membership on hospital committees, interviewing candidates etc.
- Reading, studying and research does not count towards the eighty hours
- Military commitments counts toward the 80-hour limit only if that time is spent providing patient care

Is it permissible for residents/fellows to take call from home for extended periods, such as a month?

No. The requirement for one day free every week prohibits being assigned home call for an entire month. Assignment of a partial moth (more than six days but fewer than 28 days) is possible. However, keep in mind that call from home is appropriate if service intensity and frequency of being called is low. Program directors are expected to monitor the intensity and workload resulting from home call through periodic assessment of workload and intensity of in-house activities.

What are the expectations regarding tracking and monitoring clinical work done from home?

Types of work from home that must be counted include using an electronic health record and responding to patient care questions. Reading done in preparation for the following day's cases, studying and research done from home do not count toward the 80 hours.

Residents and fellows are expected to track the time spent on these activities and report this time to the program director. The program director then will use this information when developing scheduled to ensure that residents and fellows are not exceeding 80 hours per week, averaged over four weeks. Decisions about whether to report brief periods devoted to clinical work (e.g. a phone call that lasts just a couple of minutes) are left to the individual resident/fellow. There is no requirement regarding how this time is tracked and documented and no expectation that the program director assume a role in verifying the time reported by residents and fellows.

How should the averaging of the clinical and educational work hour requirements (e.g., 80-hour weekly limit, one day free of clinical and educational work every week, and call no more frequently than every third night) be handled? For example, what should be done if a resident/fellow takes a vacation week?

Averaging must occur by rotation. This is done over one of the following:

- a four-week period;
- a one-month period (28-31 days);
- or the period of the rotation if it is shorter than four weeks.

- When rotations are shorter than four weeks in length, averaging must be made over these shorter assignments. This avoids heavy and light assignments being combined to achieve compliance.

If a resident/fellow takes vacation or other leave, the ACGME requires that vacation or leave days not be included when calculating clinical and educational work hours, call frequency, or days off.

How do the ACGME common clinical and educational work hour requirements apply to research activities?

- Work hour requirement pertain to all required hours in the program

  The only exceptions are reading and self-learning.
- When research is a formal part of the accredited program research hours and any combination of research and patient care activities must comply with the requirements.
- If residents/fellows conduct research on their own time these hours do not count toward the limit on clinical and educational work hours.

  The combined hours spent on self-directed research and program-required activities should meet the test for a reasonably rested and alert resident/fellow when he or she participates in patient care.

  Adding clinical activities to "pure" research rotations, such as having research residents/fellows cover "night float" could result in hours that exceed the weekly limit and could also seriously undermine the goals of the research rotation. Review Committees have traditionally been concerned that required research not be diluted by combining it with significant patient care assignments.

Entrustable Professional Activities

7 Common Subspecialty EPAs

4 Pediatric Endocrinology Specific EPAs

Curricular Components now developed for both common and pediatric endocrine specific EPAs (on ABP website)

Entrustment Scales developed for all (method of evaluating the level of competency/entrustment for individual fellows)

Common Subspecialty EPAs

EPAs that cross the generalist to subspecialist role:

- Provide for and obtain consultation from other health care providers caring for children. (Read More)
- Contribute to the fiscally sound and ethical management of a practice (e.g., through billing, scheduling, coding, and record keeping practices). (No. 13 General Peds)
- Apply public health principles and improvement methodology to improve care for populations, communities, and systems. (No. 14 General Peds)
- Lead an interprofessional health care team. (No. 15 General Peds)
- Facilitate handovers to another healthcare provider. (No. 16 General Peds)

EPAs that are common to all subspecialties:

- Engage in scholarly activities through the discovery, application, and dissemination of new knowledge. (*broadly defined*) (*Under construction*)
- Lead within the subspecialty profession. (Read More)

Pediatric Endocrinology EPAs

Manage patients with acute endocrine disorders in ambulatory, emergency or inpatient settings.

Manage patients with chronic endocrine disorders in the ambulatory or inpatient settings.

Facilitate the transition of patients with endocrine disorders from pediatric to adult health care.

Know the indications for performing the common procedures of the pediatric endocrinologist and be able to interpret the results.

FACILITATE THE TRANSITION OF PATIENTS WITH ENDOCRINE DISORDERS FROM PEDIATRIC TO ADULT HEALTH CARE	
1	Trusted to observe only
2	Trusted to execute with direct supervision and coaching
3	Trusted to execute with indirect supervision and discussion of information gathered and conveyed for selected simple and all complex cases
4	Trusted to execute with indirect supervision and may require discussion of information gathered and conveyed but only for selected complex cases
5	Trusted to execute independently without supervision

KNOW THE INDICATIONS FOR PERFORMING THE COMMON PROCEDURES OF THE PEDIATRIC ENDOCRINOLOGIST AND BE ABLE TO INTERPRET THE RESULTS	
1	Trusted to observe only
2	Trusted to determine testing and provide interpretation with direct supervision and coaching
3	Trusted to determine testing and provide interpretation with indirect supervision for simple cases only; complex cases require direct supervision
4	Trusted to determine testing and provide interpretation with indirect supervision and may require discussion of interpretation but only for selected complex cases
5	Trusted to execute independently without supervision

MANAGE PATIENTS WITH ACUTE ENDOCRINE DISORDERS IN AMBULATORY, EMERGENCY OR INPATIENT SETTINGS	
1	Trusted to observe management only
2	Trusted to manage with direct supervision and coaching
3	Trusted to manage with indirect supervision and discussion of information gathered and conveyed for selected simple and all complex cases
4	Trusted to manage with indirect supervision and may require discussion of information gathered and conveyed but only for selected complex cases
5	Trusted to manage independently without supervision

MANAGE PATIENTS WITH CHRONIC ENDOCRINE DISORDERS IN AMBULATORY, EMERGENCY OR INPATIENT SETTINGS	
1	Trusted to observe management only
2	Trusted to manage with direct supervision and coaching
3	Trusted to manage with indirect supervision and discussion of information gathered and conveyed for selected simple and all complex cases
4	Trusted to manage with indirect supervision and may require discussion of information gathered and conveyed but only for selected complex cases
5	Trusted to manage independently without supervision

Where are we headed?

ABP has not yet stated a specific desire to use EPAs as a means of assessing competence for board certification

SPIN Network is designing research questions and studies aimed at investigating how EPAs might be used to standardize what “readiness” for graduation looks like

Most recent study aimed at evaluating the Level of Entrustment that Program Directors felt was appropriate for those completing fellowship and then whether or not they felt achieving this level would be a requirement for graduation

Pediatric Endocrinology had 76% of our programs complete the survey. **Thanks to all those who participated!!**

DO FELLOWSHIP PROGRAM DIRECTORS AND CLINICAL COMPETENCY COMMITTEES AGREE IN FELLOW ENTRUSTMENT DECISIONS?

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Harbor-UCLA Medical Center, Torrance, CA; American Board of Pediatrics, Chapel Hill, NC; University of Utah, Salt Lake City, UT; Stanford University, Stanford, CA; Jefferson Medical College/AlfPont Hospital for Children, Wilmington, DE; University of Rochester, Rochester, NY; University of Arkansas for Medical Sciences, Little Rock, AZ; Emory University, Atlanta, GA; Boston Children's Hospital, Boston, MA; Yale-New Haven Medical Center, New Haven, CT and University of Illinois College of Medicine at Chicago, Chicago, IL

Introduction

- Throughout fellowship, Fellowship Program Directors (FPD) assess fellow performance, including their required level of supervision
- Clinical Competency Committees (CCC) now also evaluate fellow progress
- Unlike in residency, members of the CCC and the FPD both have extensive longitudinal interactions with most, if not all, fellows
- As a result, assignment of the required level of supervision would be expected to be similar

Hypothesis

We examined the association of the entrustment levels determined by the FPD with that of the CCC for 6/7 common pediatric subspecialty Entrustable Professional Activities (EPAs), hypothesizing that there would be a strong correlation and minimal bias between their judgments

Methods

Study Network

- Study utilized the Subspecialty Pediatrics Investigator Network (SPIN)
- Network links the 14 pediatric subspecialty fellowship program director organizations
- SPIN subspecialty representatives recruited programs to participate

Data Collection

- One week before CCC meeting, FPDs assigned level of supervision for each fellow for the 6 common pediatric subspecialty EPAs (Fig 1)
- Then, at the CCC meeting, CCC assigned a level of supervision for each fellow for the 6 EPAs
- FPD reported whether he/she was a CCC member
- Data collection in fall 2014 & spring 2015

Methods

Fig. 1 Common Pediatric Subspecialty EPAs	Abbreviation
Apply public health principles and improvement methodology to improve care for populations, communities, and systems (QI)	Pubhealth
Provide for and obtain consultation from other health care providers caring for children	Consultation
Contribute to the fiscally sound and ethical management of practice (e.g., through billing, scheduling, coding, & record keeping practices)	Management
Facilitate handovers to another health care provider	Handover
Lead and work within interprofessional health care teams	Leadteam
Lead within the subspecialty profession	Leadprof
Engage in scholarly activities through the discovery, application, and dissemination of new knowledge	Not evaluated in this study

Level of Supervision Scales

- Supervision scales with five levels were created and subsequently validated in the study
- Scales were developed to be consistent with current approach to fellow supervision
- No faculty development provided

Data Analysis

- For each EPA, the correlation between FPD and CCC assessments was analyzed with Spearman rho
- Group correlations were compared with Chi-Square
- Bias was calculated as CCC minus FPD values

Results

Fig 2. Study Participation	Fall 2014	Spring 2015
Number of Programs	208	209
Fellows (n)	1040	1058
FPD member of CCC	598	594
FPD not member of CCC	442	464

Results

Fig. 3 Correlation of FPD/CCC assignment of level of supervision

EPA	Period	FPD on CCC	FPD Not on CCC
		Rho	Rho
Pubhealth	Fall	0.70	0.63
	Spring	0.79	0.64
Consultation	Fall	0.77	0.70
	Spring	0.82	0.76
Management	Fall	0.74	0.64
	Spring	0.77	0.61
Handover	Fall	0.80	0.63
	Spring	0.81	0.70
Leadteam	Fall	0.79	0.62
	Spring	0.80	0.75
Leadprof	Fall	0.74	0.61
	Spring	0.74	0.56

- In both periods, the correlation for FPD not on the CCC was slightly lower ($p<0.001$) compared with FPD on the CCC (Fig 3)

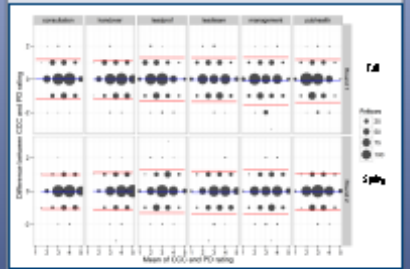

Fig 4 Bland-Altman plot showing bias for FPD on the CCC. Red lines indicate 1.96 SD from the mean difference

- Mean (95% CI) bias for the FPD on (Fig 4) not on (Fig 5) CCC in the fall was -0.05 (-0.05 to -0.04) vs -0.12 (-0.13 to -0.11) and -0.05 (-0.05 to -0.05) vs -0.04 (-0.05 to -0.04) in the spring, respectively

Results

Fig 5 Bland-Altman plot showing bias for FPD NOT on the CCC. Red lines indicate 1.96 SD from the mean difference

Conclusions

- There is a strong correlation between FPD and CCC assignment of entrustment levels for these 6 common pediatric subspecialty EPAs
- Although the association is slightly weaker when the FPD is not a CCC member, since the bias is very small, this is unlikely to be important in determining fellow level of entrustment

SPIN Steering Committee

Collaborators

- Special thanks to Alma Ramirez, BS
- Financial support provided by the ABP Foundation

Strategic Plan for Training Council

Curriculum Development

- Solicit current best practices to share nationally

- Development of subspecialty core

Workforce

- Continued discussion about shortening the timing of fellowship

- Economic arguments are significant. Can we find a way to promote loan forgiveness or other ways to improve the financial interests?

- ? Create program targeted at medical students/residents

Visiting Fellows

- Current model: 1-2 week of intensive lectures and clinical experience proposed by institutions

- Potential new model similar to ISPAD

- Fellows identify a specific mentor/program that is not available at home institution

- likely 7-14 days

- Solicit interest from programs to develop list of potential sites for fellows

- Second and third year fellows preferable

- Letters for fellow, PD and proposed mentor