National Pediatric Hospital Medicine Leaders Conference
April 4-5, 2013
Summary

On April 4-5, 2013 a Pediatric Hospital Medicine Leaders Conference convened at the American Board of Pediatrics (ABP) headquarters to discuss the options concerning potential certification for PHM. The meeting was funded by the ABP Foundation. The participants were:

Becky Blankenburg (Pediatric Program Director)
Ryan Bode (STP Sub-Committee (Residency Track) Co-Chair
Doug Carlson (Joint Council of Pediatric Hospital Medicine (JCPHM) – SHM rep)
Erin Stucky Fisher (JCPHM chair)
Chris Maloney (STP co-chair)
Jennifer Maniscalco (PHM education task force)
Rachel Marek (AAP SOHM Community hospitalist subcommittee co-chair)
Vineeta Mittal (JCPHM – APA rep)
Mary Ottolini (JCPHM – at-large member)
Ricardo Quinonez (JCPHM – AAP SOHM rep)
Shawn Ralston (VIP rep)
Daniel Rauch (JCPHM – AAP SOHM rep)
Ken Roberts (Community hospitalist)
Neha H. Shah (PHM Fellowship Director)
Suzanne Swanson Mendez (STP co-chair)
Tamara Simon (JCPHM – PRIS rep, via phone)
Jeffrey Simmons (JCPHM – APA rep)
David Zipes (JCPHM – SHM rep)

Douglas Barrett (ABP Board of Directors)
Carol Carraccio (ABP Director of Competency-Based Assessment Programs)
Joe Gilhooly (Chair, Accreditation Council for Graduate Medical Education (ACGME) Pediatric Residency Review Committee (RRC))
David Jaffe (ABP Board of Directors)
Stephen Ludwig (invited facilitator)
Gail McGuinness (ABP Executive Vice President)
Paul Miles (ABP immediate past Vice President for Maintenance of Certification and Quality)
David Nichols (ABP President and CEO)

The pediatric hospital medicine participants represented programs from all areas and settings including community/urban and adult-pediatric/pediatric only settings. The ABP participants advised on the function of the ABP, the Maintenance of Certification (MOC) process and past subspecialty petitions (successful and unsuccessful). The ABP staff did not participate in discussion or voting regarding the certification options.

All agreed on two basic tenets: 1) Improve care for hospitalized children and 2) Provide the public with assurances, defining pediatric hospital medicine and pediatric hospitalists. What skills, knowledge and attitudes are required to ensure high value care of hospitalized children?

This led to our two questions to be addressed at this meeting:
1) What is the best way to improve the care of hospitalized children?
2) What is the best way to ensure the public trust?

The first day was spent covering information from background materials including mission and vision statement of the JCPHM and brief overview (Fisher); survey statistics from the Society of Hospital Medicine state of hospital medicine 2012 and AAP resident survey (Rauch); previous work of the Strategic Planning Committee (STP) (Maloney and Mendez); status of The American Board of Internal Medicine (ABIM) MOC pilot (Carlson); experiences of General Academic Pediatrics and Pediatric Emergency Medicine (Ludwig); changes to residency training (Gilhooly); and MOC and subspecialty certification process (McGuinness).

Four options were considered:

1. Utilizing the new residency guidelines to create a pediatric hospital medicine track (6 units of individualized curriculum)
2. Some variation of MOC similar to the ABIM Recognition of Focused Practice
3. Additional standardized post-residency training
4. Traditional 3 year fellowship

All options were carefully and thoroughly deliberated. Each option was reviewed in small breakout groups and then presented for full group discussion. Each option was evaluated on the ability to provide the best model with regard to: ensuring high value care to hospitalized children; ensuring the public trust; attaining PHM competencies; validity and feasibility; comparison to the other 3 models.

MODEL	To children	To public	Competencies	Validity/feasibility	Comparison
Residency	Not met	Not met	Not met	*Not feasible to fully train in residency, even with the 6 individualized months, even if standardized across all residency programs	See below
MOC	Yes – but unclear if this addresses knowledge gap after	Unclear, but positive potential	Yes, if rigorous MOC Dependent on ACCME and	*No extra infrastructure cost compared to fellowship/additional training models *No perceived	Not best model to meet patient and public trust tenets

	residency program		profession and individual	barriers to entry of PHM practice * Not a successful model so far in adult hospital medicine ^	
Additional training	Yes	Yes – but only if accredited and certified	Yes but duration not clear	*Consider 1-2-3-4 years option *Harder to standardize *Scholarship included in training	Additive to residency model
Fellowship	Yes	Yes	Yes	*Yes but cost *Advances field *Community hospital training a must *Scholarship included in training	Additive to residency model Best model but at 2 years
In all models, the residency track (6 units of individualized curriculum) was seen as adjunct to training needed. ^ ABIM MOC model has limited number (<350) engaged in the hospital medicine MOC model after 2 years of implementation					

There was overwhelming consensus that the practice of PHM requires post residency training (16 for, 1 against, 1 abstain). The purpose of Pediatric Residency (per the ACGME Pediatric Program Requirements) is to "provide educational experiences that emphasize the competencies and skills needed to practice general pediatrics of high quality in the community. Education in the fields of subspecialty pediatrics enables graduates to participate as team members in the care of patients with chronic and complex disorders". This leaves a significant gap in knowledge and skills needed to provide ongoing care to the population of hospitalized children. Key areas include but are not limited to communication skills, negotiation, leadership, Quality Improvement (QI), pain management, sedation, procedures, transport, billing/coding, autonomous decision making, and scholarly practice.

There was overwhelming consensus that an MOC program could not provide the rigor to insure that all pediatric hospitalists would meet a standard.

There was overwhelming consensus that a standardized training program resulting in certification was the best option to assure adequate training in the PHM Core Competencies and provide the public with a meaningful definition of a pediatric hospitalist (17 for, 1 abstain).

There was overwhelming consensus that the duration of such training should be 2 years, recognizing that there may be trainees who will seek additional training to attain expertise in selected areas (16 for, 2 abstain). Deliberation addressed the following areas: meeting the competencies, efficiency, ability to adequately incorporate community-based experiences, cost, and time for scholarly work. Costs both for the infrastructure (fellowship program growth and sustainability) and to the individual participants (cost of test is neutral as board exam is already required; costs incurred during lesser salaried fellowship period) were discussed. The two year program was determined to best meet the needs of all, and remain within financially reasonable limits. Center for Medicare and Medicaid (CMS) and , Children's Hospitals Graduate Medical Education (CHGME) funding, and individual University Departments and Schools of Medicine are typical current sources of financial support for many fellowship training programs. These are always at risk given the fiscal environment. Hospital funding is promising, given the QI work and roles filled by PHM within institutions. Grant funding is an option mentioned by one participant.

There was overwhelming consensus that a 2 year accredited fellowship track was optimal path to provide the best patient care for hospitalized children and assure the public the qualifications of physicians practicing Pediatric Hospital Medicine. It was also agreed that this path was most likely to move the field forward, leading to worthy scholarship that will benefit hospitalized children.

For questions please email individual participants or jointcouncilPHM@gmail.com

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- Community hospitalists - Rachael Marek rlmarek@hotmail.com
- Kenneth Roberts kenrobertsmd@gmail.com
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- Fellowship directors - Neha Shah NShah@childrensnational.org
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- Residency - Becky Blankenburg rblanke@stanford.edu
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The meeting was adjourned on April 5, 2013.

Pediatric Hospital Medicine Certification meeting

Clarifying information on subspecialty process

FAQs:

- What is the process for creation of a new subspecialty?
  - A petition must be submitted to the ABP. The ABP may not accept the petition. A 2 year fellowship program is not the current standard for fellowships at the ABP.
- If it is successful, how long does the process take to create a new subspecialty?
  - The process for petitioning the ABP for sub specialty status is typically a 6 year process during which time ABP and American Board of Medical Specialties (ABMS) approvals are obtained and the test is created.
- When would fellowships need to be accredited?
  - Once a certifying examination has been implemented, the ACGME will begin the fellowship program accreditation process. Typically this occurs a year or two after the first exam.
- I did not do a fellowship, can I take the test? I am currently in a fellowship; can I take the test?
  - Current pediatric hospitalists who meet minimal experiential standards will be able to sit for the exam the first 3 test dates (so called 'grandfathering'). The test is given every other year so there will be 4 years from the first test for non-fellowship trained individuals to be eligible to take the exam. This process allows everyone currently practicing PHM and most future pediatric hospitalists for at least the next 7-8 years the ability to sit for the exam.
  - Everyone in a fellowship program that exists at the time testing begins to be offered will be eligible for the test. All PHM fellowship programs are currently not ABP accredited, as no such accreditation exists. Once the fellowship accreditation process does exist, then only ACGME approved fellowships will be able to have their graduates sit for the exam.
- When do I have to take the test, if I want to be "grandfathered"
  - If someone applies and is approved for the exam, he/she has 7 years to become certified, i.e. take and pass the exam. So one can actually defer taking the exam beyond the "grandfathering " period. The clock starts ticking for the seven year time limit the year of approval for the exam if under the practice pathway.
- I am not in a fellowship now. Do I have to get into one in the next few years?
  - No, if you are currently in practice, or if you are in a currently non-accredited fellowship you will be "grandfathered" in as noted above. Only those entering the field of hospital medicine in the future - after the ACGME approves fellowships – will need to be in a fellowship in order to sit for the certification test.
- When would future pediatric residency graduates need to enter a PHM fellowship?
  - After the ACGME approves fellowships, or approximately 8 years from the time of initiating the subspecialty process.
- If I take the PHM subspecialty boards, do I also need to maintain my general pediatric board certificate?
  - No, there will be no need to maintain board certification in General Pediatrics once PHM certification is attained.
- What does "accredited" mean? What does "certified" mean?

- An accredited training program is a residency or fellowship program that is approved by a reviewing body, such as the ACGME. A certified individual is one who has met the expectations of a reviewing body, such as the ABP.