Application for Subspecialty Certificate
(for a new subspecialty)

Upon completion, please forward this application for a new or modified subspecialty certificate to Lois Margaret Nora, MD, JD, MBA, ABMS President and Chief Executive Officer, in care of David B. Swanson, PhD, at dswanson@abms.org. If you need any assistance with the completion of this application, please contact Paul Lawlor, Manager, Program Review and services, at plawlor@abms.org.

1. Provide the name of the proposed new or modified subspecialty certification:
   Pediatric Hospital Medicine

2. State the purpose of the proposed new or modified subspecialty certification in one paragraph or less:
   The purpose of the new certification is to assure the best care of hospitalized children. Hospitalist care as practiced today has a positive impact on children's health via efficiency, cost, certain measures of care quality, generation of practice guidelines, immediacy of access and provider/patient satisfaction. Certification will assure the public that the title 'Board Certified Pediatric Hospitalist' indicates a proficient level of skill and knowledge has been attained and validated. Certification would improve standardization of curricula and consistency of hospitalist fellowship training and result in a better definition of hospitalists' scope of practice, thus supporting public accountability. As a new subspecialty, pediatric hospital medicine (PHM) should further accelerate improvements and innovation in quality improvement (QI) science as applied to pediatric inpatient care, create a new and larger cadre of QI experts and mentors, and enhance development of professionals skilled in addressing child health safety issues within the context of health care systems. Certification will raise the level of care of all hospitalized children by establishing best practices in clinical care and disseminating them to all settings caring for hospitalized children.

3. Document the professional and scientific status of this special field by addressing (a) through (e) below.

   a. In the space provided, please describe how the existence of a body of scientific medical knowledge underlying the proposed new or modified subspecialty area is in large part distinct from, or more detailed than, that of other areas in which certification is offered:
   Over the past 15 years, pediatric hospitalists have been defining the unique knowledge base of this evolving field with a focus on improving care at the bedside and improving processes of care within the hospital system. Two textbooks devoted to pediatric hospital medicine have been published, as well as a clinical manual by the American Academy of Pediatrics (AAP), and numerous soft cover books. These publications address common and complex clinical conditions with an approach that emphasizes the whole child, family, and coordination of care within the hospital encounter and at
transitions of care. The approach taken by hospitalists toward clinical and sociobehavioral issues often differs from that of subspecialists, reflecting the generalist approach of hospitalists. Numerous journals now publish PHM content. There are two indexed journals of note: the Journal of Hospital Medicine focuses exclusively on hospital medicine content and includes pediatric hospitalists on its editorial board, and Hospital Pediatrics focuses exclusively on PHM. There are original science sessions for PHM at the Pediatric Academic Societies annual meeting, the Society of Hospital Medicine (SHM) annual meeting, and the American Academy of Pediatrics (AAP) National Conference and Exhibition. Of note, the annual National PHM Conference in existence over 10 years, focuses exclusively on PHM inclusive of multiple scientific sessions (see below). In addition to new science, PHM physicians are active in translational research and have been authors on many recent practice guidelines that have been shown to improve the care of children. The Pediatric Research in Inpatient Settings (PRIS) network (www.prisnetwork.org) - a research network founded and led by pediatric hospitalists - is driving the research agenda and has attained over $20 million in funding. The Value in Pediatrics network (VIP), a collaborative quality improvement network also founded and led by pediatric hospitalists, is now part of the AAP Quality Innovations Improvement Network (QuIIN) program. The VIP network has been leading national collaboratives to improve benchmarking, data collection, and care, targeting common issues such as bronchiolitis and hand-off processes. Importantly, the field has also produced the PHM Core Competencies that serve as a foundation for the core set of knowledge, skills, attitudes and systems improvement attributes for pediatric hospitalists. This document serves as the template for current PHM fellowship programs' curriculum. Originally published in 2010, those competencies are now undergoing planned periodic review and revision.

Pediatric hospitalists are actively engaged in promoting the rapid evolution and dissemination of the discipline's body of knowledge. Members of the discipline have been meeting as a "stand alone" professional group since 2003. These now annual National PHM Conferences have multiple "tracks" encompassing the many domains that make up pediatric hospital medicine. The annual National PHM Conference has now become the major venue for the debut of much original research performed by pediatric hospitalists. Original research presentations have grown from a handful of abstracts at the early meetings to hundreds of scientific abstracts presented at multiple sessions across a three and a half day meeting. In addition, the number of pediatric hospitalist researchers has grown exponentially over the past decade, increasing the field's breadth of investigators. The quality of scientific research has also advanced as many early investigators are now seasoned and in mid-career.

Attendance at the annual National PHM Conference has grown substantially in no small part due to its scientific content. Attendance at the first meeting in 2003 of less than 100 has grown to 875 in 2015. In 2016, there were over 240 scientific abstracts submitted through a formal and blinded review process. The primary areas of interests include: clinical research, educational research, epidemiology, health services
research, practice management, and quality improvement. The annual meeting typically schedules the top 5 submissions in each category as an oral presentation (20-30 total oral presentations) to highlight the most scholarly work.

Publications

Given the emergence of this distinct area of scientific investigation and clinical practice, the AAP elected to launch a peer-reviewed medical journal dedicated to PHM entitled Hospital Pediatrics. This is only the second such journal to be published by the AAP. The first edition issue was issued in July 2011 and the journal is now published monthly. In October 2013 Hospital Pediatrics was approved for MEDLINE indexing by the National Library of Medicine. Pediatric hospitalists are also extensively represented on the editorial board of the Journal of Hospital Medicine, including at the Associate Editor level. There is ample pediatric content in that widely circulated monthly journal focused exclusively on hospital medicine. JAMA Pediatrics published a PHM specialty issue in October 2012 and also counts several pediatric hospitalists on its editorial board. The PHM Core Competencies were published as a supplement to the Journal of Hospital Medicine and also in bound form by Wiley publishers (http://www.wiley.com/WileyCDA/WileyTitle/productCd-0470903589.html accessed 04/07/2016). Pediatric hospitalists have also held or currently hold editorial roles for Pediatrics, Journal of Pediatrics, Pediatric Grand Rounds, Pediatrics in Review and Academic Pediatrics.

Several texts of PHM have now been published in the US, including:
1) Pediatric Hospital Medicine: Textbook of Inpatient Management by Ronald M. Perkin MD MA, James D. Swift MD, Dale A. Newton MD and Nick G. Anas MD
2) The Inpatient Pediatrics Work-Up by Samir S., Shah MD, and Gary Frank MD MS
3) Caring for the Hospitalized Child: A Handbook of Inpatient Pediatrics by American Academy of Pediatrics Section on Hospital Medicine, Daniel A. Rauch MD FAAP and Jeffrey C. Gershel MD FAAP
4) Comprehensive Pediatric Hospital Medicine, by Lisa B. Zaoutis MD and Vincent W. Chiang MD.

Distinction from Current General Pediatrics Residency Training

The purpose of Pediatric Residency is, “to provide educational experiences emphasizing 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.” Graduating residents are prepared to care for common problems in the in-patient setting, but it is not the role of categorical training to prepare pediatricians to care for the wider population of hospitalized children with complex disease or to specifically improve the hospital system. All residents must have a minimum of 9 months (out of 36 months total training) of experiences in inpatient settings such as inpatient ward, NICU, PICU, yet there is varied and inconsistent exposure of pediatric residents to a robust patient mix and complexity in the inpatient setting. The experiences of residents at community based programs will differ from
those at children’s hospitals that provide tertiary and quaternary care. Over the past
decade total time spent on inpatient ward rotations is stable or has decreased at many
institutions, despite the reality that inpatient care has become more complex. Work
hour restrictions, continuity clinic and mixed call schedules may result in fragmented
inpatient experiences. Continuity clinic with longitudinal experiences with patients in
a medical home, community pediatrics, developmental-behavioral pediatrics, and
other core elements of the categorical pediatric training program are critical to
developing a competent general pediatrician and are central to the practice of
ambulatory pediatrics in the community.

An appreciation of the importance of systems-based practice and an experience with
a quality improvement project is an expectation for all general pediatric residents.
However achieving true expertise in quality improvement, systems-based practice,
safety science and being an innovative leader or effective mentor in these areas
requires more time and focus than is generally practicable during residency. The PHM
curriculum and competencies go beyond general pediatrics residency topics and add
significant training in other areas for acute and complex care, quality improvement,
procedural skills, academic scholarship and advancement of the field through research.
Thus, there is a recognized gap between what competencies can be achieved in a
general pediatrics residency program and mastery of the PHM core competencies. The
most rigorous way to achieve mastery is through standardized accredited fellowship
training leading to certification.

b. Explain how this proposed new or modified subspecialty addresses a distinct and
definable patient population, a definable type of care need or unique care
principles solely to meet the needs of that patient population:
The last decade has seen a dramatic change in the demographics of the hospitalized
child population as well as a shift in where children are hospitalized. While overall non-
newborn pediatric admissions have been relatively stable or declining7, both acuity and
length of stay have increased7. Hospitalized children in 2016 are sicker than those in
previous years and are more likely to have a co-morbid condition(s). This has
necessitated that inpatient providers have a knowledge and skill set to care for
complex and often technology-dependent patients that require coordination of
multiple aspects of their care. Moreover, the ever increasing focus on efficiency plus
other economic stressors have compressed care, making clinical decision-making and
care delivery more “intensive” and time sensitive. Pressures on healthcare systems
have resulted in increasingly complicated discharges, with more ongoing care plans
being completed outside the acute care hospital setting. This adds another layer of
complexity to hospital care, in that the inpatient providers must be able to manage the
hospital system and advocate for patients to provide safe, efficient, and cost-effective
care as well as assure safe, effective transitions of care back to the medical home. In
the non-children’s hospital setting this means advocating for children’s services within
hospital environments where pediatrics is a small part of the overall service. The field
of PHM promotes standardizing care across tertiary and non-tertiary hospital settings
and provides the practicing hospitalist with the skills to provide high quality, safe, effective care wherever the child is hospitalized.

Current Pediatric Practice
An additional factor influencing the growth of pediatric hospital medicine is the decline in primary care providers who serve as attendings for their hospitalized office patients. An AAP survey from 3 years ago found that over the past 5 years, over half of office-based pediatricians reported that they managed fewer of their inpatients themselves and that an increased number of these pediatricians referred their hospitalized patients to hospitalists. More strikingly, 72% of today’s graduating pediatric residents who choose careers in general practice report that they intend to provide little or no care for hospitalized patients. This is driven in no small part by the increasing demands of ambulatory care, with the many pressures of managing both high volume and time-dense complex patient visits. Care for many common acute conditions that once required hospitalization is now provided by general pediatricians in the outpatient setting (pneumonia, asthma, seizures, urinary tract infections, etc.) Ambulatory practice is changing with an increased emphasis on behavioral health, coordination of care for patients with multiple ambulatory needs, and meeting increasing numbers of audit and regulatory expectations. These demands coupled with the continually and rapidly evolving complexity of care for the hospitalized child has resulted in divergent scopes of practice. Maintaining a solid presence in both settings is not viable for many general pediatricians. Other drivers influencing the growth of PHM include the economic disincentive of low reimbursement for hospital care, time commitment needed to see typically only one or two hospitalized patients, work-life balance choices, and the loss of revenue from missing outpatient volume. The hospital system has also become more complex with electronic health records (EHR) including order entry and other technology changes that make it difficult to easily work intermittently in the hospital.

c. To provide COCERT with information about the group of physicians concentrating their practice in the proposed new or modified subspecialty area, please indicate the following:
i. The current number of such physicians (along with the source(s) of the data):
Conservative estimates based on membership of the American Academy of Pediatrics Section on Hospital medicine (AAP SOHM), Academic Pediatric Association Hospital Medicine Special Interest Group (APA HM SIG), and Society of Hospital Medicine Pediatric (SHM) – the three core societies in which Pediatric Hospitalists live - put the current PHM workforce at about 3000 making it one of the largest pediatric medical subspecialties. AAP and ABP surveys indicate that new graduates are choosing PHM as a career at a 6-10% rate indicating that the current workforce is not only sustainable but likely to grow.

The field of PHM has grown tremendously over the past 10 to 15 years. Prior published estimates of pediatric hospitalists asserted a doubling in number from 300 in 1999 to 600 by 2002. Currently, the AAP’s SOHM alone had more than
1500 members in 2016. Based on 2011 AMA Masterfile data there are approximately 58,726 physicians practicing general pediatrics and 28,374 practicing a pediatric subspecialty in the US. In 2009, the AAMC added the question “Are you a hospitalist?” to its Survey of Primary Care Physicians. Contrary to its title, this survey included a sample of general and subspecialty pediatricians and the sampling strategy was specifically designed to be representative for workforce planning issues. Approximately 8% of the physicians surveyed identified themselves as hospitalists, including 10% of those who identified themselves as pediatric subspecialists and 5% amongst those who identified themselves as general pediatricians. Based on this survey the AAMC estimated 27,600 to 29,700 practicing hospitalists in the US, of which approximately 5,000 should be pediatric hospitalists if the sampling strategy were indeed representative. Therefore our working number of 3000 pediatric hospitalists is conservative.

ii. The annual rate of increase of such physicians in the past decade (along with the source(s) of the data):
The AAP Section on Hospital Medicine represents the largest cohort of pediatric hospitalists. These are the annual membership totals for academic years 2005-2015:

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</tr>
<tr>
<td>2015</td>
<td>1517</td>
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There has been consistent growth over the last decade, the only specialty section of the AAP to do so.
iii. The current geographic distribution of this group of physicians, its projected spread in the next five (5) years, and an explanation of how you arrived at this projection:
This is the current geographic distribution of the AAP SOHM membership as of January 2016:

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<tr>
<td>MS</td>
<td>WVY</td>
<td>3</td>
</tr>
</tbody>
</table>
A 1998 survey of academic pediatric department chairs revealed 50% reported the active presence of hospitalists in their departments and another 27% planned on adding hospitalists. Freed et al surveyed the current state of pediatric hospital medicine circa 2005 as part of a series of studies sponsored by the ABP Research Advisory Committee. They found extensive use of hospitalists at children’s hospitals with most PHM services being new and planning to expand. More recent studies have shown that hospitalist services are the norm in large children’s hospitals, including all 2014-15 US News & World Report Honor Roll Children’s Hospitals.

In January 2014 a survey of the websites of 138 allopathic medical schools which belong to the AAMC was undertaken to assess the presence of a distinct group of pediatric hospitalists within their academic departments of Pediatrics. Sixty eight departments (49%) maintain a formally distinct section or division of PHM. A follow-up survey in January 2016 revealed that the number of distinct sections or divisions of PHM within departments to have risen to 84 (61%), while in a recent unpublished survey the Association of Medical School Pediatrics Department Chairs (AMSPDC) estimates this percentage to be even higher (75%). Of the remaining medical schools with formal departments of Pediatrics, more than 90% list pediatric hospitalists amongst their faculty in general pediatrics or, less commonly, critical care.

The most recent and largest ever survey (n=542, response rate 43%) of Pediatric Hospitalists is the AAP SOHM workforce survey performed in 2012-2013. This survey sampled AAP SOHM members only. Respondents were 64% female and the median year of medical school graduation was 2001. A large majority (68%) worked in a either a free-standing children’s hospital or a children’s hospital within a hospital, 14% in community hospitals with either full or significant pediatric subspecialty and surgical resources, and 17% in community hospitals with limited or no pediatric subspeciality support. Most (72%) hospitalists worked in urban hospitals, 22% suburban, and 6% rural. Perhaps most significantly 70% planned careers as full-time hospitalists and 22% planned careers as part-time hospitalists indicating a much more mature workforce and field than the earlier studies by Freed et al.

d. For COCERT, please identify the existing national societies, the principal interest of which is in the proposed new or modified subspecialty area:
The existing national societies most involved with Pediatric Hospital Medicine are:
- The Academic Pediatric Association (APA)
- The American Academy of Pediatrics (AAP)
- The Society of Hospital Medicine (SHM)

i. Indicate the existing national societies’ size and scope, along with the source(s) of the data:
APA (from academicpediatrics.org): “The APA is dedicated to improving the health and well-being of all children and adolescents by promoting research, advancing a scholarly approach to education, developing innovations in health care delivery, advocating for an equitable child health agenda, and fostering leadership and career development of child health professionals. The vision of the APA is to create a better world for children and families by advancing child health and well-being through the work of our members and collaborators.”

Membership has consistently exceeded 2000 for the last several years.

The Academic Pediatric Association (APA) has an active hospital medicine special interest group (SIG) founded in 2001 with approximately 300 members. The SIG has been sponsoring hospital medicine content at the Pediatric Academic Societies (PAS) annual meeting since 2002, with increasing numbers of hospital medicine themed platform sessions for the past several years - three each in 2012 and 2013 and four in 2014. Hospitalists are also active in other APA SIGs, notably Tobacco, Family-Centered Care, Complex Care, and Quality Improvement. Hospitalists have served as leaders and active participants in other APA special programs, (i.e.: Educational Scholars, Research Scholars, and Quality Scholars programs). Since 2010-13, six APA Young Investigator awards have gone to hospitalists for projects ranging from serious bacterial infections in infants to improving hospital to home transitions. In the same time frame pediatric hospitalists have received three of the last six Ray Helfer Awards given for outstanding teaching programs and the 2015 Miller/Sarkin award for mentorship. The APA Leadership Conference has specifically targeted hospitalists and is offering a precourse to the national PHM meeting in 2015.

AAP (from aap.org): “The American Academy of Pediatrics is an organization of 64,000 pediatricians committed to the optimal physical, mental, and social health and well-being for all infants, children, adolescents, and young adults”. The AAP is the major professional society in Pediatrics. It issues policy statements and practice guidelines, provides educational programs for pediatricians and advocates for children. The AAP works with government, communities and other organizations to address child health and safety concerns.

The AAP Section on Hospital Medicine (SOHM) was formally established in 1999 and now has a membership of almost 1500 making it the second largest subspecialty section in the AAP. The SOHM has been instrumental in several of PHM’s milestones such as serving as the driving force for launching the journal, *Hospital Pediatrics*. The SOHM has its own program at the AAP National Conference and Exhibition (NCE) as well as shared sponsorship of the annual PHM meeting described above, along with the APA and SHM. The section has contributed significantly to AAP policy statements and guideline development, proposing a new guideline on Apparent Life Threatening Events (ALTE) which is chaired by a hospitalist. The Urinary Tract Infection (UTI) guideline was also co-chaired by a hospitalist, and current revision to the bronchiolitis guideline is
hospitalist led. The section has sponsored a yearly PHM fellows’ conference since 2011, which provides fellows introductory core research, education and leadership skills. A Pediatric Review and Education Program (PREP) product for pediatric hospitalists is in development as one of many similar products available for the other subspecialties of pediatrics. The SOHM also sponsors a new program for training hospitalists to become master teachers at the bedside (APEX) and through its subcommittee in quality has launched a new national quality improvement collaborative dealing with best practices for handoff of patients from inpatient to outpatient providers (Project Impact) that has been approved for Maintenance of Certification part 4 credit.

**SHM:** The Society of Hospital Medicine (SHM) was formally established as the National Association of Inpatient Physicians (NAIP) in 1997, and currently has approximately 600 pediatric members and 450 med/peds members of its total membership of over 14,000. The pediatric committee sponsors an entire pediatric track at the SHM’s annual meeting as well as other regional and joint conferences. The pediatric presence within SHM has often been recognized for excellence, with 5 pediatric hospitalists winning annual awards for research and 5 winning awards for service to hospital medicine out of the 16 given in each category since their inception in 2001. There has been a pediatric member on the SHM’s Board of Directors since inception. Three Masters in Hospital Medicine (a distinction given to only 2-3 hospitalists nationally each year) have been pediatricians in recent years as well. The SHM’s *Journal of Hospital Medicine* published the Pediatric Core Competencies and will publish the upcoming adult and pediatric planned updates to these documents. The SHM supported a PHM member on the recent Infectious Disease Society of America (IDSA) community acquired pneumonia guideline panel. The SHM was an early participant in the Choosing Wisely initiative and their entry was notable for containing a fully realized set of pediatric hospital medicine recommendations as well.¹⁹ This work was published in the *Journal of Hospital Medicine.*²⁰

ii. Indicate the distribution of academic degrees held by their members, along with the source(s) of the data:

**AAP:** from AAP Department of Membership 3/18/16
MD/DO/MBBS: 63,964
Allied Health: 988
DDS: 147

**APA:** from APA Executive Director Connie MacKay 3/2/16
MD: 1937
PhD: 154
Other: 109
iii. Indicate the relationship of the national societies’ membership with the proposed new or modified subspecialty area:

All three organizations are highly supportive of the PHM community. They are equal partners in sponsoring the national PHM annual summer conference with the lead for any given year rotated annually among them. All three organizations are represented in the Joint Council of Pediatric Hospital Medicine (JCPHM), an umbrella organization designed to help coordinate activities in the larger PHM community including moving forward with the application to attain subspecialty status through certification by the ABP. Funding for JCPHM activities comes from the APA, AAP, and SHM. There is currently no movement to a freestanding PHM society so that it is anticipated that the three national organizations will remain fundamental to the PHM community and all three continue to welcome pediatric hospitalists. The APA and AAP are strong supporters of PHM achieving subspecialty status through certification. The SHM remains neutral on the issue due to its predominance of internal medicine and family practice constituents and its support of the designation of Focused Practice in Hospital Medicine by means of Maintenance of Certification through the American Board of Internal Medicine (ABIM) and the American Board of Family Medicine (ABFM).

e. For the entities described below, please provide the number of those who have a primary educational effort devoted to the proposed new or modified subspecialty area, along with their geographic locations and the source(s) of the data:

i. Medical schools:

Every medical school includes exposure to inpatient pediatrics and Pediatric Hospitalists are active in every state with >90% of allopathic medical schools listing pediatric hospitalists on their faculty. Within academic institutions PHM is part of the Pediatric Department and so does not exist as a separate department. Within community hospitals where there is a pediatric inpatient service, the department of pediatrics is often effectively a PHM department with varying degrees of neonatal, normal newborn, emergency, and outpatient coverage. The AHA counts about 2000 pediatric inpatient units nationally of which only a small minority (although a majority of beds) are in academic centers or free standing children’s hospitals. A survey of the 138 US allopathic medical school websites in January 2016 revealed that the total of distinct
sections or divisions of PHM within Pediatric departments is 84 (61%). In the rest of the schools PHM resides within General Pediatrics, Critical Care, or Emergency Medicine.

ii. Hospital departments: see above

iii. Divisions: see above

iv. Other (please specify): n/a

4. Please list the number and names of institutions providing residency and other acceptable educational programs in the proposed new or modified subspecialty area:

a. Indicate the total number of trainee positions available currently (along with the source(s) of the data):

1st year PHM Fellows as of July 2016: 45 positions in total (out of 49 offered)

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<th>1st year spots (filled 2015)</th>
<th>Duration of fellowship (years)</th>
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</tr>
<tr>
<td>Cincinnati Children’s Hospital Medical Center</td>
<td>Cincinnati OH</td>
<td>2(2)</td>
<td>3</td>
</tr>
<tr>
<td>Cleveland Clinic Children’s Hospital</td>
<td>Cleveland OH</td>
<td>1(1)</td>
<td>2</td>
</tr>
<tr>
<td>Dell Children’s Medical Center</td>
<td>Austin TX</td>
<td>1(1)</td>
<td>2</td>
</tr>
<tr>
<td>Harbor-UCLA Medical Center</td>
<td>Torrance CA</td>
<td>1(1-fills every other year)</td>
<td>2</td>
</tr>
<tr>
<td>Helen DeVos Children’s Hospital</td>
<td>Grand Rapids MI</td>
<td>1(0)</td>
<td>2</td>
</tr>
<tr>
<td>K. Hovnanian Children’s Hospital at Jersey Shore University Medical Center</td>
<td>Neptune NJ</td>
<td>1(1)</td>
<td>1</td>
</tr>
<tr>
<td>Kaiser Oakland Medical Center</td>
<td>Oakland CA</td>
<td>1(1-fills every other year)</td>
<td>2</td>
</tr>
<tr>
<td>Maimonides Infants and Children’s Hospital</td>
<td>Brooklyn NY</td>
<td>1(1)</td>
<td>1</td>
</tr>
<tr>
<td>Mattel Children’s Hospital UCLA</td>
<td>Los Angeles CA</td>
<td>1(1)</td>
<td>2</td>
</tr>
<tr>
<td>Medical University of South Carolina</td>
<td>Charleston SC</td>
<td>1(0)</td>
<td>2</td>
</tr>
<tr>
<td>--------------------------------------</td>
<td>---------------</td>
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</tr>
<tr>
<td>Miami Children’s Hospital</td>
<td>Miami FL</td>
<td>1(1)</td>
<td>1</td>
</tr>
<tr>
<td>Phoenix Children’s Hospital</td>
<td>Phoenix AZ</td>
<td>1(1)</td>
<td>2</td>
</tr>
<tr>
<td>Rainbow Babies and Children’s Hospital/Case Medical Center</td>
<td>Cleveland OH</td>
<td>2(1)</td>
<td>1</td>
</tr>
<tr>
<td>Riley Hospital for Children at Indiana University Health</td>
<td>Indianapolis IN</td>
<td>1(1)</td>
<td>1</td>
</tr>
<tr>
<td>Stanford University Lucile Packard Children’s Hospital</td>
<td>Palo Alto CA</td>
<td>1(1)</td>
<td>2</td>
</tr>
<tr>
<td>State University of New York/Kings County Hospital, Brooklyn</td>
<td>Brooklyn NY</td>
<td>1(0)</td>
<td>2</td>
</tr>
<tr>
<td>The Hospital for Sick Children</td>
<td>Toronto Ontario CANADA</td>
<td>6 (3 1-yr and 3 2-yr spots)</td>
<td>1 or 2</td>
</tr>
<tr>
<td>Tufts University School of Medicine, Floating Hospital for Children</td>
<td>Boston MA</td>
<td>1(1)</td>
<td>2</td>
</tr>
<tr>
<td>University of Alabama at Birmingham/Children’s Hospital of Alabama</td>
<td>Birmingham AL</td>
<td>2(2)</td>
<td>2</td>
</tr>
<tr>
<td>University of California, San Diego, Rady Children’s Hospital</td>
<td>San Diego CA</td>
<td>2(2)</td>
<td>2</td>
</tr>
<tr>
<td>University of California, San Francisco/Benioff Children’s Hospital</td>
<td>San Francisco CA</td>
<td>1(1)</td>
<td>2</td>
</tr>
<tr>
<td>University of Colorado School of Medicine/Children’s Hospital of Colorado</td>
<td>Aurora CO</td>
<td>1(1)</td>
<td>2</td>
</tr>
<tr>
<td>University of Utah Primary Children’s Medical Center</td>
<td>Salt Lake City UT</td>
<td>1(0 – fills every other year)</td>
<td>2</td>
</tr>
</tbody>
</table>

In development:

<table>
<thead>
<tr>
<th>St. Louis Children’s Hospital/ Washington University School of Medicine</th>
<th>St. Louis MO</th>
</tr>
</thead>
<tbody>
<tr>
<td>TTUHSC/Covenant Children’s</td>
<td>Lubbock TX</td>
</tr>
<tr>
<td>Golisano Children’s Hospital</td>
<td>Rochester NY</td>
</tr>
<tr>
<td>Children’s Hospital of the King’s Daughters</td>
<td>Norfolk VA</td>
</tr>
<tr>
<td>Children’s Hospital of Wisconsin</td>
<td>Milwaukee WI</td>
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<tr>
<td>Nationwide Children’s</td>
<td>Columbus OH</td>
</tr>
<tr>
<td>St. Christopher’s Hospital for Children</td>
<td>Philadelphia PA</td>
</tr>
<tr>
<td>Seattle Children’s</td>
<td>Seattle WA</td>
</tr>
</tbody>
</table>

b. Provide the number of trainees completing the training annually (along with the source(s) of the data):

**Total Number of Trainee positions available** as of February 2016 (obtained from Council of Pediatric Hospital Medicine Fellowship Directors, [www.phmfellows.org](http://www.phmfellows.org) and NRMP): **49 per year**

*Six programs take variable numbers year to year (Boston Children’s 1-2, CCHMC 2-3, Sick Kids 3-9, and Kaiser, UCLA Harbor, and Utah each 1 every other year)*

c. Describe how the numbers of training programs and trainees are adequate to:
i. **Sustain the area of subspecialization:**
   The current numbers of fellows is already greater than that in several pediatric subspecialties for which the ABP offers certification. We anticipate a similar growth in the total number of fellowships comparable to that of Pediatric Emergency Medicine which totals 523 current trainees in 75 fellowship programs.

ii. **Allow for a sustained critical mass of trainees necessary for trainee testing validity and training program accreditation:**
   The current number of fellows (>40/year) as well as those who will potentially qualify for the certifying examination under the practice pathway far exceeds those for several other pediatric subspecialties for which there are adequate numbers of trainees for testing validity and program accreditation. With the anticipated growth of the number of fellowships to reach about 75 and >100 trainees in any given year, each exam, given every other year, could have >200 potential applicants.

5. **Please provide the number and type of additional educational programs that may be developed based on this proposed new or modified subspecialty area. Please indicate how you arrived at that number:**
   The current number of fellowships is 34 with at least eight more in the active stage of planning. These programs offer almost 50 positions each year. However, the 2015 ABP survey of first time ABP General Pediatrics exam takers indicated that 88 people (2.7% of test takers) were in hospitalist training. Some respondents may be in first or subsequent years of pediatric hospital medicine fellowship training, while others may be receiving training while completing non-accredited fellowships in General Academic Pediatrics (GAP) which allows the clinical component of training to be focused in PHM. This is a potential pool of training programs that could transition to PHM fellowships.

   Pediatric hospital medicine as a field has mirrored the development of Pediatric Emergency Medicine (PEM). Since 2000, eight years after the first PEM certifying exam, the number of first year fellowship positions in PEM has more than doubled. Given that the 2015 ABP survey of first time exam takers in general pediatrics indicated that 345 people were currently employed as hospitalists (roughly equal to the number of chief residents and one third of all subspecialty fellows) there appears to be a substantial number of individuals who might choose fellowship training and certification if available.

6. **Please provide responses to (a) through (d) below regarding the duration and curriculum of existing programs:**
   a. **The goals and objectives of the existing programs:**
      The goals and objectives of fellowship training are included in Appendix B.
   b. **The expected competencies that will distinguish this subspecialist from other subspecialists in the areas of cognitive knowledge, clinical and interpersonal skills, professional attitudes and practical experience:**
The PHM community developed the PHM Core Competencies, published in 2010 to define the core set of knowledge, skills, and attitudes for PHM\(^5\). The competencies have served as the template for fellowship curriculum design as well as a point of reference for content at the annual national PHM conference. The document is organized into four sections: Clinical Diagnoses and Conditions, Core Skills, Specialized Clinical Services, and Healthcare Systems. Available at: [http://onlinelibrary.wiley.com/doi/10.1002/jhm.v5.2s/issuetoc](http://onlinelibrary.wiley.com/doi/10.1002/jhm.v5.2s/issuetoc)

c. **The scope of practice:**
Although there is heterogeneity in the roles and the current scope of practice of those who identify themselves as pediatric hospitalists, pediatric hospital medicine, whether practiced in a children’s facility or a community site, has at its core the care of the child “between” the emergency department and critical care units. Hospital medicine is a specialty dedicated to the delivery of comprehensive medical care to hospitalized patients including those with acute serious complications of common problems, those more complicated patients with multiple co-morbidities and/or injuries, complex chronic diseases, special healthcare needs, technology dependency and those needing palliative care.

Practice in PHM encompasses care for both the individual patient at the bedside and the population of hospitalized children which includes systems improvements. In addition to their core expertise in managing the acutely ill hospitalized patients, pediatric hospitalists work to enhance the performance of healthcare systems by:

- employing quality and process improvement techniques
- collaboration, communication and coordination with all physicians and healthcare personnel caring for hospitalized patients
- safe transitioning of patient care within the hospital and from the hospital to the community which may include oversight of care in post-acute care facilities
- efficient use of hospital and healthcare resources

There are a variety of settings in which pediatric hospitalists practice necessitating competence in a broad scope of clinical skills. Many practice in general or children’s hospitals providing tertiary and quaternary care. These settings with high acuity and medically complex children provide the benefit of extensive resources including facilities and equipment specifically for children, as well as easy access to other pediatric subspecialists and surgical specialists. Others practice in community hospitals with a patient mix of lesser acuity and fewer resources. Some pediatric hospitalists provide procedural sedation and newborn care and may work in intensive care units and emergency departments. In addition to providing clinical care, many pediatric hospitalists play important roles in teaching medical students and residents, conducting research and providing leadership in quality improvement and safety efforts in healthcare systems.
d. The body of knowledge and clinical skills required and whether it is broad enough to require at least 12 months of training:

Formal training in PHM is required because of a recognized gap between the competencies achieved in general pediatrics residency training and successful demonstration of mastery of the PHM Core Competencies, which are noted above in #6b. There is a consensus in the community of pediatric hospitalists that two years of training are needed to meet the goals and objectives defined in Appendix B, since PHM focuses not only on improving care at the bedside, but also on improving processes of care within the hospital system.

Current fellowships in PHM provide additional training in the clinical care of children with serious acute complications of common conditions and those with complex diseases, special health care needs and multiple co-morbidities. In addition, procedural competence beyond which can reasonably be achieved during residency is expected in order to care for more complicated and complex patients.

Required core skills would include:

- Procedural sedation
- Venipuncture
- NG tube placement
- PIV placement
- IO placement
- Bag-Mask Ventilation
- Intubation
- Bladder catheterization
- Lumbar puncture
- Arterial puncture
- Neonatal resuscitation
- Pediatric resuscitation

Additional skills may include (depending on PHM fellow’s career goals):

- PICC line placement
- Central line placement/Umbilical line
- Chest tube placement/needle thoracotomy
- Bedside sonography

Quality improvement and patient safety, clinical research, and innovation in medical education are domains that relate to the efficient and safe delivery of high-quality patient care in a complex medical system. Most notably, quality improvement and safety are core to PHM training. Pediatrics residencies and other fellowships require trainees to have an engagement in a quality improvement project; whereas PHM requires that fellows lead a quality improvement initiative. The difference in these terms, “engagement” versus
“lead”, is significant. QI project leadership requires formal training in teams, QI and safety processes, data analysis, culture change, and more.

A standard 2 year curriculum has been developed over the past 2 years. This curriculum has been designed to allow fellows in PHM to gain skills and knowledge to become experts in the field. The curriculum is composed of 26 four-week educational units with 2 units of vacation/leave time: The details of these educational units are provided in Table A.

<table>
<thead>
<tr>
<th>Table A</th>
<th>Number of Units</th>
<th>Rotations Included</th>
<th>Additional Requirements</th>
</tr>
</thead>
</table>
| Core Clinical Rotations                      | 8               | 6 units required to include areas of:                                               | 1 unit must be at community based site
|                                              |                 | • Hospital Medicine                                                                 | 4 units must be at tertiary or quaternary site |
|                                              |                 | • Complex Care                                                                      |                                                                                        |
|                                              |                 | • Co-management,                                                                   |                                                                                        |
|                                              |                 | • Care & Stabilization of critically ill child                                     |                                                                                        |
|                                              |                 | • 2 additional clinical units of fellow/program selection to meet clinical training needs |                                                                                        |
| Systems & Scholarship                        | 8               | To include general training in each category and focus in 1:                       | Must meet ABP requirements for scholarly activity in at least one domain |
|                                              |                 | • Improvement Science                                                              |                                                                                        |
|                                              |                 | • Clinical & Translational Research                                                |                                                                                        |
|                                              |                 | • Medical Education                                                                |                                                                                        |
|                                              |                 | • Leadership                                                                        |                                                                                        |
|                                              |                 | • Business Administration                                                           |                                                                                        |
|                                              |                 | • Patient Safety                                                                    |                                                                                        |
|                                              |                 | • Advocacy                                                                          |                                                                                        |
| Individualized Curriculum                    | 8               | May include clinical and non-clinical activities. Must be determined by the learning needs and career plans of each fellow and must be developed through the guidance of a faculty mentor. |                                                                                       |
|                                              |                 | Examples of clinical rotations related to the practice of pediatric hospital medicine that would be acceptable include but are not limited to: |                                                                                       |
|                                              |                 | • Sedation                                                                          |                                                                                       |
|                                              |                 | • Newborn Care                                                                      |                                                                                       |
|                                              |                 | • Internal Medicine (for Med Peds trainees)                                         |                                                                                       |
|                                              |                 | • Transitions in care                                                               |                                                                                       |
|                                              |                 | • Child Abuse & Neglect                                                             |                                                                                       |
|                                              |                 | • Palliative Care                                                                   |                                                                                       |
|                                              |                 | • Acute Pain                                                                         |                                                                                       |
|                                              |                 | • Transport Medicine                                                                |                                                                                       |
|                                              |                 | Examples of non-clinical experiences that would be acceptable include but are not limited to: |                                                                                       |
|                                              |                 | • Degree study in field-applicable degree                                           |                                                                                       |
|                                              |                 | • Further study in any of the systems & scholarship areas                            |                                                                                       |
|                                              |                 | • Medical informatics                                                               |                                                                                       |
|                                              |                 | • Time dedicated to developing, implementing, analyzing or disseminating a scholarly project |                                                                                       |
The American Board of Pediatrics believes that scholarly work is a core value of subspecialty fellowship training and requires all fellows to engage in a robust scholarly project under the oversight of a committee and provide a written work product at the end of training. This requirement would extend to fellowship training in pediatric hospital medicine thus contributing to the requirement for 24 months of training.

In addition it should be noted that the ABP has begun working with our 14 subspecialties for which we currently provide certification to develop entrustable professional activities (EPAs) common to all subspecialties and those specific to individual subspecialties and to outline the functions needed to perform the EPAs. Through an iterative process the Pediatric Hospital Medicine Fellowship Directors Group developed EPAs which defined their discipline and should be used in evaluation of their fellowship. (See Appendix C) The ABP will assist the pediatric hospital medicine community in refining its EPAs and in mapping them to critical competencies and milestones needed for an entrustment decision. Of note, academic scholarship is an underlying core competency for all ABP subspecialties with the acknowledgement there is flexibility in the types of scholarly work to demonstrate that competency.

It should be noted that the model of Focused Practice in Hospital Medicine recognized through Maintenance of Certification (MOC) as currently used by the ABIM and ABFM was considered by the PHM community prior to their application to the ABP. For the reasons listed above and elsewhere in this application, the pediatric hospital medicine community decided to seek subspecialty certification. Pediatric residency training is designed to prepare trainees to practice high quality care in the community and is distinctly different from training in Internal Medicine in the time spent in hospital versus ambulatory rotations and the nature of the patient population. Pediatric residents do not graduate with as much inpatient exposure and the exposure received varies depending on the training program (tertiary versus community hospital setting). Furthermore, the qualifications for attaining recognition of Focused Practice through MOC are defined by individual patient encounter thresholds. There is no formal requirement to engage in systems improvement. Subspecialty certification and fellowship training in PHM will foster the development of a critical mass of academic and community hospitalists who will move the field forward by generating new knowledge, educating the next generation and improving the care of all hospitalized children in a systematic manner.

7. Please provide a projection and the methodology used for the projection of the annual cost of the required special training:

The cost of fellowship training depends on the number of fellows and cost will vary from program to program. It is likely, given the indirect benefit of PHM programs to hospitals and the current financial support most hospitals provide to PHM programs, that hospitals will bear some of the costs of PHM fellowships and so reduce the burden on pediatric
departments. An estimate of the cost of a typical two-year fellowship program with one first year and one second year fellow follows:

**Direct costs**

Salaries and benefits for fellows:
- PGY4: $75,500
- PGY5: $78,000

Salaries for staff:
- Program Director (0.5 FTE including benefits): $100,000
- Program Coordinator and other Non MD staff support: $20,000

Program needs:
- Technical equipment (computers, phones, pagers, etc.): $1500 x 2
- Books, journals: $500 x 2
- Society dues (AAP + SOHM, APA, SHM): $270 x 2
- Office supplies: $500
- Travel/CME: $2000 x 2
- Recruitment: $5000

**Total annual costs**: $287,540

**Other considerations**

a. Trainees in an ACGME accredited program will not be able to bill for services.
b. As with any fellowship, trainees accept a lower annual salary in return for dedicated training and protected time for scholarly work. This cost (investment in training) is born by the trainee.

**Potential Cost Benefits**

a. As with all fellowships, retention of fellows to academic faculty may provide cost saving in faculty recruitment.
b. Fellowship graduates enhance scholarly activity of the respective division at the sponsoring institution.
c. Attractiveness of fellowship to current residents may alleviate fellowship recruitment costs.

**Unique to PHM fellowships:**

a. Fellow projects in quality and safety align with and are therefore of benefit to hospitals. This may be seen as a positive return on investment for hospitals.
b. Research focus areas include education, quality, and clinical effectiveness. These may be seen as a positive return on investment for hospitals, academic departments, and schools of medicine.

a. As the sponsoring Member Board, do you have, or access to, the resources to conduct a regular certification and MOC program in this specialty?
The ABP currently administers 14 subspecialty certification and MOC programs and co-sponsors an additional six with other ABMS boards. We have the resources to add PHM.

b. Do you plan to ask for ACGME accreditation for this new program?
   Yes

c. If these programs are not accredited by the ACGME, please document the accrediting body for this program and whether you have the resources to review these programs in a fashion comparable to ACGME.
   The ABP believes that ACGME accredited training is required for subspecialty certification. We have informed the Review Committee for Pediatrics and the ACGME’s Vice President for Medical Specialties of our plan to seek accreditation of PHM training programs provided that ABMS grants its approval to move forward. The ABP does not have the resources to review these programs nor do we believe it is appropriate to do so. There does not appear to be any impediment to ACGME accreditation based on the number of programs estimated to seek accreditation.

8. Please outline the qualifications required of applicants for certification in the proposed new or modified subspecialty area, as it pertains to the following:

   a. Possession of an appropriate medical degree or its equivalent:
      The applicant must be a graduate of a medical school that has been accredited by the Liaison Committee on Medical Education (LCME) in the United States, by the Royal College of Physicians and Surgeons of Canada (RCPSC) in Canada or by the American Osteopathic Association (AOA) in the United States. An applicant who is a graduate of a medical school outside the United States or Canada, but listed by the World Health Organization may apply for the examination if he or she has a standard certificate either from the Educational Commission for Foreign Medical Graduates (ECFMG) or the Medical Council of Canada.

   b. General certification by an approved primary specialty Board:
      An applicant in PHM must be currently certified in general pediatrics by the ABP. Once certified in PHM, there will be no requirement to maintain the primary certification in general pediatrics.

      i. Will diplomates from other ABMS Member Boards be allowed to apply for this subspecialty certificate? No
         a. If only specific ABMS Member Board diplomates would be allowed to apply for this subspecialty certificate, please list those Member Boards. N/A
         b. If "yes," would you require diplomates to maintain their primary certificate? N/A

   c. Completion of specified education and training or experience in the subspecialty field:
There will be a temporary period during which candidates may qualify to take the certifying examination based on practice experience or training in a non-accredited fellowship program in pediatric hospital medicine. This temporary period will be determined by the ABP and is usually the first three examination cycles (i.e.: 5-6 years). During this temporary period there will be three pathways to qualify for the examination:

1. **Non-Accredited Training:** The applicant must have successfully completed a pediatric hospital medicine fellowship of 24 months duration that is acceptable to the ABP. The fellowship training curriculum as well as a description of the actual training experience must be submitted. Applicants who have completed a 24 month fellowship in general academic pediatrics (GAP) may be considered if the supervised clinical training was devoted to pediatric hospital medicine. Non-accredited fellowship training must occur in a program operated in association with a general comprehensive pediatrics residency program accredited by the ACGME.

2. **Practice Pathway:** A practice pathway is available for applicants who can demonstrate a significant practice experience concentrated in the discipline of PHM. The most recent four years of full time practice must have consisted of at least 50% time spent engaging in professional activities (clinical care, teaching, quality improvement, research, administration, etc.) related to the care of hospitalized children. At least half of that time must be devoted to direct patient care of children, i.e.: 25% of full time professional practice. Professional activities must be of such type and quality that they are sufficient to substitute for the experience one would encounter during formal subspecialty fellowship training. For those graduates of residency training programs in internal medicine-pediatrics who are practicing as hospitalists caring for both adults and children, non-patient care related professional time devoted to activities related to adults may qualify. However the time devoted to direct patient care for children must meet the minimal requirement stated above.

3. **Combination of Fellowship and Practice:** An individual completing less than two years of fellowship may qualify with an additional two years of practice experience that meet the requirements stated above.

After the period of temporary eligibility criteria has ended all candidates must complete 24 months of training in a pediatric hospital medicine fellowship accredited by the ACGME which includes a requirement for the demonstration of scholarly activity. An application will be submitted to ACGME to accredit training programs.

d. **Additional qualifications:**
A valid, unrestricted allopathic and/or osteopathic medical license in at least one jurisdiction in the US or its territories or Canada is required. If more than one license
is held in these jurisdictions all licenses must meet the requirement of being unrestricted. At the sole discretion of the ABP, the ABP may review instances of licensure actions to determine whether such actions constitute a restriction in violation of this policy. Individuals practicing exclusively abroad, i.e.: who are not practicing in the US or Canada and do not hold a US or Canadian license, must provide proof of licensure of the country in which they practice.

9. Please describe how candidates for certification in the proposed new or modified subspecialty area will be evaluated. In your response, include a description of the method(s) of evaluation (e.g., written, oral, simulation) and the rationale behind the method(s) used in the evaluation process:

Clinical competence and professional behavior are evaluated throughout training by a structured process overseen by the program director and the faculty. The ABP will require attestation of clinical competence and appropriate professional behavior from each candidate’s program director according to ABP’s standards. Many of the current non-accredited PHM training programs have embraced a competency-based evaluation system which has been further refined utilizing the pediatrics milestones which are currently being reported to ACGME.

For individuals utilizing the practice pathway, evaluation forms will be required from an individual who has personal and direct knowledge of the qualifications of the candidate and can attest to clinical competence. Appropriate evaluators might include a PHM fellowship training program director, a pediatric department chair, or chief of pediatrics in the hospital(s) where the applicant is now or has been practicing pediatric hospital medicine.

All qualified candidates will take a secure written cognitive examination administered by computer based testing. The examination will consist of single best answer multiple choice questions linked to the examination blueprint. Content validity will be established by members of a subboard which functions as an examination committee. The subboard will be composed of experienced pediatric hospitalists who are working in various practice settings in academics and in the community. Passing scores will be determined by a standard setting process currently used for the other criterion referenced examinations given by the ABP under the direction of a psychometrician.

10. For (a) through (d) below, please project the need for and the effect of the proposed new or modified subspecialty certification on the existing patterns of subspecialty practice. Please indicate how you arrived at your response.

a. How the Member Board will evaluate the impact of the proposed new or modified subspecialty certificate:

i. On its own primary and subspecialty training and practice:
The ABP has a robust process in place to review petitions for subspecialty certification. Because of the potential impact of certification in pediatric hospital medicine on the practice of both general pediatrics and its subspecialties, extensive internal and external vetting was conducted under the auspices of the ABP’s New Subspecialties Committee. The committee conferred with key stakeholder organizations and committees including the ABP’s Education and Training Committee, each of the ABP’s subspecialty subboards, the Association of Pediatric Program Directors, the AAP, AMSPDC, the Children’s Hospital Association (CHA), the SHM, the Medicine-Pediatrics Program Directors Association (MPPDA) and our specialty societies, etc. An in-depth evaluation of the body of evidence, objective data, and various opinions and viewpoints from both pro and con perspectives was undertaken over a two year period. In the future the ABP will evaluate the impact of the certification by continued interaction with these groups but also through our ongoing analysis of workforce data which is gathered through a series of surveys during training, at the time of application for our examinations, and during the enrollment period for MOC every five years. On balance, the ABP judged that the benefits to children outweighed any potential unintended consequences of certification in pediatric hospital medicine. Several important issues regarding the impact of PHM certification on pediatric training and practice are addressed in the paragraphs below.

General pediatricians and pediatric hospitalists have complementary roles as stewards and partners in the care of children across the continuum of care. However as these roles evolve community-based general pediatricians might be concerned that their admitting privileges and credentialing could be threatened if hospitals begin to require PHM subspecialty certification to admit children. According to the annual survey conducted by the American Hospital Association, there are ~2,000 pediatric inpatient units in the United States, certainly well more than the number of university and children’s hospitals. Establishing certification in PHM does not mandate that certified pediatric hospitalists be the attendings in every pediatrics unit. The expected impact is to improve quality of care for the hospitalized child and family, through a more rigorously trained workforce skilled in clinical care, systems-based practice and quality improvement, research, and education and to advance the development of the discipline.

The PHM community is fully committed to the standards for credentialing as set in the 2012 AAP Policy Statement “Medical Staff Appointment and Delineation of Pediatric Privileges in Hospitals”21. Credentialing is a local hospital process that can vary greatly from hospital to hospital. Clinical privileges are defined by departments within each hospital and are based on the complexity of care required by the patient with credentialing for procedures based on training and/or demonstrated competence. As such, there are no inherent limitations that subspecialty certification confers that will limit the ability of general pediatricians or family practitioners who meet the standard of competence as defined at each hospital from attaining credentialing to provide care to the hospitalized child.
Since it is clear that there will not be enough board certified hospitalists to care for the entire population of hospitalized children, it is unlikely that hospitals without hospitalists will create credentialing standards that will limit their ability to provide care. Fortunately, “practitioner crowd out” has not been observed with the other “generalist type” pediatric subspecialties of Emergency Medicine, Adolescent Medicine or Child Abuse Pediatrics. Even in “closed” critical care settings there is often a mix of physician and midlevel providers collaborating on a care team. Of note is the unambiguous language of the AAP Policy Statement “Guiding Principles for Pediatric Hospital Medicine Programs” that was first written in 2005 and revised in 2013\(^2\). Since its first publication, it has clearly stated that general inpatient units should not be closed to general pediatricians. Both this policy statement and the one noted above were authored by hospitalists and have the full endorsement of both the AAP and the PHM community.

Interest in PHM as a career choice has been relatively stable at for the past several years. In recent years, six to ten percent of third year residents identify PHM as their career choice. It is not clear whether PHM subspecialty certification would accelerate, slow, or have no impact on the growth of a PHM workforce. Factors that could increase the development of the workforce include the recognition associated with formal training and subspecialty certification and increased visibility of the field to the public and to employers, while the requirement for additional training and mounting debt burden might limit workforce development. Outside factors that have driven the growth of PHM are unlikely to change, so further growth of the field is projected with both certified and non-certified practicing hospitalists, similar to the pattern seen with pediatric emergency medicine.

Some subspecialists have hypothesized that if the required training for PHM is two years instead of the standard three years for most other pediatric subspecialties, some of the residents who are interested in fellowship training and are debating multiple options may be attracted to a shorter fellowship for financial and personal reasons. However residents are already choosing to pursue careers in PHM (both directly after residency and through completion of fellowship training) even without pediatric hospital medicine having a process for certification. Thus the new subspecialty is not expected to negatively impact the other subspecialties of pediatrics. As the interest in PHM grows among pediatric residents, the interest in the other 14 pediatric subspecialties remains strong. Over the last 15 years the number of individuals entering first year fellowships has nearly doubled. However, the potential impact will be evaluated by monitoring the number of trainees that seek subspecialty training in the other 14 subspecialties of pediatrics.

Many subspecialists emphasize the benefit that results from having hospitalists provide care for subspecialty inpatients, “taking the pressure off subspecialists” and allowing them to more efficiently care for their outpatients and see both inpatient and outpatient consults in a timelier manner. This practice is well established in internal medicine and occurs increasingly in pediatrics with...
hospitalists collaborating on the care of the patients of the general pediatrician and certain pediatric subspecialists. Hospitalists whose practice is restricted to one subspecialty or another is an emerging trend, especially in adult medical and surgical services. The implications of a new subspecialty designation for PHM on the need for such practitioners is not known. The committee speculated that hospitalists may cover some daytime and nighttime care for subspecialty patients but would not have the depth of knowledge to take over full subspecialty care.

ii. **On the primary training and practice of other Member Boards:**

Subspecialty certification in pediatric hospital medicine should have no impact on the primary training and practice of other member boards. Of note, the ABIM and the ABFM have opted to recognize the focused practice of adult hospital medicine through their MOC program rather than by subspecialty certification. Some individuals trained and certified in both internal medicine and pediatrics (Med-Peds) have expressed concern about the need to extend training in order to be certified in PHM while ABIM would recognize them as hospitalists without additional training. However, certification is not a requirement to practice and the choice to complete a PHM fellowship would be an individual one. The PHM fellowship directors are currently working with the Med-Peds community to identify opportunities that would integrate scholarly projects and non-clinical training that is applicable to both pediatric and adult aged patient populations. Many components of PHM fellowship such as education and quality improvement skills training have competencies unique to the field of hospital medicine, but are not exclusive or limited to the age of the patient population. It would be anticipated then, that these would be valuable for any Med-Peds trainee who chooses to pursue a PHM fellowship and might foster the development of an academic career in such individuals. While no trajectory can be predicted, it is possible that PHM will most closely parallel the evolution of Pediatric Emergency Medicine (PEM) as a discipline. Emergency departments in community and general hospitals do not often attract PEM trained physicians, while those in children’s hospitals most often do so, but they also have a wide variety of providers ranging from midlevel providers and general pediatricians to those trained in emergency medicine or pediatric emergency medicine. For PHM, we anticipate staffing of community and children’s hospitals may follow a similar track. However, given the broader training in systems and quality improvement, it may be that community hospitals would choose a fellowship trained physician to lead such activities.

The community of Med-Peds hospitalists has expressed concerns about the proposal for PHM to become a new subspecialty because currently ~10% of pediatric hospitalists are Med-Peds trained and they may be lost to the future workforce if hospitals require fellowship training and certification for an individual to practice as a pediatric hospitalist. However the practice patterns of recently graduated Med-Peds hospitalists indicate that a majority provide inpatient care to
adults only (35%) or to adults to a greater degree than children (41%). Only 3% provide care exclusively to children.\textsuperscript{23}

b. The \textit{value} of the proposed new or modified subspecialty certification on practice, both existing and long-term (in health care, \textit{value} is typically defined as \textit{quality divided by cost}), specifically:

i. Access to care (please include your rationale):

Pediatric hospital medicine should improve access to primary care physicians (PCPs), and pediatric medical and surgical subspecialists. There has been a notable decrease in PCPs caring for their own patients within the hospital setting for a variety of factors including time, efficiency, and system and patient complexities. The emergence of hospitalists has allowed PCPs to remain in their office setting to address the increasing complexity of outpatient care and an increasing population of outpatient visits for time-intensive behavioral, developmental and mental health problems.

The AAP Periodic Survey data reveal consistently high levels of satisfaction by referring office based pediatricians with care provided by pediatric hospitalists. In 2012, 60% of office based pediatricians reported a decrease in the number of inpatients they managed themselves over the past 5 years and 53% reported an increase in the number of hospitalized patients referred to hospitalists.\textsuperscript{24} Reasons for referrals to hospitalists have been consistent across AAP Periodic Surveys from 2002 and 2012 and include the following\textsuperscript{24}:

- Hospitalists provide best care because they are available full time (61%, 62%)
- Hospitalists provide best care because they work full time with hospitalized children (54%, 50%)
- Attending inpatients takes too much time away from office practice (57%, 49%)

Office based pediatricians’ report that the overall impact of hospitalists has been to increase or greatly increase (75%) quality of care and increase or greatly increase (59%) office productivity. Overall, 89% of office-based pediatricians who referred patients to hospitalists were satisfied or very satisfied with care provided by pediatric hospitalists to their patients, and 85% reported that their patients and families seem to be satisfied or very satisfied with care provided by pediatric hospitalists.

The same phenomenon has begun to occur in pediatric medical and surgical specialties\textsuperscript{25}. The increasing role of hospitalists in the co-management of these patients is likely to improve ambulatory access to subspecialty care as subspecialists are able to spend less time in the hospital, and like PCPs, more time in their ambulatory clinics providing care that might prevent unnecessary ED or hospital visits. This may address some of the realities facing subspecialties that
are struggling to meet their own workforce needs. In addition, the use of telemedicine affords opportunities to expand the PHM partnership with subspecialist colleagues to more rural areas thus potentially preventing unnecessary and costly transfers.

ii. Quality and coordination of care (please include your rationale):
Hospitalists serve as experts in efficiency, hospital throughput, information technology, process design and flow, and coordination of complex care. PHM has adopted, championed and moved forward the concept of family centered rounds, and shared decision making\textsuperscript{26,27}. Literature has demonstrated decreased hospital costs, lengths of stay across multiple diagnoses and resource utilization. Hospitalists utilize standardized and evidence based clinical pathways to drive quality care that minimizes unnecessary and unproven practice variation\textsuperscript{28}. Hospitals are complex environments and pose significant risk for medical errors, hospital acquired conditions and potential serious safety events. The hospitalist has a major role in driving patient safety efforts in these realms.

With the transition from an ambulatory environment to the inpatient setting and from a PCP or specialist to hospitalist, the coordination and transition of care are of critical importance. It is well documented that transitions of care are vulnerable points in health care and prone to serving as the impetus or contributing factor to medical errors. The hospitalist role is crucial in the coordination and transition of care\textsuperscript{29}. Hospitalists have been at the forefront in the research on transitions and handovers – most notably with the “I-PASS” model\textsuperscript{30}. Quality transitions foster improved quality of care and potential lesser cost by the avoidance of medical errors.

iii. Benefits to the public (please include your rationale):
The pediatric hospitalist model is well established throughout our healthcare system. A large number of pediatricians currently practice as hospitalists and a significant number of graduating trainees choose to enter the field. The practicing pediatrician in the community is increasingly less likely to care for his or her hospitalized patient. The process of certification requiring accredited training with standardized curricula will improve the consistency and educational quality of current and future hospitalist fellowship programs. The public will benefit from highly trained practitioners who have expertise in areas of patient safety, quality improvement, transitions and coordination of care, and clinical practice pathways. Designation of pediatric hospital medicine as a new subspecialty would likely result in a better definition of a hospitalist’s scope of practice so there is trust among the public and referring pediatricians that the title hospitalist has meaning and value.

c. Please explain the effects of the proposed new or modified subspecialty certification on:
i. Immediate costs and their relationship to the probable benefits (please indicate your methodology):
Pediatric Hospital Medicine clinical programs have been in existence for over 15 years with the first PHM fellowships established in 2003. During this time there has been rapid growth in these clinical programs without evidence of significant cost to the healthcare system. However, it must be acknowledged there will be increased costs as new fellowships are established or current fellowships increase in length of training. Pediatric hospital medicine has benefitted the public by lowering cost of care, increasing use of evidence based medicine, and providing more effective care in comparison to the traditional model of inpatient care. In 2006 a systemic review of the literature found that on average pediatric hospitalist programs decreased the cost of hospitalized care by 10% and decreased length of stay by 10\%\textsuperscript{31}. The use of hospitalists to co-manage patients with subspecialists has also achieved similar results with decrease in length of stay\textsuperscript{32}.

Increased use of evidence based medicine by pediatric hospitalists has led to the decreased use of ineffective treatments. This has been achieved by a national research network of pediatric hospitalists. One study found the overall use of bronchodilators to treat bronchitis was decreased by 46% on average in 17 centers participating in the national research network\textsuperscript{33}. Pediatric hospitalists in community settings have also reported decreased utilization costs by implementation of evidence-based order sets for respiratory illnesses\textsuperscript{34}. The drive to provide more effective, lower cost care has led to benchmarking among pediatric hospitalist programs to limit the use of treatments or medications that are not supported by current evidence\textsuperscript{35}.

In addition to reducing healthcare costs, pediatric house staff have reported hospitalists as superior educators compared to traditional attendings in the following realms: effective role models and teachers, more knowledgeable and accessible, and provided better feedback on resident performance\textsuperscript{36}. A more recent survey of 300 pediatric residents again found that working with hospitalists enhanced their education\textsuperscript{37}.

ii. Long-term costs and their relationship to the probable benefits (please indicate your methodology):
Long-term costs are unlikely to change substantially from current costs and are related to fellowship program development and funding. However, the long-term benefits will be the continued decrease in healthcare costs and utilization while improving the quality of care provided. As detailed above, in the past 15 years pediatric hospitalist have demonstrated the ability to decrease LOS and hospital utilization both in general pediatrics and as a member of a subspecialty team. The benefits outlined in 10.c.i. can only be expected to increase and spread as pediatric hospital medicine research matures and the number of hospitalists trained in quality improvement and research methodology increases. There is no doubt that hospital medicine will continue to grow. However, the key to
consistent and meaningful improvement in quality while decreasing cost of hospital care depends on the ability of the PHM field to develop and expand the research capabilities of its members. One key to this growth is the recognition of the field as a subspecialty and enhanced training of its members.

d. Please explain the effects if this subspecialty certification is not approved:
If pediatric hospital medicine subspecialty certification is not approved, it will likely have a significant impact on the advancement of the discipline and the care of hospitalized pediatric patients. Certification will result in the better definition of the hospitalist’s scope of practice, standardize training and provide assurance to the public that the hospitalist has the competencies needed to provide high quality care. Without a certification process, patients, families, medical colleagues and hospital administrators have no way of identifying a physician who has the appropriate training and the expert knowledge and skills to provide care to hospitalized patients. In the discipline of pediatrics there is historical evidence that suggests that subspecialty certification was a seminal moment that aided further growth and development of the discipline. The certification process has served as the basis for rigorous training and professional recognition and has enhanced the development of professionals skilled in the discipline, created a new and larger cadre of experts and mentors for trainees, and accelerated the development of new knowledge in the field.

II. Please indicate how the proposed new or modified subspecialty will be reassessed periodically (e.g., every five years) to assure that the area of clinical practice remains a viable area of certification:
The ABP has been collecting workforce data to inform its operations for over 30 years. We are currently engaged in a longitudinal survey project that tracks the work experiences and career choices of pediatricians over the continuum of their careers beginning from residency throughout fellowship training and into maintenance of certification. Common questions in the surveys provide a cross-sectional snapshot of the field as well as describe trends over time. This project allows the ABP to better understand training, the current workforce and workforce trends for both generalist and subspecialty pediatricians. We intend to use this framework to determine whether the subspecialty of PHM remains viable for the near and the long term. The following data will be collected:

1. Number of physicians entering the field as determined by trainees entering and completing accredited training programs and by the number of new diplomates certified.
2. The development of new fellowship programs will be tracked including the number of fellows graduating and the number of fellows taking and passing the certification examination from each program.
3. Periodic cost analysis in order to keep the examination and training programs economically sound.
4. Diplomates will be tracked and surveyed for their practice patterns both longitudinally and cross-sectionally. Data will be collected for general pediatricians and all subspecialists, including pediatric hospitalists.

12. Please list key external public stakeholders that COCER may solicit for possible public comment on the proposed new or modified subspecialty area:
   - American Academy of Pediatrics
   - Academic Pediatric Association
   - Children’s Hospital Association
   - Society for Hospital Medicine
   - American Hospital Association
   - Institute for Patient and Family Centered Care
   - Agency for Healthcare Research and Quality
   - National Institute for Children’s Health Quality
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Pediatric Hospital Medicine

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References


10. N. Alexander MPP, Manager Division of Hospital and Surgical Services American Academy of Pediatrics; Connie MacKay, Executive Director Academic Pediatric Association; Ethan Gray, Membership Director Society of Hospital Medicine. Personal communications, 2014.


21. Rauch DA. Medical Staff Appointment and Delineation of Pediatric Privileges in Hospitals. Pediatrics 2012; 129: 797-802


Appendix B
Global Goals and Objectives for Pediatric Hospital Medicine Fellowship

The goal of Pediatric Hospital Medicine Fellowship is to attain expertise clinical care, administration, academics, research, and advocacy related to the care of hospitalized children. The objectives and methods by which these are met are delineated below:

INPATIENT CARE:

Fellow must be able to provide family centered patient care that is developmentally appropriate, compassionate, and effective for the treatment of acute and chronic health problems and the promotion of health.

Competency: Information – history and examination

Knowledge/Skills/Attitudes Benchmarks:
- Interview patients and families accurately and comprehensively attending to all developmental level and/or age specific needs
- Perform an efficient yet comprehensive physical examination
- Perform a focused history and physical examination when performing consultations yet attends to global general pediatric healthcare issues

Competency: Diagnostic and therapeutic decisions and planning

Knowledge/Skills/Attitudes Benchmarks:
- Demonstrate recognition of acute problems in patients with common and uncommon disease states
- Demonstrate recognition of need for and efficiently initiates critical care consultation and transfer
- Formulate and prioritize a differential diagnosis, plans and implements a management strategy
- Use critical thinking skills and sound judgment to apply laboratory tests and imaging studies results to patient care decision
- Coordinate care for patients with complex conditions and/or those with multiple subspecialty consultants
- Appropriately counsel and educate patients regarding the management plans and discharge follow-up needs

Competency: Medical procedures (invasive and non-invasive) considered essential for the scope of practice.

Knowledge/Skills/Attitudes Benchmarks:
- Demonstrate consistently competent performance of core skills such as IV access, sedation, and pain management
- Consistently identify proper indications for use of these procedures, and obtains proper informed consent in a manner that is sensitive to cultural, developmental, family and patient-specific needs
- Accurately document all procedures following appropriate policies and procedures (time monitoring, and others).
MEDICAL KNOWLEDGE:

Fellow must demonstrate knowledge about established and evolving biomedical, clinical, and cognitive sciences and the application of this knowledge to patient care and the education of others.

**Competency: Diseases and pathophysiology**

**Knowledge/Skills/Attitudes Benchmarks:**
- Demonstrate ability to describe common and uncommon disease states, articulating the pathophysiology accurately for the majority of conditions encountered in both community and tertiary pediatric inpatient settings.
- Articulate risks, benefits, and alternatives to medications and technology choices available in these settings.
- Accurately create a differential diagnosis, properly prioritizing based on patient-specific information.
- Demonstrate an analytic and investigatory approach to clinical situations, and can describe the process to other learners.

**Competency: Interpretation and Ordering of Studies**

**Knowledge/Skills/Attitudes Benchmarks:**
- Accurately interpret common laboratory and imaging studies and demonstrates ability to support interpretation from knowledge of the literature, likelihood of error rates for the study, prevalence rates of disease states and other information.
- Demonstrate use of evidence based medicine principles when ordering studies.

**Competency: Transport Triage and Stabilization**

**Knowledge/Skills/Attitudes Benchmarks:**
- Accurately interpret information from facilities requesting emergency transport and efficiently creates a stabilization plan.
- Demonstrate ability to apply physiologic principles into practice to stabilize, treat, and safely transport pediatric patients.

PRACTICE-BASED LEARNING AND IMPROVEMENT:

Fellow must be able to investigate and evaluate his/her patient care practices, appraise and assimilate scientific evidence, and improve his/her patient care practices.

**Competency: Analyze practice experience**

**Knowledge/Skills/Attitudes Benchmark:**
- Describe the process of practice assessment- from identifying key issues for improvement to analysis to implementing change, to analysis of change.
• Demonstrate culture of accountability for error identification, reporting, education, and systematic assessment
• Discuss evaluation results and interpret as appropriate for clinical, presentation/education and research growth.
• Review information from articles on presentation skills and apply to own practice
• Participate in Presentation Skills Workshops.
• Create an individual career plan attending to lifelong learning

**Competency: Use of scientific studies related to patients’ health problems.**

**Knowledge/Skills/Attitudes Benchmarks:**

• Interpret the principles of evidence-based medicine and statistics by demonstrating basic skill in use of principles and statistical techniques necessary for these analyses (e.g., ARR, NNT, p values, risk ratios, meta-analyses, etc.)
• Review relevant peer reviewed articles and interpret in the context of patient and population care
• Locate search engines (e.g., Ovid, MD Consult) to effectively search the literature.

**Competency: Fellow as educator**

**Knowledge/Skills/Attitudes Benchmarks:**

• Demonstrate responsibility and leadership in engaging learners in the educational process at a level appropriate for fellow/junior faculty member.
• Effectively participate as educator for medical students’ physical examination rounds, transport team educational sessions, and housestaff conferences.
• Teach others via presentations at/to: Division Journal Club twice yearly, midlevel providers, Fellows’ Research Conference, and one regional or national venue as appropriate

**INTERPERSONAL/COMMUNICATION:**

Fellow must be able to demonstrate interpersonal and communication skills that result in effective information exchange and teaming with patients, families, and the healthcare team.

**Competency: Communicate effectively with patients and families**

**Knowledge/Skills/Attitudes Benchmarks:**

• Identify self and other members of the health care team and explains role appropriately to patient
• Consistently communicate effectively by using appropriate language at the proper developmental/educational level for the patient and/or caregivers/family; attending to cultural needs; using effective listening skills, and developing a therapeutic relationship with sensitivity to the patients’ individual needs.
### Competency: Effectively communicate with and lead a health care team

**Knowledge/Skills/Attitudes Benchmarks:**
- Consistently demonstrate respect for all team members
- Assume the appropriate leadership role on the team
- Effectively supervise housestaff and midlevel providers
- Communicate effectively and respectfully with other members of the health care team including consultants and primary care pediatricians
- Document effectively and accurately in the health record.

### Competency: Effectively communicate with the healthcare community

**Knowledge/Skills/Attitudes Benchmarks:**
- Consistently demonstrate respect for community physicians
- Use sound judgment to triage healthcare needs of pediatric patients throughout the community, in partnership with emergency medicine physicians and others.
- Effectively and efficiently assist with transports of patients to and from the hospital from distant sites

**PROFESSIONALISM:**

Fellow must demonstrate a commitment to carrying out professional responsibilities, adherence to ethical principles, and sensitivity to a diverse patient population.

### Competency: Responsiveness to the needs of patients

**Knowledge/Skills/Attitudes Benchmarks:**
- Demonstrate initiative and accountability for all aspects of patient care
- Consistently interact with patients, staff, colleagues, and other health professionals in a respectful manner
- Consistently demonstrate dedication to the needs of the patient over the self
- Consistently advocate for patient care needs

### Competency: Ethical principles

**Knowledge/Skills/Attitudes Benchmarks:**
- Recognize ethical dilemmas and access appropriate resources to address issues that arise
- Adhere to the laws and rules governing the confidentiality of patient information
- Obtain proper informed consent from patient or family member/legal guardian, recognizing the situational need for determining competence
- Participate actively in ethics conferences
- Engage with social workers on a continual basis to support patient and family needs
**Competency: Diversity and Cultural Awareness**

**Knowledge/Skills/Attitudes Benchmarks:**
- Recognize the impact that characteristics such as culture, age, gender, and disability has on patient care, preferences/perceptions, and outcomes
- Consider the impact of disability on a patient’s life and that of the family

**Competency: Leadership and Responsibility**

**Knowledge/Skills/Attitudes Benchmarks:**
- Assume the role of leader in various inpatient settings
- Function as Director of Inpatient Services when rotating at the hospital at attending level with direct and indirect supervision
- Seek, accept and deliver effective feedback
- Seek opportunities to educate and counsel learners as appropriate on principles of professional behavior
- Role model professional attitude and dress at all times
- Articulate the basic hospital medical staff and administrative structure and defines the role of the hospitalist within these.
- Arrive promptly to conferences and meetings

**SYSTEMS-BASED PRACTICE:**

Fellow must demonstrate an awareness of and responsiveness to the larger context and system of health care and the ability to effectively call on system resources to provide care that is of optimal value.

**Competency: Coordination of Care**

**Knowledge /Skills/Attitudes Benchmarks:**
- Identify and efficiently access appropriate community resources for patients and families
- Create safe, comprehensive yet concise discharge plans with appropriate follow-up

**Competency: Business Practice**

**Knowledge/Skills/Attitudes Benchmarks:**
- Demonstrate consistent cost-effective use of resources including testing, procedures, medications and consultation services
- Adhere to ethical and legal coding and billing practices
- Discuss the influence of finance on medical practice at individual, division, hospital, and national levels

**Competency: System Management**

**Knowledge/Skills/Attitudes Benchmarks:**
- Articulate the goals of effective and efficient healthcare in the hospital setting, and properly assists with improving proper patient placement and throughput attending to safety and patient/family satisfaction
Competency: Quality Improvement and Patient Safety

Knowledge /Skills/Attitudes Benchmarks:

- Identify opportunities for and utilizes care pathways appropriately
- Articulate improvements in process and clinical outcome afforded by properly used clinical pathways
- Demonstrate ability to assess a clinical problem and create an effective aim statement to address the issue
- Actively participate in general pediatric inpatient pathway meetings
- Lead one interdisciplinary quality or safety group/committee meeting
- Attend Quality Improvement meetings at the Hospital level where appropriate
- Participate in division Peer Review
Appendix C
Pediatric Hospital Medicine Entrustable Professional Activities

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<tr>
<td><strong>Clinical</strong></td>
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<td>Care of children with common clinical conditions</td>
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<tr>
<td>a. Evidence-Based Guidelines for diseases</td>
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<td>b. Efficient work up and diagnosis of common presenting problems</td>
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<td>Direct the undifferentiated or complex patient</td>
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<td>Diagnose, and coordinate care management for medically complex, chronically ill patients</td>
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<td>Procedures (including Sedation)</td>
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<td>Facilitate Hospital Throughput and advocate for needed resources for pediatric patients</td>
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<td>Provide for and obtain consultation from other health care providers caring for children (include surgical patients)</td>
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<td>Effectively communicate with patients and families about the disease process and treatment options</td>
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<td><strong>Leadership</strong></td>
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<td>Lead and work within interprofessional health care teams</td>
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<td>Facilitate handovers to another healthcare provider</td>
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<td>Lead comprehensive, coordinated, and safe transitions of care between inpatient and outpatient settings</td>
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<td><strong>Quality and Performance Improvement</strong></td>
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<td>Lead a Quality/Process Improvement Initiative</td>
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<td><strong>Teaching</strong></td>
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<td>Supervise and Teach FCR</td>
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<td><strong>Scholarship</strong></td>
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<tr>
<td>Engage in scholarly activities through the discovery, application, and dissemination of new knowledge (broadly defined)</td>
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<tr>
<td><strong>Health Care Finances</strong></td>
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<tr>
<td>Contribute to the fiscally sound and ethical management of a practice (e.g., through billing, scheduling, coding, and record keeping practices)</td>
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Appendix D
Written Comments from External Stakeholders
May 20, 2015

Gail A. McGuinness, MD
Executive Vice President
The American Board of Pediatrics
111 Silver Cedar Court
Chapel Hill, NC 27514

I am writing on behalf of the Board of Directors of the American Academy of Pediatrics (AAP) to indicate our strong support of the Joint Council of Pediatric Hospital Medicine’s application for a new subspecialty in Pediatric Hospital Medicine (PHM).

The AAP has always supported the best interests of children. PHM has demonstrated a unique body of knowledge and a large community of providers who are committed to this field and to the advancement of it through subspecialty certification. Pediatric hospitalists serve as teachers to all level of trainees. They provide care to hospitalized children in community settings where they may be the only pediatric provider and in tertiary facilities where they provide efficient and effective care in consultation with specialists. Children have been better served through PHM and ABP recognition is important to continue the growth of PHM.

The PHM petition also provides the template for other specialties to consider modifying their current training duration and content. We believe a two year fellowship might encourage additional trainees to consider specialty training and improve the national pediatric specialty shortage. The PHM focus on quality is something that should be spread to all other fields. The AAP is aware that both the community of pediatric hospitalists and generalists are in agreement about PHM achieving subspecialty status. The practicing pediatrician is increasingly less likely to care for his or her hospitalized patient. The hospitalists are eager for a standardized definition of the term itself, so that there is trust among the public and referring pediatricians that the title ‘hospitalist’ has meaning and value. Recognition by the ABP will serve to define the field and raise the level of care for all hospitalized children.

Thank you,

Sandra G. Hassink, MD, FAAP

SGH/dr

cc: Ricardo Quinonez, MD, FAAP
     Brian Alverson, MD, FAAP
     Daniel Rauch, MD, FAAP
July 17, 2014

David G. Nichols, MD, MBA
President, CEO
Gail A. McGuinness M.D.
Executive Vice-President
American Board of Pediatrics
111 Silver Cedar Court
Chapel Hill, NC 27514

Dear Drs. Nichols and McGuinness:

On behalf of the Children’s Hospital Association, we support for the Pediatric Hospital Medicine (PHM) petition for subspecialty board exams.

CHA has a long history of leadership in activities surrounding quality improvement, patient safety, and advocacy for hospitalized children. Pediatric hospitalists throughout the nation have been engaged in CHA collaboratives and have worked with CHA in leadership roles on various quality committees. CHA has supported the work of the Pediatric Research in the Inpatient Setting Network (PRIS). Dr. Siivastova, the Chair of PRIS, has presented to CHA on a number of occasions and has proven the value of a pediatric hospitalist run research network.

Support for PHM subspecialty exams will further advance this developing field that is addressing quality improvement for hospitalized children in all settings. The scholarly approach taken to education, quality and safety, and clinical research will grow much more rapidly within a subspecialty certification system that includes accredited fellowship training.

Thank you for your leadership in advancing this important subspecialty in PHM with the American Board of Pediatrics.

Very best regards,

Mark Wiesehu
President and CEO

Champions for Children's Health
August 22, 2014

Gail A. McGuinness, MD
Executive Vice President
American Board of Pediatrics
111 Silver Cedar Court
Chapel Hill, NC 27510

Dear Dr. McGuinness,

On behalf of the Board of the Academic Pediatric Association (APA), I would like to inform you that the APA Board fully supports the Joint Council of Pediatric Hospital Medicine’s application for a new subspecialty in Pediatric Hospital Medicine. The APA would be happy to provide additional information as needed during the review process.

Please feel free to contact me with any questions or concerns.

Sincerely,

Mark Schuster, MD, PhD
President
Academic Pediatric Association
Application for Admission to Subspecialty Certifying Examination

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Credit Card Information

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<tbody>
<tr>
<td>Credit Card Number</td>
<td></td>
</tr>
<tr>
<td>Is this a Corporate Card?</td>
<td>Yes</td>
</tr>
<tr>
<td>Expiration Date</td>
<td>Month</td>
</tr>
<tr>
<td>CVV2 Verification Number</td>
<td></td>
</tr>
<tr>
<td>Cardholder's Name</td>
<td></td>
</tr>
<tr>
<td>Street Address (first line only)</td>
<td></td>
</tr>
<tr>
<td>Zip Code</td>
<td></td>
</tr>
<tr>
<td>(or, if outside United States)</td>
<td>(Postal Code)</td>
</tr>
</tbody>
</table>

Contact Telephone Number

Please provide a telephone number where you can be reached if there are questions concerning the processing of your application.

<table>
<thead>
<tr>
<th>Field</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Contact Telephone Number</td>
<td>Area Code</td>
</tr>
<tr>
<td>(or, if outside United States)</td>
<td>Country</td>
</tr>
</tbody>
</table>

Information On File

This section displays the information that the American Board of Pediatrics has on file. If the information below is not accurate, please update it as necessary.

<table>
<thead>
<tr>
<th>Field</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>First Name</td>
<td></td>
</tr>
</tbody>
</table>
**Middle Name**

**Last Name**

**Suffix (eg., Jr., Sr.)**

<table>
<thead>
<tr>
<th>Government ID</th>
<th>Social Security</th>
<th>Social Insurance</th>
</tr>
</thead>
</table>

**Date of Birth**

- **Month**
- **Day**
- **Year**

**Gender**

- Male
- Female

### Current Address

If your address is not correctly displayed below, please click here and provide your complete mailing address. Please provide street or P.O. Box and apartment number, if applicable.

### Medical Degree Information

- **Country of Medical School**
- **Degree Date**
- **Degree Type**

### Certification Information

The certification information that the ABP has on file for you is listed below.

<table>
<thead>
<tr>
<th>Certification</th>
<th>Certificate Number</th>
<th>Date of Certification</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pediatric Cardiology</td>
<td>987654321</td>
<td>07/26/2015</td>
</tr>
</tbody>
</table>
If your certification is not current, please provide comments.

Training Information

The ABP may have your residency and fellowship training on file. If so, it will be displayed below. Please check the information for accuracy. If the information below is inaccurate, incomplete, or blank, click here to complete and submit a Training Addendum.

<table>
<thead>
<tr>
<th>Code</th>
<th>Training Program</th>
<th>Specialty Area</th>
<th>Level</th>
<th>Type</th>
<th>From</th>
<th>To</th>
<th>Months Credit</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>[no training information on file]</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

If you have any additional comments regarding the training information listed above, please provide that information in the box to the right.

Plan

Please select the plan that best describes the route under which you are applying. For a description of the plan, click here.

Plan A: Fellowship Training

If you are applying by Plan A, you should:

a) Complete the application (items which are applicable; please indicate which items are not applicable). The ABP will send Verification of Competence Form(s) to program director(s) responsible for supervising your training.

b) Complete the “Description of Subspecialty Fellowship Form.” You may duplicate this form if needed.
Plan B: Four Years of Practice in Pediatric Hospital Medicine

If you are applying by Plan B, you should:

a) Complete the application (items which are applicable; please indicate which items are not applicable).
b) Complete the "Description of Practice Form." You may duplicate this form if needed.
c) Submit the "Evaluation Form" to either the pediatric hospital medicine program director (if there is a subspecialty fellowship training program) or the pediatric department chair or the chief of pediatrics in the hospital(s) where you are now or have been practicing pediatric hospital medicine.

Plan C: Training and Pediatric Hospital Medicine Practice

If you are applying by Plan C, you should:

a) Complete the application (items which are applicable; please indicate which items are not applicable). The ABP will send Verification of Competence Form(s) to program director(s) responsible for supervising your training.
b) Complete the "Description of Subspecialty Fellowship Form." You may duplicate this form if needed.
c) Complete the "Description of Practice Form." You may duplicate this form if needed.
d) Submit the "Evaluation Form" to either the pediatric hospital medicine program director (if there is a subspecialty fellowship training program) or the pediatric department chair or the chief of pediatrics in the hospital(s) where you are now or have been practicing pediatric hospital medicine.

License Information

A copy of your valid (current), unrestricted medical license must be provided to the ABP by the licensure deadline. Please provide information about your license below. If you currently do not possess a medical license, please leave this section blank and proceed to the Licensure Status section. Please review the Licensure Policy for complete details.

License Number
Licensing State or Province
Expiration Date Month Day Year

Licensure Status

Answer each of the following questions which apply to any license to practice medicine you currently hold or have held in the US or any other country. If the answer to any question is "Yes," provide full details in the section below.

- Have any of your licenses to practice medicine ever been denied, revoked, suspended, restricted, and/or had conditions placed upon them?
- Are there any actions and/or conditions pending against you before any state Licensing Board at this time?
- Are any of your licenses to practice medicine restricted in any way? (Residents and fellows in training, is your educational/training license restricted beyond the training requirement restriction?)

If you answered "Yes" to any of the questions above, please provide an explanation in the space below.
Your Comments

If you have any comments regarding your application, or if you would like to provide additional information, please enter that information in the box below.

Consent To Release Information And Agreement To Conditions

Read the following statement of terms and conditions.

I hereby make application to the American Board of Pediatrics® (ABP) and, if applicable, to its Subboard to take this certifying examination based on my qualifications as a pediatric subspecialist and, if successful in such examination, for a certificate as a pediatric subspecialist, all in accordance with and subject to the rules and regulations of the ABP and the Subboard. In connection with my application for admission to the examination, I consent to the release of information to the ABP regarding my credentials and professional qualifications by persons named in my application and other persons/organizations as the ABP and the Subboard may deem appropriate. I hereby certify that all information on this form is complete and true to the best of my knowledge and belief. I acknowledge that I have read the current rules and regulations in A Guide to Board Certification-Booklet of Information, Eligibility Criteria of the Subboard and the Subspecialty Certification section on the ABP website and agree to be bound by the conditions therein. I do assume the obligation to keep myself acquainted with such changes as may be published from time to time in A Guide to Board Certification-Booklet of Information of the ABP and the Eligibility Criteria of the Subboard. I acknowledge that I have no vested right in any rule and regulation and that the same are subject to change from time to time at the discretion of the ABP and the Subboard.

I have answered the licensure status questions above and have provided a separate explanation of the relevant circumstances regarding the licensure status questions to which I have answered "Yes." I agree that the ABP and the Subboard may, after consideration of these circumstances, deny my entrance to the certification process or withhold my certificate.
I understand that the decision as to whether my examination qualifies me for a certificate vests solely and exclusively in the ABP and that its decision is final. I agree to hold the ABP, Subboard, its members, officers, and agents free from any complaints, claims, or demands for damage or otherwise by reason of any omission of commission that they, or any of them, may take in connection with this application, the score of my examination, or the failure of the ABP to issue to me such certificate.

I understand that my examination results will be reported by name and score to the subspecialty program director at the institution(s) where I trained for use in evaluation of the program by the director. I understand that the names of certified subspecialists, but not their scores, will be sent to the appropriate organizations.

I understand that some items on the examination may be included for experimental purposes only and that these items will not contribute to my score.

Honor Code
The American Board of Pediatrics (ABP) expects residents and fellows in training, candidates for initial certification, and its diplomates to uphold fundamental moral and ethical principles. As specified by The Accreditation Council for Graduate Medical Education and the American Board of Medical Specialties, residents, fellows, candidates, and diplomates must demonstrate a commitment to carrying out professional responsibilities, adherence to ethical principles, and sensitivity to diverse patient populations.

The materials developed by the ABP for its in-training, certification, and maintenance of certification examinations and other certification activities are copyrighted as the sole property of the ABP and may not be reproduced in any way. Reproduction of copyrighted material, in whole or in part, is a federal offense. Irrespective of copyright, any attempt to distribute ABP in-training, certification, or maintenance of certification materials, in whole or part, undermines the fairness of the certification process and will be considered unethical, unprofessional, and dishonorable, and will constitute grounds for the ABP to disqualify the resident, fellow, candidate, or diplomate from future examinations and/or other certification activities, invalidate current activities, revoke certificates, or take any other action deemed appropriate by the ABP and its legal counsel.

Residents, fellows, candidates and diplomates must understand that unethical and unprofessional behavior including but not limited to the listing below may be sufficient cause for the ABP to deny admission to an examination for a period of up to five years, to terminate participation in an examination, to invalidate the result of an examination, to withhold scores or certificates, to require an individual to retake an entire activity or portions thereof, to revoke a certificate(s), or to take other appropriate action as deemed appropriate by the ABP and its legal counsel:

a. Falsification of an ABP application;
b. Submission of any falsified documents to the ABP;
c. Use of any falsified ABP documents or the submission of such documents to other persons;
d. Giving or receiving of aid in an examination as evidenced either by observation at the time of the examination or by statistical analysis;
   e. Unauthorized possession, reproduction, recording, discussion, reconstruction of content from memory, or disclosure of any materials, including, but not limited to, examination questions or answers before, during, or after an examination or other certification activities;
   f. Offering of any financial or other benefit to any director, officer, employee, proctor, or other agent or representative of the ABP in return for any right, privilege, or benefit which is not usually granted by the ABP to other similarly situated candidates or persons.

Candidates and diplomates must also understand that the ABP may withhold scores and may or may not require a candidate or diplomat to retake one or more portions of an examination if the ABP is presented with sufficient evidence that the security of one or more portions of the examination has been compromised, notwithstanding the absence of any evidence of personal involvement in such activities. Candidates must agree that the ABP will not be liable for candidate travel and/or other losses or expenses incurred as a result of an examination cancellation or postponement for such cases.

I intend to be legally bound by the foregoing.

Select the "Submit" button to submit your application or select the "Clear" button to clear the content of the form. Remember, by selecting the "Submit" button, you signify that you understand and agree to all terms and conditions outlined in the statement listed above.
1. ______ COMPLETE all items on the application form and review any information already provided by the ABP. Make any additions, deletions and/or corrections necessary.

2. ______ COMPLETE the required forms for the Plan under which you are applying.

**Plan A – Subspecialty Fellowship Training**
If you are applying by Plan A, you should:
  a) Complete the application (items which are applicable; please indicate which items are not applicable). The ABP will send Verification of Competence Form(s) to program director(s) responsible for supervising your training.
  b) Complete the “Description of Subspecialty Fellowship Form.” You may duplicate this form if needed.

**Plan B – Four Years of Practice in Pediatric Hospital Medicine**
If you are applying by Plan B, you should:
  a) Complete the application (items which are applicable; please indicate which items are not applicable).
  b) Complete the “Description of Practice Form.” You may duplicate this form if needed.
  c) Submit the “Evaluation Form” to either the Pediatric hospital medicine program director (if there is a subspecialty fellowship training program) or the pediatric department chair or the chief of pediatrics in the hospital(s) where you are now or have been practicing hospital medicine.

**Plan C – Combination of Subspecialty Fellowship and Pediatric Hospital Medicine Practice**
If you are applying by Plan C, you should:
  a) Complete the application (items which are applicable; please indicate which items are not applicable). The ABP will send verification of Competence Form(s) to program director(s) responsible for supervising your training.
  b) Complete the “Description of Subspecialty Fellowship Form.” You may duplicate this form if needed.
  c) Complete the “Description of Practice Form.” You may duplicate this form if needed.
  d) Submit the “Evaluation Form” to either the Pediatric Hospital Medicine program director (if there is a subspecialty fellowship training program) or the pediatric department chair or the chief of pediatrics in the hospital(s) where you are now or have been practicing Pediatric Hospital Medicine.

3. ______ SUBMIT YOUR APPLICATION by submitting the application you are agreeing to the conditions set forth in the Eligibility Criteria of the Subboard and the Booklet of Information-A Guide to Board Certification in Pediatrics.

4. ______ SUBMIT a copy of your valid (current), unrestricted license to practice medicine that includes your name, license number and expiration date. See License Requirement in Instruction Booklet for information concerning submission of your license.

Please keep the ABP informed of any changes in your contact information.
All applicants applying subspecialty fellowship training toward the admission requirements for the certification examination in pediatric hospital medicine should complete this form. Please answer all questions using “O” or “None” where applicable. Additional forms can be printed if you trained at more than one fellowship program. If your fellowship training was completed before _____, apply under the Practice Pathway, or Combination of Fellowship and Practice Pathway.

Name of Applicant

Name of Training Institution       City/State

Name of Program Director who supervised your training

From _______ To _______ What were the dates of your pediatric hospital medicine fellowship training?  

(Month/Year)  (Month/Year)

If you completed fellowship before _____ year, please refer to the Eligibility Criteria for additional instructions.

__________ How many months of full-time credit was awarded during this period?

If this training was part-time or discontinuous, please provide details: ______________________________________

__________________________________________________________________________________________________

__________________________________________________________________________________________________

__________________________________________________________________________________________________

What percentage* of your time in pediatric hospital medicine was spent in the following areas?

__________ Direct patient care of hospitalized children

__________ Teaching

__________ Quality Improvement

__________ Research/Scholarly Activity

__________ Administrative activities

__________ Other (Specify: ____________________________)

*Total should equal 100 percent.

Please submit this form to the ABP _______.
All applicants applying practice experience in pediatric hospital medicine toward the admission requirements for the certification examination in pediatric hospital medicine should complete this form. The most recent four years of pediatric hospital medicine practice must consist of at least 50% of time spent engaging in professional activities related to the care of hospitalized children with at least half of that time devoted to direct patient care of children. Please answer all questions using “O” or “None” where applicable. Complete a separate form for each institution if you have practiced in more than one location over this four year period. Additional forms can be printed. Attach a current copy of your CV.

<table>
<thead>
<tr>
<th>Name of Applicant</th>
<th>Title/Position</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Name of Institution</th>
<th>City/State</th>
</tr>
</thead>
</table>

From _____ To _____  Provide the most recent dates of your subspecialty practice experience at the above institution

Please indicate the percentage of professional time you spent in the practice of pediatric hospital medicine during this period. This may include time spent in clinical care, teaching, administration, quality improvement, research, scholarly work, and other activities.

Full-time practice equals at least 40 hours per week.

<table>
<thead>
<tr>
<th>%</th>
<th>10%</th>
<th>20%</th>
<th>30%</th>
<th>40%</th>
<th>50%</th>
<th>60%</th>
<th>70%</th>
<th>80%</th>
<th>90%</th>
<th>100%</th>
</tr>
</thead>
</table>

*50% equals a minimum of 20 hours per week

How many months were you actively engaged in the practice of hospital medicine (Months) at this specific time commitment?

If you cannot adequately explain your practice using the scale above, or if any part of this practice time was considered part-time or discontinuous, please explain:

__________________________________________________________________________________________________

__________________________________________________________________________________________________

What percentage* of your time in pediatric hospital medicine was spent in the following areas?

| Percentage | Direct patient care of hospitalized children | Teaching | Quality Improvement | Research/Scholarly Activity | Administrative activities | Other activities (Specify: _________________________________) |

*Total should equal 100 percent.

Provide a typed, narrative description of your professional practice and a current copy of your CV. Include descriptions of your professional activities related to pediatric hospital medicine to include time spent in clinical care, teaching administration, quality improvement, research, scholarly work, and other activities. If any of your practice experience was considered part-time, please describe in your narrative. If needed, continue on the reverse or on a separate sheet of paper.

Please submit this form to the ABP by ________
EVALUATION FORM FOR PRACTICE EXPERIENCE

All applicants applying subspecialty practice experience toward the admission requirements for the certification examination in pediatric hospital medicine must have this form completed by either the pediatric department chair, the chief of pediatrics, or the pediatric hospital medicine program director (if there is a subspecialty training program). Completion of this form by a partner or practice associate is not acceptable. Additional forms can be printed if needed.

Name of Applicant          Title/Position

Name of Institution        City/State

In what capacity do you have knowledge of this physician’s work qualifications in pediatric hospital medicine during the past four years?

_____________________________________________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________

From ______ To ______ What were the dates of this applicant’s practice experience in pediatric hospital medicine at your institution?

(Month/Year)    (Month/Year)

Please indicate the percentage of professional time the applicant spent in the practice of pediatric hospital medicine during this period. This scale assumes full-time practice is at least 40 hours per week.

___10%    ___20%    ___30%     ___40%     ___50%*    ___60%     ___70%     ___80%     ___90%    ___100%

*50% equals a minimum of 20 hours per week

If you cannot adequately explain the applicant’s practice using the scale above, or if any part of this time was considered part-time, or discontinuous, please explain. _____________________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________

What percentage* of the applicant’s scheduled time in pediatric hospital medicine was spent in the following activities?

________ Direct patient care of hospitalized children
________ Teaching
________ Quality Improvement
________ Research/Scholarly Activity
________ Administrative activities
________ Other activities (Specify: _____________________________________________)

*Total should equal 100 percent.
Provide a typed, narrative description of the applicant’s professional practice. Include descriptions of the applicant’s professional activities related to pediatric hospital medicine to include time spent in clinical care of children, teaching, administration, quality improvement, research, scholarly work, or other activities. If needed, continue on the reverse or on a separate sheet of paper.

I certify that the above-named applicant has demonstrated the necessary attitudes, knowledge, clinical judgment, technical skills, and interpersonal skills and is judged to be fully prepared for independent responsibility in pediatric hospital medicine; to my knowledge, he/she has moral and ethical integrity. The applicant is recommended for examination.

Signature __________________________

Name (print) _________________________

Title/Position _________________________

Email _______________________________

Address _____________________________

City/State ____________________________

Telephone ___________________________

Date ______________________________

Notary Public

Return directly to the American Board of Pediatrics (ABP)
111 Silver Cedar Court, Chapel Hill, North Carolina 27514-1513

Please submit this form to the ABP by _____
The American Board of Pediatrics
and its
Subboard of Pediatric Hospital Medicine
hereby declare that

________________

was certified in Pediatric Hospital Medicine
on ______________ and issued certificate No. ________
as a Diplomate of the American Board of Pediatrics

Ongoing certification is contingent upon meeting the requirements of
Maintenance of Certification

Chair, American Board of Pediatrics
President, American Board of Pediatrics
Chair, Subboard
Secretary, American Board of Pediatrics