



Association of Pediatric Program Directors

Annual Report

April, 2006

*Association of Pediatric Program Directors
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April 2006

Dear APPD member,

APPD as an organization is in a period of significant maturation and growth. This Annual Report documents the activities of so many individual members who have volunteered their time and contributed to the growth and enhanced visibility of APPD as a pediatric organization. You will read about our task forces, regional activities, sections, awards, special projects, communication, outreach, and interactions with related organizations.

As you browse this report, please note topics or activities of particular interest to you personally and consider becoming a more active participant in APPD activities. Twelve years ago when I first attended an APPD Annual Meeting, I made a commitment to become more involved in APPD because it was my home as a pediatric program director. I can attest to the impact APPD has had on my professional development and I hope that you can also take advantage of what the organization has to offer you and how it can facilitate your contributions to pediatric graduate medical education.

I offer thanks and gratitude to the leadership of APPD including the Board of Directors, Officers, Task Force and Regional Leaders, Laura Degnon and her administrative team, Kathy Haynes and George Degnon. I look forward to having Rob McGregor take over as President of APPD as he presides over the next period of growth and maturation for APPD.

Welcome to the 2006 Annual Meeting with its theme, "Training the Next Generation of Pediatricians: Our Ongoing Mission." We have a great program in this wonderful city of San Francisco. I hope you enjoy the meeting and have time to take advantage of the sites and attractions in this spectacular Bay Area.

Warmest personal regards,



Theodore C. Sectish, MD
President, Association of Pediatric Program Directors



APPD Leadership

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APPD Membership

The APPD membership dues year is from July 1-June 30. Annual dues are \$1000 per accredited pediatric program, which includes the program director, associate program director, department chair, coordinator and chief residents. **We also invite individuals from programs such as Pediatric Emergency Medicine, Medicine Pediatrics, Child Psychiatry, Pediatric Physical Medicine and Rehabilitation, Genetics, and Subspecialty Training Fellowship Directors to join the APPD.** There is a \$75 charge for each additional individual. **For the 2005-2006 member year, programs were offered the option to include an unlimited number of members from their program for \$1500.** APPD’s membership currently includes 188 programs, totaling 1302 individuals.

Our Regions

There are eight regions within APPD, broken down as follows:

- New England:** ME, NH, MA, CT, VT, RI
- New York:** NY, Northern NJ
- Mid-Atlantic:** Southern NJ, East PA, DE, MD, Washington DC
- Southeast:** VA, NC, SC, GA, FL, AL, MS, LA, AR, TN
- Mid-America:** West PA, OH, WV, KY, IN, MI
- Midwest:** IL, WI, MN, IA, MO, KS, NE, OK
- Southwest:** TX, AZ
- Western:** CA, NV, OR, WA, HI, CO, NM, UT

Programs that wish to belong to a region outside of the above structure are free to do so. The program must notify the APPD office, their 'old' regional chairs, and their 'new' regional chairs.

INITIAL PLANS FOR REGIONS

- Each region is to develop their own rules of operation.
- More formalized regions led by Regional Chairs (made up of a program director or a coordinator, or both) to be part of Council of Regional Chairs (similar to Task Forces).

- A specific outline of leadership roles (terms, 3 year terms, staggering terms, etc) and responsibilities (expectations, i.e., minutes, postings, newsletters, teleconferences, listservs, face-to-face meetings, financing local projects that would allow for intermittent dues).
- Clarified guidelines for the regularity of teleconferences and face-to-face meetings, the frequency of APPD internal/external communications tools/products (such as newsletters, website, listserv, etc) and the quality control of these products by APPD Communications Director and Executive Director.

The sixteen elected Regional Chairs and the APPD President-Elect will comprise the Council of Regional Chairs.

If for any reason a Regional Chair cannot fulfill the elected term, a special election will take place. The vacating Regional Chair will notify the Executive Director that a vacancy will occur. Nomination for replacement will be submitted to the appropriate region. A vote will take place to select a new Chair. This may be done by mail, electronically, or at a face-to-face meeting.

Regional Reports

New England

The NPPD continues to meet twice yearly. Membership continues to include the following pediatric residency programs: Albany Medical College, Bay State Medical Center, Brown University at Hasbro Children's Hospital, the combined program of Boston Children's Hospital and Boston City Hospital, Dartmouth at CHAD, Maine Medical Center, Massachusetts General Hospital, University of Massachusetts, Tufts NEMC, University Of Vermont, Yale University at Yale New Haven Children's Hospital and the University of Connecticut at Connecticut Children's Medical Center. Co-chairs are Aida Velez and Ed Zalneraitis of the University of Connecticut.

Spring of 2005, the meeting was in Providence, Rhode Island, at the Brown University Pediatric Residency Program at Hasbro Children's Hospital. As reported previously, the meeting included activities for the regional Program Coordinators, finishing and rising Chief Residents and Program Directors and Associate Directors. Dr. Aaron Friedman, the host Chair of the Brown University Department of Pediatrics, provided a presentation on the 360-degree assessment tool. There was a combined session on diagnosing the problem resident. There was a concluding session with all participants combined to address common problems for the three groups.

The fall 2005 session was at the University of Connecticut at Connecticut Children's Medical Center. Coordinators, current Chief Residents and Program Directors and Associate Directors participated again. Dr. Vincent Chaing of Boston Children's Hospital provided a presentation on Effective Teaching, and Dr. Paul Dworkin the host Chair of Pediatrics for the University of Connecticut Pediatric residency Program spoke about When Bad Things Happen. Chief Residents Mike Dedekian (UMass), Jody Terranova (UConn) and Corrie Steeves (UConn) led the Chief Resident session on duty hour standards, board review, conference attendance, morale and international electives. The Program Directors spent a fair amount of time on the new RRC requirements, but also addressed the difficult resident and documentation of competency. Coordinators discussed RRC site visit preparation, the new RRC guidelines, task delegation and registration of learners.

The spring 2006 session will be held in Boston and hosted by Massachusetts General Hospital Pediatric Residency Program on April 6. The finishing and rising Chief residents will again attend, and there will be a focused agenda around current issues. This will be summarized in the next report.

Edwin Zalneraitis, MD
Chair, New England Region

New York

The NY / NJ region held a Regional Retreat at the Fort Hamilton Army Base Officer's Club on April 5th. This is the third year that the meeting will be an all day event, including a keynote speaker and several breakout sessions designed to address the needs of the attendees.

The regional retreat includes Chief Residents (current and future), Program Directors, and Program Coordinators. Our keynote speaker's presentation focused on "Negotiation Skills". We are in the process of a needs assessment, to ensure that the needs of each interested party are met. The current recruitment year appears to have been quite positive, with many programs reporting increased numbers of residency applications. Our region anxiously awaits the outcome of the residency match.

Co-Chairs:

Susan Guralnick, MD, Program Director, Stony Brook University, NY
Mary Gallagher, C-TAGME, Program Coordinator, Long Island College Hospital, NY

Mid-Atlantic

The Mid-Atlantic Region's main forum for communication has been our listserv, as well as our annual Fall regional meeting. This past year the meeting was held at Geisinger Medical Center in Danville, PA on September 20, 2005. Our on-site hosts for the meeting were Paul Bellino (PD) and Mary Anne Wesner (PC). Over 45 participants representing 17 programs attended.

The first 90 minutes of the meeting were spent hearing about various educational innovations from 7 different programs, followed by a plenary session addressing direct observation of residents by Joe Lopreiato from the National Capital Consortium. After a catered lunch, we had three separate break-out sessions—one for coordinators, one for chief residents, and one for program directors/assistant program directors. We closed with a quick summation from our discussion groups.

Although we have had no formal meetings since then, a number of the programs in our region have been in contact with each other regarding interpretation of new RRC guidelines among other issues.

Our plans for the Spring meeting are to hear reports from the two programs in our region who had recent site visits under the new RRC guidelines, specifically one program which utilized the new PIF. We then anticipate discussing the agenda for our fall meeting as well as determining the site of the meeting.

We look forward to seeing a strong representation of the Mid-Atlantic Section in San Francisco at the end of this month!

Clifton E. Yu, MD, FAAP
Program Director
National Capital Consortium Pediatric Residency

Kathryn Miller
Program Coordinator
Johns Hopkins University Pediatric Residency

Southeast

Program Directors, Coordinators, and Chief Residents affiliated with the Categorical, Subspecialty and Combined Training programs in pediatrics in the Southeast Region met as a group during the Spring Meeting of the APPD held in Washington, D.C. Lee Sanders, MD, MPH presented an overview of the Continuity Research Network (CORNET). Programs expressed interest in joining the Network and will be contacted by Dr. Sanders in the near future. The Region has also established a Listserv that has been used very successfully to provide a forum for discussion about common issues. The structure of the Listserv was discussed and it was agreed that this would continue to be a closed list open to those affiliated with programs in the Southeast. It will continue to be hosted at Duke University at this time. Regional organization was a significant topic of discussion. It was again agreed that geography made it difficult for formal meetings in the regions at times other than the Spring APPD meeting. However, several cluster groups have met over the preceding year, including Georgia, North Carolina and Virginia. Next year a consideration will be made to group tables by geographic location within the region to facilitate discussion by programs that are close to each other.

After completion of the agenda items, an open forum was held. It became evident from this discussion that break out time for Program Directors and Coordinators to meet with their own groups would be helpful. Also, lively discussion was held concerning the start dates for fellowship and what was the expectation for ending of residency training. It was decided that the Southeast Regions would like to communicate to the APPD leadership that the Region supports a delayed start for fellowships. Frustration was voiced that as the meeting has grown larger, it has become more difficult to get to know individuals from the Region or to know exactly who is attending from the Region. The group would like to suggest that the attendance roster contain a section that is broken down by Regional Attendees.

Even though time was limited in the group meeting, members of the Region continued to discuss Regional issues throughout the meeting. One frustration in particular voiced by some of the directors of smaller programs was the limited options for their residents to find electives at other institutions in subspecialties that the home program does not offer. Further discussion will be held through the Listserv with an attempt to develop a listing of programs offering opportunities for visiting residents.

Since the meeting in Washington, the listserv has been an ongoing resource for program directors and coordinators to bring issues up for discussion by the group. However, it has become apparent that the current listserv membership has become outdated. It is also apparent that lists from the APPD also will often lag behind changes in program leadership. An ongoing project of the

Southeast Region will be to develop and maintain current rosters of membership with up-to-date contact information.

Cluster meetings have been held in some areas since the last Spring Meeting. These have been viewed as very helpful by the membership. However, as this region spans 10 states with 37 programs, it is difficult to hold meetings outside of the Annual Meeting that could be easily accessible to the majority of the membership. In recognition of this, the Region held its first Regional Conference call on March 29, 2006. Fourteen programs represented 8 of the region's states participated in this call. A very lively discussion was held about duty hours and its effect on resident workforce, elective experiences in the era of duty hours and revised program requirements, residency end dates and fellowship start dates, continuity case logs and procedure logs, as well as further organization of the Region and the desirability of future communication within the Region. Much of this discussion will be continued at the Regional Breakfast in San Francisco.

Potential areas of focus for the Region to be discussed at the Regional Breakfast:

- Further organization for the Region
 - Program director leadership and coordinator leadership
 - Organization by cluster
- Formation of a research consortium
 - Avenue for regionally-based projects
 - Pooling of resources
 - Evidence of research productivity at program level
 - Opportunities for Chief Resident participation
- Avenues for communication between meetings
 - Improved access to listserv
 - Future conference calls spaced throughout year

Jenny Myers
Marc Majure, MD
Chairs, Southeast Region

Mid-America

Spring 2005 breakfast meeting

Attendance: Mark Anderson, Jill Arendall, Jean Ashley, Mariah Barnes, Bob Broughton, Ann Burke, Lynn Campbell, Fran Carbone, Laura Carravallah, Mary Ciccarelli, Rachel Christensen, Jenny Christner, Annie Church, June Dailey, Alex Djuricich, John Frohna, Javier Gonzalez Del Rey, Abdulla Gosi, Jodi Graeber, Hilary Haftel, Melissa Hamp, Scott Holliday, Peter Jennings, Jeff Kempf, Raheel Khan, Russ Kolarik, Kimberly Longstreet, John Mahan, Mia Mallory, Christine Mayes, Rosha McCoy, Leslie Mihalov, Anne Mortensen, Doug Moses, David Rosen, Pam Occhipinti, John Roberts, Jerry Rushton, Randy Schlievent, Kate Sheppard, Diane Skeen, Sarah Crance Stobie, Delana Vanover, Jeri Whitten, Gary Williams, Martha Wright and Doug Ziegler

1. Selection/election of leadership
2. Plans for fall meeting
3. Regional Projects/Studies

4. Upcoming Regional Workshops

Fall 2005 Meeting in Columbus

Attendees: Mary Kay Kuzma, Raj Donthi, Delana Vanover, Christine Mayes, Jeffrey Kempf, Raheel Khan, Jeri Whitten, Jerry Rushton, Mary Ciccarelli, Leslie Mihalov, Abdulla Gon, Travis Neely, Tara Williams, Fran Carbone, Michael Wolfe, Javier Gonzalez DelRey, Diane Skeen, Joash Raj, Benjamin Sarver, Randy Schlievert, Ricki Benner, Gary Williams, Cheri Russell, Mona Pfifer, Dan Schulteis, Michael Duffey, John Mahan

1. ILPs – How to use them (and Pedialink) and Why – *Ann Burke*
2. Learning Style/Emotional Intelligence: Methods to better understand your residents and their learning idiosyncracies – *Karen Heiser*
3. Applying the Myers-Briggs Personality Inventory to improve your resident’s learning and work (and entertain them) – *Mary Kay Kuzma*
4. Program Directors and Chief Residents- Is there anyway to help residents prepare for the boards? – *John Mahan*
5. Coordinator’s Session
 - Update on Coordinator credentialing – *Jeri Whitten*
 - Creating a resident file

Plans for Spring Meeting 2006

Survey sent to Regional membership to select topics for discussion

- Direct observation of resident performance
- Further discussion of ILP
- Developing faculty as mentors
- ACGME case log-improving compliance

Dena Hofkosh, MD
Raheel Khan
Mid-America Region Co-Chairs

Midwest

After much planning, the Midwest Region is having its inaugural meeting on 4/26/06 prior to the start of the APPD meeting. This date was decided upon based on a survey done of regional members about timing and content of the meeting. The topics to be discussed include: 1. “Resident Continuous Quality Improvement Projects at the Children’s Hospital of Iowa – what’s worked, what hasn’t”; 2. “Dealing with the Difficult Resident”; 3. “Measuring Resident Performance in Professionalism and Practice Based Learning and Improvement: a new metric”. At the regional breakfast on 4/28/06, we plan to summarize Wednesday’s meeting, to discuss location and content for future regional meetings/conference calls, to elect a regional coordinator elect and regional chair elect for the period 2007-2009 and review any other issues the Midwest Region members want to discuss. We look forward to a stimulating inaugural regional meeting, and an always educational and motivating APPD meeting!

Thomas N. George, MD
Chair, Midwest Region

Southwest

Our region utilized our regional list serve to help each other in scramble. We found out that this was a very effective way to help each other. I was the recipient of help and input from my colleagues in Southwest region. Prior to that we were in touch via list serve for helping our colleagues in New Orleans and Houston during Hurricanes Katrina and Rita respectively.

We find that our interactions via the regional list serve are very effective. Due to scheduling conflicts we could not have our fall regional meeting. I feel that our region is very helpful to each other. We should expand our dialogue to help each other in recruitment of residents next year.

Respectfully submitted,
Surendra K Varma, MD
Chair, Southwest Region

Western

Following our regional breakfast meeting in Washington DC on May 13, 2005 the Western Region was scheduled to meet at Children's Hospital, San Diego in September 2005. However the meeting was rescheduled after Hurricane Katrina devastated the Southeast. Many of our regional members responded immediately to this disaster. We are very proud of all the physicians, nurses and staff that provided emergency assistance with follow up aid to families in need.

In February 2006, Dr. Robert Kamei accepted a position with Duke University opening their new medical school in Singapore and subsequently stepped down from his position as Program Director at UCSF. I took over the position of Regional Chair in March 2006 at the Western Regional meeting in San Diego.

Dr. Michael Gottschalk from UCSD and his staff hosted the spring meeting on March 10th 2006. 30 participants from 10 programs were in attendance. Attendees included Program Directors, Associate Directors, Program Coordinators, Program Assistants and Chief Residents.

A. The morning presentations included:

1. Meeting the challenges of the new RRC requirements;
 - Roni Vasan MD and Jennifer Seanz MD; USC Pediatrics LAC+USC Medical Center University of Southern California
2. Pediatric Residency Program;
 - Gregory Blachke MD; Naval Medical Center
3. Pediatric Residency Program;
 - Grace Caputo MD; Phoenix Children's Hospital / Maricopa Medical Center
4. Internal Medicine - Pediatrics Residency Program;
 - Francis Chan MD; Loma Linda University Medical Center
5. Pediatric Residency Program;
 - Cindy Ferrell MD; Oregon Health and Science University

B. During lunch, members made the following suggestions for discussion during the Regional Breakfast meeting on April 28, 2006 in San Francisco.

1. Continuity clinic case logs

2. Experience with the Individualized Learning Plans (ILP) – Systems associated with the ILP/ Pedialink.
 3. Phase 3 of the ACGME outcomes project / evaluating outcomes.
 4. Redesign of Pediatric Residency Education – future direction?
 5. Impact of the new RRC requirements eg; PICU rotation requirements
 6. Compliance with the new PIF requirements – ideas for proactive data collection.
- C. Following lunch, break out sessions were held for Program Directors, Coordinators and Chief residents.
1. Topics discussed by Program Directors included;
 - a. Implementing Continuity Clinic Case Logs
 - b. Defining Competency based goals and objectives at Program level year of training
 - c. MedPeds Continuity clinics
 - d. Duty Hours / ACGME survey
 - e. Recruitment
 2. Topics discussed by Program Coordinators included;
 - a. Coordinator certification course
 - b. Recruitment and time management during the interview season
 - c. Residency management systems
 - d. Monitoring the RRC requirements
 - i. GME server to enhance internal communication and documentation
 - ii. Resident curriculum profile
 3. Chief Residents had an interactive open - table conversation. Topics included;
 - a. Teaching conferences
 - b. Solving unexpected resident absences
 - c. Working within duty hour requirements
 - d. Gaining respect from fellow residents
- D. The meeting adjourned with a guided tour of Children’s Hospital.

Rukmani ‘Roni’ Vasan MD, MEd
 Chair, Western Region

2006 Fellowship Directors Activities

APPD Spring Meeting

- Workshops specifically designed for fellowship directors
- Forum for Fellowship Directors including an update from the ACGME, a model for collaboration within a department for fellowship directors and program directors working toward common training needs and ample discussion time for hot topics and common needs

PAS/APPD Mini Course: Educating Pediatric Fellows in a Competency-based World

- New ACGME Common Requirements for Subspecialties
- Competencies in Action
- Turning Fellows into Teachers

APPD Fall Meeting

- Fellowship Directors Workshop

Proposed Council of Pediatric Subspecialties

Bruder Stapleton of AMSPDC, Richard Behrman of FOPO, William Schnaper of the Alliance Societies of the PAS, and Theodore C. Sectish and Laura Degnon of APPD helped organize a meeting in Memphis on January 29 – 30, 2006. As a result of this meeting there will be a proposal to form a Council of Pediatric Subspecialties and have further discussion at the PAS meeting in San Francisco this spring. Although this organization would address issues beyond those of fellowship directors, graduate medical education will always be a major topic if this organization were to be formed. See pages 28-29 for a summary of the Memphis meeting.

APPD Awards

Robert S. Holm, MD Leadership Award

2004 Recipient: Carol D. Berkowitz MD

2005 Recipient: Kenneth B. Roberts, MD

2006 Recipient: Edwin L. Zalneraitis, MD

This award honors a Program Director or Associate Program Director (past or present) for extraordinary contribution in pediatric program director leadership or in support of other pediatric program directors as a mentor, advisor or role model for the many duties and responsibilities of the position.

Walter W. Tunnessen, Jr. MD Award for the Advancement of Pediatric Resident Education

2004 Recipient: Carol Carraccio MD

2005 Recipient: Gail A. McGuinness, MD

2006 Recipient: Theodore C. Sectish, MD

This award honors a Program Director or Associate Program Director (past or present) for extraordinary or innovative contribution(s) in pediatric graduate medical education.

Carol Berkowitz Award for Lifetime of Advocacy and Leadership in Pediatric Medical Education (for a Coordinator)

2005 Recipient: Jeri Whitten

Special Program Director Award

2006 Recipients:

Bonnie C. Desselle, MD, Louisiana State University

Hosea J. Doucet, MD, Tulane University

These awards were given for extraordinary individual service to the pediatric residency programs at LSU and Tulane in the aftermath of Hurricane Katrina.

Special Regional Award

2006 Recipients:

Baylor College of Medicine

University of Texas at Houston

Our Lady of the Lake Regional Medical Center, Children's Hospital

These awards were given for extraordinary service in the aftermath of Hurricane Katrina.

Special Projects Funded by APPD in 2005 – 06

The following projects were funded in 2005:

Structured Clinical Observation: A Collaborative Study of Direct Observation of Residents

Investigator:

Ellen K. Hamburger, MD
Children's National Medical Center
Office of Medical Education
111 Michigan Avenue
Washington, D.C. 20010
Funding: \$9,791

Reforming Pediatric Procedural Training: A Proposal to Develop an Evidenced-Based Curriculum

Investigators:

Michael Gaies, MD and
Shaine Morris, MD
Children's Hospital Boston
300 Longwood Avenue
Boston, MA 02115
Funding: \$20,000

Design for a Pediatric Resident Curriculum and Evaluation Tool in Pediatric Resuscitation

Investigator:

Julia McMillan, MD
Pediatric Residency Program Director
Associate Dean for Graduate Medical Education
Johns Hopkins School of Medicine
600 North Wolfe Street, CMSC 2-124
Baltimore, MD 21287
Funding: \$10,000

Structured Clinical Observations of Pediatric Residents: Implementing the 360-Degree Evaluation

Investigator:

Karen P. Zimmer, MD, MPH
Johns Hopkins School of Medicine
600 North Wolfe Street, Park 351
Baltimore, MD 21287
Funding: \$8,782

Resident Sign-Out: A Precarious Exchange of Critical Information in a Fast Paced World

Investigator:

Linda A. Waggoner-Fountain, MD
Program Director
University of Virginia
Department of Pediatrics
Division of Infectious Diseases
PO Box 800386
Charlottesville, VA 22908
Funding: \$8,700

Learning Style and Academic Self-Efficacy: A Pilot Study

Investigator:

J. Marc Majure, MD
Director, Pediatric Graduate Medical Education
Duke University Medical Center
Durham, NC 27710
Funding: \$7,760

Updates on each project can be found on pages 33-39 of this Annual Report.

The following projects were funded in 2006:

Evaluating an Advocacy Track in a Pediatric Residency Program: Using Self Assessment, Mock Advocacy Scenarios and Portfolios to Measure Resident Competence

Investigator:

Lisa Chamberlain, MD, MPH
Clinical Instructor in Pediatrics
Director of Community Health and Public Service Concentration
Stanford University School of Medicine
750 Welch Road, Suite 325
Palo Alto, CA 94304
Funding: \$10,000

Developing Problem-Based Cases for Pediatric Residents Using Objectives Linked to the ACGME Competencies and an Internet Application

Investigator:

David T. Price, MD
Associate Professor
Pediatric Residency Program Director
East Tennessee State University
Department of Pediatrics
P.O. Box 70578
Johnson City, TN 37614-0578
Funding: \$7,500

Overcoming Obstacles to Resident Education on a Busy Clinical Service: A Model for Web-based Learning

Investigator:

John Kheir, MD
Chief Resident
Cincinnati Children's Hospital
333 Burnet Avenue, M.L. 5018
Cincinnati, OH 45229
Funding: \$7,500

A Pilot Study to Evaluate the Feasibility and Effect of an Interactive Breastfeeding CD on Pediatric Residents' Breastfeeding Counseling Skills

Investigator:

Jennifer A. F. Tender, MD, IBCLC
General Pediatrics
Children's National Medical Center
111 Michigan Avenue, NW
Washington, DC 20010
Funding: \$7,500

Development and Testing of a Tablet Computer Survey for Parental Assessment of Resident Competency in Interpersonal and Communication Skills

Investigator:

John Patrick T. Co, MD, MPH
Massachusetts General Hospital for Child and Adolescent Health Policy
50 Staniford Street, Suite 901
Boston, MA 02114
Funding: \$10,000

The Pediatric Emergency Medicine Patient Perception Survey: Development of an Instrument to Measure Patient Perception with Medical Care Delivered by Resident Physicians in a Pediatric Emergency Department

Investigator:

Deborah C. Hsu, MD
Associate Fellowship Director
Assistant Professor
Pediatric Emergency Medicine
Baylor College of Medicine
Texas Children's Hospital
6621 Fannin Street, MC 1-1481
Houston, TX 77030
Funding: \$7,500

Communication with our Membership

A Communications Director, Annamaria Church, MD, has been appointed to oversee our various methods of communication to and among our members. Those methods include:

- Listserv – disseminated every two weeks
- Newsletter – produced 3 times a year
- Annual Spring Meeting for the entire membership
- Annual Fall Meeting for new program directors and coordinators and programs preparing for an RRC site visit
- Discussion Board at our website www.appd.org
- Brief web-based surveys.

We also have many active sections, task forces, and regions and will convene action teams to address hot topics needing broad and timely input. These action teams combine threaded web-based discussion with conference calls and posted summaries on the APPD website to promote discussion and share knowledge about important topics.

ACGME Case Log System “Continuity Clinic Pilot” Update

In spring 2005 the ACGME asked the APPD to “test drive” the on-line system for entering continuity clinic patients. In the past, as many of us recall, the ACGME/Pediatric RRC mandated that programs utilize the procedure log portion of the “case log” system as of July 2004. This was presented at the 2004 Annual meeting. There was concern amongst program directors about the perceived suddenness of this mandate. Also mentioned at that time, in 2004, was the future RRC plan to mandate that continuity clinic patients and eventually, patients on other rotations (PICU, Inpatients, NICU) be entered into the Case Log system. To include program directors in the current process, and get necessary, direct feedback, the ACGME proposed having a “pilot” for the continuity case log system.

Our membership has been heavily involved with 61 pediatric programs utilizing the system. The pilot group’s “wish list” was discussed on a conference call in September 2005. The minutes of that conference call were forwarded to Jerry Vasiliadis, PhD. Jerry, the new Pediatric RRC Executive Director, has been quite interested regarding our input. Jerry met with a number of program directors at the Fall Meeting to make sure the APPD membership’s concerns were understood. Details of the proposed improvements were also discussed. Additionally, John Mahan and the Technology Task Force are working with the ACGME to further refine the “procedure log” function of the Case Log System.

The following are some of the feedback points made to the ACGME: allow report access to program directors that is allowed to the Pediatric RRC when evaluating programs, have the ability to enter a resident and easily see the patients in their continuity clinic panel, easily allow residents and program directors to see how frequently a single patient was seen by a single resident, streamline the mechanism to get reports, and regroup the most common diagnoses seen in continuity clinic to decrease search time for residents. The common, overriding concern that was voiced to the RRC was that the data out (to the accrediting body) is only as good as the entry of that data in. If residents don’t enter their patients, it will appear that they are not meeting RRC requirements with regard to number and variety of patients. Of note, there were many positive

comments. Many people thought the patient entry was relatively simple. Again, these comments and more were shared with Jerry Vasiliadis. Jerry reported that he is working with the IT people at the ACGME to remedy some of these issues. The evolution of the case log system will be an ongoing process. It is important to continue to express our needs, concerns and ideas to the ACGME.

The APPD is pleased to get such broad participation of the Continuity Case Log system. We will continue to critique the system and offer suggestions to the ACGME. If anyone wishes to get involved in the pilot, or has feedback for the ACGME, please contact Ann Burke at ann.burke@wright.edu or call (937) 641-3443.

APPD Response to FOPO's Task Force on Women Report

The Report of the Task Force on Women in Pediatrics addresses many concepts and issues that are completely pertinent to and need to be discussed within the pediatric community. As mentioned in the report, the central responsibility of our profession - "the commitment of pediatrics to the health and well being of children and youth should encompass the families of those who choose to pursue careers in pediatrics"- is a compelling reason to tackle these issues head-on. In that sense, it is a welcome document to open a rich dialogue amongst us all. As an association that provides support to the trainers of pediatricians, many of the recommendations apply directly to program directors and their daily work. In principle, most pediatricians, and certainly most pediatric program directors, would support most of the recommendations. These recommendations will, however, cause fundamental changes in the way many pediatric residency programs function in terms of reimbursement and duration of training. Additionally, they will be a big cultural change for some programs, while other programs already "follow" some of the recommendations regarding residency. Discussion about the issues of families and women in pediatrics via FOPO, to include all of the pediatric organizations, is a necessary path to affect change and build consensus. The APPD is encouraged that this FOPO task force has undertaken this project, and is pleased to be able to play a substantial role in the development and implementation of these recommendations.

The APPD discussed the report at our Annual Fall Board Meeting on September 28, 2005. There was lively discussion and debate about the implications of the report. There were varied points of view about endorsing this report. Therefore an "Action Team" was formed. It is made up of 4 APPD Board Members and chaired by Ann Burke. The goal of the Action Team is to present the recommendations to our membership, hear their thoughts and concerns, and report back to FOPO with specific modifications. We have been asked to respond to five questions about the recommendations. At this point, we feel we need more time to carry out a thoughtful, accurate assessment of the recommendations AND include our membership. The action team will answer the five questions about the recommendations in June 2006. Our plan is as follows:

1. Survey our membership to get an idea of how Program Directors (PDs) currently deal with extending residencies, time off for family needs, and other parenting issues.
2. Workshop/Discussion at the Annual APPD Spring Meeting to specifically discuss the FOPO Task Force Recommendations and how they impact PDs and training programs. We hope to gain substantial insight into unintended consequences and benefits from this exercise. A summary of that workshop will be forwarded to the Chair of FOPO.

3. Have, at a minimum, three conference calls of the APPD Action Team between January 1 and June 1, 2006 to discuss the 6 residency training recommendations in great depth and detail.
4. Provide a summary of the Action Team's activity, thoughts and recommendations by June 1, 2006. This summary will provide a directed, detailed response to the 5 questions posed by FOPO.

This extended 6-month timeline will set a thoughtful groundwork for our organization. It will dictate how APPD will proceed to modify (if needed) and implement many of the recommendations among the APPD membership in the future. This is a big and necessary undertaking in pediatrics as a whole and, specifically, residency training. Thank you all for being the catalyst for formally addressing these issues.

TASK FORCES

Curriculum Task Force

The Curriculum Task Force provided feedback and guidance for curriculum development and dissemination throughout the year. Three activities stand out as the year is reviewed: 1) Members provided input and acted as reviewers for various curriculum development projects from other organizations, 2) members discussed new concepts for the curriculum tool shed on the APPD website and future directions for this application, and 3) the Task Force sponsored workshops to disseminate ideas and curriculum pertaining to some of the more difficult competencies.

1) We continue to work as liaisons to other groups. Our members give clear input from the program directors perspective. Some examples include curricular development in "Genetics in Primary Care," the Bright Futures curriculum/materials at the AAP, resident corner of Pedialink (AAP), and AAP Resident Education Committee on Breastfeeding. At our Annual Spring meeting in Washington (2005), members offered excellent ideas to the AAP Pedialink representatives.

2) The concept of the Curriculum Tool Shed was strengthened by use and questions from the membership. Some new material is up and running. Other Task Forces have followed with their own tool sheds. Discussions about the next steps to make the APPD website more integrated are underway.

3) The task force sponsored the first Task Force driven workshop at the APPD annual meeting (2005). It was a success, with a full crowd and enthusiastic participation. Ideas about Practice Based Learning and Improvement (PBLI) and Systems Based Practice curricula were discussed. We had a wide array of presenters. This will be continued this year (2006) with a workshop focused solely on PBLI curricula.

The Task Force and its members are energetic and ready to review curricula, provide input, work on pilot testing and interact with any group who needs our assistance. We also encourage any APPD member interested in resident curriculum who is not active in a task force to join us.

Evaluation

The Evaluation Task Force continues to work to develop evaluation tools which can be validated and correlated to the level of pediatrician competence. We have placed tools which directors have developed onto the APPD web-site. As the new RRC guidelines are instituted and many new evaluation methods and tools are developed to comply with these new guidelines, the task force will post those as well. As the tools are used by various programs, we will obtain feedback. When the number of trials is sufficient, we will attempt to validate the tools to measurable outcomes.

Faculty Development

This year the Taskforce worked on several projects:

- **The Mentoring Program:** for the 2005-2006 academic year, we matched 11 new program directors with 11 mentors. As of the first informal survey of the group, it appeared folks were happy with their matches. We hope to have additional data by the spring meeting as well as have a new class of mentors – mentees. It is our belief that this program will help new program directors assimilate into their new roles more quickly and more easily.
- **Workshop:** once again, the taskforce believed that a workshop submission was important. Susan Guarlnick, Miriam Bar-on, and Surendra Varma submitted a workshop on behalf of the taskforce. The new requirements now specify that all program directors must ensure that faculty must participate in faculty development activities. Therefore, our focus this year was on doing faculty development for your colleagues. We will use a train the trainer model and work with the attendees to engage their faculty in learning about and implementing the competencies. We thought that our target audience at home was the reluctant learner and hence the title of the workshop – *The Reluctant Learner: Engaging your Faculty in Teaching and Assessing the Competencies*.
- **Pre – Conference Workshops:** Although it was a goal of the taskforce and one of our specific items in the strategic plan, we had to forego planning pre – conference workshops for this meeting secondary to lack of meeting space. Our target audience for these workshops is mid to senior level program directors. We hope to engage this group in stimulating workshops that can be used for both self development and or academic promotion.
- **Tool shed:** We are going to be assembling faculty development methodologies for program directors to use for both their own faculty and for themselves. More on this aspect of our work as it becomes finalized.

Learning Technology

The APPD Learning Technology Task Force continues to make progress on several fronts. Based on the Learning Technology Task Force meeting in Washington DC on 5/12/05, a number of initiatives are underway:

1. Expanding the process of LT vendor presentations at the annual Spring Meeting. The AAMC Medical Education list serv and lists of vendors attending COMSEP and Internal Medicine will be mined for potential vendors. A request to APPD members to identify education vendors will also be conducted this winter.
2. The format for the APPD website LT Resource Center was reviewed and approved. This center will serve as a mechanism to post useful (and non-useful) LT for review by APPD members.

3. A commitment by the LT Task Force to work with the ACGME on the Pediatric Case Log System (Procedures, Continuity Patient Panel) was confirmed. The group identified three items of particular interest for Pediatric PD's in regards to the Case (Procedure) Log System:
 - a) the need to develop reports from the ACGME Log that are useful to PD's
 - b) methods to upload data from commercial procedure services
 - c) further efforts to streamline the ACGME system for easier data entry.
4. Willingness for the LT Task Force to contribute to future progress of the APPD PediaLink site was expressed and several future enhancements useful for residents and PD's were discussed.
5. The potential for LT Task Force collaborative proposals was discussed, including:
 - a) pilot projects to study electronic sign outs versus paper sign outs
 - b) the effect of a sleep study module completion on knowledge acquisition, safe behaviors
 - c) best methods to implement self-learning modules

Recent Breaking Developments include:

1. Abhay Dandekar has agreed to be the LT Task Force Resource Center Czar and post new submissions and monitor. We plan to have the site in operation by the end of the year.
2. I have received a commitment from Tom Richter, Systems Manager for ACGME, to work with an APPD ACGME-LT Task Force Action Team. Five members of the APPD LT Task Force have volunteered to participate in the series of conference calls.

We will keep the members of the APPD posted of all developments, particularly with our work with the ACGME. The work of Abhay on the LT Resource Center will be noticed by all and should be a real asset to the members of the organization.

As always, the opportunities to integrate LT into the training of pediatric residents are legion. If anyone is interested in becoming involved, please contact John Mahan at jmahan@chi.osu.edu.

Research

Our task force discussions centered around a few important areas: 1) Survey Policy: Since the approval of the survey policy in the summer of 2005, three surveys have been submitted for circulation to the membership, with two already having been distributed at the time of press. The first survey distributed related to Procedural Training in Pediatrics, and was well received and responded to by the membership. This work was accepted for Platform Presentation at the Pediatric Academic Societies Meeting. We are awaiting feedback from the second survey and will distribute the third in the spring. Another discussion regarding surveys surrounds decreasing survey burden to the membership by creating mechanisms to prevent survey reminders being sent to the members that have completed surveys, while at the same time protecting confidentiality. Survey reviewers are also needed, with a request for volunteers sent via the listserv. 2) Collaboration with COMSEP (Council on Medical Student Education in Pediatrics): Several task force members suggested that educational research could be strengthened through doing work that links medical student and resident performance. Preliminary discussions were held on how this could possibly be structured. 3) Periodic survey of the membership: Members have begun discussing several topics that the membership would be surveyed on every 1 to 3 years, with the goal of survey responses being used to track educational trends and inform educational policy.

Interactions with Liaison Organizations

Primary Care Organizations Consortium (PCOC) Meeting

APPD was represented by Susan Guralnick at the PCOC meeting held October 17, 2005. The Primary Care Organizations Consortium spring meeting was attended by representatives from Pediatrics, Family Medicine, Internal Medicine, Combined Internal Medicine/Pediatrics, and the American College of Osteopathic Family Physicians. Also represented were the Bureau of Health Professions (BHRP/HRSA), the Center for Primary Care Research (AHRQ), the American Academy of Medical Colleges (AAMC), the American Association of Colleges of Osteopathic Medicine, and the American Medical Student Association. This meeting addressed the status of Primary Care specialties among graduating medical students, and ways to promote careers in primary care. BHRP presented information regarding the current and predicted healthcare workforce and shortage estimates, and the status of Title VII funding. Resident training grant submissions were encouraged. A legislative update was provided by the AAP representative. The APA presented current data on use of the APA Educational Guidelines, and goals for expansion of their application. In order to focus on the needs of patients rather than institutions, the AAMC plans to focus more attention on residency education and continuing medical education, and will encourage training in the care of patients with chronic diseases. The growth of Practice Based Research Networks (PBRN) was discussed, as were PBRN meetings and resources. AHRQ has updated its Guide to Clinical Preventive Services recommendations. The final version of this document is now available in print and online at <http://pda.ahrq.gov>. The AHRQ will be making a concerted effort to increase the number of Pediatric recommendations in this guide. This meeting was an excellent opportunity for the different primary care organizations to learn how they can work together to achieve common goals.

Committee on Pediatric Education (COPE) Meeting

APPD was represented by Susan Guralnick at the AAP COPE Meeting held in Chicago, November 20 – 21, 2005. Other participants included several representatives from the AAP, APPD, the National Association of Children's Hospitals and Related Institutions (NACHRI), the Ambulatory Pediatric Association (APA), the Council on Medical Student Education in Pediatrics (COMSEP), the Med-Peds Program Director's Association (MPPDA), the AAP Sections Forum, Pediatrics in Review, PREP SA, the AAP Resident Section, the journal Pediatrics, the Advisory Committee to the Board of Education (ACBOE), General Pediatrics, the Society for Adolescent Medicine (SAM), the American Pediatric Society (APS), the Association of Medical School Pediatric Department Chairs (AMSPDC), the American Board of Pediatrics (ABP), the Federation of Pediatric Organizations (FOPO), the AAP Committee on Continuing Medical Education (COCME), the Canadian Pediatric Society (CPS), the Society for Pediatric Research (SPR), and the Society for Developmental and Behavioral Pediatrics (SDBP).

The purpose of this committee is to serve as a think tank within the AAP for discussion, consensus building and collaboration on emerging issues facing pediatric education. Each member of the committee presented information about the recent activities and current goals of his/her organization.

APPD issues presented included: our outreach efforts toward Subspecialty Fellowship Directors, including a half-day program at our annual meeting and a Mini-Course to be offered at the 2006

PAS meeting; the *PediaLink* Resident Center including the Individualized Learning Plan; early plans for an Educational Warehouse, and our new Action Group on Women and Life Balance.

The AAP Resident section emphasized a strong interest in International Rotations and Disaster Education.

The AAP presented results of an early survey of residents and program directors about the impact of resident work hours limitations on resident well-being, program morale, quality of patient care, resident education, and continuity of patient care was presented, with overall positive results. However, this is all opinion based, and not evidence-based, and there was some concern on all fronts about the continuity of patient care. Further studies are planned.

The ABP presented a new and very exciting initiative entitled the Residency Review and Redesign in Pediatrics (R³P) Committee. This committee, to be chaired by Dr. Douglas Jones, will include the major stakeholders in residency education (including patients/families), and will take a fresh look at pediatric residency training. They plan to start with a clean slate and attempt to determine what residency training should include, and how it should be evaluated. This will be a lengthy process, expected to take approximately 4 years. Among activities included in this process will be national symposia, the first expected in summer 2006.

The MPPDA addressed their upcoming accreditation by the ACGME, expected to begin July 2006, and the need for education among Med-Peds and Internal Medicine programs in Transitional Care.

The APA discussed their plans to develop guidelines for Academic General Pediatric Fellowship programs, with the hope to someday attain ACGME accreditation for this. The Educational Guidelines Project was presented, as was the New Century Scholars Program aimed at increasing minority participation in Academic General Pediatrics, and the new APA Faculty Development Certification Program in Educational Scholarship which will be available at the 2006 PAS meeting.

There was a group of presentations on International Pediatric Education and Disaster Preparedness. The Canadian Pediatric Society presented an overview of their recent efforts in Pediatric Advocacy, Professional Education and International Pediatrics.

Also discussed in brief were ideas to provide a more optimal pricing structure for eQIPP, balancing work-life (www.lifecurriculum.info), and an introduction of the Residency Review and Redesign Project (R³P) from the American Board of Pediatrics

Association of Medical School Pediatric Department Chairs (AMSPDC) Executive Committee Meeting

APPD was represented by Ted Sectish at the AMSPDC Executive Committee Meeting held on October 2, 2005 in Seattle, WA where he discussed the Special Projects Program and APPD outreach activities to fellowship directors. Rob McGregor and Ted Sectish attended the AMSPDC Executive Committee Meeting in Phoenix, AZ on March 3, 2006. At that meeting, Rob and Ted presented the Annual Report and highlighted APPD activities that were of particular importance to the pediatric department chairs such as the new dues structure, the Fellowship Directors Track at APPD meetings, our regional structure and our response to the FOPO Task Force on Women.

APPD and AMSPDC have been working closely together with Richard Behrman of FOPO and William Schnaper of the PAS Alliance Societies to lead a national discussion about whether to create an organization of pediatric subspecialties.

Council on Medical Student Education in Pediatrics (COMSEP) Executive Committee Meeting

The COMSEP Executive Meeting was held on April 8, 2005 in Greensboro, North Carolina. Ted Sectish presented the Annual Report and focused discussion on our Special Projects Program, the alignment of COMSEP and APPD Task Forces, new APPD awards and our four-pronged approach to communication within the organization and with our liaison organizations.

COMSEP was very interested in the Special Projects Program and would like to join with us in facilitating a national discussion about how to promote rigorous research.

National Resident Matching Program (NRMP)

APPD was represented by Adam Pallant at the NRMP meeting. The board discussed whether or not to sign onto the AAMC sponsored "Residency Compact Document." Their discussion very much reflected ours. In summary, the board sensed that while the statements were "motherhood and apple pie," they also had potential legal implications if the NRMP was a formal cosignatory. They're understandably skittish about what they can be held legally liable for after the anti-trust proceedings. For instance, the compact contains statements such as "We pledge our utmost effort to ensure that all components of the educational program for resident physicians are of high quality, including our own contributions as teachers." Could the NRMP be sued if they matched a resident to a program that didn't fulfill that pledge? The board ultimately decided to write a separate letter of "support of principles," but neither to formally endorse or sign onto the document as an official sponsor.

The board began a discussion regarding a loop-hole for osteopathic students. The AOA has requested that the NRMP block the ability of allopathic programs to contract with osteopathic students outside of the match. As it currently stands, allopathic programs can hold positions outside the match, and offer them to non-allopathic students. The AOA is concerned that allopathic schools are given the opportunity to cherry-pick the best osteopathic students and lure them away from osteopathic residency programs.

I shared a different concern as an allopathic residency director. There is a theoretical concern that a host of positions that might have gone to allopathic students are being held out of the match and offered selectively to osteopathic students. Of note, the number of osteopathic graduates has risen substantially over the past several years, and there have been several new osteopathic medical schools opened in the last decade. Additionally, while there are several osteopathic medical schools in Texas, there are no osteopathic residency programs there, thus placing substantial pressure upon Texas DO's to find allopathic positions if they wanted to remain in state.

It seemed to me that this process put allopathic applicants at selective disadvantage. Allopathic applicants may NOT be offered positions outside of the match if that program accepts ANY

allopathic students during the NRMP match. I shared my concern about this inequity. The board decided to gather more information to make a more informed assessment as to how broad a problem this may actually pose before making a final decision. Osteopathic observers to the board meeting estimated that roughly 200 positions are likely offered to osteopathic students in allopathic programs outside the match, but was not definite about that number.

The board began to discuss the potential of creating a "dynamic" list of unmatched residents during the scramble period. This poses a very large number of questions and ripple effects that have to be teased out (much like the discussion regarding the "second match" proposal). The board agreed to put together a subcommittee to begin to sniff out the issues surrounding this topic.

I asked if the board would contemplate establishing a similar but separate "dynamic list" of individuals that were either available or seeking positions in specific residency fields across the year. I felt that this could be potentially helpful for program directors that have sudden openings arising in their programs that need to be filled with qualified, board and ECFMG certified applicants. The board asked their working group to look at this recommendation as a possible valuable service to both residents and program directors.

There was additional topical discussion regarding board membership composition, as well as what minimal qualifications programs might need in order to be accepted into the NRMP matching process.

Organization of Program Director Organizations (OPDA)

APPD was represented by Ed Zalneraitis at the OPDA meeting with the Council of Medical Specialty Societies, November 17 through 29, 2005 in Chicago. The Executive Committee discussed learner self-assessment as a future topic to be addressed. It was noted that determining the status of residents as novice, advanced beginner, competent, proficient or expert for each item of a self-assessment was one way to allow the learner and mentor to track progress more effectively. The Committee also considered ways to access learning materials that could be used across disciplines. Medbiquitous was cited as a general resource. Free CD resources were noted to be available through the "Life" program at Duke (see below), for all who register. Updates are also distributed to those who register. Additional CD resources were noted to be available through Dr. Deb Simpson at Medical college of Wisconsin.

Dr. David Leach led off the OPDA program announcing an ACGME effort called "Extreme Makeover Plus" that would target accountability, excellence and professionalism of the ACGME. The process will be one of self-assessment and assessment of others, and the plan is to redesign GME and the accreditation process. The use of individualized learning portfolios will be a focus tool in this effort. An effort will be made to have an "alignment" across the continuum from medical student through to retirement from medical practice. There will be an emphasis on group learning and a smooth technologic interface in the redesign. It was hoped that ease of use of the redesigned and collaboration would enhance the participation by all groups across the continuum.

Dr. Carol Carraccio presented the REBEL portfolio as an example of a target activity in the redesign. Portfolio was defined as a collection of evidence to determine competence. Portfolios were described as a framework for learning and evaluation that can be used to address competence in each of the areas of general competence. The components included structured learning objectives such as benchmarks for competence and assessment tools. Reflective and

creative components were cited in such tools as self-assessment, journaling and threaded discussions. Combined structured and reflective activities were recognized as such elements as critical incidents, 360 evaluations, projects and logs. The outcome is to be a streamlined accreditation process, decreased program director work and a reorientation of medical education with EBM, links to outcomes, validity and reliability of that which is measured and tracked across the continuum. A call was made for an advisory group from OPDA.

Kathryn Andolsek, M.D., Ph.D. introduced the Life Curriculum developed at Duke University SOM. Currently, it has modules that include diagnosis of the impaired resident and residents with suboptimal performance, recognition of fatigue, burnout, the disruptive resident, and balance between clinical education and well being. All can sign up for free copies of the CD presentations for use in faculty development and resident education. Future CD modules will be automatically sent to all who sign up for the original ones. These can be found and obtained through www.lifecurriculum.info. Dr. Andolsek indicated that she is willing to present a workshop for any of the member Associations. This should be discussed as a possible future activity of the APPD.

Federation of Pediatric Organizations (FOPO) and the Pediatric Education Steering Committee (PESC)

The Federation of Pediatric Organizations met September 16, 2005 and January 17, 2006. Drs. Ted Sectish and Ed Zalneraitis represented APPD. The highlights were as follows:

The September meeting reviewed progress from the Task Force Report on Women in Pediatrics. The recommendations of the task force were reviewed, and these are available on the FOPO web site www.fopo.org. Each member organization was asked to indicate whether or not they agreed with the recommendations pertinent to their organization. If the organization did not agree, they were asked to indicate their objection(s). Each organization was asked for suggestions for improving the report and additional recommendations. Finally, the organizations were asked for their priorities and timetables with regard to the recommendations. In response, the APPD established an action group to develop a response. These responses will be shared and discussed further with the APPD membership. A final response will be forthcoming from APPD.

The FOPO statement on Uniform Subspecialty Applications and Timing was noted to be still under consideration. This has not been a priority for progress among fellowship programs. Further progress may be elicited through other organizations such as the AMA, where the resident section has come out strongly for reform in this area. FOPO reaffirmed its support for this initiative. Scholarship activity in fellowship programs was also discussed, and it was indicated that the RRC does not currently monitor scholarly activity. The APS, SPR, APA and NACHRI discussed implementation of external oversight of scholarly activity in fellowships, but no specific information was yet available. It was agreed to seek baseline data and to continue to pursue the process for scholarly activity oversight.

The Community Pediatric Training Initiative, a follow up to the Dyson Initiative, is now being made available through the AAP. Programs can find handouts, presentations and best practices on the AAP web site. There was a call for tracking the outcome of these efforts to produce evidence that these programs were effective in achieving their targets in education and changes in pediatric participation in the community. Disaster preparedness was discussed, reviewing the events around hurricane Katrina, but also taking a larger look at the roles of FOPO member

organization in future disasters. It was decided that the AAP should take the lead in this area and Dr. Alden was asked to follow up with the formation of an action group for such events. FOPO member organizations will identify appropriate members for the group. Dr. Fan Tait, from the AAP section was selected to lead the group.

The spring meeting focused on the role of FOPO and its future organization. It was decided that the PESC had done its intended service, and that it should be folded into FOPO going forward. It was decided that FOPO would be most effective with continued leadership to facilitate and promote the agenda of FOPO membership and the pediatric community. A short timetable was established to develop a job description for leadership going forward and to proceed with the process of setting the future structure and function of FOPO. Also at the spring meeting, FOPO member organizations selected Dr. Carol Berkowitz as this year's St. Geme Award. Dr. Tait presented the plans from the Committee on Pediatric Response to Future Disasters. Drs. Miles and Perelman presented the plans of the ABP and AAP for quality initiatives in Pediatrics. The responses to the Task Force Report on Women in Pediatrics were reviewed, and plans were made to continue to work on implementation of the recommendations. FOPO representatives were supportive of moving forward in each of these areas.

Electronic Residency Application System (ERAS) Advisory Board

The ERAS Advisory Board met February 14, 2006 in Washington, D.C. Dr. Zalneraitis represented program directors in general and the APPD. The highlights were as follows:

It was indicated that ERAS use continues to increase, and feedback indicates that it is working well. It has been the most effective mechanism during the "scramble" after the match. Lag time for downloads has been reduced to one hour. It is preferable to Find a Resident for the scramble. The Find a Resident only has the common application form, and is better used for other times of the year. My ERAS 2007 will continue with improvements. An automatic option to indicate when a program is no longer accepting applications will be available. Applicants will be able to specify the specialties for which each letter of recommendation applies. AOA honor society status will be added to the MSPE, but not the Gold Humanism Awards yet. Phone help will continue. This year, there were 3493 calls and 7500 e-mails for help by applicants. The use of these two systems will be tracked.

Original letters of recommendation will not be forwarded or available after the match. Photographs should be sent in MS Paint, and they will be automatically re-sized for files. Applicants and schools will be advised. The NBME sent almost a million USMLE transcripts to ERAS this year. The process of transfer will be reviewed for both the NBME and the NBOME. Of note, the failure rate on CS of step 2 remains at 4%, and contrary to student rumor, this component will continue.

Dr. George Richard of the AAMC presented *Careers in Medicine* that is now on line at the AAMC web site. There are extensive resources available at the site. The program is a four-phase advice and guidance service to help career planning for medical students. Dr. Bob Sibalis also presented the companion effort at the AAMC called *A Roadmap to Residency*. This is collaboration between the AAMC, AMA, OPDA, and ECFMG. It provides detailed information for applicants applying to residency. This is available on line, and can be downloaded as a PDF for free. Hard copies can be obtained for \$1.50 each. The AAMC would like to enrich these postings with more data. They are interested in such things as how program directors are using

USMLE results, especially step 2 CK and CS. They would like more information on the factors that program directors are using in screening applicants and selecting them. They would like this to be specialty specific. The problems in getting valuable data and possible misuse of the data were discussed. It was suggested that OPDA attempt to obtain information from member associations.

Internal Medicine fellowships went into ERAS this year, resulting in a dramatic increase in volume of ERAS use. As a result, ERAS will add future programs at a slower pace, to allow for earlier and better service in informing and educating new users. Included in this year's new programs using ERAS are pediatric rheumatology, neurology, and pediatric hematology-oncology.

There will be a pilot web-based PDWS this fall. It is not decided yet who will be able to participate in the pilot. This initial experience with a web-based system will target use by interviewers, and will be a "read only" site. It will be done with passwords and limited access. Program directors will determine who will be able to access materials and what they will be able to access.

The ERAS Investigation Process is a new initiative to investigate false information sent in ERAS files. The process will look at reports of irregular and suspicious information submitted in ERAS applications. Examples include: omissions of education extensions, omissions of previous training, forged or altered MSPE, transcripts and letters of recommendation, and plagiarism of personal statements. Program directors should report instances of such submissions to ERAS, including common web sites from which plagiarized materials are obtained. The process includes obtaining reports from the programs and applicants, legal review and violations reported to all programs and medical schools involved. The violation is posted for all letters and applications sent by the violator. There will be a campaign to publicize this process, and this will include a presentation by ERAS Director, Ms. Renee Overton at OPDA.

Dr. Bob Sibalis also presented an update on criminal background checks for all entering medical school. A broad-based Committee on Criminal Background Checks will be moving forward with their plan soon. They will be checking 17,000 entrants to LCME schools. They will check only those accepted, and it will start in the fall of 2007 for students entering medical school in 2008. There is a similar system in place for Osteopathic Schools as well. The LCME will centralize the checks through the AAMC, while the AOA will continue with a decentralized process.

Council of Pediatric Subspecialties Organizational Meeting

A group of concerned and interested pediatricians met in Memphis on January 29-30, 2006 to consider whether benefit would be derived from developing a formal organization to represent the interests of pediatric subspecialists. The group was drawn from participants in active, formal organizations already promoting pediatrics, including member organizations of the Federation of Pediatric Organizations. In particular, participants were solicited from various pediatric subspecialty groups, including members of societies, training program organizations, subboards and AAP sections. This report seeks to convey the sense of the resulting deliberations.

Rationale. Although there are a number of groups supporting the interests of pediatricians, including those of subspecialists, the sheer numbers of general pediatricians and those in non-academic practices is so great that the primary focus of these organizations is on issues of importance to general pediatricians. A variety of cross-cutting issues are of specific concern to subspecialists, particularly academic subspecialists. It was broadly felt that a venue to communicate regarding these issues, both among the subspecialties and to other pediatric organizations, would be beneficial.

Issues of concern. The issues of greatest interest to the assembled group related to regulatory, organizational and practical aspects of training of new subspecialists. Other concerns included communication as described in the *Rationale*; workforce issues such as numbers of subspecialists and quality of life in these subspecialties; and career development. Additional possible issues included reimbursement for care, transition from pediatric to adult care, research funding, public policy/advocacy, and others.

Models of organizational structure. A useful model was presented by Kevin High, President of the Association of Subspecialty Professors (ASP), a member group of the Alliance for Academic Internal Medicine. This model had a lot to offer, in particular its ability to assess and prioritize issues, its approach of developing time-limited task forces to address particular problems, and its service as a structure for academic subspecialists to communicate with other interest groups in academic internal medicine. However, our group noted that some of the purposes served by the ASP already were served by other pediatric organizations, and we desired to take advantage of those pre-existing groups rather than being redundant. A consensus structure included the following elements:

- The organization would serve as a council that promotes communication, rather than a society.
- There would thus be no large annual meeting, although the council would meet in conjunction with such meetings.
- The council would be composed of two representatives of each subspecialty (one of whom would be a training program director) plus representatives of the other, existing pediatric organizations as appropriate.
- It would identify issues of common interest and, where necessary, empower task forces to develop information regarding these issues and plans to address them
- Communication would be by electronic means and take advantage of existing infrastructure where possible.

Participating societies. There was no firm consensus on what subspecialties should be included. There was general agreement regarding all ABP subspecialties, plus Neurology, Allergy-Immunology, APA; there was less consensus around Dermatology, Genetics, Sleep Medicine, etc. Liaison representatives should include at least one member of AMSPDC, APPD, ABP, AAP and FOPO.

Issues that were not addressed:

- The financial needs of such an organization and how they would be met.
- Who would initially represent each of the subspecialties, and how they would be chosen.
- Nature of relationship to FOPO organizations.

Initial plans. It was agreed that an open meeting would be held during the PAS meeting on April 30 from 7-8am to further discuss planning for this council. Before that meeting, a tentative plan would be developed by a working group of Dick Behrman, Bill Schnaper, Ted Sectish and Bruder Stapleton. This plan would be vetted by planning council including two members from each

subspecialty, at least one of whom was present at the Memphis meeting. There was a general consensus that success of the organization would depend upon the development of cohesive action around specific, pressing issues. Since the issue of subspecialty training was of great importance to all, this should be the first interest of the organization. However, over time, it is anticipated that the concerns of the group would broaden considerably.

Coordinator's Certification

Professional development and education, both for program directors and coordinators, continues to be the primary focus of APPD. The continued development of tools such as our online handbook provide valuable resources for residency program coordinators. Certification for residency program coordinators/training administrators has been one of the long range goals of the coordinators' section.

In October 2003, the National Board for Certification of Training Administrators of Graduate Medical Education (TAGME) was established. TAGME was formed in order to establish national standards of knowledge and skills, and provide assessment tools for certifying training administrators/residency program coordinators from all specialties as qualified in their field. Jeri Whitten, representing APPD, was named to the TAGME Board of Directors in May 2004. In March of 2004, the pediatric assessment tools were presented and approved by the Board of Directors. Pediatrics and General Surgery were chosen to pilot the certification process. June Dailey and Rosemary Munson, members of the Task Force on Certification for Pediatrics, were named at-large members of the Board of Directors of TAGME. In July of 2005, the first monitored assessment for pediatrics was offered during the in-training examination. Part II of certification includes a Work Product which is completed by the coordinator at her home/office and submitted. Twenty-one candidates applied and sixteen were approved for certification at the November TAGME Board meeting. To date, 19 coordinators in pediatrics have been certified.

The 2006 monitored assessment will be given on Wednesday, April 26 from 2 to 7 pm at the San Francisco Marriott, immediately prior to the APPD meeting. Part I and Part II will be "graded" and successful applicants approved at either the May or October TAGME Board of Directors meeting, at which time certification is granted.

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Coordinators Executive Committee

The Members of the Coordinators Executive Committee have had a very busy and productive year. The Coordinators Executive Committee had monthly conference calls where we planned for both our Fall and Spring meetings. We also discussed policy changes that would impact the coordinators section. As the coordinator's representative on the APPD Board, Cindy Colpitts and/or Louise Kadane also participated in monthly APPD Board Conference calls and attended the Spring and Fall Board meetings in Washington, D.C. and Virginia. We will attend our final board meeting in San Francisco in April.

Cindy Colpitts and Louise Kadane organized the Coordinator's Section of the APPD Fall Meeting. The Coordinators Section of the conference was attended by 34 coordinators and received positive feedback. A dinner was also organized specifically for the coordinators to become better acquainted with each other. The following Coordinators on the Executive Committee also attended: Mary Gallagher, Sally Koons, Therese D'Agostino and Vanessa Pichette.

Therese D'Agostino and Vanessa Pichette began the process of the preliminary planning of the APPD Spring Meeting to be held in San Francisco.

In 2001, "the buddy system," our mentoring program, was introduced. For unknown reasons it did not continue. Sally Koons has revived this program for the 2006 Spring Meeting. The purpose of this mentoring program is to bring new and experienced coordinators together for advice, guidance and reassurance. Mentors/Mentees will be introduced to each other at the Spring Meeting – Coordinators Section ice breaker on the first day.

As most of you know, there is a listing on the APPD website of all current programs, including the names and e-mail addresses of the program director and program coordinator. The coordinators have taken on this project and have gradually been adding their photos to the page. They want to also include photos of each program director. Therese D'Agostino and Vanessa Pichette will continue to oversee this program.

The Carol Berkowitz Award for Lifetime Advocacy and Leadership in Pediatric Medical Education was instituted at the Spring 2005 meeting in Washington, D.C. Jeri Whitten was the first recipient of this award. Nominations will be solicited each year from the coordinators section and will be announced at each Spring Meeting.

2005 Special Project Updates

Structured Clinical Observations of Pediatric Residents: Implementing the 360-Degree Evaluation

Karen P. Zimmer, MD, MPH,
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We thank the APPD for their support of our project. Now that residency training programs are required to use reliable instruments to assess resident performance, we chose to evaluate the feasibility and usefulness as well as consistency of a 360-degree evaluation tool used to assess resident performance in the competency areas of communication, patient care, and professionalism. Our primary aims were: 1) to assess the feasibility and usefulness of integrating this evaluation process into a general pediatric continuity setting, 2) to assess the consistency in evaluations of resident performance among the three stakeholders (i.e. the preceptor, parent (or patient ≥ 16 years), and the resident) and 3) to compare the Structured Clinical Observation (SCO) scores longitudinally for each resident and residents grouped by level of training.

This study is being conducted in the Harriet Lane Clinic (HLC) which serves as the medical home to approximately 10,000 children and adolescents in Baltimore City. Fifty-seven pediatric residents (70%) in the Johns Hopkins Children's Center training program have their continuity experience in the HLC.

The development of this tool and faculty development was a multi-step process. We developed our Structured Clinical Observation scale (SCO) from a synthesis of two previously validated tools: a medical student evaluation tool developed by J Lindsey Lane and a communication framework developed by Cohen-Cole. This synthesis provided more emphasis on communication and interpersonal relationships. We then videotaped a mock clinical encounter for the faculty development phase of this project and the SCO was used to score the video. The following 6 domains were used to evaluate the video encounter: opening the interview, history-taking, relationship skills, personal manner, negotiation and management, and physical examination. Scores were tabulated and the variances in scores were discussed in a continuity preceptor faculty meeting. If there was a variance of 1 point or greater on an item, the wording of the item within a domain was modified by group consensus to express more concisely the targeted competency area. After the SCO was modified based on faculty input regarding the clarity of items in the preceptor, the Structured Clinical Observation scale (SCO) was adapted for use for each stakeholder (preceptor-SCO, parent/patient-SCO, and resident-SCO) to assess resident performance during the same clinical encounter.

All observation tools included similar questions to address these 6 domains (opening the interview, history-taking, relationship skills, personal manner, negotiation and management, and physical examination) of the patient encounter. Each resident was observed during a continuity clinic session, and the preceptor, parent/patient, and resident each completed a SCO scale based on a particular observed patient encounter (3 SCOs for the observed encounter). Two additional parent/patient SCOs were obtained sequentially for each resident to maintain parent/patient confidentiality to the parent/patient involved in the direct observation encounter (totaling 5 SCO evaluations for each resident). The preceptor provided feedback to the resident a week and sometimes a few weeks later. Preceptors waited until they had parent/patient as well as resident self SCOs before providing feedback to the resident.

The first phase of the project took place from August 29th through December 21st, 2005. Fifty six of the 57 residents who have their continuity clinic in Harriet Lane had observations completed. Of the 56 residents, 49 (87%) had all 5 evaluations done and 7 residents had 4 evaluations completed. Of the 7 residents with 4 complete evaluations, 2 residents were missing one of the observed parent/patient SCO from the observed visit and 5 were missing one of the supplemental parent/patient SCO. These evaluations were copied and placed in the resident's file for educational purposes. Upon completion of the fall session, we compared the stakeholders' SCO scores by question and domain using Wilcoxin signed ranks test. It appears that all stakeholders (including the resident themselves) scored the resident performance lowest in the area of negotiation/management. This trend existed across all years of training. It also appears that there was no statistical difference in the responses between the preceptors and the residents in all 6 areas for the interns and the senior residents. There were two domains where 2nd year residents differed from the preceptor (history-taking-information gathering and personal manner).

The spring evaluation session for each of the residents began February 27th and will continue through May 15th, 2006. After the second evaluation is completed in the spring, we also will analyze SCO scores longitudinally (fall vs. spring) for each resident as well as by year of training and across years of training and compare parent/patient scores to resident and faculty scores.

On January 30th, interim feedback questionnaires were distributed to the residents by their preceptors to be completed. The purpose of this questionnaire was to obtain qualitative comments from residents and preceptors concerning the implementation and usefulness of this type of evaluation. All 10 of the preceptors completed the questionnaire (100%) and 66% of the residents who were observed completed the questionnaire (37/56). Because signing one's name was optional, we are unable to determine exact percentage of respondents for each year of training. Although the parent/patient feedbacks had limited variability, it was interesting to note that the residents ranked the parent/patient evaluation as most important and was "very valuable." When asked what was valuable about the experience, one resident wrote, "Sometimes things I perceived as doing well were not perceived that way by the parents." Another commented, "Good to know what my families think—I am unsure how much they would tell me if they have criticism of me and besides SCO there is no way for families to give feedback other than directly to me."

The residents in general found their self evaluation was only somewhat valuable. However, one resident wrote, "I do self-evaluation a lot; however, this did require me to do it in a specific, organized manner." Yet the overall experience was valuable. One resident commented, "Rare to have anyone observe an entire session—sometimes I feel I am not sure how well I am doing so it was good to hear positive feedback as well as constructive advice. Perhaps the positive was even more valuable than the criticism."

There have also been a number of challenges. The most commonly reported challenge by the preceptors with the implementation of the 360-degree evaluation was finding the time to do the observations and secondly finding the time to give feedback. With the new 80 hour work week restriction, there are a number of resident clinic absences which add to the complexity of scheduling observations. Upon completion of the spring evaluation session (June), we again will hand out the feedback questionnaires to compare responses longitudinally.

In summary, we are on target with our timeline. Following completion of the spring evaluation (May 15) and the second follow-up questionnaire (June 30) we will conduct a longitudinal analysis and describe the quantitative and qualitative results in using this standardized,

comprehensive tool to assess resident performance Detailed feedback from the preceptor and parent/patient at this time appears to be important to the residents and may enhance patient-centered care.

Reforming Pediatric Procedural Training: A Proposal to Develop an Evidenced-Based Curriculum

Michael Gaies, MD, Shaine Morris, MD

Intern Project

Data collection has been completed for the intern portion of this protocol. All 38 categorical interns in the Boston Combined Residency in Pediatrics gave consent to participate in the study. Pre-intervention data were collected on all 38 subjects. The randomized intervention group participated in the procedural skills curriculum during intern orientation, and we successfully collected data from all subjects at that time to assess the immediate effect of the curriculum on procedural knowledge and skills. Data were collected for 6 months on procedures performed on live patients by interns from both the intervention and control groups, during which time 244 separate procedures were catalogued. We then performed follow-up testing on the same skills and knowledge tests done at orientation to assess the effect of the curriculum 6 months later. We had an 80% follow-up rate at 6 months. Qualitative data have been collected on the value of the curriculum, and all respondents have indicated satisfaction with the experience. The data have been entered into a database and will be analyzed with the help of a statistician beginning April 1st. Preliminary analyses will be presented at Children's Hospital Boston Medical Grand Rounds on May 15th. We plan to submit an abstract of our results for the 2007 PAS meeting and subsequently submit a manuscript to JAMA for consideration for publication in the 2007 Medical Education Issue.

Design for a Pediatric Resident Curriculum and Evaluation Tool in Pediatric Resuscitation

Nicole Shilkofski, MD, Kristen Nelson, MD,
Elizabeth Hunt, MD, Julia McMillan MD
March 20, 2006

To date, our study team has accomplished several preliminary studies in preparation for design of a resident curriculum in pediatric resuscitation. These will be outlined below.

First, we have gathered data from 25 other pediatric programs of varying size in order to determine what the educational practice standard in pediatric resuscitation is at various institutions. The goal of this survey was to determine a “needs assessment” in pediatric resuscitation in order to design a curriculum that is generalizable to multiple programs nationwide. The results of the survey identified resuscitation tasks with high measures of comfort (i.e. which tasks residents felt they could successfully accomplish at the time of graduation from residency). These included bag mask ventilation, neonatal intubation, and chest

compressions. However, the survey also identified multiple tasks with very low measures of comfort in successful completion, including non-neonatal intubation, placement of intraosseous needles, defibrillation/ cardioversion, administering code medications, and leading a code team. Also of interest, there was not a correlation between comfort measures in resuscitation tasks with the number of Pediatric ICU or ER rotations that a program required. Other interesting data from the survey included information that 100% of programs surveyed required completion of Pediatric Advanced Life Support (PALS) course during training. In addition, 96% of programs surveyed held mock codes regularly (mean 5.9 mocks per resident per year). At 72% of institutions surveyed, a senior level resident was the leader of the hospital code team. We concluded that resident self-efficacy for most resuscitative maneuvers is low despite current teaching methodologies. These preliminary data will allow us to better target our curriculum to areas of weakness as documented by resident self-assessments.

The second pilot study we have completed is a study of pediatric resident recognition and treatment of unstable supraventricular tachycardia (SVT) using a simulation scenario. This pilot was a necessary preliminary study that will relate directly to the design of our curriculum, as one of the primary curricular modules will focus on pediatric dysrhythmia recognition and treatment. The pilot SVT study examined time to recognition and successful cardioversion in unstable SVT by teams of pediatric residents. We determined the median time to cardioversion was 8.9 minutes (range 5.3 min. to ∞). We were also able to document delays to cardioversion and maneuvers performed by the teams prior to the initiation of cardioversion. We determined that many delays to cardioversion were secondary to lack of recognition of “unstable” SVT due to failure to assess patient perfusion and mental status. These data will be used in our curriculum design to emphasize the importance of using definitive criteria to discriminate between “stable” versus “unstable” SVT, and to use this discrimination in therapeutic decision making. Data from this study will be presented as a poster by our group at the Pediatric Academic Society meeting in San Francisco in May.

Additionally, we have taken initial steps to begin the design of an online resident curriculum. Our group has partnered with Dr. Howard Schwid from the University of Washington to design cases for a screen-based pediatric simulation. Dr. Schwid has already designed software that presents a simulated patient and requires a series of commands as the scenario progresses to resuscitate the patient. These simulation scenarios will be utilized in our curriculum as pre- and post- tests prior to and after resident participation in our online curricular modules, in order to allow assessment of the curriculum effectiveness. We are in the process of expanding the case library with Dr. Schwid for these simulations in addition to designing a system to validate these simulations within our curriculum. Our group has also met with Dr. Harry Goldberg, a biomedical engineer here at Johns Hopkins University, who will be assisting us in the process of creating our online curricular modules. As we begin to design the “blueprint” for the first module, he will be translating the blueprint to an online didactic module over the next 2-3 months.

Finally, we have begun the process of validating the Pediatric Resuscitation Assessment Tool (PRAT) mentioned in our grant proposal. We are starting to use the tool as a completion checklist in our teaching sessions and team mock codes as a way to structure resident feedback about performance in code scenarios.

Resident Sign-Out: A Precarious Exchange of Critical Information in a Fast Paced World

Linda A. Waggoner-Fountain, MD

With this proposal we plan to clearly define the goals and characteristics of concise and complete sign-out for resident physicians caring for pediatric inpatients on a general pediatric acute care ward, and then to develop a curriculum that teaches these skills. After we have characterized an idealized sign-out process, we plan to create a secure web-based database system that facilitates and supports this clearly delineated sign-out process. We hypothesize that this project will enhance the quality and efficiency of information exchange at sign-out, ultimately improving patient safety and the quality and efficiency of patient care.

Specific Aims of this study include:

1. explicitly identify the goals of sign-out
2. characterize the information needed for a concise and complete sign-out,
3. develop a structured sign-out process that enhances the quality and efficiency of information exchange
4. develop and implement curricula for housestaff that explicitly teaches them how to sign out efficiently and effectively (as defined by specific aims 1,2 and 3)
5. develop and implement a web-based database system that facilitates and supports the clearly delineated sign-out process identified in specific aims 1,2 and 3)
6. Assess the quality, completeness and efficiency of sign-out at baseline
7. Assess the quality, completeness and efficiency of sign-out after developing and implementing a teaching curriculum and web-based sign-out system (specific aims 4 and 5).

We have obtained two sets of baseline preliminary data to date.

1. Post-Call Survey:

For three months, immediately following call nights, resident physicians rotating on the pediatric acute care wards completed a confidential survey characterizing their night on call, the adequacy of the sign-out they received, and where they went to get information they didn't receive during sign-out. Out of a total potential 196 surveys, 158 were completed. 60% of the surveys were completed by members of general pediatric ward team, and 40% of the surveys were completed by residents who were "cross-covering" on the wards at night.

On 49 of 109 surveys (31%), residents indicated something happened while on call they were not adequately prepared for. For 40 of these 49 instances (82%), they indicated there was information they didn't receive during sign-out that would have been helpful to them in caring for the patient overnight, and in 33 of the 40 instances (82.5%), they indicated the situation should have been anticipated and discussed during sign-out. When nights when something happened the resident was not adequately prepared for were compared to nights they felt adequately prepared, the quality of sign out assessed with a 5 point Likert scale (1 = "inadequate to answer call questions" to 5 = "adequate to answer call questions") was significantly different (3.58 ± 0.92 versus 4.48 ± 0.70 , $p=.001$). There were no differences in how busy the nights were, patients on service at the beginning of call, number of admits, and number of transfers to an ICU. Resident physicians were no more likely to report events they were unprepared for when they were "cross-covering" at night than when they were members of the general pediatric ward team. Similarly,

when resident physicians reported an event they were unprepared for, they were just as likely to have cared for that child previously as not.

2. Recorded Sign-Out Sessions:

During a two month period, 15 sign-out sessions were recorded using a digital recorder. Using the RATE tool, time stamps were integrated and discussions of individual patients separated. The recordings were then converted into individual WAV files that can be archived on DVD. Complete transcriptions were created from the first three sign-out sessions, and two pediatric faculty physicians and two human factors engineers characterized the types of patient information that were exchanged as well as the types of questions that were asked, comments that were made, and types of distractions to the sign-out process. As additional sign-out sessions were observed and recorded, the categories were refined. The initial category set comprised 29 categories and was extremely detailed and characterized individual pieces of information (e.g., past history, history of present illness, past treatments, current medications, laboratory results, etc), whereas the final categories focused on higher level groupings of information as they relate to the care provided overnight for a given patient (e.g. the patient background category now includes all past information). The final grouping consists of four different types of communication other than simple information exchange and ten categories of patient information exchanged during sign-out. In addition, three primary sources of distraction during sign-out were identified.

During these 15 recorded sessions, 211 patients were discussed. The average number of patients discussed per sign-out session was 14.07 ± 3.6 (range 8 to 20). The average duration of a sign-out session was 34.27 ± 15.53 minutes (range 11.01 to 70.2 minutes). Significant background noise was audible for $12.8 \pm 11.3\%$ of the time (range 0 – 37.8%). During the 15 recorded sign-out sessions, pagers went off 46 times (3.01 times per session) and there were 14 other types of interruptions (0.9 per session). The total time resident physicians spent “off task” was $21.79 \pm 13.7\%$ (range 7.1 – 49.4%).

Three observers independently listened to two complete sign-out sessions during which a total of 24 individual patients were discussed. For each individual patient discussed, each of the three listeners assessed which of the ten categories of information outlined above had been discussed, and which of the four types of communication had taken place. The percent agreement for all raters and all questions was 68.91% (215 out of 312). Other conclusions were that there was no apparent order with which the residents discussed patients (e.g. alphabetical or reverse alphabetical order, sickest children first and least sick last, or based on the child’s physical location on the wards), nor did it appear that the residents always spend more time on the sickest/most complicated children who were most likely to have problems overnight than they did on less complicated children). During sign-outs, residents consistently provided information about certain topics such as patient identification and background, but they often did not discuss the child’s current condition or potential problems that child might experience overnight (what-ifs?). Moreover, the residents infrequently engaged in collaborative cross-checking, summations or read-backs. Finally they spent significant amounts of time engaged in off-topic discussions.

Our current stage in this research project includes working with our engineering colleagues and hospital based facilitators to begin creating a straw model of ideal check out. Concurrently we are creating examples of ‘good’ sign out vs. ‘weak’ sign out to use as demonstrations for teaching all levels of pediatric residents. As part of CQI process, each resident will have an individual auditory audit of a sign out session reviewed with a faculty member to identify individual strengths and weaknesses.

The preliminary results noted above will be presented in a platform presentation at the 2006 PAS meetings.

Learning Style and Academic Self-Efficacy: A Pilot Study

J. Marc Majure, MD

Funding for this project was delayed until the fall. When funding was secured, key personnel started training in the administration of the tools to be utilized in the study. This training has been completed. Exemption for Phase I has been obtained from the Institutional Review Board of Duke University Medical Center and data is being collected. For the purposes of this study, the domain of learning Evidence-Based Medicine has been identified as the focus of study. Items for the efficacy scale in this area are currently being identified and tested. Once these items have been appropriately clarified and worded, these will be used will be used in the implementation phase of the study.

Finances

As of June 30, 2005 APPD's Net Assets = \$398,876.

Budget Overview July 1, 2005 through June 30, 2006

Income

Dues	\$210,000.00
Spring Meeting	\$142,000.00
Other (Interest/Donations)	\$10,000.00
Fall Meeting	\$27,000.00
Total Income	\$389,000.00

Expense

Admin, Legal, Acct	\$126,025.00
Spring Meeting	\$99,500.00
Other Meetings	\$10,000.00
Operating Expenses	\$29,500.00
Membership Services	\$30,000.00
Fall Meeting	\$38,100.00
Special Projects	\$50,000.00
Total Expense	\$383,125.00

Net Income **\$5,875.00**