



EDITOR'S COLUMN

Annamaria Church, MD

The best time in the year of a program director is here! Recruitment season is over. Your graduating residents have hopefully secured wonderful positions as they move into the next phase of their careers. Your PL-1's have figured out the system and adjusted it to their lives-outside-of-residency (gives "LOR" new meaning). Your PL-2's are starting to see the light at the end of the tunnel. The PL-2 dol-drums have finally gotten a second wind as your second-years enthusiastically see beyond residency. You and your coordinator finally have time to review your program, identify what worked well this year as well as what didn't. (If you have trouble identifying the problems, just ask your faculty!) You have time now to thoroughly review the new RRC guidelines and assure your program has everything in place. You can create and innovate as you look forward to the next academic year.

Have you ever tried explaining this post-recruitment euphoria to a non-program director or coordinator? Like Rodney Dangerfield, you get no respect. The private practice pediatricians on your faculty don't think you are a "real doctor." You don't know what it's like out in practice, worrying about keeping a roof over your office, providing quality care in each 10-15 minute time-slot and complying with all those pesky federal, state and insurance regulations. Your on-site faculty avoids you like the plague for fear you want them to commit to another lecture or curricular change. The subspecialists are tired of hearing you quote RRC guidelines instead of their favorite textbook, reciting competencies like you're naming the seven dwarfs and telling them once again that asking the resident to perform a new consult after being on-call all night is a no-no. Administration can't understand how you can possibly need more funding when your productivity hasn't increased.

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PRESIDENT'S COLUMN

Theodore Sectish, MD, Program Director, Stanford University

Preparing Residents for the Future of Pediatrics

I have been thinking a lot about where the field of pediatrics is heading and how we need to train pediatricians for their future roles. In this column I will share with you my thoughts about the future of the field of pediatrics just as I did with applicants this year who interviewed for pediatrics residency. It is my intention to stimulate reflection by offering several ideas about potential areas of change within our training programs to better prepare residents for the future of pediatrics.



1. Teach Quality Improvement and Population-based Approaches to Health Care

The pediatrician of the future must view her role as much as a manager of a population of patients as a personal physician for each individual patient in order to improve the health care of all children in the practice. Managing a population requires learning a set of skills that should be taught during pediatrics residency. Future pediatricians will participate in quality improvement projects and will need to redesign systems in their practices to support data collection and tracking. As they define and measure outcomes of their practice efforts they will have real time knowledge about outcomes such as immunization rates, compliance with best practices, or hospitalization rates for patients with a chronic condition. These new activities will fulfill one component of the American Board of Pediatrics Program for Maintenance of Certification in Pediatrics. In residency training, we should develop specific experiences that will prepare our residents for these quality improvement activities.

2. Incorporate Improved Systems and New Models of Care for Children with Chronic Conditions

The increased prevalence of children with chronic illness is a reality with significant impacts on the practices of pediatric specialists and generalists. Parents of children with chronic health conditions often navigate the complex environments of our medical centers on their own. Despite receiving cutting-edge and highly technical and life-saving care, children and families still report many unmet health care needs. It is time to coordinate the efforts of specialists and generalists using a disease management model that spans the continuum of care and engages a host of caregivers in inno-

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vative and effective ways. Although we recognize the need for teams composed of different levels of training and expertise, we have not yet refined the models and team composition to provide optimal care. In today's children's hospitals, children with special health care needs make up a greater proportion of children on inpatient wards and in outpatient clinics. Therefore, it is incumbent upon all of us in residency training programs to work collaboratively with clinical services to develop new systems and models of care to address this need on behalf of patients and families.

3. Re-engineer Inpatient Pediatric Care

Not so long ago, inpatient care in pediatric teaching hospitals was provided by residents with little guidance from supervising physicians. In fact, we called our supervising physicians, "visits," because they visited the wards from time to time to check in with the senior resident and chief resident for questions or to provide teaching sessions. Fortunately, the safeguards in the system were that senior residents or chief residents functioned at the level of junior faculty. Chief residents in particular, often had additional clinical training beyond residency in fellowships or in military service. Today the acuity and complexity of pediatric inpatients demand a re-examination of the composition and function of inpatient care teams in order to provide the best care while preserving the integrity of these rich educational opportunities for trainees. It is likely that in future years there will be greater reliance on hospitalists and non-physician providers who can provide more consistency and greater continuity than residents and faculty who rotate at frequent intervals. Among the many challenges in this proposition (including financial) is the unlinking of educational needs from service requirements without jeopardizing the essential and responsible role for residents on inpatient care teams.

4. Train Pediatricians to Better Meet Children's Mental, Emotional, Behavioral, and Developmental Needs

Our nation will never train enough mental health care providers to meet the mental, emotional, behavioral, and developmental needs of our patients and their families. Over the last three decades, pediatricians have been increasingly involved in the diagnosis and management of children with Attention Deficit Hyperactivity Disorder. However, as compared to our colleagues who treat adults, we have shied away from having a similar role in the care of children with mental disorders such as anxiety, depression, and mood disturbances and still refer many patients with significant emotional, behavioral and developmental needs to other providers. Yet we know that prevalence of these conditions is growing. In a recent perspective in the *New England Journal of Medicine* (*NEJM* 2005. 353; 11: 1089 – 1091), Kadison cites that 25 – 50 % of US college students seeking counseling services are taking antidepressants. This clinical need must be matched

by an effort within training programs to provide appropriate training in the diagnosis and management of mental health disorders. In addition, behavioral interventions and counseling techniques, currently the domain of a variety of pediatric subspecialists, may appropriately become the domain of the general pediatrician.

5. Promote Self-directed Learning as a Life-long Skill

The ever-expanding knowledge base in the field of pediatrics requires individual effort on the part of all pediatricians to stay abreast of new knowledge and to shorten the time from discovery to everyday practice. Our expectations must change from merely providing clinical exposure in rotations or passive learning in a core conference series to a much broader array of educational activities that place the trainee in an active and central role for their learning. Knowing what to learn is less important than knowing how to access knowledge and information quickly and efficiently. Once knowledge and information is accessed, it will be important to incorporate that knowledge into the workflow process to enhance its application in real time. Our challenge as educators is to make the process of learning one which occurs as part of patient care delivery on a day-to-day basis and to be explicit in our expectations that self-learning is the key factor for keeping knowledge updated.

As stewards of the training program that we direct, we should reflect about what the future may hold so that we are updating our programs accordingly. I invite you to think about the future of pediatrics and share your thoughts about the challenges and the needs of training.

Let me also tell you about an announcement that will be coming from the American Board of Pediatrics in the next month – the Residency Review and Redesign Project (R³P Project). This is the first serious examination of the training requirements for certification in over 25 years. As a member of the R³P Project Committee, I can reassure you that the project will require broad input from many stakeholder organizations, especially APPD. There will be many opportunities for our members to provide their perspectives, opinions, reactions and advice. APPD has had an impressive track record of providing rich and reasoned responses to other organizations such as the ACGME and will certainly be an important source of information and guidance for the R³P Project.

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REGIONAL HAPPENINGS

Midwest Region

Tom George, MD, Children's Hospital of Iowa

Members of the Midwest Region of the APPD were recently surveyed to determine the interest level in, timing of and topics of interest for an inaugural regional meeting. The majority of respondents are interested in such a meeting and a rank order of topics of interest was generated as a result of this survey. We are presently determining if the meeting would best be held on Wednesday prior to the start of the APPD meeting or at a separate regional meeting. The challenges facing our region with the long distances between programs could make just prior to the APPD meeting a good choice for this initial meeting. We plan to use the results of the survey to start to address a few of the topics of interest utilizing content experts within the region as leaders/facilitators. Additionally, at the regional breakfast meeting, we plan to further develop our regional goals per the APPD proposal from 2005: to determine our rules of operation; to determine the frequency of teleconferences/face-to-face meetings; to determine regional goings-on that we want to share with the full membership; and to determine a regional chair-elect. We look forward to seeing everyone in San Francisco!

Western Region

Rukmani 'Roni Vasan MD, MEd, Program Director, USC Pediatrics, Los Angeles County and University of Southern California Medical Center

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 who provided emergency assistance with follow-up aid to families in need.

We are very excited that Dr. Michael Gottschalk from UCSD and his staff have rescheduled the regional meeting for March 10th 2006. We will be sharing information about our Programs in the morning, followed by afternoon break-out sessions for Program Directors, Program Coordinators and Chief Residents. Suggested topics for the breakout sessions include the new RRC requirements, developing tools to assess competency and individual learning plans. This will be followed by a tour of the Children's Hospital.

Dr. Robert Kamei has stepped down from his position as Program Director at UCSF. He has accepted a position with Duke University to open their new medical school in Singapore. As the regional chair-elect, I look forward to working with the regional membership and representing our region at the National level promoting the mission of the APPD.

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In fact, they've had to increase the budget so much more to cover patient care ever since you introduced the 80-hour rules. Finally, your family simply smiles and nods as they secretly worry you've gone off the deep end.

There is one place where people truly understand what you do and why you do it. They don't think it's unusual to debate the merits of direct observation versus post-tests in evaluating residents. They understand the nuances involved in moving your adolescent rotation from second year to first. They understand the "LOR" wordplay above. They actually can recite the competencies, duty hours and RRC guidelines as well as you. Comparing ideas with them helps you develop your program further. Make sure to join us at the APPD Annual Meeting. It's a place where every program director and coordinator belongs. See you in San Francisco!

MENTORING

Miriam Bar-on, MD, Loyola University

In 2005 the APPD developed a mentoring program to support program directors. Our goal is to target new program directors and those who have had this role for less than three years, as it is perceived there is the greatest need during this time. Last year we paired 11 new/relatively new program directors with more seasoned or experienced individuals to serve as their mentors. These mentors are volunteers from the organization who believe that they can provide assistance to someone recently appointed to the program director role. We hope to pair individuals based on both areas of need and areas of expertise. It is our expectation that the mentor-mentee relationship will be long term, or last at least as long as the mentee feels the need for it to exist. We anticipate that this relationship will evolve not only into a contact for networking, but also into a friendship.

☐ If you are a new program director and would like to have a mentor, please contact the national office at info@appd.org. We will pair you with a mentor and you can have your first face-to-face meeting at the annual meeting in San Francisco.

☐ If you are an experienced program director and would like to become more involved with the organization and make a direct contribution to someone's career, consider becoming a mentor. If you are interested, please contact the national office at info@appd.org.

COORDINATORS' CORNER

Training Administrators in Graduate Medical Education Certification Update - November, 2005

Minimal Qualifications to Apply

- ◆ 3 years continuous day to day experience in residency program administration/coordination
- ◆ Attendance at one national meeting in past 3 years, focused on graduate medical education
- ◆ Participation in a site visit or internal review within past 3 years
- ◆ Personal professional development within past 3 years (presentations at national, state, institutional, or departmental level; poster presentations or manuscripts published)

Assessment Content

Part I – Monitored Assessment

- ◆ Institutional Requirements/ACGME requirements
- ◆ Common Program Requirements
- ◆ Pediatric Program Requirements
- ◆ ACGME Policies and Procedures
- ◆ Pediatric Acronyms
- ◆ Definition of Terms
- ◆ Core Competencies

Beginning with 2006 monitored assessment, there is a 5 hour time limit. 260 possible points (a minimum of 75 correct is required for successful completion). For Sections I, II, III, and IV, there are two possible points for most questions. The candidate answers a multiple choice question or true/false question and then cites the source from the requirements or policies and procedures. Part VII questions may have multiple answers, as more than one competency may fit the question **or** scenario.

Part II – Work Effort Product

This portion is completed at the training administrator's office/home. The basis for this portion of the certification process is to assess the administrator's knowledge, skills, abilities and attitudes in management of his/her training program and knowledge of how the program functions within the guidelines set forth by the ACGME and RRC for Pediatrics. Content includes such scenarios as duty hours, core competencies, web navigation, recruitment and web surveys.

The work product is reviewed by the three pediatric members of the TAGME Board, as well as one outside reviewer for objectivity.

2005 Results

21 administrator candidates for certification

- ◆ Monitored Assessment – 95% successful completion rate for first time takers

- ◆ Work Product – 76% successful completion rate for first time takers

76% were recommended for certification at November TAGME Board Meeting

What Happens If You Are Not Successful

Candidates who are unsuccessful have a one year opportunity to reassess without cost.

What's Up For 2006?

- ◆ Discussion was held November 2-4 at the TAGME Board Meeting regarding offering the monitored assessment at both the APPD National Meeting in San Francisco and again during the IT Exam at the Administrator's home institution. It was decided, in order to maintain confidentiality of the assessment, that only approved sites such as the APPD meeting will be offered. In future, sites at other professional meetings, such as APCS (surgery) will be made available to any coordinator certification candidate. (That means a pediatric candidate could take their monitored assessment at the surgery meeting, psychiatry meeting, etc. if the location was closer and more convenient.)
- ◆ In order to maintain confidentiality and the integrity of the monitored assessment, questions are chosen from a bank, so that the assessment is different each year.
- ◆ Work Efforts will be sent to the candidate at the time the application is accepted as complete, and will be returned to the TAGME Board Member at the site with the monitored assessment.
- ◆ Pediatric Board Members will assess content and make appropriate adjustments based on input from our 2005 candidates and to reflect the new Program Requirements for Residency Training in Pediatrics, effective January 1, 2006.
- ◆ Slight changes were made in the Work Product to reflect feedback from both surgical and pediatric candidates regarding the content.

PEDIATRIC RESIDENCY SPECIAL INTEREST GROUP AT PAS

Please come to the Pediatric Residency Special Interest Group at PAS! This is a unique opportunity to hear from residents from around the country about their concerns and issues. Each year residents meet and discuss problems at their residencies and share what solutions worked and didn't work. Each year has been a fascinating exchange of ideas between residents and directors about issues that concern us all.

We hope you can come to this year's meeting with a special focus on how to incorporate business planning into residency in addition to other issues. The resident-director discussion will be on Sunday April 30, at 10am, place TBA. Join us for a lively round of resident discussion, philosophy and dialogue!

UPDATE FROM THE AAP RESIDENT SECTION

Sarah Corathers, MD, Cincinnati Children's Hospital Medical Center

Earlier this year, members of the Resident Section were invited to participate in the Annual Leadership Forum of the American Academy of Pediatrics (AAP). The meeting was an exciting opportunity to update members on the broad scope of activities of the Academy that range from lobbying in Washington for Medicaid coverage for all children, to local and international advocacy campaigns, to being the largest publisher of pediatric medical literature. In addition, the meeting brings together leaders from the chapters, districts, sections, and committees to discuss resolutions written by members of the Academy during the past year. Residents were asked to comment on topics related to resident education and workforce issues. At the conclusion of the weekend, the approved resolutions were voted upon in rank order. The ranked list was submitted to the board of directors for the AAP to help define priority items for the upcoming year. Three of the top ten resolutions were strongly supported by the resident section including: fruit juice and WIC recommendations, pediatricians and children's oral health and insurance coverage for obesity care. The weekend provided an excellent opportunity for the concerns of residents to be heard by the leadership of the Academy.

The section has benefited significantly from the addition of Julie Raymond as the new Resident Section Manager. Julie is already working full time to coordinate all of the resident activities within the entire Academy. It is an incredible asset to have a staff member dedicated to resident affairs. The position is another manifestation of the support the resident section receives from the Academy and we are truly grateful.

The section leadership has continued to pursue a unified timeline and application process for fellowships that would move the application and acceptance dates closer to one year prior to beginning the training program. A policy to this effect would permit pediatric residents to benefit from the opportunity to experience a broad spectrum of subspecialties and more general training as a pediatrician before making a decision to apply for a subspecialty fellowship. The application process would also be simplified. Subspecialty training programs would benefit from having more information about an applicant's performance as a pediatric resident and greater confidence that the applicant's choice of subspecialty is an informed judgment before deciding to accept an applicant for a subspecialty fellowship. We will continue to update the membership as progress is made towards this goal.

The Resident Section's first advocacy effort began last year in the form of a letter writing campaign to remove soft drinks in schools and has proven to be very successful. Residency

programs have worked with local chapters to use the letter as a tool for advocacy with the state legislature, publishing an open letter in the newspaper to increase public awareness of the issue or distributing the letter for signature at noon conferences and grand rounds in association with obesity education. Although there remains great variability across the country regarding the availability of sugared beverages in schools, the topic is clearly gaining more attention as an important aspect of children's nutritional health and well being. The focus of our next advocacy project will be discussed at our upcoming long range planning meeting.

Getting Involved - Creating a Program Delegate

The purpose of the AAP Resident Section is to advocate for residents, fellows, and medical students, develop leadership within the Section, and educate Section members on how to advocate for infants, children, adolescents and young adults. The Resident Section of the AAP is the largest of approximately 50 sections. As such, residents have a tremendous voice within the Academy. The leadership of the section is comprised of an executive committee that includes a Chair, Vice-Chair, Secretary, District Coordinator (DC), and Assistant District Coordinator (ADC) from each of the ten districts around the country, as well as resident liaisons to other interest groups both within and beyond the Academy.

The AAP Resident Section webpage, www.aap.org/residents provides tools and information relevant to resident training, advocacy, boards, practice management, fellowship opportunities, grants and scholarships, conferences and much more. I would encourage you to become familiar with the website to ensure the residents within your program are aware of the information they have at their fingertips. Each district also has a resident newsletter that the DC and/or ADC publish at least biannually to enhance resident knowledge regarding AAP issues and opportunities. The newsletters are then posted on the district portion of the resident section website.

Despite our leadership structure, the section depends most heavily on individual members for our strength. In order to have clear communication between nearly 10,000 members and the elected executive committee we must have grass roots support. **Program delegates** act as a direct link between residents within a training program and the AAP Resident Section. The program delegate is the one individual at a program that all residents can identify as a resource for information regarding the Academy. Furthermore, the delegate is a conduit to express concerns of the residents at a specific program to the section at large.

The role of program delegate provides a wonderful opportunity for a resident to enhance their understanding of the American Academy of Pediatrics, strengthen leadership skills and build networking connections that may influence many personal and professional facets in their lives for years to come.

ACGME CASE LOG SYSTEM “CONTINUITY CLINIC PILOT” UPDATE

Ann Burke, MD, Wright State University

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 plans 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 Vasilius, PhD. Jerry, the new Pediatric RRC administrator, 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 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 Vasilius. 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 in the piloting 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 me at ann.burke@wright.edu or call (937) 641-3443.

ASK THE ABP

Gail A. McGuinness, MD, Senior Vice-President, American Board of Pediatrics

Will the ABP Allow Waivers of Training for those Residents Who Experienced Interruptions in their Training Secondary to Hurricane Katrina?

The American Board of Pediatrics (ABP) will not provide a blanket waiver of training for residents who have experienced interruptions in their training secondary to Hurricane Katrina. Each individual’s circumstances will be considered on a case-by-case basis since the ABP is responsible for the certification of individuals after the verification of competence by the program director at the end of training. The ABP’s current policies are quite flexible since the Board permits interruptions in training, transfers to another accredited program, and part-time training. As long as training is completed in an accredited program for the required period of time, trainees will be eligible for certification. Up to three months of training in an RRC accredited program may be in a non-accredited setting as an elective. However, there must be appropriate supervision and the program director must approve the training. In addition, the ABP has a policy which allows a program director to request a waiver of training (up to two months) if the candidate is well qualified and has met all core training requirements as specified by the RRC. Waivers are granted on a case-by-case basis near to the completion of training and after the review of specific circumstances, eg, extended illness, parental leave, etc. The ABP will be receptive to requests for waivers of training due to hardship caused by Hurricane Katrina.

It is important that program directors carefully track the dates that the affected residents are in training, the site of the training, and the rotations completed whether they be in an accredited or non-accredited setting. In addition, if a resident has permanently transferred to another program secondary to the hurricane, then it is important that the ABP be notified in the usual manner by means of a transfer form.

Any questions can be directed to Gail McGuinness, MD at the ABP.

MED-PEDS PROGRAM DIRECTORS ASSOCIATION

Allen Friedland, MD, FAAP, FACP, Immediate Past President

Our medical community is very proud of the grass roots efforts of Med-Peds residents that participate in the National Med-Peds Residents' Association (NMPRA). This organization started in 1997 to advocate for combined residents. It is a resident-driven organization dedicated to providing information, opportunities, and programs to current and potential Med-Peds residents. Membership has grown from 36 programs to 66 so far this year and from 882 to 1300 resident members in the past two years. (Remember there are only 1500 or so residents in training at any one time.) I welcome you all to check out their website at www.medpeds.org which is organized into four sections: "About NMPRA," "About Med-Peds," "Especially for Residents," and "Especially for Medical Students." There is a job board, fellowship guide, mentoring initiative, newsletter, request a med-peds speaker, and more.

On a separate note, many pediatric and med-peds residents with other residents, faculty and volunteers from all specialties were involved with Hurricane Katrina efforts and we applaud all that have helped out. Dr. Emery Chang, a resident who just completed med-peds training at Tulane in June 2005, and has written a small article to be the basis of some personal preparedness for disasters for your residents.

Money Matters: If I Only Knew...Planning for a Disaster

Emery H Chang, MD, UCLA HIV Fellow, NMPRA Treasurer 2002-2005

As a refugee of Hurricane Katrina, I have been separated from my home and most of my belongings. Though I don't know the condition of everything, I've had to replace many important documents. With some advance planning, you can help yourself and your patients with recovery and replacement of important information and documents.

Make Photocopies. Photocopy everything: medical licenses, certifications, diplomas, social security card, passports, birth certificates, ID, titles, medical files, etc.

Safekeeping. With much of my medical paperwork, my residency program has everything on file, which is generally a good backup; however, all the files at Tulane are just as inaccessible as my files. So, give the copies that you make to someone you trust, preferably in a different city. My parents had some things, but not enough.

Digitalize. Much of our stuff can be replaced but not everything. Things that people miss tends to be photos of important people and events, letters from important people such as grandparents, lovers and children. Given how easy it is to scan everything, DO IT! These records can be stored on websites, in email accounts and on discs.

Photograph It. Insurance companies and FEMA will want to know what you lost and have you prove it. Take digital photos and make a log of expensive items such as electronics, jewelry, artwork, and musical instruments. Periodically appraise very expensive items. Take out specific insurance on specific items in addition to your renters or homeowners insurance.

Know Your Insurance. Know what it covers and take out additional insurance if needed. Do you need separate flood, wind or earthquake coverage? Are special items adequately covered?

Keep it Together. Keep your finances and documents in a safe, but easily accessed place or container. If you have some warning to evacuate, you can simply grab the few items that you need.

Prepare Your Home. Have enough water, food, batteries, medicines and other essential goods to keep your household self-sufficient for at least one week.

It's impossible to prepare for every possible problem, but a few simple steps can be done so that if something goes wrong, you can recover faster and with less hassle. GOOD LUCK!

WHERE ARE THOSE FELLOWSHIP PROGRAM DIRECTORS?

John D. Mahan, MD, Pediatric Residency Program Director, Children's Hospital/Ohio State University

It is clear to me, and to the members of the APPD Board, that extending the range of services and support of APPD to Pediatric Fellowship Program Directors is one way that APPD can accomplish our mission to ensure the optimal health and well being of children. In fact the APPD Board adopted this strategy into our strategic plan in 2002.

This year, as the General Pediatric Program Director, I was able to enroll 8 Pediatric Fellowship PD's from Children's Hospital/The Ohio State University in Columbus as members of APPD by including their names and information in our Children's Hospital Membership renewal form. This took less than 15 minutes of time for my Program Coordinator and cost our Children's Hospital an additional \$350 to fund our institution's application fee at the unlimited membership charge of \$1500. This added 7 different fellowship PD's to the membership role of APPD.

What did this potentially accomplish? As recipients of the APPD newsletter, email and other electronic announcements, the Fellowship PD's in our institution may: 1) learn something more about medical education principles and methods, 2) become aware of the many education activities offered by APPD, including national meetings, workshops and the APPD workshops directed to Fellowship PD's, 3) take advantage of some of the APPD educational activities, 4) be better equipped to meet the challenges of being a Pediatric Fellowship PD in the modern era.

The draft of the Common Requirements for Pediatrics calls for the General Pediatric PD to meet with the Pediatric Fellowship PD's at least twice a year to coordinate pediatric resident and fellow educational activities within institutions. At our institution, as I suspect in many of yours, I am being increasingly called upon to (gladly) help our Fellowship PD's with addressing core competency assessment methods, curriculum development, work duty hours regulations and more.

Please help in the effort of the APPD to increase our effectiveness in improving the health and well being of children in the US. It may take a request for your institution or department to allot more funds to acquire APPD membership for all of the pediatric graduate medical education training program directors at your institution - your Fellowship PD's. It may take a few more minutes of your time. But the payoff can be substantial. Enroll your Pediatric Fellowship PD's in the APPD!



2006 Annual Spring Meeting

Training the Next Generation of Pediatricians: Our Ongoing Mission

San Francisco Marriott ■ San Francisco, CA ■ April 26 - 29

Program-at-a-Glance

Wednesday, April 26

2:00 - 7:00 p.m.

Coordinators TAGME Exam (*For more information, please contact Jeri Whitten
jwhitten@hsc.wvu.edu*)

Thursday, April 27

7:30 - 10:00 a.m.

APPD SIG

7:30 - 10:00 am

Coordinators Sessions

Welcome/Opening Remarks/Icebreaker, *Vanessa Pichette, University of Vermont and Therese D'Agostino, Massachusetts General Hospital*

Program Coordinators: Who are we?, *Mary Gallagher, Long Island College Hospital/Beth Israel Medical Center, Brooklyn, NY*

Filling your Professional Toolbox: Creating a Job Manual, *Michele A. Parsons, The Children's Hospital (UCHSC), Denver, CO*

10:00 - 10:15 am

Break

10:15 am - 12:15 pm

Plenary Session

Association of Pediatric Program Directors - *Theodore C. Sectish, MD*

Residency Review Committee - *Carol Carraccio, MD*

American Board of Pediatrics - *Gail McGuinness, MD*

Pediatric Education Steering Committee - *Richard Behrman, MD*

American Academy of Pediatrics - *Robert Perelman, MD*

Resident Section, American Academy of Pediatrics - *Speaker TBD*

APPD Financial Update - *Ann Burke, MD*

APPD Awards - *Robert McGregor, MD and Carol D. Berkowitz, MD*

Recognize Outgoing Leaders - *Theodore C. Sectish, MD and Robert McGregor, MD*

APPD Election Results - *Edwin L. Zalneraitis, MD*

Break

Interactive Panel Discussion (Q&A) - *Ann Burke, MD, Moderator*

12:15 - 1:15 pm

Lunch (on your own)

1:30 - 4:30 pm

Invited Workshop/Presentation: Here Comes Generation Why! Interacting With the Next Generation of Learners, *John B. Molidor, Ph.D., Professor and Assistant Dean, CEO and President, Michigan State University, College of Human Medicine-Flint Campus*

4:30 - 6:30 pm

Task Force Meetings

LEARNING TECHNOLOGY TASK FORCE - *John D. Mahan, MD, Task Force Leader*

CURRICULUM TASK FORCE - *Ann Burke MD, Task Force Leader*

RESEARCH TASK FORCE - *John Co MD, Task Force Leader*

EVALUATION TASK FORCE - *Annamaria Church, MD - Task Force Leader*

FACULTY DEVELOPMENT TASK FORCE - *Miriam Bar-on MD, Task Force Leader*

Coordinators Executive Committee Meeting

Friday, April 28

8:00-9:30 a.m.

Regional breakfasts

10:00 a.m. -12:00 p.m.

Workshops I

12:00-1:00 p.m.

Lunch (on your own)

12:00 - 1:00 p.m.

Regional Chairs Luncheon

Council of Task Force Chairs Luncheon

1:00-3:00 p.m.

Workshops II

Friday, April 28, continued

3:00-3:30 p.m. Break
3:30-5:30 p.m. Workshops III
5:30-6:30 p.m. Posters with exhibits and Wine/Cheese Reception

Saturday, April 29

8:00 am - 12:00 pm **Coordinators Session**
Update from the Accreditation Council for Graduate Medical Education (ACGME) Effective Supervision as an Education Coordinator, Beth A. Hahn, Mayo School of Graduate Medical Education, Rochester, MN
Simplify, Sally H. Koons, Penn State Hershey Medical Center, Hershey, PA, Susan Quintana, University of New Mexico, Albuquerque, NM
Break
Training Administrators for Graduate Medical Education (TAGME) Update, Jeri L. Whitten, C-TAGME, Program Coordinator, West Virginia University (Charleston Division), Vice President/President Elect, TAGME
2006-2007 AAP Resident Membership Program, Terri Howard, Director, Division of Member Services, AAP

8:00 am - 1:00 pm **Forum for Directors of Small Programs/Affiliate Chairs**, Surendra Varma, MD, Texas Tech University, Lubbock, TX and Lynn Campbell, MD, University of Kentucky Medical Center Program, Lexington, KY

8:00 am - 5:15 pm **Forum for Fellowship Directors***
Teamwork! The Key to Implementing Competency-Based Training
Introductions and Welcome, Theodore C. Sectish MD, Stanford University, Palo Alto, CA
What can the APPD do for you?, Theodore C. Sectish MD, Stanford Univ., Palo Alto, CA
Update from the ACGME: New requirements for Pediatric Subspecialty programs, Common Citations, Jerry Vasilius PhD and Caroline Fischer, RRC for Pediatrics, ACGME, Chicago, IL
Discussion
Break
Pediatric Subspecialty programs: Collaborating to meet new ACGME and ABP requirements, William F. Balistreri MD, Cincinnati Children's Hospital Medical Center, Cincinnati, OH
Discussion
Residents and fellows demonstrating competency together: Common learning activities and evaluation tools (open, facilitated brainstorming session) Various faculty
Wrap up and closure
Lunch on your own
PAS/APPD Mini-Course: Educating Pediatric Fellows in a Competency Based World (PAS requires a separate registration fee)
Overview
A Brave New World! New Common Requirements for Subspecialties, Carol Carraccio
Survivor GME: Fellowship Competencies in Action, Joseph Gilhooly and John Mahan
Turning to Fellows as Teachers: From Curricula to Evaluation, Nancy Spector and Susan Guralnick

8:00 am - 5:00 pm **Forum for Chief Residents**



Special Offer for APPD Members: The fourth (4th) person registering from the same program is free if received by April 3. (All 4 must be APPD members.)

* **Fellowship Directors: One Day Registration Available** ~ In order to make this track more accessible to fellowship directors who would not normally participate in the APPD meeting, a one-day only registration fee has been established. Registration for the session is available to APPD members for \$100 and to non-members for \$200.

For complete conference details, including registration and housing information, please visit www.appd.org.

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FACULTY DEVELOPMENT TASKFORCE

Miriam Bar-on, MD, Loyola University

The Faculty Development Taskforce has been dormant during the recruiting season. We are gearing up for the annual meeting with preparation of a workshop titled *The Reluctant Learner: Engaging your Faculty in Teaching and Assessing the Competencies*. This workshop will be held on Friday April 28 from 3:30 – 5:30. If you have struggled to get your faculty up to speed with all of the changes, this workshop is for you.

The taskforce has almost completed its first year sponsoring the mentors program. This program, offered to new program directors matches experienced program directors with new ones. The matches are done based on individualized requests. However, if no requests are made, the match is based on other similar program characteristics. We purposely try to avoid matching individuals in the same geographic region so that competition for applicants does not interfere with the mentor – mentee relationship. Anyone who is interested in either being a mentor or having a mentor should contact the APPD national office at info@appd.org. We will find matches for everyone needing a mentor (see mentor article for more details).

Because of space issues this year, we were unable to plan pre-conference workshops aimed at mid or senior career program directors. We hope the APPD will be able to host such

workshops in Toronto in 2007. Discussion about pre-conference workshops is going to be a major item on the taskforce agenda for the meeting. Anyone interested in faculty development – both developing one's skills as an educator/program director and developing one's career – is invited to join us at our annual meeting Thursday April 27, 2006, room to be announced. We look forward to a lively, exciting session.

APPD Leadership

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