

# Association of Pediatric Program Directors



2006 Annual Meeting  
April 26 - 29  
San Francisco, CA

## ***FINAL PROGRAM***

*Training the Next Generation of  
Pediatricians: Our Ongoing Mission*

San Francisco Marriott  
San Francisco, CA

Sponsored by the:  
Association of Pediatric Program Directors  
In Cooperation with:  
The Center for Continuing Education,  
Tulane University Health Sciences Center

*New Addition This Year:  
Track For Fellowship Directors*

## Continuing Education Credit

### Accreditation

This activity has been planned and implemented in accordance with the Essential Areas and Policies of the Accreditation Council for Continuing Medical Education (ACCME) through the joint sponsorship of Tulane University Health Sciences Center and the Pediatric Academic Societies. Tulane University Health Sciences Center is accredited by the Accreditation Council for Continuing Medical Education to provide continuing medical education for physicians.

### Designation

Tulane University Health Sciences Center designates the APPD educational activity for a maximum of **22.5** credits in Category 1 toward the AMA Physician's Recognition Award. Each physician should claim only those credits that he/she actually spent in the educational activity.

The American Medical Association has determined that physicians not licensed in the United States who participate in this CME activity are eligible for AMA PRA Category 1 credit.

Tulane University Health Sciences Center presents this activity for educational purposes only and does not endorse any product, content of presentation, or exhibit. Participants are expected to utilize their own expertise and judgment while engaged in the practice of medicine. The content of the presentations is provided solely by presenters who have been selected because of their recognized expertise.

### Disclosure Policy

It is the policy of the Center for Continuing Education at Tulane University Health Sciences Center to plan and implement all its educational activities in accordance with the ACCME's Essential Areas and Policies to ensure balance, independence, objectivity and scientific rigor. Prior to presentations, all faculty participating in educational activities certified for Category 1 credit are required to disclose commercial interests and relationships to the educational activity audiences. This disclosure pertains to relationships with pharmaceutical companies, bio-medical device manufacturers or other corporations, whose products or services are related to the subject matter of the presentation topic, including off-label, experimental or investigational use of drugs or devices. Any real or apparent conflicts of interest related to the content of their presentations must be resolved prior to their presentations.

Per the ACCME's *2004 Updated Standards to Ensure the Independence of CME Activities*, faculty are now required to complete a Financial Disclosure statement before the educational activity for review and to resolve conflicts of interest. Disclosure information will be compiled and made available to attendees in the form of a handout. The presenter will be expected to disclose to the audience all information on their form verbally and on a slide at the beginning of the presentation.

### Educational Objectives

At the conclusion of this educational activity, the participant should be better able to:

- Comprehend new information and skills in various areas of basic and clinical pediatric research;
- Apply knowledge gained in all areas of pediatric investigation and practice;
- Understand new tools for teaching and practicing of medicine related to pediatrics.

### Core Competencies

The American Board of Medical Specialties endorses the six General Physician Competencies defined by the ACCME for Maintenance of Certification (MOC) to demonstrate evidence of a physician's commitment to lifelong learning and practice improvement.

- *Patient Care* (gathering information; making informed decisions; managing patient health conditions; performing procedures; educating and counseling patients)
- *Medical Knowledge* (applying established and evolving biomedical, clinical and cognate scientific knowledge)
- *Practice-Based Learning and Improvement* (investigating and improving patient care; appraising and using scientific evidence; using information technology)
- *Interpersonal and Communication Skills* (exchanging information with patients and their families; being a team player)
- *Professionalism* (demonstrating accountability to patients and ethical principles and sensitivity to a diverse patient population)
- *Systems-Based Practice* (being responsive to system needs; practicing cost-effective care; advocating quality care; partnering with managers to improve patient care)

## AAP Credit

This continuing medical education activity has been reviewed by the American Academy of Pediatrics and is acceptable for up to **22.5** AAP credits. These credits can be applied toward the AAP CME/CPD Award available to Fellows and Candidate Fellows of the American Academy of Pediatrics.

## Nursing Credits

Nursing credits are being provided through the Ambulatory Pediatric Association. Please complete the appropriate form at the Continuing Education Desk at Meeting Registration. Provider is approved by the California Board of Registered Nursing, Provider Number CEP 4754, for **22.5** contact hours. Hours should be claimed based on those hours actually spent in an educational activity.

## A Word of Welcome

### Recognition of New Program Directors

In attendance at this meeting are several Program Directors who have begun their duties in the past year. They can be recognized by the "green dot" you'll see on their name badges. Please take a moment to welcome them to APPD.

### First Time Conference Attendees

It is always a pleasure to welcome first time attendees to the APPD Annual Meeting and this year we have a significant number. We urge you to look for the name badges with an "orange dot" so that you may "show them the ropes" and help ensure that their first experience is a pleasant and successful one.

### *A special appreciative note of thanks...*

*...is extended to the members of the APPD Leadership*

<i><b>President</b></i>	Theodore Sectish, MD
<i><b>President-Elect</b></i>	Robert McGregor, MD
<i><b>Secretary-Treasurer</b></i>	Ann Burke, MD
<i><b>Past-President</b></i>	Edwin L. Zalneraitis, MD

#### ***Board of Directors***

Annamaria Church, MD ~ Joseph Gilhooly, MD ~ Susan Guralnick, MD ~ Adam Pallant, MD, PhD

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Cindy Colpitts ~ Therese D'Agostino ~ Mary Gallagher  
Louise Kadane ~ Sally Koons ~ Vanessa Pichette

#### ***Council of Task Force Chairs***

Miriam Bar-on, MD ~ Ann Burke, MD ~ Annamaria Church, MD ~ John Co, MD, MPH  
John Mahan, MD ~ Theodore Sectish, MD ~ Edwin L. Zalneraitis, MD

#### ***Nominating Committee***

Miriam Bar-on, MD ~ Dena Hofkosh, MD ~ Edwin L. Zalneraitis, MD

***Association of Pediatric Program Directors***  
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***Executive Director: Laura Degnon, CAE; Association Manager: Kathy Haynes***

# Program Schedule

## Thursday, April 27

6:30 am	<b>Registration Begins</b>	
7:00-7:30 am	<b>Continental Breakfast</b>	<b>Yerba Buena Gardens - Salon 7</b>
7:30-10:00 am	<b>APPD Special Interest Group (SIG)</b> <i>Dena Hofkosh, MD, University Health Center of Pittsburgh; Lynn Campbell, MD, University of Kentucky Medical Center Program; Jerry Rushton MD, Indiana University School of Medicine</i> The SIG (Special Interest Group) is a key forum during the APPD meeting to allow Program Directors to brainstorm and prioritize issues to discuss. This year the SIG will generate discussion about topics that are most on the minds of Program Directors. By positioning the SIG prior to the plenary session and allowing time for Q&A following the plenary, we hope to provide plenary speakers a list of specific questions to discuss for all APPD attendees.	<b>Yerba Buena Gardens - Salon 8</b>
7:30-10:00 am	<b>Coordinators Sessions</b>	<b>Yerba Buena Gardens - Salon 3-6</b>
7:30-8:30	<b>Welcome/Opening Remarks/Icebreaker</b> , <i>Vanessa Pichette, University of Vermont and Therese D'Agostino, Massachusetts General Hospital</i>	
8:30-9:15	<b>Program Coordinators: Who are we?</b> , <i>Mary Gallagher, Long Island College Hospital/ Beth Israel Medical Center, Brooklyn, NY</i> Does anyone in your department know exactly what you do? Does your immediate supervisor, your Program Director, or your Chairman/Chairwoman realize the amount and diversity of work you are responsible for? Do you have a job description? Does it match what you do? And does your HR department have a copy of it and when was it updated last? If the answer to any of the above questions is no, we need to talk! Attendance at the APPD meetings over the last several years has called my attention to the fact that we are a very diverse group of people with wide-range duties and responsibilities. Many of the coordinators use a job description template from their HR department equivalent to an administrative assistant's position. Those of us who have been in the healthcare field for many years have watched our duties and responsibilities evolve to a much higher plateau while the job description was never updated accordingly. The catch all phrase of ORD (other related duties) should never be indicated on our job descriptions or resumes. Coordinators are the bridge between PD and the residents; between the residents and the attending staff; and between the residents and administration. Take time to reflect and update your job description to illustrate your organizational skills, your knack for problem-solving, your ability to prioritize, and your talent for juggling several projects all at the same time. Remember, a well-written job description is activity focused, not outcome focused and will clarify your job title. It can be brief, but make sure you use objective and summary statements. Make sure your institution realizes you are a multi-talented, integral part of the residency program, which, under the best of circumstances, would not function without your assistance.	
9:15-10:00	<b>Filling your Professional Toolbox: Creating a Job Manual</b> , <i>Michele A. Parsons, The Children's Hospital (UCHSC), Denver, CO</i> The Pediatric Residency Program is very cyclical in nature. The Residency Coordinator is responsible for a multitude of tasks with varying deadlines. Coordinators are often faced with competing priorities and in some cases answer to multiple supervisors. <b>What is the best way for a Residency Coordinator to strategically manage their time and to guarantee success in their role in the GME office?</b> This seminar will explain how to build and use a <i>Job Manual</i> as well as explain why this can be the most valuable tool in your professional tool box. A <i>Job Manual</i> that includes a comprehensive timeline is the blue-print any Residency Coordinator can use to accomplish job tasks with accuracy and timeliness. A <i>Job Manual</i> is an effective planning tool for the Coordinator as well as a resource for the entire GME office. This seminar will instruct Residency Coordinators how to: Build and use an effective Resident Coordinator Job Manual, Build and use a Chief Resident Manual, Identify Professional Resources and Build your Professional Portfolio.	
10:00-10:15 am	<b>Refreshment Break</b>	

10:15 am-12:15 pm	<b>Plenary Session</b>	<b>Yerba Buena Gardens - Salon 8</b>
10:15-10:20	Association of Pediatric Program Directors - Theodore C. Sectish, MD	
10:20-10:25	Residency Review Committee - Carol Carraccio, MD	
10:25-10:30	American Board of Pediatrics - Gail McGuinness, MD	
10:30-10:35	Pediatric Education Steering Committee - Richard Behrman, MD	
10:35-10:40	American Academy of Pediatrics - Robert Perelman, MD	
10:40-10:45	Resident Section, American Academy of Pediatrics - Angela Fimbres, MD	
10:45-10:50	APPD Financial Update - Ann Burke, MD	
10:50-11:00	APPD Awards - Robert McGregor, MD and Carol D. Berkowitz, MD	
11:00-11:05	Recognize Outgoing Leaders - Theodore C. Sectish, MD and Robert McGregor, MD	
11:05-11:10	APPD Election Results - Edwin L. Zalneraitis, MD	
11:10-11:25	Break	
11:25-12:15	Interactive Panel Discussion (Q&A)- Ann Burke, MD, Moderator	
12:15-1:15 pm	<b>Lunch (on your own)</b>	
1:30-4:30 pm	<b>Invited Workshop/Presentation</b>	<b>Yerba Buena Gardens - Salon 8</b>
	HERE COMES GENERATION WHY! INTERACTING WITH THE NEXT GENERATION OF LEARNERS <i>John B. Molitor, PhD, Professor and Assistant Dean, CEO and President, Michigan State University, College of Human Medicine-Flint Campus</i>	
	We now have four generations of learners in our institutions: the Silent Generation, the Baby Boomers, Generation X, and Generation Why. And it is starting to create havoc. Generation Why's attitudes, personalities, technology usage, and beliefs are challenging us in new ways. Come join us in a lively and entertaining session, as you will learn some creative ideas, concepts, and skills you can use to teach and interact more effectively with this new generation of medical students and residents.	
	As a result of this workshop, you will be able to:	
	<ul style="list-style-type: none"> <li>◆ Identify similarities and differences among the four generations</li> <li>◆ Learn new teaching techniques to use with Generation Why</li> <li>◆ Experience some of the conflicts that exist within and among the four Generations</li> </ul>	
	Dr. Molitor is a Professor and Assistant Dean at Michigan State University/College of Human Medicine and serves as the CEO and President for his medical school's Flint Campus. Prior to his current position, he served as his medical school's Dean of Admissions, Student Affairs, and Educational Programs. He is an author, educator, and psychologist. But most importantly, he is one of 10 children, with 25 nieces and nephews, and 14 great nieces and nephews...all of whom are teaching him about the differences among the four generations!	
4:30-6:30 pm	<b>Task Force Meetings</b>	
	LEARNING TECHNOLOGY TASK FORCE <i>John D. Mahan, MD, Task Force Leader</i>	<b>Yerba Buena Gardens - Salon 4</b>
	CURRICULUM TASK FORCE <i>Ann Burke, MD, Task Force Leader</i>	<b>Yerba Buena Gardens - Salon 3</b>
	RESEARCH TASK FORCE <i>John Co, MD, MPH, Task Force Leader</i>	<b>Yerba Buena Gardens - Salon 5</b>
	EVALUATION TASK FORCE <i>Annamaria Church, MD - Task Force Leader</i>	<b>Yerba Buena Gardens - Salon 2</b>
	FACULTY DEVELOPMENT TASK FORCE <i>Miriam Bar-on, MD, Task Force Leader</i>	<b>Yerba Buena Gardens - Salon 6</b>
	<b>Coordinators Executive Committee Meeting</b>	<b>Yerba Buena Gardens - Salon 1</b>

**Note:** Task Force meetings and Regional Breakfasts are open to all attendees. We encourage you to get involved!

**Friday, April 28**

8:00-9:30 am

**Regional breakfasts****New England**ME, NH, MA, CT, VT, RI (*Aida Velez and Ed Zalneraitis, MD*)**Golden Gate Hall B1****New York**NY, Northern NJ (*Mary Gallagher and Susan Guralnick, MD*)**Golden Gate Hall C1****Mid-Atlantic**South NJ, East PA, DE, MD, Wash DC (*Kathy Miller and Cliff Yu, MD*)**Golden Gate Hall A3****Southeast**VA, NC, SC, GA, FL, AL, MS, LA, AR, TN (*Jenny Myers and Marc Majure, MD*)**Golden Gate Hall C2****Mid-America**West PA, OH, WV, KY, IN, MI (*Christine Mayes and Dena Hofkosh, MD*)**Golden Gate Hall B3****Midwest**IL, WI, MN, IA, MO, KS, NE, OK (*Connie Love and Tom George, MD*)**Golden Gate Hall B2****Southwest**TX, AZ (*Judy Behnke and Surendra Varman, MD*)**Golden Gate Hall A1****Western**CA, NV, OR, WA, HI, CO, NM, UT (*Tracie Barnett and Rani Vasan, MD*)**Golden Gate Hall A2**10:00 am-12:00 pm **Workshops I****1. Teamwork: enhance communication and collaboration for patient safety and provider****Yerba Buena Gardens - Salon 14**

*Bonnie O'Connor, PhD, Adam Pallant, MD, PhD, Anne Winch, RN, Brown Medical School, Providence, RI, Suzanne Gordon, University of California San Francisco School of Nursing, San Francisco, CA*

Patient handoffs, resident sign-outs, nursing shift changes, and practitioner duty hour limitations are the daily norm in modern inpatient systems. At the same time, hospital culture typically fosters separation in the multidisciplinary patient care provided by nurses, therapists, residents, attending and subspecialty physicians. Multiple groups working in relative isolation pose significant risk for medical error, and can foster a sense of competition instead of collaboration. The goal of this workshop is to demonstrate and create practical means and methods to break down barriers to effective collaboration and partnership amongst caregivers. We will draw upon experience and successful models used in other high risk industries and settings to elucidate effective approaches to enhancing teamwork and safety. Participants in this workshop will have a hands-on practicum in team building methods, and should be able to leave the workshop with practical examples and concepts to deploy at the home institution. Additionally, the workshop will enhance programs' abilities to bulk up their training and documentation in the ACGME core competencies of Communication and Systems Based Practice for their own RRC accreditation.

**2. Everyone has a Say: Implementing 360 Degree Evaluations****Yerba Buena Gardens - Salon 5-6**

*Miriam Bar-on, MD, Loyola University Medical Center, Maywood, IL, Franklin Trimm, MD, University of South Alabama, Mobile, AL*

The evolution of competence from medical expertise and clinical decision making to the current ACGME competency domains has forced educators to look at different methods of learner assessment. The January 2006 version of the Residency Requirements require input into the evaluation process from ancillary health personnel and patients/parents. Once used exclusively in the business world, the 360 degree or multisource evaluation has become a popular method to assess these new competency domains and collect the necessary data. This workshop will be highly interactive. After a brief didactic introduction to the 360 degree evaluation, attendees will have the opportunity to develop a 360 degree evaluation for a fictitious residency program. Working in small groups, participants will create various aspects of a 360 degree evaluation. The groups will then reconvene to discuss their individual instruments and share with the whole group examples of newly designed questions. The leaders will facilitate a discussion on giving evaluation feedback to residents from the 360 degree evaluation, using role plays to demonstrate challenging situations. At the conclusion of the workshop, participants will have samples of 360 evaluations developed by the individual groups representing the various constituent groups participating in this process. Attendees will also receive an annotated handout along with slides used by the presenters.

**3. Recruitment Challenges - The Real Fear Factor****Yerba Buena Gardens - Salon 3-4**

*Melodie Parker, BS, Baylor College of Medicine, Houston, TX, June Dailey, C-TAGME, Indiana University, Indianapolis, IN, Tony Mauro, LSW, Children's Hospital of Philadelphia, Philadelphia, PA*

This workshop will be an interactive discussion lead by coordinators from three of the largest pediatric training programs in the US. Each program recruits for 30-40 residents per year and interviews 250-400 applicants each season.

Whether recruiting for one or 40 residents per year, this workshop will encourage group discussions regarding challenges each person in the target audience faces during the recruitment process from time management to personal crisis. Coping skills will

10:00 am-12:00 pm, Workshops I, continued

be introduced that will allow each participant to take away one or more skills that will assist them in managing the recruitment process more effectively. Time management skills will be shared that have allowed the team leaders to recruit successfully for the past 20 years. Audience participation will be encouraged by breaking into small groups with a specific topic for discussion and then reporting back to the target audience. Tip sheets may be provided from audience participation by e-mail once tallies have been completed if interested.

#### **4. Exploring the Family Friendly Workplace: The FOPO Report of the Task Force on Women**

**Yerba Buena Gardens - Salon 2**

*Ann E. Burke, MD, Wright State University, Dayton, OH, Adam Pallant, MD, PhD, Brown Medical School, Providence, RI*

Background: The Federation of Pediatric Organizations (FOPO) released a "Report of the Task Force on Women in Pediatrics" in April 2005. This document outlines specific recommendations through the whole spectrum of pediatrics from medical students to senior faculty. The recommendations are aimed at goals, which address issues of "family balance in the lives of pediatricians during training and practice, including concerns regarding productivity, career advancement and individual fulfillment." All of the pediatric organizations have been asked to consider, modify and endorse the specific goals. The membership of the APPD should be deeply involved in this process and dialogue, as the goals will have significant impact on training programs. Objectives: To open a dialogue about family friendly issues in residency training. These issues will include flexibility for extended leave, accommodations for lactation, resources for childcare, non-traditional residency training schedules and general work/life balance concerns. Description: An overview of the report with a detailed look at the six residency training recommendations will be shared with participants. The next segment will involve an open and engaging discussion of various points of view. Extended leave policies, financial barriers, definitions of family friendly environments and part-time residencies will be reviewed and discussed with active input from participants. After this lively discussion, participants will self-select a group. Each of the groups will discuss in detail their 1-2 specific assigned FOPO Task Force Summary recommendations. Groups will work for approximately 40 minutes. Each group will verbally summarize, for all workshop participants, issues raised on their group's specific recommendations regarding feasibility, barriers, possible improvement in language and additional ideas/concepts. The final goal of the workshop is to begin to lay the foundation of pragmatic approaches to residency designs that incorporate personal, family and professional fulfillment. This discussion and work will be conveyed to the chair of FOPO.

#### **5. No Competency Left Behind - Professionalism in Residency Training**

**Yerba Buena Gardens - Salon 13**

*Ann P. Guillot, MD, Garrick A. Applebee, MD, Vanessa Pichette, Meredith Monahan, MD, Vermont Children's Hospital, Burlington, VT*

Professionalism (as outlined in the ACGME General Competencies) is hard to define, and therefore difficult to teach and evaluate. We believe that developing a skill set that allows residents to work well and supportively with colleagues will increase success in a career that requires commitment to patients, community, colleagues and family.

Participants in this workshop will:

- Discuss historical perspectives of professionalism;
- Hear about the current curriculum at University of Vermont/Vermont Children's Hospital;
- Discuss successes and challenges in our program over the past several years;
- Discuss specific examples throughout all levels of training with the goal of producing pediatricians who are sensitive and responsive to their colleagues, to their work group, and to their patients;
- Discuss how curricular development of Professionalism has a positive impact on attainment of other General Competencies, especially Interpersonal and Communication Skills, as well as Practice Based Learning and Improvement;
- Participate in small groups to develop workable solutions to obstacles and challenges that are occurring in their own programs.

#### **6. Using Simulation to Orient Residents and Fellows to the NICU:**

**Yerba Buena Gardens - Salon 15**

##### **Applying High Fidelity Simulation Techniques with Practical Low Tech Tools**

*Louis P. Halamek, MD, Theodore C. Sectish, MD, Kimberly A. Yaeger, RN, Allison M. Murphy, MD, Suzanne Swanson, MD, Julie Lipps, MD, Kristi Boyle, RN, NNP, Stanford University, Palo Alto, CA*

High fidelity simulation has been used successfully to train professionals in a number of high risk domains and recently has been applied to physician education. The Center for Advanced Pediatric Education at Stanford (CAPE) has developed an array of clinical scenarios to train residents, fellows and other members of the multidisciplinary medical team in a number of complex medical domains.

This workshop, led by the director of CAPE and other Stanford faculty, will present the evidence that exists in the medical and educational literature regarding the use of simulation-based training in residency and fellowship programs and demonstrate

*description continued on next page*

through sample videos the types of skills training that can be enhanced by using simulation-based methodologies. Examples of training in the cognitive, technical and behavioral skills necessary for successful delivery room resuscitation, perinatal counseling, ECMO crises and other pediatric clinical care situations will be shown and used as discussion topics.

The workshop will feature small group activities focused on: 1) scenario design, 2) video recording using inexpensive technologies, 3) constructive debriefing, 4) formal trainee and program evaluation and 5) other elements of program development that are necessary to sustain a successful simulation-based training program.

**7. Nothing You Learned in Med School Taught You to Be a Manager: Effectively Managing Non-Physician Professional Staff** **Yerba Buena Gardens - Salon 12**

*Hilary M. Haftel, MD, MHPE, Mary Ellen Bozynski, MD, MS, Casey White, PhD, University of Michigan, Ann Arbor, MI*

Physicians enter the medical education realm with many responsibilities. They function as content experts, models for clinical practice and self-directed learning, and frame the overarching curriculum of medical education. The knowledge required to perform these functions comes from their own education and clinical experience. With the responsibilities of medical education leadership, however, comes job functions for which physicians are often poorly trained: dealing with regulatory bodies such as the RRC and ACGME, the difficulty of teaching in both the inpatient and ambulatory settings, and the complexities of scheduling and documentation of professional competence. In addition, today's medical pedagogy is supplemented by newer processes and technologies, such as computer-based learning and medical simulation technologies. These responsibilities require the physician-educator to interact with and frequently manage professional, technical, and clerical support staff. The medical curriculum does not educate the physician in management skills, thus leaving the physician-educator poorly equipped to manage their professional staff. As with any new pedagogy, development is needed to provide physicians with a grounding in basic management skills. Objectives: The specific objectives of the workshop are (1) Provide an understanding of general management tools for managing staff; (2) Understand one's own strengths and weakness in managing non-physician staff; (3) Develop skills necessary to troubleshoot Human Resource issues, solve HR problems, and facilitate professional development of staff.

Format: Attendees will participate in large and small group activities to achieve the knowledge, skills, and attitudes needed to develop a successful management style aligned with their own strengths and weaknesses. Emphasis will be placed on the development and use of a management model at the local level. Participants will be expected to develop skills to apply the model knowledgeably, while accounting for their individual style to apply these skills at their own institutions.

**8. Learning Styles/Emotional Intelligence - Methods to Better Assist Your Residents' Learning** **Yerba Buena Gardens - Salon 10-11**

*John D. Mahan, MD, Karen E. Heiser, PhD, Leslie K. Mihalov, MD, Raj Donthi, MD, Children's Hospital, Columbus, OH*

Learning styles (LS) describe the preferred ways individuals concentrate, process, internalize and remember new and difficult material. They are perceptual strengths that define best ways of interacting with and retaining information. Learning styles (auditory, visual and kinesthetic) and processing styles (global, analytic and mixed) are innate and variably affect residents' acquisition of knowledge, skills and attitudes. LS may be defined via standardized tests or by attention to learning techniques preferred by residents, fellows and faculty. Better understanding of the diverse styles and "teaching" to the styles of the learners can generate more interest and improved learning.

Emotional intelligence (EI) describes the capacity to recognize the meaning of one's own feelings and those of others to more effectively motivate and manage emotions in relationships with others. Emotional intelligence, although largely innate, can be developed in individuals and understanding EI can help teachers and learners be more successful. In support of self-directed learning, better grasp of LS and EI can help residents develop self-awareness and foster good decisions in self and relationship management.

Successful completion of this workshop will allow the participant to understand and integrate LS into clinical teaching and learning, define the impact of EI in teaching and learning and apply LS and EI principles to promote a positive learning environment for residents.

Participants will 1) learn about the principles of LS and EI, 2) become familiar with several standardized assessment tools applicable to pediatric residents and 3) understand methods to define LS and EI by observation of residents "at work". Participants will be asked to address four challenging clinical education problems (people and situations) via small group problem solving of scenarios. At the end, the facilitators will provide feedback on the efforts of the small groups, discuss how programs may incorporate these processes into their activities and provide further resource materials for the participants.



12:00-1:00 pm

**Lunch (on your own)**  
**Regional Chairs Luncheon**  
**Council of Task Force Chairs Luncheon**

Laurel  
Willow

1:00-3:00 pm

**Workshops II****9. Organizational Diagnosis: How Healthy is Your Program?****Yerba Buena Gardens - Salon 2**

*Christiane Corriveau, MD, Children's National Medical Center, Karen Smith, MD, Hospital for Sick Children, Ira Todd Cohen, MD, Children's National Medical Center, Washington, DC*

A paradigm shift has forced academic medicine into the world of business. In today's competitive healthcare market, an academic clinician's value is often defined as their billable encounters or extramural funding and not the intangible values they contribute to the overall mission of the institution. Academic Health Centers (AHC) often focus on return on investment (ROI) as opposed to recognizing the strengths of their human capital. Personnel are an organization's most valuable assets, making employee (faculty) satisfaction, development, and retention paramount concerns.

This workshop will familiarize physicians in leadership positions with business terminology and models, enabling them to diagnose the health of their organization as well as demonstrate their departments and its members as economic value added. After introductions and statement of objectives, workshop attendees will form small groups to perform a SWOT analysis (Strengths, Weaknesses, Opportunities, Threats) of an academic clinician in an AHC. Viewing the AHC as an Open System, each group will report on their SWOT findings creating a diagnostic diagram. Reformulated groups will use the open system schematic to 1) Assess System Fits, 2) Examine Interdependencies, and 3) Identify System Gaps.

After a short break, participants may choose among other diagnostic tools, such as 1) the Six-Box Model, 2) Stream Analysis, 3) Strategy Formulations, and 4) Force-Field Diagrams. By performing these activities the participants will come to appreciate their role in the survival and success of the AHC. Participants will gain an organizational perspective of faculty contribution and the importance of 1) Investing in Human Capital, 2) Return on Investment, and 3) Adding Economic Value. The importance of being aligned with your organization's strategic plan will be highlighted. Concluding feedback will focus on how each participant will apply their new knowledge and skills at their own institutions.

**10. Putting the "Practice" into Practice Based Learning and Improvement****Yerba Buena Gardens - Salon 3-4**

*Adam Pallant, MD, PhD, Bonnie O'Connor, PhD, Michael Kelly, MD, Karen Sullivan, MD, Cedric Priebe, MD, Brown Medical School, Providence, RI*

While the ACGME has mandated that all American residency training programs teach and evaluate self-improvement techniques, many program directors continue to struggle with how to implement this practice into their regular curriculum.

The goal of this workshop is to provide participants with a "basket" of tools and methods to accomplish this competency goal in a practical fashion that can fit their own residency or fellowship program. Examples of readily adaptable techniques demonstrated will include: approaches to the design of robust 360° evaluations, construction of effective individual learning plans, documentation of evidence based medicine exercises, and board preparation strategies. Additionally, participants will learn how to utilize several web-based resources to enhance knowledge as well as to improve documentation of resident attainment of learning goals.

Facilitated discussions will provide a forum for participants to discuss successes and obstacles to realistic implementation of PBLI methods that are responsive to individual institutions' needs while also satisfying ACGME requirements.

**11. Speaking the Unspoken: Using a Reflection Group to Teach Professionalism****Yerba Buena Gardens - Salon 13**

*Dana M. Brazdziunas, MD, Ruby Roy, MD, Lisa Martin, MD, Miriam Bar-on, MD, Pediatrics-Loyola University Medical Center, Maywood, IL*

Competency-based education mandates that medical educators teach and evaluate professionalism, which has been traditionally learned informally through role modeling. Teaching professionalism is a new challenge requiring creativity and innovation. Self-awareness and an understanding of doctors as healers with complex relationships with patients are at the foundation of professionalism. Key issues include identifying and addressing our own feelings and stress, promoting self-care, finding meaning in our work, and caring for our colleagues and patients. To address these issues, we have used a model of sharing personal reflections in a facilitated group to support the resident professional development. The goal of these sessions was to foster group process and sharing among the residents to develop mutual support and encourage professional self-awareness.

Two years ago we started a facilitated reflection group, for residents, to focus on issues relevant to professionalism and humanism. Faculty facilitators were trained in leading such groups. The sessions are comprised of a topic introduction (through a story, poem or video), followed by reflection, discussion and an appropriate closing. Faculty facilitators choose topics based on resident interest, select the introduction, and then encourage residents to share their experiences. Active listening to each

1:00-3:00 pm, Workshops II continued

other is encouraged; judging and advice-giving is discouraged. The sessions remain confidential and are limited to residents and facilitators. Residents have shared experiences of vulnerability, strength, frustration and inspiration in ways rarely seen in typical educational formats. End of session evaluations comment on the value of being listened to and having a chance to talk with colleagues in a novel way.

Our workshop will address issues in teaching professionalism. We will demonstrate a reflection group with workshop participants followed by debriefing and discussion of the issues inherent in this model of teaching. Attendees will gain an understanding of the reflection model through experiencing it. References and handouts will be provided.

**12. The Community Pediatrics Toolbelt: Something Every Resident Should Wear**

**Yerba Buena Gardens - Salon 14**

*Jeffrey Kaczorowski, MD, AAP Community Pediatrics Training Initiative, Rochester, NY, Lewis First, MD, University of Vermont, Burlington, VT*

During this interactive workshop, practical tools and resources will be presented to help residents, individually and in groups, make a difference in their communities and achieve and exceed competencies/requirements in community pediatrics. Participants and faculty will share tools and resources developed at their own institutions, and the national Community Pediatrics Training Initiative will provide resources, tools, and web linkages for training in community health and child advocacy.

Program participants will learn the status of community pediatrics training on a national level from surveys of pediatric residency programs conducted by the Dyson Initiative National Evaluation. They will have the opportunity to benchmark their individual program's development with this national data, including resident training in community settings and involvement in legislative, advocacy, and community research activities. They will also learn about important trends and developments in community pediatrics training from surveys conducted in 2002 and 2005, including didactic and experiential teaching regarding community health topics and advocacy. Programs will then generate their own "report cards" and develop action plans to achieve their next community pediatrics training goals.

Achievement of progress in these goals will be tied to competencies and will be facilitated by interaction with other participants and faculty with experience in teaching evidence-based community health, resident project development, leadership skills, legislative advocacy, and community collaboration. All workshop participants will acquire a clear understanding of community pediatrics competencies, national developments and resources, and practical next steps and tools to enhance residency training at their own programs. Participants will also have the opportunity to continue to learn/share their experiences after the workshop by posting their residency training progress on the AAP Community Pediatrics Training Initiative website, joining the list serve there, and reviewing the progress of/communicating with other participants and faculty.

**13. Can the Circle Stay Unbroken? Modeling Communication & Professionalism in a Residency Program Administration**

**Yerba Buena Gardens - Salon 10-11**

*Therese D'Agostino, Mass General Hospital for Children, Boston, MA, Vanessa Pichette, Vermont Children's Hospital, Burlington, VT, Emmett Schmidt, MD, PhD, Mass General Hospital for Children, Boston, MA, Ann P. Guillot, MD, Vermont Children's Hospital, Burlington, VT, John Co, MD, MPH, Mass General Hospital for Children, Boston, MA, Garrick A. Applebee, MD, Meredith Monahan, MD, Vermont Children's Hospital, Burlington, VT*

Good team dynamics help create an effective residency program administration. By role modeling appropriate interpersonal communication and professional behavior, the program administration enhances the resident's training experience and also supports these attributes as part of competency based residency education training.

The Mass General Hospital for Children and the Vermont Children's Hospital Pediatric Administrative Teams will demonstrate:

- How good team dynamics help to create an effective residency program
- The importance of weekly meetings, effective communications tools, and affirmative stances
- How the use of these tools helps to enhance the quality of the residency program
- The systems used at both programs and their successes and challenges
- How input and information from each team member allows the resident to feel supported in their role.

**14. Check-out Right, Tuck Them in Tight! Teaching the Art of Resident Sign-out**

**Yerba Buena Gardens - Salon 5-6**

*Patricia Baxter, Vanessa Carlo, Steven Selbst, Department of Pediatrics, Thomas Jefferson University, A.I. duPont Hospital for Children, Wilmington DE, Gary Frank, Emory University School of Medicine, Scottish Rite Hospital, Atlanta, GA, Keith Mann, Department of Pediatrics, Thomas Jefferson University, A.I. duPont Hospital for Children, Wilmington DE*

The resident sign-out process has been described as "a precarious exchange" and "one of the most poorly examined transactions in medicine." The transfer of vital information to on-call resident physicians "often happens in a remarkably haphazard

1:00-3:00 pm, *Workshops II continued*

manner." This "discontinuity of care" may lead to medical errors and inappropriate patient management. Pediatric interns do not receive adequate education and are not given clear expectations regarding the sign-out process. Clearly, poor physician communication contributes to the large number of medical errors in our nation's hospitals.

The purpose of this workshop is to share ideas and to develop a dynamic curriculum to facilitate effective, safe hospital sign-out. Workshop leaders will discuss several key elements that are crucial for improving the check-out process, including:

- 1) Teaching residents good listening skills and effective communication techniques for transfer of patient care from one physician to another.
- 2) Preparing residents to prioritize patient care needs
- 3) Standardizing essential patient information for continuity of care
- 4) Avoiding the transmission of old or inaccurate data
- 5) Developing an integrated computerized sign-out document that automatically queries the hospital's information database
- 6) Demonstrating various sign-out systems (e.g. Word processor, PDA, Web-based, Integrated).
- 7) Incorporating faculty and nurse participation without diminishing the role of the resident leader.

Obstacles to effective, safe sign-out will be discussed and participants will be asked to share their ideas and experiences. It is expected that participants will be able to develop a program at their own institutions to enhance concise communication skills and effectively transfer patient information.

### 15. "It's Totally Mod-ular": Training Residents in DBP

Yerba Buena Gardens - Salon 12

*Steven J. Parker, MD, Marilyn Augustyn, MD, Boston Combined Residency Program, Boston, MA*

Several changes in the pediatric world over the last 10 years have shifted the focus of primary care towards developmental issues. Qualified pediatricians have, for the first time, been awarded official subspecialty designation as DBP specialists. The Pediatric Residency Review Committee (RRC) has mandated that all Pediatric Residency Training programs must devote at least two months to DBP training to maintain accreditation. Yet in spite of this, the capacity for individual residency programs to provide comprehensive training in this critical area has been variable and often strained. Many programs are "DBP resource poor" and struggle with finding innovative programs to convey this important subject matter. This workshop will explore a DVD based series of modules on issues in primary called, "Developmental and Behavioral Pediatrics Educational Tools for Residency Training: The Preschool Years." These 24 modules are to be used as either preclinic conference, 1 hour didactic sessions or individual meetings on topics with residents. All 24 modules have sections with goals, pre-engagement activities, didactic materials, video or case based examples, finding the words and further references. This workshop will familiarize attendees with these specific modules as well as the basic principals of teaching residents about DBP using both examples of modules and opportunities for audience members to "teach" their fellow participants using the modules. All attendees will receive complementary copies of the DVD.

### 16. Dealing Effectively with Conflict is not Easy

Yerba Buena Gardens - Salon 15

*Fred A. McCurdy, MD, PhD, MBA, Texas Tech Pediatrics (Amarillo), Amarillo, TX*

Even though many people avoid or retreat from conflict, it is an essential and ubiquitous part of organizational life. Disagreements and conflict are essential to spark creativity and innovation within an organization. They also encourage personal growth. Therefore the goal of this workshop is to allow the participant to become more comfortable with managing disagreements and conflict. During this workshop, the participants will first understand their preferred strategies for dealing with conflict. A game will teach them new insights into the dynamics of conflict. The concept of principled negotiation will be developed that will give them new tools to use when they are in conflict with someone. Finally, they will participate in role playing exercises where they will use the new conflict management tools they have learned to deal with conflict in a constructive and positive way. Thus, at the end of this workshop the participants will:

- ◆ Understand their preferred strategies for handling conflict
- ◆ Be able to list the sources of conflict in organizations
- ◆ Know the different alternatives for responding to conflict
- ◆ Have the opportunity to use the mnemonic MANAGE CONFLICTS to aid them in understanding of the concept of principled negotiation in managing conflict
- ◆ Have the opportunity to role-play situations where they have to apply negotiation strategies to conflict resolution

3:00-3:30 pm

**Refreshment Break**

3:30-5:30 pm

**Workshops III**

### 17. Curriculum Task Force: Interactive Symposium of Curricular Tools for Practice Based Learning and Improvement

Yerba Buena Gardens - Salon 10-11

*Ann E. Burke, MD, Wright State University, Dayton, OH, Robert Englander, MD, MPH, University of Connecticut, Hartford, CT*

Background: Curricula in pediatric graduate medical education cover a wide range of material in the traditional competencies

3:30-5:30 pm, Workshops III continued

of medical knowledge and patient care areas. There are additional competencies that now need to be taught to pediatric residents. These additional competencies are possibly more difficult to define, and therefore increasingly time consuming to develop curriculum around. One of the more conceptually nebulous, non-traditional competencies is Practice Based Learning and Improvement (PBLI). In a survey of our membership, 95% of the respondents reported that they would utilize a curriculum developed by others in PBLI. This was the highest for any of the competencies. For the question "areas of curriculum development for which a workshop would be helpful," respondents selected PBLI as their first choice among eight subject areas. There appears to be a large need in disseminating ideas and information about curricula in PBLI. Objective: To share and disseminate curricular ideas and methods utilized in various programs to teach PBLI. These ideas and methods will be conveyed to the participants via practical examples of curricular practices in real programs. Participants will work in small groups to further brainstorm and work on solidifying their ideas for curricula in PBLI. Description: The first 80 minutes will consist of various program directors presenting 10-15 minute condensed explanations of what they are doing in their programs to teach PBLI. These will be solicited prior to the meeting from program directors on the Curriculum Task Force and poster proposals received by the APPD pertaining to PBLI. This segment of the workshop will be similar to a platform presentation session with two moderators. The last 40 minutes will be a brainstorming discussion of additional ways and variations to teach PBLI. The brainstorming will be triggered by the previous presentations. The workshop participants will be broken into two smaller groups for this 40 minute time slot. Ideas generated and presentations will be posted on the APPD Curriculum Task Force website.

### 18. *Teaching Through Guided Learning Experiences*

Yerba Buena Gardens - Salon 14

Marc Majure, MD, Todd Bell, MD, Jeremy Baker, MD, Karin Minter, MD, Duke University, Durham, NC

In 1999, the ACGME approved six domains representing areas of skill and knowledge in which residents are expected to demonstrate competency prior to graduation. While the residency experience is rich with opportunity to learn the skills, areas of knowledge, and behaviors embodied in the six competencies, much of the teaching to which residents are exposed centers on transmission of information rather than the construction of the skills, behaviors, and knowledge necessary to become competent in the field of pediatrics. This workshop will first review the concepts of competency-based teaching. Inherent in this construct is the goal that learning will transfer beyond the initial learning situation to become incorporated into everyday practice enabling residents to spontaneously restructure knowledge in adaptive response to the radically changing situational demands of medicine. With this background, participants will explore the use of Guided Learning Experiences as a tool to provide experience-based learning scenarios which direct the attention of the learner to the concepts requisite to the competency process. The eBook will be introduced as a media venue that can be utilized to present the material in either large or small group settings as well as an individual, self-paced learning experience. In an interactive large group setting and smaller workgroups, participants will utilize the information presented in the first part of the workshop to design a short competency-based curriculum focused on basic intern skills. Workgroups of participants will suggest scenarios that could be used as guided learning experiences to teach individual skills. At the workshop conclusion, volunteers will be solicited to continue this work and complete the curriculum. Completed guided educational experiences will be placed in individual eBooks and the complete library will be placed on a compact disc. Participants desiring the curriculum will receive a copy after completion.

### 19. *"The Resistant Learner"- Engaging your Faculty in Teaching and Assessing the Competencies*

Yerba Buena Gardens - Salon 3-4

Miriam E. Bar-on, MD, Loyola University Medical Center, Maywood, IL, Susan Guralnick, MD, Stony Brook University Medical Center, Stony Brook, NY, Surendra Varma, MD, Texas Tech University Health Sciences Center, Lubbock, TX

Program directors are very familiar with the ACGME professional competencies. Implementing them into one's curriculum can be challenging. The concept of competencies varies between individuals; however, expectations from both the ACGME and especially the RRC are very specific. The new requirements specify faculty need to be educated *both to teach and assess the performance of residents in achieving the 6 ACGME domains of competence. Faculty development...must go beyond attendance at an occasional formal lecture...engaged in meaningful activities, such as curriculum development and/or workshops...*

This workshop has been designed to help program directors meet this goal. The workshop will begin with framing the competency domains in ways in which faculty can relate. Rotation planning with the focus on competency integration will be discussed and examples presented. Techniques for developing rotation specific direct observation and or competency attainment documentation will be offered. Barriers to bringing faculty on board will also be addressed. Participants will then be asked to work in small groups to simulate curriculum development of a specific rotation including assessment strategies. Suggestions from the group will be collected for workshop topics and methods and will be distributed following the meeting. Handouts with examples of content and design will be provided.

**20. What We Have is Failure to Communicate-  
Teaching Residents the Art of Effective Communication**

Yerba Buena Gardens - Salon 5-6

*Steven Selbst, MD, Kate Cronan, MD, Keith Mann, MD, Department of Pediatrics, Thomas Jefferson University, A. I. duPont Hospital for Children, Wilmington, DE, Kathleen Bradford, MD, University of North Carolina, Chapel Hill, NC, Lindsey Lane, MD, Parul Patel, MD, Department of Pediatrics, Thomas Jefferson University, A. I. duPont Hospital for Children, Wilmington, DE*

Poor communication is a major problem in medical practice. Miscommunication between physicians and patients / parents can erode feelings of trust and engender dissatisfaction. Miscommunication between physicians and other medical staff leads to numerous errors and many malpractice lawsuits. The ACGME now requires that residents demonstrate competence in communication and interpersonal skills. Unfortunately, most pediatric residencies have not yet developed formal programs to teach communication skills. Good communication is an art that must be taught and cannot be left to chance. The purpose of this workshop is to share ideas and to develop a dynamic and rewarding curriculum that teaches residents effective communication skills. Workshop leaders will discuss several elements that are crucial to house staff training including: 1) Developing good listening skills to address concerns of parents and patients. 2) Managing the difficult patient-conflict resolution. 3) Delivering bad news. 4) Obtaining informed consent. 5) Giving feedback to junior residents and medical students. 6) Transmitting essential information at morning rounds and signout. 7) Improving interactions with nursing staff to enhance teamwork and reduce tension. 7) Interacting professionally with medical colleagues and consultants. Case scenarios, videotapes and role-playing will be used to demonstrate successful communication techniques and underscore pitfalls. The importance of empathy and non-verbal gestures will be highlighted. Participants will be asked to share their ideas and experiences for enhancing communication skills. It is hoped that participants will be able to develop an effective program in their own institutions to address skillful communication. Important references will be provided.

**21. Balint Groups for Pediatric Residents: An Alternative  
Method of Meeting ACGME Competencies**

Yerba Buena Gardens - Salon 13

*William I. Cohen, MD, Pediatrics, Developmental-Behavioral Pediatrics, Pittsburgh, PA, Richard B. Addison, PhD, Family Practice Residency Program, Sutter Medical Center, Santa Rosa, CA*

Balint groups have long been used in family medicine residency programs to help the physician develop a more empathic understanding of the doctor-patient relationship and therefore be better able to care for the patient. The group meets regularly and follows an experiential, case-based format. The case is usually a continuity patient whom the doctor finds challenging to care for. The group members listen to the presenting doctor's story and then discuss the case, with a focus on the relationship not on treatment options. The leaders invite the group to reflect on the presenter's situation. In addition, the group is invited to consider the patient's point of view.

Balint groups differ from support groups in that they are case-based and focused on the dilemma of the presenting physician in caring for a challenging patient. In addition, solutions and prescriptions are avoided: rather, the goal is to develop an understanding of the factors that lead to the presenter's distress or frustration. The leader's role is central in keeping the group from straying to a didactic, instructive mode.

The ACGME competency requirements have been a source of great discussion at APPD programs. Balint groups provide a method which addresses many of these competencies and associated required skills, especially in the areas of patient care, interpersonal and communication skills, and professionalism. Material spelling out how Balint groups address the ACGME requirements will be distributed.

This workshop will introduce the Balint method. Following a short description of the Balint method, participants will have the opportunity to experience being a member of Balint group, followed by a debriefing session. This provides the best opportunity for understanding how this group differs from other case-based discussions. Lastly, the faculty will entertain questions and discuss practical matters of how to organize Balint groups in residency training, as well as the resources available to establish and support Balint work in Pediatrics.

**22. Professionalism: Curriculum and Assessment**

Yerba Buena Gardens - Salon 12

*John G. Frohna, MD, University of Michigan Program, Ann Arbor, MI; Carol Carraccio, MD, University of Maryland, Baltimore, MD; Edwin Zalneraitis, MD, University of Connecticut, Hartford, CT*

This workshop will identify opportunities to update curriculum materials and consider teaching tools and assessment methods for professionalism. It will include an interactive component to develop scenarios and other approaches to teaching and evaluation of this area of general competence. Those particularly interested in this area of competence, who would like to help begin further development of this area, are urged to attend.

### 23. Implementing ACGME Competencies into Fellowship Training Programs: How to get Ready for Your Next Site Visit

Yerba Buena Gardens - Salon 2

Joseph T. Gilhooly, MD, Cindy Ferrell, MD, MEd, Oregon Health & Science University, Portland, OR, Theodore Sectish, MD, Stanford University, Palo Alto, CA, John Mahan, MD, Children's Hospital/The Ohio State University, Columbus, OH

This workshop will assist fellowship program directors in creating an outcomes based educational curriculum for their fellows to include 1) competency-based goals and objectives, 2) identification of instructional methods, and 3) selecting evaluation tools from the "ACGME Toolbox". Participants will learn how to use and evaluate portfolios as a method to collect learning activities and evaluations. This workshop will feature a "bottom up" approach to implementing the competencies by examining what your fellowship is doing currently for fellows and placing these activities into a competency framework. Residency and fellowship directors will also discuss ways to integrate activities to accomplish common competency-based educational goals. In preparation for the workshop we will encourage participants to prepare in advance by 1) Bringing any goals and objectives in current use, 2) Browse the APA website at [www.ampeds.org/egwebnew](http://www.ampeds.org/egwebnew) to see goals and objectives written in competency-based language and determine if these examples are applicable for fellow training (download and bring to workshop), and 3) be able to review all current evaluation tools used in the program and identify all current educational activities such as in-training exams, journal clubs, M&M, human investigation training, etc.

- |           |                                                                                                                                            |
|-----------|--------------------------------------------------------------------------------------------------------------------------------------------|
| 3:30-4:45 | Hands on curriculum development<br>How to write competency based objectives<br>Choosing instructional methods<br>Identify evaluation tools |
| 4:45-5:00 | Using portfolios to document resident competency                                                                                           |
| 5:00-5:30 | Future steps, wrap up, and open discussion                                                                                                 |

### 24. Coordinators' Session

Yerba Buena Gardens - Salon 15

- |           |                                                                                                                                                                                             |
|-----------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 3:30-4:00 | Update from the American Board of Pediatrics (ABP), <i>Esther Foster, Chapel Hill, NC</i>                                                                                                   |
| 4:00-4:30 | Update from Electronic Residency Application Service (ERAS), <i>Vanessa Pichette, Vermont Children's Hospital, Burlington, VT and Therese D'Agostino, Mass General Hospital, Boston, MA</i> |
| 4:30-5:30 | Education Commission for Foreign Medical Graduates (ECFMG), <i>Stephen Seeling, JD, Philadelphia, PA</i>                                                                                    |

5:30-6:30 pm

Posters with exhibits and Wine/Cheese Reception

Yerba Buena Gardens - Salon 7

#### Poster # 1 (abstract 1012)

##### USMLE STEP 1 SCORES AS A SIGNIFICANT PREDICTOR OF FUTURE BOARD PASSAGE IN PEDIATRICS

*Quimby E. McCaskill, MD, MPH, Jim J. Kirk, DO, Dawn M. Barata, BA, Elisa A. Zenni, MD, Thomas T. Chiu, MD, MBA, University of Florida/Jacksonville, Peter S. Wludyka, PhD, University of North Florida, Jacksonville, FL*

Purpose: To explore the relationship(s) between USMLE, In-Training Exam and American Board of Pediatric (ABP) board-certifying exam scores within a Pediatric residency-training program. Methods: Data was abstracted from the records of graduated residents from the Department of Pediatrics at the University of Florida/Jacksonville from 1999 to 2004. Sixty-one (61) residents were identified and their files were reviewed for the following information: USMLE Step 1 and 2 scores (if available), in-training exam scores and eventual board scores as reported by the ABP. Correlational and regression analyses were performed and Receiver Operating Characteristic (ROC) curves were compared to evaluate the overall screening power of the tests by comparing their Area Under the Curves (AUC). Results: The correlation coefficients between USMLE, in-training exam, and ABP scores were all statistically significant. In addition, USMLE Step 1 scores showed a strong correlation with board performance. Interestingly, **none** of the three in-training exam scores had any additional impact on predicting board performance given one's USMLE Step 1 score. Step 1 scores greater than 220 were associated with nearly a 100% passage rate on the board-certifying exam. Conclusions: The data suggests that performance on Step 1 of the USMLE is an important predictor of a resident's chances of passing the pediatric boards. This information, which is available when a resident begins training, can be used to identify those at risk of not passing the boards. Individual learning plans can then be implemented early in training to maximize one's ability to pass the certifying exam.

#### Poster # 2 (abstract 1032)

##### IMPACT OF A TEACHING ROTATION ON RESIDENTS' ATTITUDES TOWARD TEACHING

*Jodi Richardson, MD, Khanh-Van Le-Bucklin, MD, UC Irvine, Orange, CA*

Introduction: Residents spend a large part of their training teaching medical students and other residents. Recognizing the tremendous role that residents play in medical education, many residency programs have instituted formal instruction on teaching. Previous studies have shown improvement in residents' teaching skills following training on teaching. A prior study using open-ended interview questions found a qualitative improvement in residents' enthusiasm for teaching after participa-

5:30-6:30 pm, Posters with exhibits and Wine/Cheese Reception continued

tion in a teaching curriculum. This study was conducted to quantitatively evaluate the impact of a teaching rotation on residents' attitudes toward teaching. Methods: Residents participated in a one month teaching rotation. The rotation included didactic sessions on lecturing, teaching in various clinical settings, and providing constructive feedback. Residents practiced these skills by lecturing at conferences and by teaching in the outpatient and inpatient settings. Before and after the rotation, residents anonymously filled out surveys with questions focused on their attitude towards teaching. The data was analyzed using a two-tailed t-test with independent variables and a one-way ANOVA followed by a post test. Results: Three categories showed significant improvement including feeling prepared to teach (28% increase,  $P=0.0045$ ), having confidence in their teaching ability (22% increase,  $P=0.0041$ ), and being aware of their expectations as a teacher (28% increase,  $P=0.0014$ ). There was an increase in the level of enthusiasm (8% increase) and a more healthy level of anxiety about teaching (10% increase), but the p-values did not reach a significant range ( $P=0.063$  and  $P=0.103$ ). The level of enthusiasm started high and was significantly higher on the pretest than the level of preparedness, confidence, and awareness of expectations ( $P<0.05$ ). Conclusion: Residents are enthusiastic about teaching and their level of enthusiasm remains high following a teaching rotation. Despite the persistence of a certain degree of anxiety, residents feel more prepared to teach, more confident in their teaching ability, and more aware of their expectations as a teacher following a formal teaching rotation.

### Poster # 3 (abstract 1049)

#### EVALUATION AND UTILIZATION OF A PEDIATRIC INTERNET CURRICULUM

*Dawn S. Tuell, MD, Debra Q. Mills, MD, Rebecca Powers MD, Karen Schetzina MD, East Tennessee State University, Johnson City, TN*

Background: In recent years, the Accreditation Council for Graduate Medical Education (ACGME), and the Ambulatory Pediatric Association (APA) have developed detailed resident learning objectives and competencies. Maintaining adequate documentation that residents are fulfilling these objectives and competencies is a challenge. Objectives: To develop and evaluate use of an internet based curriculum, EPIC (East Tennessee Pediatric Internet Curriculum) to facilitate teaching and evaluation of the core competencies. Methods: Goals and content for the site were developed based on literature review and input from a pediatric internet committee. Resident internet-based learning is being evaluated using pre- and post- surveys over a six month period. Results: EPIC is a central location for residents to access information, including announcements, phone lists, and scheduling information. Educational content is organized around the six core competencies for resident education. For example, "Medical Knowledge" consists of a portfolio system developed for the ambulatory clinic. Portfolios include a checklist of pertinent information to be covered during a patient encounter and a related downloadable article to enhance resident knowledge. The section also includes links to other learning resources. An interactive discussion forum exists to facilitate discourse on medical and residency-related topics. Residents also complete online pre- and post- test questions during every clinical rotation and receive instant feedback on their responses. All 11 residents completed the pre-survey. Frequent or very frequent internet use was reported by 54% of residents to answer specific clinical questions and 45% of residents for general medical learning during the work day. Conclusion: Pediatric residents already utilize the internet to access medical information. EPIC accommodates residents' varying schedules and is a useful adjunct to other teaching and evaluation methods.

### Poster # 4 (abstract 1055)

#### THE PERIOD OF PURPLE CRYING: A RESIDENT ADVOCACY PROJECT TO REDUCE THE INCIDENCE OF SHAKEN BABY SYNDROME

*Hillary A. Tuttle, MD, PhD, Cynthia L. Ferrell, MD, MEd, Oregon Health and Science University, Portland, OR*

Child advocacy is an important part of pediatric residency training. The advocacy curriculum at Oregon Health & Science University (OHSU) includes an advocacy lecture series coupled with longitudinal resident team projects. The OHSU Period of Purple Crying Program is the result of a 2-year advocacy project developed by 6 pediatric residents and 1 faculty mentor with the financial support of the Department of Pediatrics. Shaken Baby Syndrome (SBS) causes serious injuries to infants including blindness, developmental delay, neurologic devastation, seizures, and even death. The Period of Purple Crying program is an educational program for new parents directed at informing them about the normal patterns of crying and the risks of Shaken Baby Syndrome. The program is distributed by the National Center on Shaken Baby Syndrome and has been shown to decrease the incidence of SBS in communities such as New York where the average number of forceful shaking cases dropped from 6.5 to 2.5 per year within 3 years of program initiation. Our advocacy project was developed in an attempt to model the success of New York's program and reduce the incidence of SBS in our community. As a part of the advocacy curriculum, our advocacy team was given the time and support to investigate the Period of Purple Crying program, develop a program budget, submit a request for departmental support and create an implementation plan. The program has been unanimously accepted by all providers of maternal/newborn care at our institution. We are currently in the stage of educating nurses, social workers, and physicians about SBS and the Period of Purple Crying program and hope to implement it in early 2006. This project is evidence that an advocacy program that couples education with pediatric resident teamwork can result in projects that may directly affect our community and the welfare of our patients.

5:30-6:30 pm, Posters with exhibits and Wine/Cheese Reception continued

**Poster # 5 (abstract 1056)**

**FOCUSING ON "DO ONE": A PROCEDURE WORKSHOP**

*Miriam E. Bar-on, MD, Lisa A. Martin, MD, Francis McBee-Orzulak, MD, Karin Vander Ploeg Booth, MD, Loyola University Medical Center, Maywood, IL*

Residents have traditionally learned to perform procedures by first seeing senior colleagues and then doing the procedures with supervisors' guidance. Formal training in the performance of procedures has not been included in most training programs' curricula. Thus, potential flaws in procedural skills are passed from resident to resident. In addition, many procedures at academic medical centers are now performed by ancillary healthcare personnel, reducing learning and practice opportunities for residents. These basic procedures remain integral to practical pediatrics, especially in less urban areas. In its new iteration, the Residency Requirements for General Pediatrics state: *The program must document instruction in the performance of procedures including indications, contraindications, and complications. As part of procedural competence, residents must be able to obtain informed consent and address the pain that is associated with procedures.* To address these issues, we developed a half day workshop for intern orientation. Funding was obtained through an educational grant and was used primarily to purchase pediatric anatomic models on which procedures could be taught and practiced. Teaching modules were designed around five specific procedural skills: venipuncture, arterial stick, IO insertion, IV placement and lumbar puncture. Content for each skill station included: indications, contraindications, complications, equipment needed, anatomy, positioning of the patient, description of procedure, and sterile technique. Handouts were provided. The workshop began with a didactic session on both obtaining informed consent and on patient safety. The rest of the workshop consisted of five skills stations, where a faculty member or chief resident instructed 2-3 interns. Interns practiced at each skill station until they successfully completed the procedure and felt they could do it on patients. Interns unanimously rated the workshop very highly. Workshop outcomes have not been assessed at the present time but need to be measured.

**Poster # 6 (abstract 1059)**

**A DICTATION CURRICULUM FOR PEDIATRIC RESIDENTS**

*Naghme Moshtael, MD, MA, Carrie A. Phillipi, MD, PhD, Cindy L. Ferrell, MD, MEd, Joseph T. Gilhooly, MD, Oregon Health & Science University, Portland, OR*

Introduction: Accurate and efficient communication between health providers, patients and families is critical to the practice of medicine. A component of physician communication is written documentation including discharge summaries, operative notes, and letters to referring physicians. The timeliness and accuracy of dictations has financial, legal and medical ramifications. Very few residency programs provide formal education on this topic. To our knowledge, there are no studies demonstrating that education coupled with positive reinforcement can improve the quality and timeliness of dictated discharge summaries. To improve the quality and timeliness of dictated discharge summaries, we implemented a formal dictation curriculum for pediatric residents at OHSU. We will assess the effects of education coupled with positive reinforcement system on dictations of discharge summaries. Methods: Our intervention was based on education, dictation of a fictive patient and on-going evaluation of PL-1 inpatient dictations. IRB approval was obtained prior to study initiation. 1. Didactic component: a two-hour educational module was held during pediatric residents' noon conference. The module included practical instructions on dictation of discharge summaries. Residents who attended were placed in the experimental group. The remainder will serve as controls. 2. Dictation of fictive patient's discharge summary: 13 out of 13 PL-1s and 5 residents (PL2 and PL3s) completed this stage. Investigators are evaluating these dictations using a validated scoring sheet. 3. On-going evaluation of discharge summaries: a sample of 2-3 discharge summaries completed by PL-1s during their inpatient rotation will be evaluated using aforementioned evaluation tool. Based on the quality and timeliness of the dictation, one intern per month will receive a monetary award for outstanding performance. Results: Investigators are currently tabulating the results of the study. Final results will be available in spring 2006.

**Poster # 7 (abstract 1070)**

**RESIDENT ESCALATION POLICY**

*Susan K. Lovich, MD, MPH, Inova Fairfax Hospital for Children, Falls Church, VA*

When analyzing the root causes of patient safety events, failure to communicate and failure to escalate are commonly identified. As part of resident supervision, the pediatric residency program at Inova Fairfax Hospital for Children has created a policy providing a standard procedure for efficient and effective communication of adverse changes in a patient's condition. This includes delineating the escalation and communication of concerns to the next level of appropriate care. The policy defines and gives examples of specific conditions in which a resident must discuss a patient with his/her immediate supervisor. These include: conditions warranting ordering any studies STAT, a staff member or parent expressing significant concern regarding a patient's condition, conditions requiring increasing oxygen or other respiratory support, a lab or other study result that is unexplained/concerning, significant changes in vital signs, significant pain of unexplained etiology, and a patient too fussy, uncooperative, or otherwise obscuring the physical exam. Residents and other medical care providers are required to use the SBAR tool when communicating critical information. Each item of SBAR is a brief and concise statement: S: Situation- the current problem of the patient B: Background- pertinent background information relevant to the current situation A: Assessment - highlighting relevant information R: Recommendation- an opinion of what the communicator thinks should be done. To enhance resident education in an acute setting while addressing patient safety, the policy states that the supervising



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resident addresses the patient's condition by examining the patient and reviewing tests and procedures with the concerned resident and by escalating the level of care if necessary. The program has been accepted well by our residents. The policy has been adopted by the entire hospital and includes medical students, nursing and other patient care providers. We will track the policy's efficacy over the next year by examining the number of patient safety events with the root cause of failure to communicate/escalate by trainees.

#### Poster # 8 (abstract 1081)

##### **IF COWS COULD FLY: AN INTENSIVE EVIDENCE-BASED MEDICINE PROGRAM FOR RESIDENTS**

*Gautham K. Suresh, MD, DM, MS, George Johnson, MD, Ronald J. Teufel, MD, Joel Cochran, MD, Laura Cousineau, MLS, Lyndon Key, MD, Medical University of South Carolina, Charleston, SC*

**Background:** Residency training should include learning of the principles and practice of evidence-based medicine (EBM). However, few residency programs have a structured program to teach EBM. **Objective:** To develop and implement a phased evidence-based medicine teaching program in a residency program. **Methods:** Program development consisted of selection of 3 faculty members and a librarian for EBM teaching, with a team leader; training of faculty in the principles and methods of teaching EBM, prior to the arrival of new interns; development of an EBM curriculum; assessment of baseline EBM knowledge of new interns using the Fresno test; a series of lectures and exercises to teach EBM principles to new interns; assignment of interns to 3 teams, each assigned to a faculty member; weekly guided discussions within the intern teams around structured clinical questions; generation of clinical questions using an EBM format from cases presented in morning report; rapid literature searching using laptop computers on wheels (COW's); creation of evidence summaries related to such questions by the intern teams, with faculty guidance; formal presentation of evidence summaries during subsequent morning reports; close involvement of the pediatric residency director and the chief residents in this process; and strong encouragement from the department chair for the entire program. **Future Plans** include creation of web-based resources and tools to support EBM practice; creation of in-depth evidence summaries around selected clinical subjects, one by each intern team; and spreading the EBM culture to other faculty members and residents. The curriculum will continue in the second year with additional studies to answer questions unanswered by current literature. In year three, the residents will become the teachers and authors of the EBM experience under the guidance of faculty coaches.

#### Poster # 9 (abstract 1093)

##### **RESIDENT AND CONTINUITY CLINIC PRECEPTOR PERCEPTIONS OF THE EFFECTS OF RESTRICTED WORK HOURS**

*Dorene Balmer, PhD, Children's Hospital of Philadelphia, Philadelphia, PA*

**Objective:** The impact of ACGME's Duty Hour Standard (DHS) on longitudinal patient care has stimulated discussion, yet little is known about how it affects the only longitudinal learning relationship in pediatric residency, the resident-continuity clinic preceptor (CCP) relationship. **Purpose:** This case study of one continuity clinic in an urban, primary care center, used qualitative methods to explore pediatric residents and their CCP's perceptions of the effects of the DHS on the resident-CCP learning relationship. **Methods:** Direct observation of ten 3rd year residents and their CCPs, who had worked together in clinic before and after the DHS, was carried out for 5 months. Semi-structured, audio-taped interviews were conducted with residents before and after observation; exit interviews were conducted with CCPs. Data were managed with ATLAS software and thematically analyzed. **Results:** Postcall clinic was eliminated to meet program requirements without violating the DHS; residents were rescheduled to clinic on another day and worked less frequently with "home" CCPs. The cost of eliminating postcall clinic, disruption in the resident-CCP relationship, was perceived differently by residents and CCPs. From the residents' perspective, their schedules were "more shuffled," but their continuity experience was improved because they worked with "non-home" CCPs with different practice styles. From the CCPs' perspective, "shuffling clinic" limited their ability to tailor teaching, evaluate progress, and nurture a mentoring relationship. Residents did not openly express their positive views of the impact of the DHS in the presence of CCPs, but echoed the sentiment of CCPs by lamenting the "loosening of the ties." **Discussion:** An unintended consequence of the DHS was disruption in the resident-CCP relationship and alteration of what residents learn in this context, including professionalism. Overall, residents viewed the impact of DHS more positively than CCPs. Understanding the multiple realities of residents and CCPs extends the discussion of the impact of the DHS in new areas.

#### Poster # 10 (abstract 1106)

##### **INTEGRATED LEARNING: INCORPORATING BOARD REVIEW INTO THE CURRICULUM**

*Nicole S. M. George, MD, Valera L. Hudson, MD, Leila Stallworth, MD, Medical College of Georgia Department of Pediatrics, Augusta, GA*

In response to In-Training Examination (ITE) scores below target levels, preparation for the Pediatrics Certifying Examination was incorporated into resident training and education. Despite satisfactory program passing rates of 88% on the Certifying Examination, an aggressive approach to board preparation was adopted. A weekly intern reading group, incorporation of board review questions into morning reports and noon conferences, and assigned board preparation questions during outpatient rotations were the foundations of this new approach. The utilization of board review questions ensures that residents are able to correlate clinical and testable knowledge. The weekly intern reading group consisted of 2-3 interns on outpatient rotations along with 2-3 senior residents. The interns would choose review topics from the content specifications provided by the American Board of Pediatrics and present a one page review of the subject to the group. Morning report cases were diversified

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such that general cases were presented twice per week and subspecialty and neonatal cases each presented once per week. Following discussion of the patient's hospital course and relevant clinical decision making, the case was concluded with 3 pertinent board review questions. The noon conference curriculum was developed to provide equal general pediatric and subspecialty topics. Presenters would disperse related board review questions throughout their presentations. The questions were asked in a multiple choice format and the discussants were able to answer the questions anonymously using a keypad response system. The system displayed the distribution of correct and incorrect answers. This provided further discussion clarifying keywords and concepts on which to focus. Although ongoing assessment continues, preliminary results indicate success in our efforts. When compared to the national change in mean score from the 2004 to the 2005 ITE, our PGY2s and PGY3s changed the mean 36.5% and 21% higher respectively. In addition, verbal feedback from residents and faculty indicates increased satisfaction in the overall board review process.

**Poster # 11 (abstract 1111)**

**FAMILY-CENTERED VERSUS TRADITIONAL WARD ROUNDS: IMPACT ON RESIDENT EDUCATION AND FAMILY SATISFACTION. A PILOT STUDY**

*Divya-Devi Joshi, MD, FAAP, Marshfield Clinic, Marshfield, WI*

**INTRODUCTION:** Rounds are a focal point of resident education on the wards, improving knowledge base, professionalism and critical thinking. They are also the main contact families have with the medical team. Rounds most frequently occur with the health care team alone at first, after which the plan is communicated to the patient and family. **QUESTION:** Can the learning experience for the residents be maintained while improving patient/family integration into the rounding process? **METHODS:** This pilot study was conducted in our pediatric oncology population. Patients were divided into those admitted for chemotherapy only and those with acute illness. Eight families each experienced traditional and family-centered rounds. Three experienced residents and one attending physician participated. **RESULTS:** All residents preferred family-centered rounds because of closer contact with the family and greater involvement of families in discussion and planning. Teaching during rounds did not suffer, but tended to happen more before or after the interaction with families. Seven of the 8 patients/families preferred family-centered rounds. One family didn't have a preference. The duration of rounds was the same in 7 of 8 cases. **CONCLUSIONS:** Residents and families prefer family-centered to traditional rounds. For a complex patient, pre-rounding is advisable. The best way to approach bedside discussions without causing parental anxiety or confusion remains to be found.

**Poster # 12 (abstract 1116)**

**FACTORS ASSOCIATED WITH CAREER SATISFACTION AND SUCCESS FOR PEDIATRIC PROGRAM DIRECTORS**

*Adam Pallant, MD, PhD, Bonnie O'Connor, PhD, Brown Medical School, Providence, RI, John Hayes, PhD, John Mahan, MD, The Ohio State University COMPH, Columbus, OH*

To better understand PD duties and satisfaction, pediatric PD members of the APPD were surveyed in 2004; 161 PDs responded for a 61% response rate. Results: Pediatric PDs were relatively new in their positions, with 50% of PDs in that role for five years or less. The overwhelming majority of pediatric program directors were not in tenure track positions. Less than 1/3 of respondents indicated confidence that they would be in that position in five years. The vast majority of pediatric training programs also provided training to non-pediatric resident learners. As a group, pediatric PDs were satisfied with their positions and spent more time in the administration of their residency programs than time allotted in their job descriptions. Most PDs viewed their salary as unsatisfactory until salary surpassed the \$130,000-\$140,000 range. PDs identified "lack of time," "lack of resources", "lack of support staff," and "RRC regulations" as the most significant impediments to career satisfaction. Based on principal factor analysis, PD satisfaction could be separated into satisfaction with resources and general satisfaction with the career. By multiple regression analysis, administrative support, input into the budget, cost of living increases, salary, academic rank, and number of med/peds residents accounted for 52% of the variance associated with PD satisfaction with resources ( $R=.72, P<.001$ ). Number of categorical residents, support from an assistant PD, and quantity of secretarial support were the only factors associated with general career satisfaction but accounted for only 12% of the variance for this response ( $R=.35, P<.001$ ). Conclusions: 1) Pediatric PDs were generally satisfied with their positions, 2) Pediatric PDs identified lack of time, resources and support staff, as well as RRC regulations as most important impediments to career satisfaction and success, 3) Factors associated with satisfaction with resources (administrative support, salary issues, and academic rank) were more easily identified by PDs than factors that were associated with general career satisfaction.

**Poster # 13 (abstract 1117)**

**QUALITY IMPROVEMENT IN ACTION DEMONSTRATES IMPROVED OUTCOMES**

*Victoria W. Rogers, MD, Deana C. Voudrie, The Barbara Bush Children's Hospital, Portland, ME*

The goal of our project was to implement and measure the effectiveness of a QI curriculum in a residency program which allows residents dedicated time to learn about population-based healthcare and to improve management of patients with asthma. The curriculum was designed to schedule dedicated time for residents as part of their Ambulatory Care Block Month Rotation. We developed and implemented the curriculum to incorporate System-based Practice and Practice-based Learning and Improvement competencies into the learning experience. To teach the chart review process, we developed a tool and a process for chart review and data analysis. The chart review process was conducted by creating a registry of patients who carried a diagnosis of asthma. The residents first reviewed the charts in 2003, implemented changes and then reviewed the

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charts in 2004. We found significant improved process outcomes for the majority of the individual resident and team reviews. Although the numbers are small, this type of QI project allowed the residents to get a real time feel for population-based healthcare, clinical outcomes for asthma, and practice based learning. The residents also started to see themselves as part of a team. After the trial period, we reported findings in a workshop to the learners and clinic staff. We learned to link new ideas to requirements. Adding new elements to an overcrowded curriculum can be challenging but if these ideas meet other program requirements, the ideas will become more sustainable. We achieved better results by applying the concepts from learning experiences to real life. Early on we learned to involve the learners in the curriculum development and to create healthy competition. By sharing the data at various points along the way, learners see how they compare to their peers and the national guidelines. After the trial period we decided to expand the model. We applied this model of teaching QI to other chronic conditions as well as to preventive health care. We moved to make this to a longitudinal model of QI which ties to rotations in order to promote the concepts of lifelong learning through quality improvement.

#### Poster # 14 (abstract 1118)

##### EVALUATING CLINICAL COMPETENCY OF PEDIATRIC RESIDENTS IN A CONTINUITY CLINIC

*Lisa Gilmer, MD, University of Kansas, Kansas City, KS*

**Background** The purpose is to pilot an observational tool to evaluate resident clinical competence. An essential component of the tool is direct observation of residents by faculty which provides a basis for feedback to reinforce strong skills and to correct deficiencies. After comparing various types of observations, actual clinical encounters were chosen to reduce costs and maximize time for patient care and education. Standardized checklists, developed by ambulatory pediatricians, were also incorporated into the tool. **Objectives** 1) Document the feasibility, satisfaction and reliability of a formative evaluation of resident performance using review and checklist scoring of recorded clinical encounters. 2) Determine if the quality of resident performance in recorded clinical encounters correlates with other performance measures. **Design/Methods** All pediatric residents participated. Residents received information about the study, completed demographics and were orientated to consent and privacy issues. Four well child encounters were studied- newborn, 1 year old, kindergarten and early adolescent visits. PGY 1 residents will have each encounter recorded once a semester. PGY 2 and 3 residents will have each encounter recorded once. For each encounter, HIPAA consent was obtained and the visit was digitally recorded. All residents reviewed their own performances. PGY 1 residents and their clinic preceptors had Performance Meetings within 2 weeks of the encounter to review the recording for quality and completeness. Satisfaction for faculty and residents will be examined using focus groups. Trained raters will also score the recordings using the checklists. **Results** The demographic surveys are completed, residents are working on their first semester set of recordings, reviews and Performance Meetings. **Anticipated Conclusions** 1) Performance Meetings are feasible and satisfactory. 2) Checklists are a reliable measure of resident performance. 3) The complete tool is a valid measure of resident performance.

#### Poster # 15 (abstract 1129)

##### EVALUATING THE OSCE

*Susan Gottlieb, MD, The Brooklyn Hospital Center, Brooklyn, NY*

**Background:** Residents are increasingly being assessed using competency-based, authentic and formative measures such as the OSCE. **Objective:** To document residents' knowledge and perceptions of the OSCE at the time of their first assessment. **Design/Methods:** Pre and post OSCE questionnaires, designed specifically for this study, were completed by all residents who participated. Questionnaires addressed the purpose of the OSCE, its utility as a tool for assessment and feedback, and its comparison to more familiar evaluation methods. Subjects were all participating first year pediatric residents (N=9) who did the OSCE in May, 2005 and all third year residents (N=11) who did the OSCE in October, 2005. **Results:** First year residents felt significantly more anxious about the OSCE than did their seniors (6 vs. 1,  $\chi^2(1) = 7.21, p < .01$ ). 89% of first years and 63% of third years felt the OSCE was helpful in assessing what they knew. 89% of first years and 73% of third years felt that the OSCE provided useful feedback. Neither group (22% of first years and 0% of third years) would have preferred taking a short answer test. More third years than first years (55% vs. 22%) preferred direct preceptor observation as an evaluation method. The majority of both groups would have preferred doing the OSCE earlier in the year. 44% of first years and 55% of third years would like to do the OSCE more than once a year. **Conclusion:** The OSCE proved to be an acceptable tool, from the residents' perspective, for assessment and the provision of feedback.

#### Poster # 16 (abstract 1132)

##### A WALK IN THE PARC: TRAINING IN ADVOCACY AND COMMUNITY PEDIATRICS FOR PEDIATRIC RESIDENTS

*Benjamin Hoffman, MD, University of New Mexico, Albuquerque, NM*

Structured experiences in community pediatrics and pediatric advocacy are required by the pediatric RRC. At the University of New Mexico, this mandate was addressed through the development of a longitudinal 2 year curriculum known as the Pediatric Advocacy, Rural and Community (PARC) program. The curriculum was developed by a general pediatrician with experience in both rural pediatrics and community based advocacy. The curriculum consists of 2 structured 1 month rotations, 1 in each of the first 2 years of training. In the PL-1 rotation, residents gain skills in community assessment through completion of windshield surveys, photo essays and advocacy case analyses. They gain better understanding of their community through home visitations, WIC and Medicaid visits, and experiences in teen health centers on nearby Indian Reservations. They gain skills in legislative advocacy through a 2 day workshop and experiences at the state legislature. They gain basic skills in advocacy work

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through development of a proposal for an advocacy project and reflective exercises. In the PL-2 year, each resident travels to the Navajo Nation to work as a rural health care provider with Indian Health Service pediatricians. There they make home visits on the reservation and gain an appreciation for the IHS system, practice differences based on cultural and geographic factors, and lifestyle issues. In addition, they continue their growth as clinicians under the guidance of experienced community based faculty. This poster will describe in greater detail the curriculum, funding resources and provide suggestions on the design and implementation of a curriculum and community pediatrics and advocacy.

**Poster # 17 (abstract 1134)**

**REFORMULATING PEDIATRIC RESIDENCY GOALS AND OBJECTIVES IN A COMPETENCY-BASED FORMAT BY A COMMITTEE OF EDUCATION REPRESENTATIVES**

*Joan P. Cain, MD, Monique Naifeh, MD, Kristen Stevens, MD, Oklahoma University Health Sciences Center, Oklahoma City, OK*

In September 2004 a committee of Education Representatives (one from each rotation) was formed to work on the Goals and Objectives project. The aim was three-fold: to reformulate goals and objectives in a format which reflected the 6 competency areas; to produce user-friendly documents which would be reviewed during rotations and would also provide a template for board review; to find a way to make the goals and objectives readily available to residents and faculty. The Initial focus was on ways in which the competencies were already being taught or could be taught and evaluated in the program. In December 2004 Diane Kittredge presented grand rounds at our institution on competency based education, and conducted a seminar for the committee on the Ambulatory Pediatric Association (APA) on-line goals and objectives project, which she had chaired. The committee then chose a template, which included headings for the six competencies and columns to list teaching and evaluation methods. The program director and the chief residents created drafts for each rotation from the material on the APA website. Committee members then took those drafts to their sections for discussion and editing. By June 2005, most of the goals and objectives had been loaded on a new educational website. The idea of developing an educational website grew out of the Education Representatives committee. This website (see separate poster) can be accessed by residents and faculty either within the hospital or from home. Residents are encouraged to review goals and objectives on-line prior to the first day of each rotation. Faculty members are also encouraged to review goals and objectives with residents early in the rotation. Personal computers with internet access are available in ward team rooms so that goals and objectives (and other educational resources on the website) can be accessed during rounds. A mandatory rotation evaluation includes questions for residents about whether goals and objectives have been discussed and whether that process was educational.

**Poster # 18 (abstract 1137)**

**RESNET - CREATION OF AN INTERNAL EDUCATIONAL WEBSITE AS A RESIDENCY RESOURCE**

*Joan P. Cain, MD, Monique Naifeh, MD, Kristen Stevens, MD, Mark Wuest, Oklahoma University Health Sciences Center, Oklahoma City, OK*

The idea of creating an educational website came from a committee that was formed to reformulate rotation goals and objectives in a competency-based format (see separate poster). Initially the website was conceptualized as a way to make goals and objectives readily available as working documents. The website uses Microsoft SharePoint Services on a Windows2003 platform to set up a SharePoint Portal Website. It can be used to share documents and photo collections. It can also link to other websites and to surveys. The website has several layers. From the home page the resident can access items such as the current call schedule, the daily conference schedule and announcements about upcoming social and educational events. Links give ready access to other frequently used sites such as Case Log, Pedialink and local sites for evaluation of rotations and faculty. In addition each rotation has a designated work-space. The residency program requires the loading of goals and objectives and an orientation document for each rotation. In addition many sections have loaded other educational resources on their workspaces. Examples include in-house protocols (e.g. DKA, Sickle Cell Pain), AAP Practice Guidelines (e.g. Asthma, UTI, ADHD), selected articles, review questions from the AAP PREP series for self assessment and study, details of items to be gathered on specific rotations for collection in resident portfolios, video clips of procedures with commentary (e.g. CVL placement). In addition each workspace can link to other relevant sites. Examples include a link from Genetics to OMIM, a link from Infectious Disease to the CDC site, a link from Heme/Onc to the Children's Oncology Group. The website is password protected. All residents and pediatrics faculty have access to the website and can access it from the hospital or from home. The IT advisor, the residency program director and the chief residents have editing access for the entire site while one designated faculty member from each section has editing access to the rotation workspace. PCs are available in all team rooms so that resources can be accessed during rounds.

**Poster # 19 (abstract 1144)**

**TOUCHPOINTS™ TRAINING AS A HOSPITAL-WIDE STRUCTURED SYSTEM FOR TEACHING INTERPERSONAL SKILLS AND PROFESSIONALISM TO PEDIATRIC RESIDENTS**

*Nancy Deacon, DO, Charles Katz, PhD, Karen Long, BSN, RNC, Kirby D. Rekedal, MD, Carolyn Zagury, RN, PhD, The Children's Hospital at Monmouth Medical Center, Long Branch, NJ*

In order to teach Interpersonal Skills and Communication and Professionalism (IS&C/P) we had to establish a sound comprehensive conceptual framework of what these are. We needed to decipher how doctors build relationships, how they learn to

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communicate, and how they can be evaluated and improved in these processes. Furthermore the conceptual basis for this must be teachable and learnable on all levels of experience. A general pediatrician in practice for several years in our community found an ideal basis for teaching these skills in the Touchpoints model, and brought it to our hospital and residency program. Touchpoints training emphasizes building positive empathic relations with the developing family system, rather than the traditional doctor-directed prescriptive relationship. Our goal was to use Touchpoints training to cause a paradigm shift in resident-family relationships, from a linear, deficit oriented view to a model of joining in the multidimensional development of the family. Creating a work environment globally conducive to awareness of and improvements in IS&C/P requires drawing support and contributions from all major hospital disciplines. We held a series of intensive two-day-long training sessions for mixed groups of residents, faculty and community attendings, nurses, and other healthcare professionals to establish the foundation for shared concepts and a common language of relationship-building. These trainings are repeated 3-4 times a year, and are followed by regular reflective supervision sessions. Nurses, attending physicians, and other professionals participate in these reflective sessions with the residents, and weekly psychosocial rounds use the same Touchpoints approach. The program has been very well received by the residents and participants from all major disciplines. Multidisciplinary outcome studies are currently underway.

#### Poster # 20 (abstract 1146)

##### PROFESSIONALISM AND THE MATCH

*Richard P. Shugerman, MD, Heather A. McPhillips, MD, MPH, University of Washington, Doug Diekema, MD, MPH, CHRMC Center for Pediatric Bioethics, Wendy S. Swanson, MD, MBE, Doug Opel, MD, Sarah Archibald, MD, Joshua Weldin, MD, University of Washington, Seattle, WA*

In its Statement on Professionalism, the National Resident Matching Program has acknowledged that the Match Participation Agreement permits program directors and applicants to "express a high degree of interest" in each other. Each year, however, one of the most commonly reported violations to the NRMP is from applicants who mistakenly believed they were "promised" positions in a given program due to misunderstandings and/or misleading statements from program directors or others in a residency program. The NRMP professionalism statement is clear that statements implying commitment are prohibited and that "program directors, institutional officials, and medical school officials should avoid making misleading statements and at all times display a professional code of behavior in their interactions with applicants." This poster will review NRMP policies on contact between applicants and programs and will illustrate an ethical analysis of the methods of contact with applicants that focuses on perceptions, expectations, legality and professionalism. We will also review 3 years of survey data collected from applicants to our program regarding their perceptions of our stated "no call" policy. Of 372 applicants who returned the survey (response rate = 50%), 312 (89%) stated that a recruiting call would not have caused them to rank our program differently, 32 (8%) stated a phone call from us would have caused them to rank our program more favorably and 10 (3%) would have ranked our program less favorably.

#### Poster # 21 (abstract 1147)

##### HOW WELL ARE WE TEACHING CULTURAL COMPETENCY? USE OF STANDARDIZED PATIENTS TO ASSESS CULTURAL COMMUNICATION SKILLS

*Hilary M. Haftel, MD, MHPE, Mary Ellen Bozynski, MD, MS, University of Michigan, Ann Arbor, MI*

**Purpose:** Understanding and appreciating the influence of culture on patients and medical practice is a core competency of medical education. While there are many approaches to delivering a curriculum on sociocultural medicine, there are few reliable methods of assessing its efficacy. The Pediatric Residency at the University of Michigan has implemented a broad-based curriculum in cultural competency including workshops, web-based learning, and reflective practice. To measure the effectiveness of this curriculum, a Standardized Patient exercise was developed for the end of the first post-graduate year. The purpose of this study was to measure the effectiveness of the Standardized Patient for assessing communication skills in cultural competency and the satisfaction of the trainees with the education experience. **Methods:** A Standardized Patient scenario was developed for the task of providing informed consent to a non-English-speaking parent of a child requiring a procedure. Two standardized patients were utilized: a parent and an interpreter. Separate checklists were developed for each SP. **Results:** 45 first year houseofficers (100%) participated in the exercise over a two year period. The SPs scored performance on both clinical content (providing informed consent) and cultural content (cultural sensitivity and use of an interpreter) reliably and with acceptable spread. All residents performed in an acceptable manner, while areas of weakness were identified and remediated. Residents were highly satisfied with the educational experience. **Conclusions:** It is crucial to document competency in core communication skills, such as cultural competency. Use of a standardized patient can be a reliable and reproducible method of assessing these critical communication skills.

#### Poster # 22 (abstract 1148)

##### TEACHING RESIDENTS ON SHIFTS: THE USE OF COMPUTER-BASED INSTRUCTION IN THE PEDIATRIC EMERGENCY DEPARTMENT

*Martha S. Wright, MD, Rainbow Babies and Children's Hospital, Cleveland, OH*

Background: A challenge faced by resident educators is to identify alternate methods of delivery for didactic education during rotations that require shift work. The traditional group lecture format is often impractical in settings like the PED where shifts

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may be staggered and a critical mass of residents is available only during times of high patient volume. Computer-based instruction that allows for asynchronous learning may satisfactorily address the residents' needs for education on relevant core topics without interfering with patient care activities. Methods: Using the authoring software Lectora 2004, a computer-based instructional program that incorporated 23 Pediatric Emergency Medicine (PEM) topics identified by the PEM faculty was designed and made available to our pediatric residents on either CD-ROM or on the hospital computer shared drive. Each topic section includes a Powerpoint presentation, pertinent references in pdf format, supplemental materials (e.g. institution-specific clinical guidelines) and a quiz. The quiz feature of Lectora allows for immediate quiz results feedback to the resident and Program Director notification of residents' participation on completion of the exercise. Since introduction of this module, residents have been required to review 5 presentations during each 4-week block in the PED and satisfactorily complete the associated quizzes. Evaluation: Formative feedback on content, format and functionality was obtained from PEM faculty and Chief Residents prior to field testing. Preliminary resident feedback assessed ease of use, content and relevance; 70% reported satisfaction with the computer-based format. Collection of formative feedback from the residents is on-going. Conclusion: Alternate methods of instructional delivery may improve the resident educator's ability to provide content instruction to residents on rotations with shift-based schedules.

#### Poster # 23 (abstract 1150)

##### TEACHING "INTERN SKILLS": A CASE-BASED APPROACH

*Martha S. Wright, MD, Shreelata Durbhakula, MD, Rahul Rathod, MD, James Strainic, MD, Rainbow Babies and Children's Hospital, Cleveland, OH*

Background: Success in internship is often facilitated by early acquisition of resident-related administrative skills. Mastery of skills such as preparation of appropriate sign-out, prioritization of patient care tasks, effective presentations on rounds or by phone and development of a system for organizing patient information allows an intern to concentrate on developing competency in other patient-care related areas like interpretation of patient data and development of patient care plans. Methods: Intern Morning Report occurs one morning a week in our program under the supervision of the Pediatric Chief Residents. Using an active patient case for discussion, the Chief Residents address both clinical and administrative teaching objectives. Administrative objectives are achieved using a variety of educational techniques in the context of the case, including role-play ("present this patient to your attending on the phone"), review of examples (appraisal of actual sign-outs) and practice (prioritize the tasks on the patient's to-do list). On occasion, junior residents are invited to model effective organization systems or describe their successful approaches to duty hour compliance. Evaluation: Intern feedback on these conferences is uniformly favorable. Qualitative analysis of comments reveals three main themes; relief to know that their colleagues are struggling with similar issues, satisfaction in learning tips from each other and from more senior residents and belief that these discussions have assisted their progress in skill acquisition. The Chief Residents have found this forum serves as a useful adjunct to individualized instruction for interns who require specific intervention for time management or communication deficits. Conclusion: Integrating discussion of administrative skills into an intern-only case conference appears to be an effective and non-threatening way to share "best practices" in a case-based context.

#### Poster # 24 (abstract 1152)

##### ENHANCING EFFICIENCY AND PRODUCTIVITY IN THE PATIENT CARE ENVIRONMENT WITH THE USE OF PERSONAL DIGITAL ASSISTANTS (PDA)

*Srinivasan Suresh, MD, MBA, Anne Mortensen, MD, Kate Sheppard, MPH, MSW, Children's Hospital of Michigan/ Wayne State University, Detroit, MI*

A potentially compelling environment for the use of Personal Digital Assistant (PDA) exists in most health care facilities. This poster will demonstrate the effective use of the Pocket PC PDA in facilitating resident education, bedside clinical teaching, and patient care, sign-out and communication in the aftermath of the 80-hour week, and improving the cost effectiveness of wireless networks in the patient care setting. A hands-on component will demonstrate how these handheld computers are a valuable clinical tool for physicians by allowing them to have immediate access to relevant clinical information such as drug interactions, calculating important parameters, or expanding the differential diagnosis, providing a readily accessible and permanent means of recording and tracking patient procedures, enabling fluid transfer of vital patient information to other health care providers, and managing and accessing patient data. Most hospitals facilitate wireless access of the corporate intranet and the World Wide Web. The Wayne State University School of Medicine in Detroit is currently home to the largest wireless handheld initiative of any U.S. medical school. Every one of the 1000 students of the medical school, and every trainee from its pediatric residency program at Children's Hospital of Michigan (CHM) possesses a PDA. The wide availability of wireless access points at CHM enables the physicians to "log on" to their PDAs anywhere in the hospital. This poster will demonstrate the PDA activities at CHM, which could be a blueprint for residency training programs and children's hospitals in enhancing efficiency and productivity in the workplace. Partial listing of the poster demonstrations: 1. Streamlining the collection of procedural data 2. Integrating the PDAs in the process of learner evaluation 3. Creating a medical education "suite," which could be remotely uploaded to every PDA 4. Accessing PubMed and clinical care guidelines at the point of care, leading to better time management, and potential reduction in the length of stay (LOS) of inpatients.

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**Poster # 25 (abstract 1153)**

**A PRACTICE MANAGEMENT PROGRAM FOR RESIDENTS: DESIGN AND IMPLEMENTATION**

*Srinivasan Suresh, MD, MBA, Anne Mortensen, MD, Kate Sheppard, MPH, MSW, Children's Hospital of Michigan/Wayne State University, Detroit, MI*

The majority of today's graduating pediatric residents lack exposure to a formal structured curriculum in practice management. Most programs have optional didactic sessions in various areas of practice management, which might address some important aspects, but, still lack an organized approach. At Children's Hospital of Michigan/Wayne State University's Pediatric Residency Program, a longitudinal series on practice management issues titled "Practice Practicalities" was started two years ago. A needs assessment was done involving residents at all levels, and a 'core' and 'selective' curricula was formed. The expertise of faculty with advanced degrees (MBA, MPH, PhD) was tapped. The initial learning goals for the trainees were 1. Help in getting a job in which they are happy and not be surprised by contract & reimbursement vagaries, 2. Develop confidence in professional decision-making, 3. Understand the global healthcare system, and the physician's place therein, and 4. Comprehend insurance and business operations. This was heavily based on case studies and was meant to be fun, and interactive. The three concepts around which the curriculum was based were attitudes, knowledge and skills. Attention to the advocacy of patient welfare balanced with business realities was a key feature. The sessions focused on (but were not limited to) finances and accounting, reimbursement mechanisms, coding to maximize revenue, human resources management, marketing, contracting and negotiating skills, legal aspects of practice and personal finance. Guest speakers and alumni actively participated, depending on areas of expertise. Feedback from residents paved way for changes in the curriculum, and a better understanding of the trainees' needs. The 'core sessions' were repeated on a 12 month cycle, and the 'selectives' were offered ad hoc, or on a longer rotational basis. The ultimate goal of the course was to examine the critical issues related to the integration of business and medicine, which will lead to a better understanding of the concepts and methods by which all healthcare business transactions are conducted.

**Poster # 26 (abstract 1151)**

**DESIGNING A LONGITUDINAL CURRICULUM IN EVIDENCE BASED MEDICINE FOR LARGE RESIDENCY PROGRAMS**

*Srinivasan Suresh, MD, MBA, Anne Mortensen, MD, Kate Sheppard, MPH, MSW, Children's Hospital of Michigan/Wayne State University, Detroit, MI*

The Evidence Based Medicine (EBM) curriculum in the Pediatric Residency Program at Children's Hospital of Michigan (CHM) is designed around the competency of "Practice Based Learning and Improvement" that involves investigation and evaluation of patient care, appraisal and assimilation of scientific evidence leading to improvements in patient care. In this workshop, we will explain how the EBM curriculum at CHM could be a blueprint for similar large training programs. The key approaches to teach and foster Practice based learning and improvement include (but are not limited to) Senior and Intern Rounds, Mortality and Morbidity Conferences, Bimonthly Journal Clubs, Log and learning plans, and Improvement projects. The curriculum is grounded on adult learning theory. The advantages of effectively using the Personal Digital Assistant (PDA) to create an EBM culture especially in the aftermath of the 80-hour week will also be demonstrated. A Critically appraised topic (CAT) is a short summary of the evidence to a focused clinical question, which allows users to store the results of their critical appraisal in such a way that they can easily be shared or stored for later use. The workshop faculty will explain the process of developing CATs, both as an educational tool, and as a medium for reinforcing the critical thinking skills one should use in considering evidence.

Evidence-based medicine (EBM) is a complementary approach to clinical practice that applies the principles of clinical epidemiology to the traditional skills of patient care. A longitudinal curriculum is vital in inculcating this concept in medical students, residents and fellows.

This poster will show participants how to effectively design an EBM curriculum for trainees. The poster presenters currently perform this activity in a large residency program of about 100 residents. The logistics of ensuring that all residents are exposed to the spectrum of EBM, given their other responsibilities, will be explained. Means of incorporating continual feedback in the curriculum to achieve best clinical practices will also be demonstrated.

**Poster # 27 (abstract 1160)**

**MEDICAL SCHOOL TRAINING IN CULTURAL SENSITIVITY AMONG INTERNATIONAL MEDICAL GRADUATES - IMPLICATIONS FOR RESIDENCY TRAINING CURRICULUM**

*Thanakorn Jirasevijinda, MD, Bronx-Lebanon Hospital Center, Bronx, NY*

Residency programs are encountering an increase in diversity of trainees. The ACGME mandates that cultural sensitivity training (CST) be an integral part of residency curriculum under professionalism. Despite the increase of IMG's in residency programs, little is known about their prior CST exposure. We conducted an anonymous, self-administered pilot survey of applicants to a pediatric residency program from the 2004-5 applicant pool. We collected demographic and medical school characteristics, and whether the applicants had taken a course on cultural sensitivity as related to medicine. A total of 179 surveys were completed. Almost all applicants (98.9%) were IMG's. Applicants were trained in 42 countries, with India (32.0%), Nigeria (12.4%) and Pakistan (11.2%) representing the largest numbers. The mean age was 31.2 years, and 58.1% were male. Twenty-seven (15.2%) reported having received CST in medical school. The content of CST varied, ranging from courses on

5:30-6:30 pm, Posters with exhibits and Wine/Cheese Reception continued

epidemiology only, to health care economics, using interpreter services, communication with various cultural groups, and health beliefs in different cultures. Medical school size, location (urban vs. rural) and applicants' years since graduation were not significant correlates of their having received CST. Length and gender diversity of medical schools positively correlate with the applicants' prior CST exposure. Compared to their peers who graduated from American or Canadian schools, IMG's with little or no prior training in cultural issues related to medicine may need more guidance and practice in this area. Our finding that only a small percentage of IMG's applying to one program received any such training has important implications for the design of training curriculum to meet the ACGME requirements. Further research is needed to determine if our finding reflects a nation-wide phenomenon.

#### Poster # 28 (abstract 1162)

##### CHIEF RESIDENT NATURAL DISASTER PLANNING - A MODEL AND A PRACTICE

*Michael Cohen, MD, Paul Ufberg, DO, Miami Children's Hospital, Miami, FL*

**BACKGROUND:** Miami Children's Hospital has a comprehensive hurricane policy for the entire staff. When a hurricane warning is enacted by the National Hurricane Center the policy is activated. For the residents this means the creation of 2 teams (during and after the storm). Each team contains roughly 35 people. **OBJECTIVE:** To create and implement a new resident natural disaster plan using minimum coverage. **DESIGN/METHODS:** The new minimum coverage (18 residents) plan was put into effect on 3 separate occasions (hurricanes "Katrina," "Rita" and "Wilma"). Two teams were created for each event. The "alpha" team covered during the storm and the "bravo" team immediately post-storm. The coverage residents were identified and duties were assigned. A detailed instruction sheet was given to each participant at the onset of the hurricane warning. A chief resident attendance and dismissal log was maintained during and after the storms. **RESULTS:** Hospital assignments were given to 67 residents during the 3 storms; 21 for hurricane "Katrina", 19 for "Rita" and 27 for "Wilma." Throughout all 3 hurricanes minimum weekend staff coverage was maintained (18 residents). The variability of the total number of residents was dependent upon number of unassigned residents using hospital for shelter and anticipated hurricane time of landfall. Regular work schedule was resumed within 24 hours of hurricane clearance by the National Hurricane Center. The post-hurricane team was not activated. Resident surveys indicated satisfaction with the new plan. **CONCLUSIONS:** Coverage for a natural disaster starts with a method and plan. This begins early in the academic year and can operate independently of the institution. Using a minimum staff model it is possible to provide the coverage needed. With 18 residents working, instead of the 35 previously required, the program resumed academic and scheduled activities within 24 hours. If natural disasters extend beyond 24 hours the plan needs to be adjusted. Based upon the current experience a prospective study will be determined.

#### Poster # 29

##### IMPLEMENTATION OF PEDIALINK'S PROGRAM DIRECTOR AND RESIDENT CENTERS INTO RESIDENCY TRAINING: AN EARLY EVALUATION

*Co JPT, MassGeneral Hospital for Children, Boston MA, Leggio L, Medical College of GA, Augusta, GA, Bar-on, M, Loyola University Stritch School of Medicine, Maywood, IL, Badat MC, American Academy of Pediatrics, Elk Grove Village, IL*

### Saturday, April 29

7:30-8:00am	<b>Continental Breakfast</b>	<b>Yerba Buena Gardens - Salon 7</b>
8:00 am-12:00 pm	<b>Coordinators Session</b>	<b>Yerba Buena Gardens - Salon 1-3</b>
8:00-8:45	<b>Update from the Accreditation Council for Graduate Medical Education (ACGME)</b>	
8:45-9:30	<b>Effective Supervision as an Education Coordinator, Beth A. Hahn, Mayo School of Graduate Medical Education, Rochester, MN</b>	
	Present an overview of what I have learned in "Building a Foundation of Management Skills" course provided by Mayo. Points of interest include communications, leadership, respect, conflict, performance, and change. I believe that this would be beneficial to education coordinators who also supervise along with the many other duties that they already have to accomplish.	
9:30-10:15	<b>Simplify, Sally H. Koons, Penn State Hershey Medical Center, Hershey, PA, Susan Quintana, University of New Mexico, Albuquerque, NM</b>	
	We would like to present some tips we have come up with over the years... anything and everything a coordinator needs to know. Samples of how some coordinators organize and perform certain tasks.	
10:15-10:30	<b>Break</b>	
10:30-11:15	<b>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</b>	
11:15-12:00	<b>2006-2007 AAP Resident Membership Program, Terri Howard, Director, Division of Member Services, American Academy of Pediatrics, Elk Grove Village, IL</b>	



8:00 am-1:00 pm **Forum for Directors of Small Programs and Affiliate Chairs** Yerba Buena Gardens - Salon 4-6  
*Surendra Varma, MD, Texas Tech University, Lubbock, TX and Lynn Campbell, MD, University of Kentucky Medical Center Program, Lexington, KY*  
 With the new RRC requirements, we will get a brief presentation as well as an opportunity to ask questions. Additionally, the ACGME log system for procedures will be reviewed, as well as Pedialink and ILP issues.

8:00 am-5:15 pm	<b>Forum for Fellowship Directors</b>	<b>Golden Gate Hall B2</b>
	<b>Teamwork! The Key to Implementing Competency-Based Training</b>	
8:00-8:15	Introductions and Welcome, <i>Theodore C. Sectish, MD, Stanford University, Palo Alto, CA</i>	
8:15-8:30	How Program Directors and Fellowship Directors Work Together in the Competency-based Era, <i>Joseph Gilhooly, MD, Oregon Health and Science University, Portland, OR</i>	
8:30-9:15	Update from the ACGME: New requirements for Pediatric Subspecialty programs, Common Citations, <i>Jerry Vasilias, PhD and Caroline Fischer, RRC for Pediatrics, ACGME, Chicago, IL</i>	
9:15-9:45	Discussion	
9:45-10:00	Break	
10:00-10:30	Pediatric Subspecialty programs: Collaborating to meet new ACGME and ABP requirements, <i>William F. Balistreri, MD, Cincinnati Children's Hospital Medical Center, Cincinnati, OH</i>	
10:30-11:00	Discussion	
11:00-12:00	Residents and fellows demonstrating competency together: Common learning activities and evaluation tools (open, facilitated brainstorming session) <i>Various faculty</i>	
12:00-12:15	Wrap up and closure	
12:15-2:15	Lunch on your own	
	<b>PAS/APPD Mini-Course: Educating Pediatric Fellows in a Competency Based World (PAS requires a separate registration fee)</b>	<b>Room 2007 - Moscone West*</b>
2:15-2:25	Overview, <i>Susan Guralnick, MD, Stony Brook University Medical Center, Stony Brook, NY</i>	
2:25-3:20	A Brave New World! New Common Requirements for Subspecialties, <i>Carol Carraccio, MD, University of Maryland School of Medicine, Baltimore, MD</i>	
3:20-4:15	Survivor GME: Fellowship Competencies in Action, <i>Joseph Gilhooly, MD, Oregon Health and Science University, Portland, OR and John Mahan, MD, Children's Hospital, The Ohio State University, Columbus, OH</i>	
4:15-5:15	Turning to Fellows as Teachers: From Curricula to Evaluation, <i>Nancy Spector, MD, St. Christopher's Hospital for Children, Philadelphia, PA and Susan Guralnick, MD, Stony Brook University Medical Center, Stony Brook, NY</i>	

8:00 am-5:00 pm **Forum for Chief Residents** Yerba Buena Gardens - Salon 10-11  
*Facilitators: Edwin Zalneraitis, MD, University of Connecticut, Hartford, CT, Robert McGregor, MD, St. Christopher's Hospital for Children, Philadelphia, PA, Dalya Chefitz, MD, UMDNJ-Robert Wood Johnson Medical School, New Brunswick, NJ, Monica Sifuentes, MD, Los Angeles County-Harbor UCLA Medical Center, Torrance, CA*  
 The Chief Resident Forum will consist of a series of active learning modules for current finishing Chief Residents and those about to begin their year as Chief Resident. It will be a stimulating way to gain valuable skills through problem solving exercises. The menu of activities will include: Administration and planning; Teaching (a skill, a group, in a busy setting, other residents to teach effectively, evidence-based medicine); Group Management; Feedback; Conflict resolution; The problem resident; Leadership skills and styles.

\*This room is located in the San Francisco Convention Center

APPD WOULD LIKE TO THANK THE FOLLOWING COMPANIES  
FOR THEIR PARTICIPATION AS EXHIBITORS AT THIS YEAR'S MEETING

*Be sure to visit them in Yerba Buena Gardens Salon 7 throughout the meeting.*

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### PREPARATION FOR A SUCCESSFUL SITE VISIT

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- ❖ *Individuals Preparing For a RRC Site Visit*
- ❖ *Individuals Assisting Program Directors*

**Keynote Speaker & Dinner: September 27**

**Meeting: September 28-29**