

Association of Pediatric Program Directors



2007 Annual Meeting
May 2-5, 2007
Toronto, Ontario

Final Program

*Professional Development Across
All Levels of Residency Program Leadership*

Sheraton Centre Toronto
Toronto, Ontario

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

NEW OFFERINGS THIS YEAR
Forum for Associate Directors
Expanded Forum for Fellowship Directors
Faculty Development Pre-Conference Session

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 this educational activity for a maximum of **61.5 AMA PRA Category 1 Credits™** (includes 21 credits for APPD sessions). Physicians should only claim credit commensurate with the extent of their participation in the activity.

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 of its educational activities in accordance with the ACCME's Essential Areas and Policies to ensure balance, independence, objectivity and scientific rigor. In accordance with the ACCME's 2004 Standards for Commercial Support, everyone who is in a position to control the content of an educational activity certified for *AMA PRA Category 1 Credit™* is required to disclose all relevant financial relationships with any commercial interests within the past 12 months that creates a real or apparent conflict of interest. Individuals who do not disclose are disqualified from participating in a CME activity. Individuals with potential for influence or control of CME content include planners and planning committee members, authors, teachers, educational activity directors, educational partners, and others who participate, e.g. facilitators and moderators. This disclosure pertains to relationships with pharmaceutical companies, biomedical device manufacturers, or other corporations whose products or services are related to the subject matter of the presentation topic. Any real or apparent conflicts of interest related to the content of the presentations must be resolved prior to the educational activity. Disclosure of off-label, experimental or investigational use of drugs or devices must also be made known to the audience.

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 ACGME 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.)

A Word of Welcome

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 their purple and gold ribbons so that you may “show them the ropes” and help ensure that their first experience is a pleasant and successful one.

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 “blue dot” you’ll see on their name badges. Please take a moment to welcome them to APPD.

Fellowship Directors Track

Please note the shaded sections of this program, highlighting sessions of particulare interest to fellowship directors.

A special appreciative note of thanks...

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

<i>President</i>	Robert McGregor, MD
<i>President-Elect</i>	Susan Guralnick, MD
<i>Secretary-Treasurer</i>	Ann Burke, MD
<i>Past-President</i>	Theodore Sectish, MD

Board of Directors

Annamaria Church, MD ~ Joseph Gilhooly, MD ~ Adam Pallant, MD ~ Monica Sifuentes, MD

Coordinators' Executive Committee

Judy Behnke ~ Valarie Collins ~ Therese D'Agostino ~ Mary Gallagher
~ Vanessa Goodwin ~ Sally Hollowell Koons

Council of Task Force Chairs

Susan Bostwick, MD ~ Annamaria Church, MD ~ John Co, MD
John Mahan, MD ~ Robert McGregor, MD ~ Theodore Sectish, MD ~ Surendra Varma, MD

Nominating Committee

Miriam Bar-on, MD ~ Theodore Sectish, MD ~ Surendra Varma, MD

Association of Pediatric Program Directors

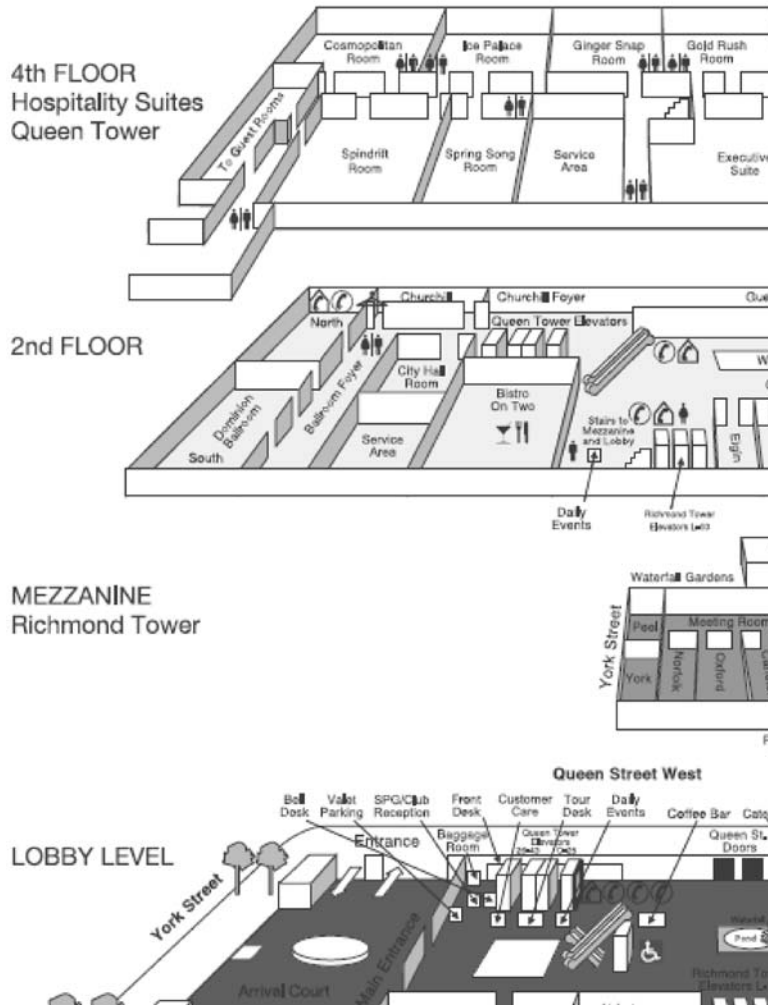
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Executive Director: Laura Degnon, CAE; Association Manager: Kathy Haynes Johnson

Floor Plan Sheraton Centre Toronto ~ 123 Queen Street West



Program-At-A-Glance

Wednesday, May 2	Thursday, May 3	Friday, May 4	Saturday, May 5
<p>12:30 p.m. Registration Begins <i>Civic Ballroom Foyer</i></p> <p>1:30 - 5:00 p.m. Faculty Development Pre-Conference Workshop (additional fee required) <i>Civic Ballroom South</i></p> <p>2:00 - 7:00 p.m. Coordinators TAGME Exam (prior application and scheduling necessary) <i>Simcoe Dufferin Room</i></p> <p>3:00 - 5:30 p.m. APPD Midwest Regional Meeting <i>Civic Ballroom North</i></p>	<p>6:45 a.m. Registration Open <i>Vide Foyer</i></p> <p>7:00 - 7:30 a.m. Continental Breakfast in Exhibit Hall <i>Sheraton Hall E</i></p> <p>7:30 - 10:00 a.m. APPD "Hot Topics" SIG <i>Grand Ballroom East & Centre</i></p> <p>7:30 - 10:00 a.m. Coordinators Session <i>Grand Ballroom West</i></p> <p>10:00 - 10:15 a.m. Break in Exhibit Hall <i>Sheraton Hall E</i></p> <p>10:15 a.m. - 12:15 p.m. Plenary Session <i>Grand Ballroom East & Centre</i></p> <p>12:15 - 1:30 p.m. Lunch (on your own)</p> <p>1:30 - 5:00 p.m. Invited Presentations: Setting the Stage for Change <i>Grand Ballroom East & Centre</i></p> <p>5:00 - 6:30 p.m. Task Force Meetings Curriculum <i>Sheraton Hall C</i> Evaluation <i>Sheraton Hall A</i> Faculty Development <i>Sheraton Hall B</i> Learning Technology <i>Conference Room G</i> Research <i>Conference Room D/E</i></p> <p>Coordinators Executive Committee Meeting <i>Elgin Room</i></p>	<p>7:00 - 8:00 a.m. RRC Program Requirements <i>Conference Room B</i></p> <p>Education Innovation Project <i>Conference Room D/E</i></p> <p>8:00 - 9:30 a.m. Regional Breakfasts Mid-America <i>Conference Room H</i> Mid-Atlantic <i>Windsor Room West</i> Midwest <i>Conference Room B</i> New England <i>Conference Room G</i> New York <i>Conference Room F</i> Southeast <i>Conference Room D/E</i> Southwest <i>Windsor Room East</i> Western <i>Conference Room C</i></p> <p>10:00 a.m. - 12:00 p.m. Workshops I (pgs 9-11)</p> <p>12:00 - 1:00 p.m. Lunch (on your own)</p> <p>12:00 - 1:00 p.m. Regional Chairs Luncheon <i>Sheraton Hall B</i></p> <p>Council of Task Force Chairs Luncheon <i>Sheraton Hall C</i></p> <p>1:00 - 3:00 p.m. Workshops II (pgs 12-15)</p> <p>3:00 - 3:30 p.m. Break in Exhibit Hall <i>Sheraton Hall E</i></p> <p>3:30 - 5:30 p.m. Workshops III (pgs 15-17)</p> <p>5:30 - 6 :30 p.m. Posters with Exhibits and Wine/Cheese Reception <i>Sheraton Hall E</i></p> <p>7:00 - 8:00 p.m. MPPDA Reception <i>Sheraton Hall C</i></p>	<p>7:00 - 8:00 a.m. Continental Breakfast <i>Grand Ballroom Foyer</i></p> <p>8:00 a.m. - 1:00 p.m. Coordinators Session <i>Essex Ballroom</i></p> <p>8:00 a.m. - 11:00 a.m. Forum for Associate Directors <i>Grand Ballroom Centre</i></p> <p>8:00 a.m. - 1:00 p.m. Forum for Small Programs/Chairs <i>Grand Ballroom West</i></p> <p>8:00 a.m. - 3:30 p.m. Forum for Fellowship Directors <i>Grand Ballroom East</i></p> <p>8:00 a.m. - 5:00 p.m. Forum for Chief Residents <i>Sheraton Hall A</i></p> <p>8:00 a.m. - 5:00 p.m. MPPDA Meeting <i>Osgoode Ballroom</i></p> <p>6:00 p.m. - 11:00 p.m. MPPDA Dinner (additional fee required) <i>Alice Fazooli's Restaurant</i></p>

Program Schedule

Wednesday, May 2

12:30 p.m.

Registration Begins
Civic Ballroom Foyer (2nd Floor)

1:30 - 5:00 p.m.

Faculty Development Pre-Conference Workshop (additional fee required)
3 CME Credits Available
Civic Ballroom South (2nd Floor)

Facilitator: *Fred A. McCurdy MD, PhD, MPA, Professor & Chairman & Pediatric Residency Program Director, Texas Tech University, Health Sciences Center*

Managing educational systems is as challenging as it is rewarding. What can be done to ensure individual beliefs and attitudes do not impede personal or organizational goals? First, understand that YOU are the key to success. Leadership begins with understanding the "ME". Why? Because today's complex educational organizations require leaders who have a deep understanding of themselves, who are able to articulate a vision of future direction, build high levels of trust and create a sense of community.

This workshop is intended for all members of the APPD. The entire afternoon will be spent actively engaged in personal skill development. Every attendee will find the material very challenging. The first segment (90 minutes) is entitled: Getting to Know You: Career Planning Basics. The focus is on understanding "ME". At the end of this first segment, each participant will have:

1. determined their personal values
2. created a personal mission
3. determined a vision for their professional life
4. and, examined whether or not their personal passions match with the expectations of their current organization.

The second segment (90 minutes) is entitled: Negotiation/Conflict Resolution: Gaining Dynamic Insight. The focus of this segment is developing a specific skill that will help each participant to manage and lead people he/she works with every day, the "We" of an organization. At the end of this segment, each participant will:

1. have tried to "Win As Much As They Can"
2. be able to describe the difference between taking a position and exploring an interest
3. be able to describe how perceptions, communication and emotions factor into any negotiation and/or conflict situation, and
4. have the opportunity to practice negotiating with their "Department Chair".

Each attendee will leave the session with a workbook full of suggestions that can be immediately applied to their current professional circumstance. The workshop leader, Fred McCurdy, is an experienced program director as well as a department chairman. Fred will engage you in an active dialogue based on personal success and failure experienced in his own career as a Pediatric Educator.

2:00 - 7:00 p.m.

Coordinators TAGME Exam (prior application and scheduling necessary)
Simcoe Dufferin Room (2nd Floor)

3:00 - 5:30 p.m.

APPD Midwest Regional Meeting
Civic Ballroom North (2nd Floor)

Thursday, May 3

6:45 a.m.

Registration Open
Vide Foyer (Lower Concourse)

7:00 - 7:30 a.m.

Continental Breakfast in Exhibit Hall
Sheraton Hall E (Lower Concourse)

- 7:30 - 10:00 a.m. **APPD “Hot Topics” SIG**
2.5 CME Credits Available
Grand Ballroom East & Centre (Lower Concourse)
Lynn Campbell, MD, Program Director, University of Kentucky Medical Center Program; Jerry Rushton, MD, MPH, Program Director, Indiana University School of Medicine; Brian Youth, MD, Program Director, Maine Medical Center
 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.
- 7:30 - 10:00 a.m. **Coordinators Session**
Grand Ballroom West (Lower Concourse)
- 7:30 - 8:30 Welcome/Opening Remarks/Icebreaker
Judy Behnke, Children’s Hospital of Austin; Valarie Collins, C-TAGME, University of South Florida
- 8:30 - 9:15 The Coordinator’s Role in Graduate Medical Education
Sally Hollowell Koons, C-TAGME, Penn State Children’s Hospital, Hershey, PA; Avis Wiener, Carolinas Medical Center/Levine Children’s Hospital, Charlotte, NC; Mary Gallagher, C-TAGME, Long Island College Hospital/Beth Israel Medical Center, Brooklyn, NY
 This is a presentation outlining the role, expectations and challenges facing today’s coordinator. This workshop will emphasize the role of the coordinator in a supportive role as well as the autonomy of the job and the flexibility needed to succeed. An interactive presentation involving the audience in different scenarios will also be included.
- 9:15 - 10:00 How To Get The Most Out Of Your Med-Peds Team
Allen Friedland, MD, FACP, FAAP, Program Director; Niraj Sharma, MD, MPH, Program Director, University of Miami, Miami, FL; Debbie Harris, Med-Peds Program Coordinator, Christiana Care Health System, Newark, DE; Cindy Chuidian, Pediatrics Program Coordinator, DuPont Hospital for Children, Wilmington, DE
 Med-Peds programs and residents present a unique set of issues and challenges to programs and institutions. In this session, presenters will discuss the impact of the Accreditation Council of Graduate Medical Education’s requirements on med-peds residents and residencies. The workshop will also focus on practical issues of coordination and communication amongst those involved with administering med-peds residencies. The presenters will encourage sharing of ideas of different structures and models of administration and different ways to create and maintain an effective medicine-pediatrics file. The accreditation process of med-peds programs and issues of site visits will be discussed as well.
- 10:00 - 10:15 a.m. **Break in Exhibit Hall**
Sheraton Hall E (#5, Lower Concourse)
- 10:15 a.m. - 12:15 p.m. **Plenary Session**
Grand Ballroom East & Centre (Lower Concourse)
- 10:15-10:20 Association of Pediatric Program Directors - *Robert McGregor, MD*
 10:20-10:25 Residency Review Committee (RRC) - *Carol Carraccio, MD*
 10:25-10:30 American Board of Pediatrics (ABP) - *Gail McGuinness, MD*
 10:30-10:35 Federation of Pediatric Organizations (FOPO) - *Theodore C. Sectish, MD*
 10:35-10:40 Council on Medical Student Education in Pediatrics (COMSEP) - *William V. Raszka, Jr., MD*
 10:40-10:45 American Academy of Pediatrics (AAP) - *Robert Perelman, MD*
 10:45-10:50 Resident Section, American Academy of Pediatrics - *Christopher Strother, MD*
 10:50-10:55 APPD Financial Update - *Ann Burke, MD*
 10:55-11:05 APPD Awards - *Robert McGregor, MD and Carol D. Berkowitz, MD*
 11:05-11:10 Recognize Outgoing Leaders - *Robert McGregor, MD*
 11:10-11:15 APPD Election Results - *Theodore C. Sectish, MD*
 11:15-11:30 Break
 11:30-12:15 Interactive Panel Discussion (Q&A)- *Ann Burke, MD, Moderator*

12:15 - 1:30 p.m.	Lunch (on your own)										
1:30 - 5:00 p.m.	<p>Invited Presentations: Setting the Stage for Change *3 CME Credits Available* Grand Ballroom East & Centre (Lower Concourse) Chair, Theodore C. Sectish, MD, Past President, APPD</p>										
1:30 - 2:15	<p>American Board of Pediatrics R3P Project Update <i>Gail McGuinness, MD, Senior Vice President, American Board of Pediatrics (ABP); M. Douglas Jones, Jr., M.D., Professor, Department of Pediatrics, University of Colorado School of Medicine, Denver CO</i></p>										
2:15 - 2:45	<p>Are Pediatric Training Programs Reducing or Widening Disparities in Child Health? <i>Paul Wise, MD, Stanford University</i></p>										
2:45 - 3:15	<p>Learning Pediatrics Vs Becoming a Pediatrician <i>Edward L. Schor, MD, Vice President, The Commonwealth Fund, New York, NY</i></p>										
3:15 - 3:45	<p>The Future of Pediatric Primary Care - Discussion of Future Needs and Potential Roles for Primary Care Physicians <i>Tina L. Cheng, MD, MPH, Chief, Division of General Pediatrics & Adolescent Medi- cine, Johns Hopkins University, Baltimore, MD</i></p>										
3:45 - 4:00	Break										
4:00 - 5:00	<p>Panel Discussion/Question and Answer Period <i>Gail McGuinness, MD, Senior Vice President, American Board of Pediatrics (ABP); M. Douglas Jones, Jr., MD, Professor, Department of Pediatrics, University of Colorado School of Medicine, Denver CO; Edward L. Schor, MD, Vice President, The Commonwealth Fund, New York, NY; Paul Wise, MD, Stanford University; Tina L. Cheng, MD, MPH, Chief, Division of General Pediatrics & Adolescent Medicine, Johns Hopkins University, Baltimore, MD</i></p>										
5:00 - 6:30 p.m.	<p>Task Force Meetings</p> <table border="0"> <tr> <td>Curriculum</td> <td><i>Sheraton Hall C - Lower Concourse Level</i></td> </tr> <tr> <td>Evaluation</td> <td><i>Sheraton Hall A - Lower Concourse Level</i></td> </tr> <tr> <td>Faculty Development</td> <td><i>Sheraton Hall B - Lower Concourse Level</i></td> </tr> <tr> <td>Learning Technology</td> <td><i>Conference Room G - Mezzanine</i></td> </tr> <tr> <td>Research</td> <td><i>Conference Room D/E - Mezzanine</i></td> </tr> </table> <p>Coordinators Executive Committee Meeting <i>Elgin Room (2nd Floor)</i></p>	Curriculum	<i>Sheraton Hall C - Lower Concourse Level</i>	Evaluation	<i>Sheraton Hall A - Lower Concourse Level</i>	Faculty Development	<i>Sheraton Hall B - Lower Concourse Level</i>	Learning Technology	<i>Conference Room G - Mezzanine</i>	Research	<i>Conference Room D/E - Mezzanine</i>
Curriculum	<i>Sheraton Hall C - Lower Concourse Level</i>										
Evaluation	<i>Sheraton Hall A - Lower Concourse Level</i>										
Faculty Development	<i>Sheraton Hall B - Lower Concourse Level</i>										
Learning Technology	<i>Conference Room G - Mezzanine</i>										
Research	<i>Conference Room D/E - Mezzanine</i>										

Friday, May 4

7:00 - 8:00 a.m.

RRC Program Requirements Discussion Conference Room B (Mezzanine Level)

The RRC Program Requirements specify documentation of competence by direct faculty observation and by evaluations by colleagues, supervisors, patients and parents.

- Should the American Board of Pediatrics (ABP) require specific numbers of specific types of instruments (e.g., multisource surveys, mini-CEX-type evaluations, etc.)?
- Should residents have the responsibility to submit such documentation to the ABP?
- What is the view of the APPD with regard to the utility of a high-stakes clinical skills examination, analogous to, not necessarily identical to, the NBME clinical skills examination? This would be a burden for residents. On the other hand, the US is the only English-speaking country that does not have such an exam. And a clinical skills exam would almost certainly alter residents attitudes toward acquisition of pediatric clinical skills.

Education Innovation Project Discussion Conference Room D/E (Mezzanine Level)

Various Internal Medicine groups have made recommendations regarding the content and format of Internal Medicine residency education. In addition, the Internal Medicine RRC has solicited proposals for new approaches to achievement of better patient outcomes and better competency-based education and outcomes-based assessment. What does the APPD think this has to say to Pediatrics, especially the use of an RFA approach to stimulate outcomes-based innovation?

8:00 - 9:30 a.m.

Regional Breakfasts - Mezzanine Level***1 CME Credit Available***

Mid-America	Conference Room H
West PA, OH, WV, KY, IN, MI	(Christine Mayes and Dena Hofkosh, MD)
Mid-Atlantic	Windsor Room West
South NJ, East PA, DE, MD, Wash DC	(Kathy Miller and Cliff Yu, MD)
Midwest	Conference Room B
IL, WI, MN, IA, MO, KS, NE, OK	(Tom George, MD)
New England	Conference Room G
ME, NH, MA, CT, VT, RI	(Aida Velez and Ed Zalneraitis, MD)
New York	Conference Room F
NY, Northern NJ	(Mary Gallagher and Susan Guralnick, MD)
Southeast	Conference Room D/E
VA, NC, SC, GA, FL, AL, MS, LA, AR, TN	(Marc Majure, MD)
Southwest	Windsor Room East
TX, AZ	(Judy Behnke and Surendra Varma, MD)
Western	Conference Room C
CA, NV, OR, WA, HI, CO, NM, UT	(Tracie Barnett and Rani Vasan, MD)

10:00 a.m. - 12:00 p.m. **Workshops Session I*****2 CME Credits Available***

1. How To Show What you Know: Using Advocacy Training to Document the ACGME Competencies
Lisa Chamberlain, MD, MPH, Stanford University School of Medicine, Palo Alto, CA; Anda Kuo, MD, UCSF - Pediatric Leadership for the Underserved, San Francisco, CA; Benjamin Hoffman, MD, University of New Mexico, Albuquerque, NM
Dominion Ballroom South (2nd Floor)

All pediatric residency training programs must incorporate training in advocacy and community pediatrics. Programs have developed a wide variety of innovative curricula to address these areas of training, and in the process have created a number of useful tools that can help programs document their trainees' competence in a variety of areas defined by the ACGME. This workshop will help program directors and administrators better understand how to use advocacy training to help document these competencies, especially Systems Based Practice, Interpersonal and Communication Skills, Practice Based Learning and Improvement and Professionalism. Using examples from a number of programs around the country and an interactive workshop format, participants will identify areas within their own programs where these competencies are already being demonstrated, apply tools to better document these competencies, and develop strategies for implementing new experiences for pediatric residents in advocacy and community pediatrics. We will then use the results to develop an advocacy training toolbox that programs can utilize to help them better document their resident's competence.

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

Ann Burke, MD, Wright State University School of Medicine, Dayton, OH; Robert Englander, MD, MPH, Connecticut Children's Medical Center, Hartford, CT; Susan Bostwick, MD, New York Presbyterian-Weill Cornell, New York, NY

Civic Ballroom South (2nd Floor)

10-10:15	Introductions
10:15	A Pediatric Resident Curriculum For Practice-Based Learning And Improvement And Systems-Based Practice <i>Shannon E. Scott-Vernaglia, M.D. MassGeneral Hospital for Children</i>
10:30	How Does Resident Participation in Hospital-Initiated Quality Improvement Activities Affect Knowledge and Attitudes about Quality Improvement? <i>Ellen Lipstein, MD Seattle Children's Hospital & Regional Medical Center</i>
10:45	The Hospital as a Learning Lab: A Hands On Quality Improvement Curriculum <i>Michelle Thompson, MD Geisinger Health System</i>
11:00	Break
11:15	Teaching the ACGME Core Competencies in a Morbidity and Mortality Review Conference <i>Jill Fussell, MD University of Arkansas for Medical Sciences</i>
11:30	Cognitive Forcing Strategies in Morning Report <i>Satid Thammasitboon, MD, MHPE West Virginia University</i>
11:50	Closing

3. Efficient, Competency-Based Schemes to Document the Clinical Performance of Students, Residents and Fellows. A P.R.I.M.E.R for You
Clifton Yu, MD, National Capital Consortium Pediatric Program, Washington, DC; Joseph Lopreiato, MD, MPH, Uniformed Services University of the Health Sciences, Bethesda, MD; Gregory Blaschke, MD, MPH, Naval Medical Center San Diego, CA, San Diego, CA; Timothy Shope, MD, MPH, Naval Medical Center Portsmouth, Portsmouth, VA
Grand Ballroom East (Lower Concourse)
 How can you get your faculty to provide better and more detailed written evaluations on the clinical performance of your students, residents, and fellows? How can you teach faculty to get the most out of their precepting sessions in a busy clinic or ward? In this workshop, we will tackle both problems. We will introduce participants to a scheme for standardizing your clinical observations using the mnemonic P.R.I.M.E. (Professionalism, Reporter, Interpreter, Manager, and Educator). P.R.I.M.E. is a valid and reliable method for organizing observations of learner performance along the lines of the new competencies. We will provide practical examples of P.R.I.M.E. that we have used over the last five academic years to document the new ACGME competencies. Participants will then break into small groups to practice writing resident evaluations in P.R.I.M.E. format and learn to develop evaluation tools utilizing the P.R.I.M.E. system in the clinical context of their home institution. In the second half of this workshop, we will also introduce participants to the 5 W's (What, Why, When, Whoops, and Warm fuzzies) of the one-minute preceptor concept through role play and videotape examples. Participants will then debrief their performances and discuss how to export these skills into their own clinical environment. Come learn new skills with us. You will not be disappointed.

4. Resident Retreats: Setting the stage to meet core competencies through fun and games
Kelly Leite, DO, Penn State Children's Hospital, Hershey, PA; Susan Guralnick, MD, Stony Brook University Medical Center, Stony Brook, NY
Dominion Ballroom North (2nd Floor)
 Background: Resident retreats have been included in the curriculum of many residency programs for years. Retreats offer residents protected time away from patient care duties and allow a focus on team building and improving interpersonal skills. Two programs in the Mid-Atlantic region have collected data from resident retreats over the past 10 years showing that residents' attitudes toward retreats are quite favorable. Despite having to role play and share opinions and feelings with others in the group, 95 % of residents rate their retreats as outstanding or very good. In addition, 91% of the residents report that retreats impact how they will represent the program to residency applicants. Despite their clear importance to residency programs, many program directors have no training in preparing a structured and effective resident retreat. Purpose: This workshop will offer participants strategies for incorporating structured retreats into their program curriculum, providing a method to develop resident's skills in the core competencies of professionalism, interpersonal communication and practice-based learning. Methods: In the first hour, participants will take part in setting the stage for a successful retreat. A review of setting ground rules and utilizing fun and effective introductory games will be discussed in an interactive format. Examples of an intern orientation retreat, mid-year intern retreat and a supervisory resident retreat will be used to show the longitudinal approach to building on resident's skills through retreats. Participants will offer strategies used in their program to enhance the content that is offered and to provide a variety of ideas. In the second hour, participants will complete the Thomas Kilman Conflict Mode Instrument. Using this as an example, the participants will work in groups to experientially learn how the instrument can be used in a retreat format to improve resident skills in conflict resolution. Participants will be given copies of retreat agendas, introductory games, a template for a scavenger hunt and other materials for use in their program.

5. Sustained Mentoring Relationships in an Academic Environment
Dorene Balmer, PhD, RD; Christina L. Master, MD; The Children's Hospital of Philadelphia, Philadelphia, PA; Janet R. Serwint, MD, Johns Hopkins Children's Center, Baltimore, MD; Angelo P. Giardino, MD, PhD, Texas Children's Hospital/Baylor College of Medicine, Houston, TX
Sheraton Hall A (#1, Lower Concourse)
 Collegial networks within and between academic centers are increasingly recognized as essential in medical education and in general pediatrics. Despite near universal calls for mentoring, formal mentoring programs are often difficult to launch due to time constraints and the competitive nature of academic medicine. Moreover, the type of mentoring these programs typically endorse, i.e. assigned, short-term career advisement, may be qualitatively different from classical mentoring: dynamic, reciprocal relationships that aim to promote the development of both mentors and protégés. Part lecture, part discussion, part question and answer, this workshop begins by exploring contemporary paradigms in education, grounding mentoring in education theory and challenging the notion that mentoring is "all about chemistry." A framework for mentoring that considers nurturance and reciprocity as essential to establishing and sustaining mentoring relationships will be presented. Interactive

discussion with participants will center on the roles of mentors and protégés, the contributions each makes, and what each can expect to gain from the relationship. The second half of the workshop will build on the fundamentals introduced in the first half, with facilitators sharing their personal experiences of mentoring individuals at different institutions and from various disciplines. Participants will have an opportunity to learn about tools that can augment traditional mentoring activities, such as individualized learning plans and e-mentoring. Participants will come away with a better understanding of the features of mentoring relationships, as well as innovative and practical approaches to mentoring. Recognizing that even highly motivated mentors and protégés may be constrained by academic environments that do not identify mentoring as a scholarly activity, the workshop will end with an interactive discussion about ways to institutionalize a commitment to mentoring.

6. **An Annual Educational Retreat: Utilizing structured small group discussions to satisfy a myriad of RRC requirements**

Angelika Rampal, MD, UCLA Pediatric Residency Training Program, Los Angeles, CA; Kate Perkins, MD, PhD, UCLA Pediatric Residency Training Program, Los Angeles, CA; Lee Miller, MD, UCLA Pediatric Residency Training Program, Los Angeles, CA; Abhay Dandekar, MD, UCLA Pediatric Residency Training Program, Los Angeles, CA

Civic Ballroom North (2nd Floor)

In this Workshop, participants will be introduced to the variety of ways in which a structured Annual Educational Retreat may be utilized to teach many of the general competencies, as well as to foster resident self-reflection by familiarizing residents with each of the competencies. In addition to being a creative approach to fulfilling RRC requirements, an Educational Retreat may provide an opportunity for programs to assist residents in focusing on arenas that complement the education they receive in the clinical setting. This Workshop will include an introduction to our program's Educational Retreat and the details of the small group sessions that we have incorporated into the Retreat: 1) Pediatric Organizations: Reviewing the "alphabet soup" of pediatric organizations (i.e., the ABP vs. the AAP vs. the RRC, etc.), 2) "Name that Competency!" - An interactive patient vignette designed to reinforce the ways in which residents utilize each of the competencies in daily practice and the ways in which they are evaluated in each competency domain, 3) Utilizing the Web: An interactive forum at the computer designed to introduce residents to the many available web-based resources, including ABP procedure logs, on-line pediatric teaching resources and on-line resources specific to our residency program (for example, Policies and Procedures, the Core Curriculum with goals and objectives for each rotation, etc.), 4) Cultural Competency: Using patient simulation to generate discussion, 5) The "One Minute Preceptor": Teaching residents to be better teachers for one another and better providers of feedback, in just a few simple steps, 6) Professionalism: A case-based small group discussion on professionalism, 7) Communication: Highlighting the importance of effective communication and providing strategies to improve interdisciplinary communication skills.

7. **What Have You Done For Me Lately? : The Role of the Associate Program Director**

Nancy Spector, MD, St. Christopher's Hospital for Children, Philadelphia, PA; Keith Mann, MD, Children's Mercy Hospital, Kansas City, MO; Monica Sifuentes, MD, Harbor-UCLA Medical Center, Torrance, CA
Grand Ballroom West (Lower Concourse)

The role of the Associate Program Director (APD) for Pediatric Residency Programs is often loosely defined and varies greatly among institutions. Although the APDs are the largest contingent of APPD members, we know little about whom we are and what our needs are within the organization. Those who decide to become APDs do so for many different reasons. Many young faculty aspire to become career educators, while others take on this responsibility at the later stages of their careers. Although traditionally the role of APD is a natural stepping stone to the role of program director, there are plenty of people who do not have those same career aspirations. Within the role itself, many people focus on a specific task (i.e., recruitment), while others model the program director and are involved in all aspects of the residency program. Using case scenarios and small group discussions, the workshop will help participants define the different niches within the varied role of the Associate Program Director, create networking opportunities within these niches, discuss different career options, provide opportunities for future collaboration, discuss peer mentoring, and begin to develop a framework for addressing APD needs within the APPD.

8. **Developing Tomorrow's Pediatricians Through Family-Centered Rounds**

Stephen Muething, MD; Jeffrey Simmons, MD; Javier Gonzalez-del-Rey, MD, Cincinnati Children's Hospital Medical Center, Cincinnati, Ohio

City Hall Room (2nd Floor)

A recent AAP policy statement calls for rounds (patient presentations and discussions) of all hospitalized patients to occur in the presence of the patient and family to facilitate information sharing and active family involvement in decision-making. In addition, the ACGME, as part of implementation of a competency based curriculum, requires that attending physicians directly observe resident skills in these areas. Family-Centered Rounds (FCRs) is

a practical approach to accomplish both goals at the same time. Initially, FCRs were implemented to improve family satisfaction and decrease delays in discharge. Improvements have been noted in both of these areas. However, faculty have found that FCRs have become an indispensable tool for teaching. FCRs allow for observation, modeling and real-time feedback by faculty, families and staff. The faculty reports a significant increase in the ability to assess resident's skills interacting with patients and families. They also report a significant increase in the focus on communication skills, shared-decision making and addressing "hidden" parent concerns. FCRs also provide the perfect setting for residents' interaction with nurses, respiratory therapists, pharmacists, nutritionists, and other health care providers/resources, and give trainees the opportunity to care for children in a multidisciplinary team. This workshop will utilize a variety of interactive techniques to engage the audience, drawing on their collective experience and expertise. After a short introduction, participants will break into small groups to list perceived advantages, disadvantages, and barriers to FCRs. The medical literature relevant to these perceptions will be highlighted. Lessons learned over the past five years at Cincinnati Children's Hospital will be shared through a series of video vignettes followed by large group discussion. Small group discussion will allow for time to focus on changes that can be tested quickly by participants.

12:00 - 1:00 p.m. **Lunch** (on your own)

12:00 - 1:00 p.m. **Regional Chairs Luncheon**
Sheraton Hall B (#2, Lower Concourse)

Council of Task Force Chairs Luncheon
Sheraton Hall C (#3, Lower Concourse)

1:00 - 3:00 p.m. **Workshop Session II**
2 CME Credits Available

9. **A Practical Approach to Making PBLI and SBP Meaningful to Residents**
Linda Lewin, MD; Carol Carraccio, MD, MA; Virginia Keane, MD; Erin Giudice, MD; Gail Olsen, RN, MA, MBA, PhD, University of Maryland, Baltimore, MD
Dominion Ballroom South (2nd Floor)

Introduction: Meaningful learning about the competencies requires integration into the care of patients. However, integrating Practice-based Learning and Improvement (PBLI) and Systems-based Practice (SBP) into busy residency programs is a universal challenge. At the University of Maryland (UMD) we have created an Academic Block rotation in which we introduce residents to quality improvement, teaching skills, and systems thinking through hands-on projects and supervised activities that lay the foundation for application in the clinical setting. At the completion of the workshop participants will be able to: 1) Describe innovative and pragmatic approaches to teaching and assessing PBLI and SBP, and 2) Articulate a preliminary plan, informed by the materials from UMD and the large group discussion, for teaching and assessing these competencies at home. The workshop format will include: 1) A brief introduction to the goals and objectives of the Academic Block, 2) A description of several elements of the Academic Block (Personal Improvement Project, Clinical Improvement Project, Resident as Teacher Program, SBP learning activities) and distribution of relevant teaching and assessment tools, 3) A large group discussion of what is done in participants' home institutions that builds on learning activities described at UMD, 4) Formation of small groups to develop a preliminary plan for teaching and assessing these competencies back home in a way that is both meaningful and practical and 5) Reports from small group leaders to the large group on the substantive areas of discussion within their groups. The workshop products will include: 1) worksheets for a personal improvement project, 2) strategies for implementing team clinical improvement projects, 3) materials to enhance resident teaching skills, 4) actual teaching modules and reflective essays to address SBP, and 5) a preliminary plan for teaching and assessing these competencies in your own program.

10. **Where Does It Hurt? Diagnosing Your Program's Problems**
Karen Smith, MD, MEd, HSC Pediatric Center, Washington, DC; Ira Cohen, MD, MEd; Christiane Corriveau, MD, MEd, Children's National Medical Center, Washington, DC
Grand Ballroom West (Lower Concourse)

In pediatric departments, academic administrators are confronted with a multitude of problems on a daily basis. As with patient care, these "presenting complaints" require a systematic approach to insure all factors are weighed and all possibilities are considered. The proposed workshop will familiarize program directors and chairs with the terminology, theories, and applications of the organizational sciences. During the presentation of the workshop's objectives and road map, each attendee will be asked to list five commonly encountered programmatic challenges or "chief complaints." Through facilitated large group discussion, workshop participants - using the Open Systems Model - will create a "differential diagnosis" for the most universally shared departmental ailment. Using explanatory diagrams, the group will identify and assess: 1) System Fits, 2) System Gaps, and 3) Interdependencies. Specialized and "disease" specific "diagnostic tests" such as: Stream Analysis, the Five Box

Model, and Force-Field Diagrams, will then be introduced. The decision-making and problem-solving processes that are required to select and apply these tests will be demonstrated. Small groups will then be organized around each of the previously identified top five training program problems. Each group will choose and apply one of the diagnostic tests for a real-world programmatic issue. Upon completion of this task, the groups will report back their results and the advantages and difficulties they encountered. Attendees will also share how they plan to use these diagnostic techniques in their parent institutions.

11. Making Evidence-Based Practice Work for You and Your Learners

Rani Gereige, MD, MPH, University of South Florida Pediatric Residency Program; Kathleen Campbell, MD, University of South Florida General Academic Pediatrics, Tampa, FL
Civic Ballroom North (2nd Floor)

The ACGME competency of Practice-Based Learning and Improvement is heavily dependent on the acquisition of residents' skills in EBM principles. Historically, residency programs have struggled with designing creative methods to teach and evaluate these skills. Effective searching of the literature is one of the essential components of a curriculum for lifelong learning and is often challenging to evaluate. This workshop is intended to assist educators in implementing practical ways to teach and evaluate literature searching skills as well as basic EBM competency. Participants will rotate between two small groups: (1) The first group will have the opportunity to learn about the latest EBM databases and their applications including PDA resources. (2) The second group will focus on the various settings in which the EBM curriculum can be implemented. Participants will apply various assessment tools specifically designed for each of the teaching settings.

12. Exploring the Family Friendly Workplace: Implications for Pediatric Training

Adam Pallant, MD, PhD, Brown Medical School, Providence, RI; Ann Burke, MD, Wright State University, Dayton, Ohio
Sheraton Hall A (#1, Lower Concourse)

Background: The Federation of Pediatric Organizations (FOPO) released a "Report of the Task Force on Women in Pediatrics" in 2005. The recommendations in the report are aimed at goals which address issues of "family balance in the lives of pediatricians during training...including concerns regarding productivity, career advancement, and individual fulfillment." The FOPO goals will have significant impact on training programs. Utilizing a process managed by the APPD Action Team on Women in Medicine, member input into the six specific residency training charges was obtained. Opinion was garnered via a member survey in February 2006. Likewise, a 2006 workshop explored family friendly concepts. An endorsement of the FOPO Report with suggested modifications was sent to the FOPO Chair based on this process. The evolution of the six residency recommendations should be shaped, with considerable thoughtfulness, by the membership. Objectives: To continue a dialogue about family friendly pediatric training, with specific aims of defining attributes of such programs and clearly describing varying ways of accomplishing flexible training. Description: A brief summary (15 minutes) of the information obtained by the APPD member survey will introduce the topic. With participant involvement, a summary of family friendly considerations will be discussed for 20 minutes (flexibility for extended training, resources for child care, non-traditional training schedules, employee benefits, and general work-life balance issues). Subsequently, two FOPO recommendations will be considered in detail: 1) family friendly rating scales for programs, and 2) best practices for flexible training. The participants will break out into two groups based on the above two topics (45 minutes). The two groups will report back to the larger group for open discussion (30 minutes). The final goal of the workshop will be to lay the foundation of pragmatic approaches to residency designs that incorporate personal, family and professional development. The last 10 minutes will be used to define the Action Team's "next steps".

13. Spinning Your Web: Creating a Website as an Effective Educational Tool

Andrew McInnes, MD; Nancy Spector, MD; Paul Matz, MD, St. Christopher's Hospital for Children, Philadelphia, PA
Grand Ballroom East (Lower Concourse)

Background: Residency and fellowship programs in all specialties are faced with the challenge of creating new educational programs and evaluation tools, e.g., the recent shift to competency-based evaluations. The task of disseminating background information and resources to develop these new programs and tools can be a daunting task for faculty and program directors. Creating a web site can be an effective way for faculty and trainees to access, use, and adapt educational tools, clinical information, research data, and administrative policies. Graduate medical trainees are familiar with using these electronic resources in their educational and clinical endeavors, yet faculty members and program directors feel unprepared to develop and implement these resources. Objectives: This workshop will be a hands-on, interactive presentation that will provide participants with a framework to: 1) Choose a location to house electronic resources (intranet, internet, University-based, private web hosting); 2) Select and purchase a website domain name; 3) Research and purchase website hosting services; 3) Design an effective web site; 4) Build a web site using commonly available software; 5) Secure electronic data;

and 6) Receive academic credit for internet-based projects. Description: The workshop will begin with a short didactic presentation that will review the facilitators' experience in developing and implementing a web-based resource to assist faculty in creating a competency-based evaluation system for all graduate medical education programs at their institution. The large group will work through a systematic approach to create an effective web-based educational resource. Small groups will have the opportunity to use software to create a mock educational web site. Participants will leave with resources that will assist them in developing web sites at their own institution.

14. Turning to Residents and Fellows as Teachers: From Curricula to Evaluation

John Benjamin, MD, UNC Department of Pediatrics, Chapel Hill, NC; Nancy Spector, MD, St. Christopher's Hospital for Children, Philadelphia, PA; Jose Gonzalez, MD, MEd., UTMB-Galveston, Galveston, TX

City Hall Room (2nd Floor)

Background: The American Board of Pediatrics and the Residency Review Committee (RRC) now require that pediatric residency and fellowship programs teach and evaluate residents' teaching skills. Both the RRC and the American Board of Pediatrics are encouraging residency and fellowship programs at the same institution to work together to create teaching programs for their learners. Although most program directors agree that teaching residents and fellows to be effective teachers is extremely important, creating a forum to do this presents a significant challenge. Program directors are faced with many potential barriers to the implementation of a teaching program including: lack of available teaching curricula, lack of evaluation tools, limited faculty time and training, and competing requirements for trainees' time. Objectives: This workshop will be a hands-on, interactive presentation after which participants will be able to: 1) identify potential barriers to the implementation or advancement of their resident/fellow teaching programs; 2) discuss strategies to overcome potential barriers to the implementation or advancement of their teaching programs 3) identify available teaching curricula, learner evaluation tools and teaching resources. Description: The workshop will begin with a short didactic session that will review the facilitators' experience developing and implementing teaching curricula and evaluation systems for residents and fellows at three separate institutions each with a different number of trainees. Facilitators will share multiple teaching resources including: a web-based teaching resource center for learners, a comprehensive resident block rotation teaching curriculum and evaluation system, and a format to conduct teaching retreats for learners. Small groups will work through a systematic approach either to develop a teaching program for learners or improve an existing teaching program. Participants will leave with examples of teaching curricula modules, evaluation tools, and a strategy to implement or modify a teaching program in their own institution.

15. Integrating Professionalism into the Curriculum: Professionalism as a Measurable and Teachable Skill
Raj Donthi, MD; Scott Holliday, MD; Leslie Mihalov, MD; Cynthia Ledford, MD; John Mahan, MD, Children's Hospital/The Ohio State University, Columbus, OH

Civic Ballroom South (2nd Floor)

Traditional approaches to fostering professionalism (P) have focused on P as a set of virtues, which when adopted, lead physicians to behave professionally, even under stress. Educational strategies have focused on selecting the right student, and teaching rules through lectures and role modeling. We hypothesize that P feedback and skill building are critical elements, and integrated P skill building, evaluation and feedback into our curriculum through: 1)Code of Conduct presentation, 2)Ethics Conference: Virtues and P, 3)PL1 P Workshop, 4)PL1 P Skills Building Workshop: Medical Errors, Professional Responses, 5)ED 360 Professionalism Evaluation and Directed Counseling, and 6)P Remediation Process. In this workshop we will focus on evaluation/feedback and skill building elements. The ED 360 evaluation uncovers lapses in P, opening the door for counseling. The P Skills Building Workshop draws parallels between P lapses and quality improvement, using methods from medical error literature to analyze P situations. Analysis of situations helps develop insight and empathy to identify why a reasonable person may behave that way. Useful skills to help in P dilemmas including developing alternate strategies and crisis communication are taught. We hypothesize that the first steps to P resiliency are self-awareness, self-control, and recognizing the impact of emotions on judgment. Through presentations, analysis of case scenarios, and small group work participants will: 1. Understand how to weave P training into the curriculum 2. Define 4 methods to evaluate P and provide feedback 3. Learn to analyze causes of P lapses and identify conflicts between P values and personal needs 4. Use root cause analysis to target actionable causes of P lapse - deficient knowledge, judgment, skills, or systems 5. Identify skills that support P resiliency for residents and develop educational plans for individuals and the program as a whole.

16. Preparing for a Medicine-Pediatrics Program Site Visit

Niraj Sharma, MD, MPH, University of Miami Miller School of Medicine, Miami, FL; Bradley Benson, MD, University of Minnesota Medical School, Minneapolis, MN; LuAnn Moraski, DO, Medical College of Wisconsin, Milwaukee, WI; Allen Friedland, MD, Christiana Care Health System, Newark, DE
Dominion Ballroom North (2nd Floor)

Combined Medicine-Pediatrics (med-peds) residency programs will be accredited for the first time by the Accreditation Council on Graduate Medical Education (ACGME). Recent survey data by the Medicine-Pediatrics Program Directors Association shows that most med-peds Program Directors are not experienced in the process of accreditation. The majority have just completed their first PIF, and none have been through a Med-Peds specific site visit. This workshop will focus on the real-time tasks of preparing for your ACGME site visit. While the focus will be on the med-peds process, the objectives are just as applicable for new categorical directors or MP Co-directors with an upcoming visit. Documentation requirements, timelines, program director preparation and site review participant preparation will be discussed in detail. The objectives of this workshop will be: 1) Review the materials, resources, and timeline required to ensure a successful site visit. 2) Link the PIF completion and results to the site visit preparation materials and utilize both for program improvement. 3) Template an actual site review day, including challenges and pitfalls. 4) Lead a discussion amongst the attendees to answer questions and collate collective lessons learned.

3:00 - 3:30 p.m.

Break in Exhibit Hall
Sheraton Hall E (#1, Lower Concourse)

3:30 - 5:30 p.m.

Workshop Session III
2 CME Credits Available

17. How Are We Addressing Reflective Practice as it Relates to Professionalism in Residency Education?

Larrie Greenberg, MD, George Washington University School of Medicine, Potomac, MD; Margaret Plack, PT, EdD, The George Washington University School of Medicine, Washington, DC; Maryanne Driscoll, PhD, Touro College, New York, NY
Dominion Ballroom South (2nd Floor)

Being a professional means that one is reflective. Donald Schon's seminal book on this topic, *The Reflective Practitioner: How Professionals Think in Action*, was published in 1983 but physicians as a profession have been slow to incorporate Schon's principles into residency curricula. In fact, reflection has been a widely accepted tool for learning in higher education. It allows for the interconnections between observations, past experiences, judgment and professionalism around patient care and teacher/learner interactions. It gives meaning to experience and promotes a deeper approach to learning because it challenges trainees to question assumptions and shibboleths, reframe problems and examine situations from multiple perspectives. Reflection, a conscious effort within the context of critical incidents, helps trainees to self-assess and to be competent life-long learners. As a process, it should assist trainees in assessing their strengths and weaknesses as they address the ACGME competencies. In this workshop, we will first seek information from RTPDs re: what their programs are doing to teach reflective practice and how they are evaluating their teaching. Then we will present a brief summary of what reflective practice is and a literature review of how it is being taught and evaluated. We will then explore ways to incorporate reflective practice based on the 80-hour work week and other limitations inherent in pediatric residency programs. It is anticipated that attendees will have a better sense of what reflective practice is, and how to teach and evaluate it at the conclusion of the workshop.

18. Spinning Straw Into Gold

Bonnie O'Connor, PhD; Laura Olivieri, MD; Michael Spaeder, MD; Laura Schaffer, MPA; Adam Pallant, MD, PhD, Brown Medical School, Providence, RI
Civic Ballroom South (2nd Floor)

Feeling overwhelmed by keeping up with all of the new RRC subtleties and documentation requirements? The goal of this workshop is to give extensive assistance and preparation for attaining all the new RRC goals and demands. Workshop participants will explore a variety of methods to create and coordinate streamlined tracking systems that both serve your needs as a pediatric program director/coordinator with enormous demands on your time and energy, and thoroughly document compliance with RRC requirements. Drawing upon our own successes and flops, as well as integrating lessons from pediatric colleagues and previous APPD workshop participants, we will discuss and generate practical formats to create a robust formula for your residents and program alike. By the end of the workshop, participants should leave with a structure to design and implement resident portfolios for tracking Individualized Learning Plans, Quality Improvement Projects, Evidence Based Medicine Projects, directly observed history and physical, patient feedback, nursing feedback, and ED follow-up as some examples. Additionally, program directors and coordinator participants will receive a model Program-Based Portfolio that can be used or modified to track key program features directly toward documentation for the PIF in preparation for upcoming RRC reviews.

19. Practical Tips on Implementing a Program of Direct Observation: Lessons Learned from a Multi-Institutional Pilot Project

Angela Allevi, MD, Jefferson Medical College, Philadelphia, PA; Clifton Yu, MD, Uniformed Services University of the Health Sciences, Washington, DC; Ellen Hamburger, MD; Sandra Cuzzi, MD, Children's National Medical Center, Washington, DC; Joseph Lopreiato, MD, Uniformed Services University of the Health Sciences, Bethesda, MD

Grand Ballroom East (Lower Concourse)

The RRC now requires that all programs document direct observation of residents in the clinical setting. But who has the time? How can we get faculty and residents comfortable with the idea? In this interactive workshop, participants will learn about implementing a system of direct observation, and tips on getting buy-in from faculty and residents. Children's National Medical Center (CNMC), Jefferson Medical College and Uniformed Services University of the Health Sciences (USUHS) piloted a system of direct observation in the continuity clinic setting using a new tool to document those observations. The project involved over 75 preceptors and 120 residents working in a variety of clinic settings and residency programs. This program of direct observation has been in place for over a year and has successfully been integrated into the residency program curriculum. Workshop leaders have collected data on resident and faculty attitudes about direct observation, feasibility of the program, and analysis of the tool itself. We will share the tool we've adapted which is currently in use in both the continuity clinic and inpatient settings. Participants will have the opportunity to try out the tool and share their experiences with direct observation, as well as any tools they've used. Discussion will include our experiences during the pilot project and lessons learned regarding attitudes, need for faculty development, and feasibility of direct observation. Participants will go home with new strategies to implement or revise a system of direct observation that fits the needs of their own institution.

20. Test Driving A Practical Competency-based Curriculum for Residents

J. Peter Harris, MD; Constance Baldwin, PhD, Univ of Rochester Pediatric Residency Program, Rochester, NY

Dominion Ballroom North (2nd Floor)

This workshop will introduce a practical competency-based curriculum model, recently implemented at the University of Rochester. It is based on rotation and program planning templates in the APA Educational Guidelines. For each rotation, we identified 8-12 essential objectives and a longer list of non-essential objectives, all linked to competency domains. Essential objectives only are included in rotation-specific planning tables and evaluation forms, and evaluation of these objectives is enhanced by direct observation cards and/or oral/written exams. Individual learning plans (ILPs) list both essential and non-essential objectives. Faculty and residents review the essential objectives and ILP at the start of a rotation, check on progress midway, and discuss a summative evaluation at the end. The rotation planning tables are collated to map coverage of all ACGME competency domains across the program. Evaluation of the restructured curriculum is in progress. In this workshop, we will present the curriculum model, and then discuss how it was developed and implemented, beginning at the rotation level. Small groups will choose a rotation, review our essential objectives, and then create a curriculum planning table around the objectives list. This exercise will focus on selection of teaching and evaluation activities that are appropriate for the objectives and setting and address ACGME requirements. The whole group will reconvene to discuss one rotation planning table in detail. Next, the process of program-wide planning will be addressed. We will show how the rotation-based objectives were collated into a whole program plan, organized around ACGME competency domains. Small groups will critique our program-wide plan in one chosen domain in order to 1) identify gaps in domain coverage and recommend settings where improvement could occur, and 2) review teaching and evaluation activities and recommend places to enhance high priority educational approaches (e.g., direct observation, multi-source evaluation). The session will end with a general discussion of implementation ideas and take-away lessons, and evaluation of the workshop.

21. Four Generations Collaborating to Improve Resident Education

Jennifer Gilhooly, CPNP; Joseph Gilhooly, MD, Oregon Health & Science University, Portland, OR Sheraton Hall A (#1, Lower Concourse)

At the APPD 2006 Annual Meeting, Dr. John Molitor introduced us to the subject of generational differences. However, we did not have the opportunity to explore changes needed in resident education. Change will require a collaborative approach between the generations to identify opportunities for educational improvement. This workshop will present a review of 1) Generational differences between Silents, Boomers, X-ers, and Millennials, 2) How these differences impact teaching and resident learning styles, 3) How generational differences are changing what residents expect from their training program in terms of feedback, life-work balance, patient advocacy, and 4) How these differences ultimately effect their entry into the workforce. In a model of collaboration, participants will break into small mixed generational groups to address the values of each generation within the context of resident education. Focus areas for the small groups will include: interactive teaching styles, setting expectations of learners, ways to motivate and reward learners, evaluation and formative feed-

back, professionalism, team functioning, patient hand-offs, and patient advocacy. The small groups will report back, and the information presented will be entered into PowerPoint slides that will be distributed to the participants. At the conclusion of the workshop, participants will take with them specific information on changes that will decrease the frustration of teachers and improve the satisfaction of resident learners. Many of these changes will have the additional benefit of meeting the requirements of competency-based, learner-focused education.

22. **Teach to Your Strengths and Adapt to Your Learners! Understanding Individual Teaching and Learning Preferences to Maximize Your Teaching Potential**

Richard Shugerman, MD; Heather McPhillips, MD, MPH, University of Washington, Seattle, WA
City Hall Room (2nd Floor)

Part 1 (20 minutes). Attendees will take the Myers-Briggs Type Indicator, a self-scored instrument that divides individuals into 16 different personality styles based on the following characteristics: Extroversion (E) vs. Introversion (I), Intuition (N) vs. Sensation (S), Thinking (T) vs. Feeling (F), Judging (J) vs. Perceiving (P). Workshop leaders will then discuss differences in personality type and how these differences can impact communication, teaching and learning styles. Part 2 (40 minutes). We will break into four small groups based on scores of the Introversion/Extroversion and Intuition/Sensation components of the test. Working with a facilitator, each group will discuss individual learning preferences and teaching strengths and weaknesses intrinsic to their type and will then present a summary of their discussion to the larger group. The workshop leader will briefly summarize the discussion using videotaped examples to illustrate effective teaching for each of the four styles. Part 3 (45 minutes). Each group will be given teaching cases in which they are paired with challenging learners with learning styles similar and opposite to their own. Each group will develop a teaching strategy for the two cases and present these to the larger group for feedback and discussion. Through this process we will develop a toolbox of unique teaching strategies that may be effective with learners of different learning styles. Part 4 (15 minutes). The workshop leader will conclude the session with a brief summary of teaching to individual strengths, but adapting teaching strategies when learner preferences require it. Workshop participants will discuss how this model might be used for faculty development and teaching residents to teach in their own institution.

23. **Integrating Evidence-based Practice into Your Curriculum.**

Elizabeth Wedemeyer, MD; Maria Kwok, MD; Martin Pusic, MD, Morgan Stanley Children's Hospital of New York, New York, NY

Grand Ballroom West (Lower Concourse)

Background: An explicit RRC requirement for Pediatrics states that residency programs must demonstrate that their residents are competent in accessing, appraising, and applying knowledge from the medical literature. Programs are required to assess their residents' capabilities in this area based on direct observation and precepting in a clinical setting using faculty evaluation. In addition, programs must evaluate the competence of residents in performing an evidence-based exercise, in a journal club or other structured exercise using predetermined criteria. Goals & objectives: The goal of this workshop is to allow program directors and faculty members to explore various ways of integrating evidence-based practice into their curriculum, and to meet RRC requirements in this area. Participants will learn how to design and implement evidence-based practice into morning report, work-rounds and a structured resident presentation. We will discuss how to overcome barriers to implementation and ways to assess residents' competency in evidence-based practice. Lastly, we will discuss how you can use this training tool as means to develop your own academic career. Methods: We will review the common barriers faced by institutions when implementing a new curriculum. We will discuss how we overcame some of these barriers at our institution, and how to obtain buy-in from other faculty members and residents. Audience participation will be encouraged as we break into small groups and demonstrate how we conduct the teaching sessions with small groups of residents. Next, we will discuss how evidence-based practice can be integrated into established curriculum, such as morning report, work-rounds, and a formal resident teaching conference. We will share our different evaluation methods, how feedback is given to the residents, and how the evaluation is incorporated into the resident portfolio. Finally, we will discuss how faculty interested in teaching evidence-based practice can further develop their careers with activities such as writing reviews and performing educational research.

24. **Andragogy in Pediatrics: Self-directed learning and the ILP**

Tahniat Syed, MD, MPH; Nancy Spector, MD, St. Christopher's Hospital for Children, Philadelphia, PA; Ann Burke, MD, Wright State University, Dayton, OH; Elizabeth Stuart, MD, Stanford University, Palo Alto, CA; Michael Blair, MD, St. Christopher's Hospital for Children, Philadelphia, PA

Civic Ballroom North (2nd Floor)

Background: Pediatric residency and fellowship programs are charged with the challenge of integrating self-directed learning (SDL) within graduate medical education. To accomplish this task, educators in pediatrics are now required to have trainees complete one individualized learning plan (ILP) per year. ILPs are a tool reported to have theoretic educational benefits and are a useful for tracking SDL. This interactive workshop aims to

address the needs of Program Directors and faculty who may have little experience with these concepts and who may need ideas and guidance with regards to ILP implementation. Objectives: To provide much needed background and information on the ILP concept by summarizing the current evidence in the medical literature. To discuss approaches for programs to accomplish creating, maintaining and facilitating effective ILPs. To collaborate and share ideas and experiences of ILP implementation with other Program directors. Description: The presenters will first review their experiences with implementing the ILP. This will include their process of 1) integrating the literature on SDL and adult education learning theories, 2) identifying an interested faculty-fellow-resident task force, 3) conducting mini resident workshops, 4) educating additional faculty to become mentors, and 5) developing continuous mentorship ideals. Small groups will review example ILPs and discuss issues of feedback, maintenance and mentorship potential. Participants will be encouraged to share their experiences to date with ILP implementation, specifically with issues related to evaluation. We hope that participants will come away with a better understanding of SDL and a clear plan for ILP implementation and evaluation.

5:30 - 6 :30 p.m.

Posters with Exhibits and Wine/Cheese Reception
Sheraton Hall E (#5, Lower Concourse)

Poster 1 (Abstract 1019)

Implementing the Parent Partners in Health Education (PPHE) curriculum as a longitudinal PL2 and PL3 residency experience

Theresa Hetzler, MD, New York Medical College/Westchester Medical Center, Valhalla, NY

Background: To optimally serve children with or at risk for developmental disabilities (DD) and their families, residents need opportunities to strengthen developmental and behavioral screening skills, to work with families to better understand parent perspectives on their children with disabilities, and to reflect on these experiences with faculty and peers. We are one of 8 residencies in New York State funded by the Developmental Disabilities Planning Council (DDPC) to pilot these opportunities using the PPHE curriculum, which focuses on preparing residents to address the unique needs of children with DD and their families by partnering with families and community agencies. **Methods:** We implemented the curriculum using: orientation sessions; a pre-test created by DDPCs evaluation team for all sites; grand rounds and conferences on screening, communication skills, and legal aspects of special education; sessions in developmental/behavioral clinic; use of the MCHAT and PEDS screening tools by PL3s in continuity settings; training of junior residents to use the tools by PL3s; home and community visits to families of children with DD; and small group sessions for reflection. Evaluation will be based on a comparison of pre-post testing and on written feedback from residents. **Challenges:** We have met scheduling challenges by placing curriculum materials on line, by offering individual orientation sessions for residents unable to attend group sessions, and by having staff schedule visits. A faculty member visits continuity sites to assist PL3s in how to use the MCHAT and PEDS screening tools. **Conclusion and next steps:** The PPHE curriculum provides an excellent opportunity for residents to learn parents' perspectives concerning their children with DD, to gain skills in using screening tools, and to become more familiar with the home and community aspects of the lives of children with disabilities. Next steps include obtaining and evaluating resident feedback to inform the planning of the second year of the program.

Poster 2 (Abstract 1047)

Improving the Board Pass Rate of a Pediatric Residency Program

Eyal Ben-Isaac, MD; Michelle Thompson, MD, Childrens Hospital Los Angeles, Los Angeles, CA

Objective: The American Board of Pediatrics (ABP) certifying exam is the final step that pediatric housestaff must complete in order to achieve certification in their specialty. The national pass rate on this exam for first-time test-takers is approximately 80%. The objective of this study was to determine the effectiveness of a series of targeted educational interventions in improving the ABP exam pass rate of graduates from a pediatric residency training program. **Methods:** ABP exam scores of former residents prior to, during, and after the intervention were reviewed and compared. A retrospective analysis of the data was performed to determine whether a significant difference in mean ABP exam scores and pass rate existed between the three groups of graduates. PL-1 In-training exam (ITE) scores were also examined to ensure that any noted increase in ABP exam performance was not attributable to a difference in baseline knowledge or test-taking ability between the different groups. Finally, recent graduates were surveyed to determine their perceptions regarding the utility of the individual interventions. **Results:** The ABP exam pass rate and mean scores of the post-intervention graduates were significantly higher than those in the preceding years ($p < 0.001$). This increase did not seem to be attributable to better PL-1 ITE scores, as these were found to be similar in the pre-, during, and post-intervention groups ($p = 0.139$). Interventions used during this time period included the use of In-training exams, practical exams, targeted educational conferences, a Board Review course, and individualized study plans. Housestaff ranked PREP Self-Assessment Question & Answer Books and our home institution's Board Review Course as the most useful tools in preparing for the ABP examination. **Conclusions:** A comprehensive and proactive approach, involving both housestaff and training program, can help identify targeted areas for intervention to help ensure the success of graduates on their certifying examination.

Poster 3 (Abstract 1054)

The Missing BMI: The Next Missed Opportunity in Pediatric Medicine?

Angelika Rampal, MD; Anna Han Lee, MPH, UCLA TriCampus Residency Program, Los Angeles, CA

Background: Childhood overweight is a growing problem. Between 1999 and 2002, 10% of children ages 2-5 were overweight and 16% of children ages 6-19 were overweight. 70% of overweight children become overweight adults. Overweight is defined by a body mass index (BMI) greater than 95th percentile for age and gender. At risk for overweight is defined by a BMI greater than 85th percentile. **Methods:** In our physician-resident continuity and urgent care clinic at Mattel Children's Hospital at UCLA, we looked at the rate at which residents identified overweight. Utilizing quality improvement methodology, we provided residents with these data, allowing them to visualize the dramatic rates of overweight in our clinic compared to national data. Subsequently, an intervention was offered: For one week, at the beginning of each clinic session, residents were informed of an obesity management protocol: (1) All children between the ages of 2 and 20 should have a BMI plotted on a growth chart. (2) Children with BMIs greater than the 85th percentile should be managed using a weight management algorithm (provided to residents) and a lifestyle tracking form that provides a checklist to assist in weight and lifestyle management of individual patients. **Results:** Initial chart review revealed that of 143 patients seen in our clinic, only 17% had a documented BMI at their last visit. Further review indicated 42% of all patients had a BMI >85th percentile. Of this population, 60% were NOT identified by their physicians. Physicians were 6.4 times more likely to identify an at risk/overweight patient if the patient was seen in a well-child versus an urgent care visit (58% vs. 9%). Post-intervention data will be available by the time of the presentation. **Conclusions:** Key lessons are learned simply from the initial needs assessment: physicians do not routinely identify overweight patients. Pediatricians must change how they approach childhood overweight. Identifying overweight patients should become a priority at every visit, well-child or urgent. Identifying overweight may soon become the next "missed opportunity" in pediatrics.

Poster 4 (Abstract 1065)

The Role of Program Evaluation in Residency Education

Susan Pearson, MA, University of Wisconsin Pediatric Residency Program, Madison, WI

The ACGME now requires programs to develop and implement formal processes for using resident performance and outcome assessment data to systematically improve their educational effectiveness. To address this requirement, a process of continuous quality improvement was implemented whereby all rotations are scheduled for periodic review with our Residency Executive Committee. This Committee consists of all rotation directors in the Residency Program. Six weeks before a rotation is to be reviewed, the rotation director is given the following: (1) annual summary of rotation evaluation feedback from residents, (2) pertinent questions missed on the InTraining Exam, and (3) annual summary of resident performance data. Rotation directors are asked to review their current curriculum and the above summary data with their respective division colleagues and complete a "Rotation Continuous Quality Improvement Form" (CQI). This form asks for the identification of two specific areas where improvement is needed, a description of what will be done to make the identified improvements (e.g. revise curriculum, revise evaluation strategies, modify resident conference topics, etc.), and how the effectiveness of the improvements will be assessed and documented. Each rotation is then scheduled to provide the Residency Executive Committee with a summary report. Specific questions that must be addressed in each rotation's summary report include: (1) how effectively is the rotation performing its teaching function, (2) does the rotation have clear learning objectives, (3) does the rotation have adequate outcome assessment in place, (4) do residents receive appropriate feedback/guidance on the rotation, and (5) is the curriculum appropriate for the level of training. Through this process, it is anticipated rotation directors will be able to identify both areas of strength and weakness in their respective rotations. It is also anticipated rotation directors will learn new educational strategies from one another.

Poster 5 (Abstract 1079)

Reflection at Work: Using the Videotaped OSCE for Reflection on Interpersonal/Communication Skills and Cultural Sensitivity

Daniel Richards, MD; Thanakorn Jirasevijinda, MD, Bronx-Lebanon Hospital Center, Bronx, NY

The observed structured clinical exam (OSCE) has been used for both summative and formative assessment. Reflection is an essential component of professional growth, and has been added to the language of the ACGME competencies. To date, no literature describes using the OSCE for reflection, particularly on communication skills and cultural sensitivity. We piloted a project using the one-station videotaped OSCE as a reflective exercise for 15 PGY-1 residents. The residents were videotaped interviewing a standardized patient using a scripted scenario before undergoing 10 monthly workshops on communication skills and cultural sensitivity. Immediately afterwards, they scored their own performances with a standardized assessment tool. After the 10 training sessions, they watched their initial interviews, scored their performances again with the same tool, and then received feedback from a faculty member. They also reviewed their initial self-ratings, and reflected on the discrepancies between those and current self-ratings. Lastly, participants completed a questionnaire on the videotape review process and their reflective experience. Responses were reported on the 5-point Likert Scale (5=Strongly Agreed, 3=Neutral, 1=Strongly

Disagreed). All residents reported that the review process was helpful for improvement (93%=5, 7%=4). Many were surprised by their initial self-assessment (14%=5, 36%=4). All believed they would improve from the self-assessment exercise (67%=5, 37%=4), as they would from faculty feedback (80%=5, 20%=4). They also felt qualified to score their own performance (20%=5, 73%=4), to identify their own strengths (47%=5, 47%=4), and weaknesses (47%=5, 40%=4). Written comments highlighted 4 themes: 1) Pt interactions need to be individualized; 2) Psycho-social factors play a large role; 3) Learner-centered assessment was valuable; and 4) Reflection by comparing self-ratings at 2 separate points was useful. Reflection is a crucial step in the learning cycle, but has been underutilized in residency training. Our pilot project demonstrated that learner-centered assessment was well received by PGY-1 residents, and that the videotaped OSCE is an innovative tool for reflection. We gratefully acknowledge the support of the Association of Pediatric Program Directors.

Poster 6 (Abstract 1085)

Do Residency Programs Support Breastfeeding for Residents?

Yardaena Osband, MD, Pediatrics, Maria Fareri Children's Hospital at West, Valhalla, NY

Background: Breast milk provides optimal nutrition for neonates and infants. This is reflected in policy statements of the AAP, most recently in February 2005, that encourages pediatricians to promote and support the practice of breastfeeding. Specific guidance is included for pediatricians to "encourage employers to provide appropriate facilities and adequate time in the workplace for breastfeeding and/or milk expression". One way for residency programs to encourage residents to take on this advocacy role in their future practice is to role model program policy that supports breast feeding by its own residents. The goal of this study was to survey residency programs about how they support breast-feeding among their residents. **Methods:** A 15 question survey, approved by the APPD, was emailed to 189 pediatric program directors through the online service surveymonkey. **Results:** 130 programs responded. Female residents accounted for 71.6% of the residents in responding programs. 95 of the respondents answered the 2 survey items concerning breastfeeding accommodations for residents, and this subgroup is the focus of the current abstract. At the programs' primary teaching hospital the following are available to residents: breastfeeding rooms at 64 (67%) of programs, breast pumps at 72 (76%) of programs, and pumped milk storage facilities at 83 (87%) of the programs. Only 10 (11%) programs reported having an official policy to accommodate resident breast-pumping during working hours. 79 (83%) programs reported that arrangements for pumping are made on an individual basis between residents. At 62 (66%) programs, residents are informed of these services by word of mouth. **Conclusions:** The arrangements made by pediatric residency programs to support breastfeeding by residents indicates less than universal implementation of AAP recommendations for supporting breast feeding in the workplace. Written policy to support resident breastfeeding exists in a small minority of programs. Pediatric residency programs should improve adherence to AAP policy concerning workplace support of breastfeeding in order to better role model this advocacy standard.

Poster 7 (Abstract 1101)

Evaluating Medical Knowledge in Pediatric Residents: What Do We Really Know?

James Bale, MD; Laura Sells, MD, University of Utah, Department of Pediatrics, Salt Lake City, UT

Background: The ACGME has identified medical knowledge as one of the core areas for resident competence. Building a fund of knowledge is basic to medical education. Accurately assessing a resident's knowledge, however, may be difficult. In our program, the faculty evaluate pediatric residents at the end of clinical rotations and rate each resident's fund of knowledge using a 5-point Likert scale. The In-Training Exam (ITE), taken yearly by the residents, is an objective measure of medical knowledge. The purpose of this study is to compare faculty fund of knowledge ratings to ITE scores. **Methods:** Our department has used MyEvaluations.com as a computerized evaluation tool since 2003. Fund of knowledge scores were extracted from the evaluation data for each resident and averaged for each year of training. ITE scores reported by the American Board of Pediatrics were used for the years 2003-2006. Linear regression and correlation methods were used to compare yearly scores between these two measures. **Results:** None of the comparisons showed a meaningful correlation between fund of knowledge and ITE scores. R-squared values for the PL1, PL2, and PL3 years were .12, .0003, and .10, respectively. When linear relationships were fitted to the data, the resulting slopes were almost flat and only marginally significant. Furthermore, confidence intervals for prediction of ITE scores from faculty fund of knowledge evaluations were extremely broad and encompassed all observed values. When fund of knowledge from one year was regressed against the next year's fund score, correlation was weak (R-squared values of .19 and .08). **Conclusion:** The faculty's subjective evaluation of a resident's fund of knowledge did not predict ITE scores. New tools to objectively evaluate knowledge (for example, pre and post-rotation quizzes, or board-type questions for subspecialties) should be developed and assessed as potential measures of medical knowledge.

Poster 8 (Abstract 1103)

What Faculty Believe is Taught in Continuity Clinic: Results from a Program Audit

Wendy Hobson, MD, MSPH; Deirdre Caplin, PhD; Jaime Bruse; James Bale, MD, University of Utah, Salt Lake City, UT

Background: The Ambulatory Pediatric Association created Educational Guidelines for Pediatric Residency (APA-EG) to assist pediatric residency programs in curriculum development. The continuity clinic experience provides residents opportunities to understand and appreciate the longitudinal nature of pediatric care. An audit based on the APA-EG can provide a summary of a program's curricular content and identify potential educational gaps. The continuity clinic curriculum can be used to fill gaps. **Objectives:** To identify gaps in pediatric rotation curricula that faculty believe are taught in continuity clinic. **Methods:** Each required rotation course master completed an audit based on the APA-EG. The audit consisted of a detailed questionnaire of current curricula, focusing on competencies and rotation objectives. The audit addressed the following issues: the relative importance of a topic to training, was the topic taught in rotation? and, if yes, in what context? If the topic was not taught, was it covered elsewhere? The continuity clinic director judged whether topics were appropriate to continuity clinic. **Results:** 17 ambulatory and 4 inpatient rotations were audited. 10 ambulatory rotations had content that was deemed to be of moderate to high importance, but was not covered in the rotation, and was thought to be covered during continuity clinic. Most content topics could be grouped into the following themes: routine prevention and counseling, evaluating school problems, teaching normal physical exam findings, diagnosis of various disorders (especially from undifferentiated signs and symptoms) and appropriate referrals. A few topics, such as describing immune system development and pathophysiology, were not thought to be appropriate for teaching in the continuity setting and require inclusion in the subspecialty rotation. **Conclusions:** To create comprehensive curricula, programs can undergo an audit of their program using the APA-EG. Although not all topics are appropriate for the continuity clinic setting, continuity clinic provides a robust environment for filling programmatic gaps in a competency-based curriculum.

Poster 9 (Abstract 1104)

Documenting your Competency Evaluation: An Organized Approach to Meeting RRC Requirements

Abhay Dandekar, MD; Kate Perkins, MD, PhD; Lee Miller, MD, UCLA Pediatric Residency Training Program, Los Angeles, CA

This Poster will highlight: 1. An approach to making mentor feedback sessions uniform and comprehensive, and at the same time fully compliant with RRC requirements. 2. An approach to organizing each resident's academic binder and competency portfolio. 3. Creation of a Residency Competency Worksheet that summarizes and documents the program's evaluation of resident performance within each of the six competency arenas. 4. Facilitating resident self-reflection by integrating the ILP with each resident's individualized Residency Competency Worksheet. Our goal will be to share our approach to organizing residents' academic binders and competency portfolios, offering examples of the tools we've designed and are using. We will introduce a Feedback Checklist for faculty mentors, as well as a faculty development tool, which was developed to insure that all residents receive comprehensive, uniform feedback and counseling during their mentor sessions. The Feedback Checklist was also designed to facilitate documentation that ACGME requirements have been met. This poster session will demonstrate the contents of the feedback checklist, which include a review of the core competencies, a review of all evaluations, a review of Policies and Procedures, a discussion of the Core Curriculum, a review of subspecialty selective requirements, a review of continuity clinic logs and procedure logs, participation in EBM sessions, mentoring for career development, etc. In addition, we will share our approach to organizing the resident's academic binder and competency portfolio to both complement the Feedback Checklist and to emphasize the links between evaluation tools and resident competencies, thus facilitating teaching of the general competencies. Finally, during this poster session, we will also share an Individualized Learning Plan tool and a Residency Competency Worksheet tool, both created by our program, and demonstrate the ways in which the Program Director can facilitate resident self-reflection through the review and integration of these tools.

Poster 10 (Abstract 1113)

A Patient Care Survey to Assess Resident Skills

Robert Gillespie, MD, University of Illinois - Chicago, Department of Medicine, Chicago, IL; Karen Judy, MD, Loyola University Medical Center, Maywood, IL

The outpatient care clinic setting is an essential rotation in training pediatric residents. Missing from the current ACGME assessment toolbox are instruments to evaluate residents in this setting on the ACGME competencies of professionalism, patient care, and interpersonal/communication skills. We report the development of a patient survey to measure these competencies. **Methods:** This study was a convenience sample of patients attending the acute care clinic in an academic health care setting. Two previously existing patient surveys were combined and tested. A minimum of 50 patients completed the survey for each of nine residents over a three-month period. Patients completed the survey immediately after the residents saw the patients but before the attending physicians entered the examination room. Internal consistency of responses was determined by alpha and split-half coeffi-

cients. A Decision study was performed to determine how many surveys are needed for a reliable assessment. Validity evidence was established by correlation with attendings' ratings of residents, factor analysis of item content, and a logical analysis of survey items by 5 experts. Based upon the initial psychometric analysis valid survey items were selected and the same analyses were repeated with the new instrument. **Results:** Alpha and split half coefficients showed good reliability. D- study results suggest that 20 to 25 surveys are needed for stable patient ratings of each resident. The new assessment instrument also needed 20 to 25 surveys. Cronbach's alpha and split half coefficients again showed good reliability. Low correlations were seen between patient surveys and attending evaluations. **Conclusions:** Patient surveys are a valid and reliable way to assess residents during ambulatory rotations. It is feasible to obtain the 20-25 patient surveys per resident in the course of a four week outpatient rotation. Patient surveys appear to measure other resident ability than are captured by attending physician evaluations. The newly developed survey instrument uses pediatric-specific language, and better encompasses the selected ACGME competencies than past instruments.

Poster 11 (Abstract 1132)

How Does Resident Participation in Hospital-Initiated Quality Improvement Activities Affect Attitudes about Quality Improvement and Hospital Engagement?

Lipstein E; Kronman M; Nyweide White K; Richmond C; Shugerman R; McPhillips H

Background: The Accreditation Council of Graduate Medical Education (ACGME) places importance on quality improvement education, however little is known about how active participation in quality improvement (QI) initiatives affects residents' attitudes about QI or their engagement in the hospital community. Over the past three years, Children's Hospital and Regional Medical Center has been engaged in continuous quality improvement (CQI) activities using Lean Processing methodology. When such activities have been related directly to patient care, our residents on flexible rotations have been asked to participate. Recent initiatives include a re-design of the inpatient medical service, changes in TPN ordering and an effort to decrease pharmacy turn-around times. Approximately 25% of residents have participated in these activities over the last 3 years. **Methods:** We surveyed current and former residents of our pediatric residency for the past 6 years. The web-based questionnaire contained demographic questions, measures of participation in QI activities during or after residency and previously validated measures of attitudes towards CQI (Continuous Quality Improvement Questionnaire) and of hospital engagement (Gallup Q12). We sought to determine if residents who completed residency since the initiation of hospital wide CQI (acculturated) had more positive attitudes about quality improvement and/or increased engagement in the hospital community when compared with former residents who graduated prior to 2006 (unacculturated). A \$5 incentive was provided to all participants. **Results:** The response rate was 84% (N=162). Overall, there was a high level of engagement and positive attitudes towards CQI in all our respondents. There was no difference in the attitudes towards quality improvement or hospital engagement scores between acculturated and unacculturated residents. The first acculturated residency class had an overall participation rate of 53% in CQI activities. Acculturated residents were significantly more likely to view CQI as a positive trend in healthcare (p=0.03). **Conclusion:** Resident participation in hospital-sponsored CQI activities is an effective way of gaining experience in practice-based learning and improvement. Furthermore, completing residency in a hospital committed to CQI is significantly associated with perceiving CQI as a positive trend in healthcare.

Poster 12 (Abstract 1135)

More Than Just Teeth: Incorporating Oral Health into Pediatric Residency Training

Sherry Sami, DDS; Wendy Slusser, MD, MS; Patricia Barreto, MD, MPH; Alice Kuo, MD, PhD, MEd; Victor Perez, MD, MPH, UCLA, Los Angeles, CA

Dental caries are a leading cause of missed school days in children and possibly the most prevalent chronic disease of childhood. We present an innovative curriculum that address the APA Educational Guidelines in dental health in a comprehensive, experiential, and longitudinal fashion. The APA recommends training experiences that encourage pediatricians to take a role in oral health promotion through office-based counseling, screening and early intervention, as well as the use of public health strategies and community services. This curriculum was developed as an enhancement of our existing Community Health and Advocacy Training (CHAT) first-year rotation. In July 2006, we had two new CHAT-pediatric dentistry (CHAT-PD) residents who joined our pediatric interns on their month-long community rotation. After a year of planning with pediatric dental faculty, we were able to develop oral health curricular components that would enhance the training of both pediatric-medical and -dental residents. Some of the new components of the rotation were background didactic seminars on oral health, workshops on application of fluoride varnish, and visits to community-based dental facilities serving at-risk children. In exchange, the pediatric dental residents learned about community pediatrics and public health principles. Plans are being made for continuation of the oral health curriculum into the PL-2 and PL-3 years. This partnership between the pediatric and pediatric dental residency programs has demonstrated that partnering with a dental program can be a synergistic relationship. This fruitful collaboration has allowed us to share curricular experiences that have enhanced training for both pediatric and pediatric dental residents.

Poster 13 (Abstract 1211)

“Take Five”: A Colorful, Dynamic Tool to Enhance Resident Medical Education

Margot Paisley, MD; Rishi Lulla, MD; David Mathison, MD, Children’s Memorial Hospital, Chicago, IL

Background: Residents are exposed to a myriad of educational conferences during their training. At times, it is difficult for busy residents to integrate and retain all of this information. In addition, residents are often forced to miss portions of these conferences due to clinical responsibilities and the need to comply with work-hour rules.

Objectives: As chief residents, our goal was to create an educational tool that would improve residents’ retention of information presented at educational conferences and increase resident investment in their own education.

Methods: With these concepts in mind we created Take Five, a weekly newsletter of educational highpoints. The front page features two interesting cases presented by our residents at morning report from the week prior. Each issue has a theme that links the two cases together (i.e., acute liver failure: a case of hepatitis A and an acetaminophen overdose). The salient points of the cases are briefly presented, and key teaching points are summarized along with visual images for each case. On the reverse side, there is a “Visual Puzzler”. This is one of the most popular items as residents vie to guess the correct answer and the winner receives special mention in the next issue. There is also a section entitled “Back to Basics” which graphically depicts physiologic mechanisms in disease, as related to the issue theme (i.e. the cellular cascade of hepatic injury). Highlights from Grand Rounds and other conferences, as well as news briefs relevant to pediatrics are also summarized. The newsletter is created using Microsoft Publisher (TM) 2003 software. It is a double-sided, single page using glossy color paper. The cost is \$60/week for publication. The feedback we have received for “Take Five” from both residents and faculty has been overwhelmingly positive.

Poster 14 (Abstract 1138)

Infant Lumbar Puncture Simulation Is Valuable for Pediatric Resident Training

Victoria Cartwright, MD, MS; Robert Puntel, MD, Madigan Army Medical Center, Tacoma, WA

Introduction: Studies have shown simulation is useful to train residents, resulting in skills performed more quickly in clinical settings. There are limited articles about simulation for lumbar punctures (LPs). This study was designed to measure and compare data from a simulation center setting on LPs performed by pediatric residents. **Methods:** The Laerdal Baby Tap was used; it is a realistic model for performing infant LP in the lateral decubitus position. One observer rated all residents using a checklist derived from faculty consensus. Data such as academic year, self-reported number of prior LPs and resident ratings on usefulness of training were collected. **Results:** Eighteen residents participated in the Simulation Fair, 9 males and 9 females. All residents obtained consent after discussion of risks, used universal precautions, positioned materials properly, chose correct needle, noted appropriate landmarks, collected CSF in sterile fashion, applied site pressure, removed betadine, assessed infant after procedure and disposed of supplies appropriately. No resident noted if infant was correct patient with time out technique checking hospital band. The mean number of all errors observed during simulated LP decreased with each additional postgraduate year of training (PGY). The average number of errors for PGY1s was 4.7, PGY2s 2.2 and PGY3s 2.0. The average number of total attempts went from 1.8 to 1.2 to 1.0 with each PGY. At least 5-10 prior LPs improves the error rates from 5.75 if no prior attempts to 2.2. Most PGY1s and PGY2s found the simulated LP was moderately to significantly helpful in increasing familiarity with the procedure; all residents thought it useful. The PGY3s reported high comfort level and competency of the LP procedure. **Conclusions:** The simulated LP model is useful for improving familiarity of the procedure and self-reported comfort level of pediatric residents. The number of errors was related to PGY. Residents did well with the actual LP technique, but appear to need additional coaching to ensure safety during the procedure with time out technique to identify the correct patient.

Poster 15 (Abstract 1139)

A Pediatric Resident Curriculum for Practice-Based Learning and Improvement and Systems-Based Practice

Emmett Schmidt, MD, PhD; Shannon Scott-Vernaglia, MD, Massachusetts General Hospital, Boston, MA; John Co, MD, MPH, Partners Office for Graduate Medical Education, Boston, MA; Edward Bailey, MD, North Shore Children’s Hospital, Salem, MA

The ACGME has outlined six general competencies that residency programs are expected to develop in their trainees. We have designed and instituted an educational curriculum to teach “Practice-Based Learning and Improvement” and “Systems-Based Practice” competencies to first year pediatric residents. The four-week long rotation, Practice-Based and Community Pediatrics, is currently in its third year of development. The competency of Practice-Based Learning and Improvement is taught through a self-paced, faculty-guided approach. Residents are mentored by an experienced faculty member as they explore principles of practice-based improvement and evidence-based practice through assigned readings and an individual project. They spend time identifying areas for assessing and improving their own patient care practices. Additionally, time is spent developing the resident’s own individualized learning plan using Pedialink. The competency of Systems-Based Practice is taught through an experiential curriculum developed through collaboration with several community-based agencies that serve children in the greater Boston area. The curriculum allows residents direct contact with other non-physician providers who

care for children. Residents are provided with goals and objectives for each community experience as well as supplementary readings from the pediatric literature. Through exposure to a variety of community organizations, residents expand their understanding of the diverse programs and agencies devoted to the welfare of children and enhance their ability to interact professionally with other child advocates throughout their careers. Residents, faculty and community collaborators have expressed enthusiasm for the curriculum and content covered. The curriculum is dynamic and development is ongoing. Future curriculum development will focus on assessment and tools for demonstrating competency in these areas.

Poster 16 (Abstract 1141)

Group Feedback Model for Teaching Communication Skills and Cultural Sensitivity

Thanakorn Jirasevijinda, MD; Daniel Richards, MD, Bronx-Lebanon Hospital Center, Bronx, NY

The observed structured clinical exam (OSCE), with or without videotaping, has been used for both summative and formative assessment. Individual feedback on the OSCE with faculty is time-consuming, and logistically challenging in light of resident workload. We piloted a project that compared residents' perceptions of group feedback with their own peers vs. individual feedback with faculty, using the videotaped OSCE. Fifteen PGY-1 residents were videotaped interviewing a standardized patient with a scripted scenario before undergoing 10 monthly training sessions on communication skills and cultural sensitivity. After the training, the residents reviewed their interviews with faculty using a standardized assessment tool. Within 6 months, they attended a workshop where they watched the taped interview of one of their peers who had volunteered to share his tape. The group scored the interview using the same assessment tool. Additionally, faculty facilitated discussions and feedback comments from the group on the interview. Most participants (93%) reported that the OSCE review process as a whole was helpful, with 13% preferring group to individual review. Most (60-93%) felt 1) qualified to give feedback (67%); 2) that their feedback was valued (93%); 3) that they would improve from peer feedback (93%); 4) comfortable receiving peer feedback (73%); and 5) that peer feedback fostered collegiality (93%). Reported advantages of group feedback included 1) sharing of "common errors;" 2) increased number of ideas and input; 3) the informality of the format facilitating learning. Group feedback model using the videotaped OSCE was an efficient and effective alternative to individual review in our pilot project. The format allowed residents to collectively identify elements of effective communication skills and cultural sensitivity. One approach to minimize the intimidating factor of the group format may be to have the group review segments of taped interviews from all residents, so that all participants would receive feedback from their peers.

Poster 17 (Abstract 1142)

The Web Based Curriculum - Creation of an Interactive Learning Community Within a Pediatric Residency

Daniel Cohen, MD; Elizabeth Wedemeyer, MD, Morgan Stanley Children's Hospital of NY - Presbyterian, New York, NY

Background: Medical educators struggle to balance the dichotomy of ever-increasing topics to introduce with the need to control work hours. The need to create both more flexible and more innovative learning technologies to allow for off-hours or shorter duration learning opportunities exists. One solution is the creation of a competency based online learning community which involves faculty, alumni, and residents and fosters active and reflective participation. **Methods:** This web site was designed using constructivist teaching theory and ACGME competencies as structure. Residents were recruited to create content in mentored, structured environment. Rotations are defined by competencies on the site. Other subsections make available examples of faculty knowledge, hospital protocols, and ideas of reflective learning and ethics. There are examples of professionalism through reflective writing by attending staff. A 'virtual preceptor' forum with 35+ faculty members respond to questions posed via email in a bulletin board forum lending to greater availability to mentoring. There is also an emphasis on quality improvement and evidence based medicine on the web site. **Evaluation:** Biannual surveys are conducted to assess changes in users tastes. Likert scales are used to gauge resident appreciation of competencies and resources available to attain them. The site's usage is tracked continually. Feedback sections are devoted to specific sections and overall site function. Pre and Post testing of resident competency attainment are beginning. **Conclusion:** Web design creates a dynamic environment for teaching all competencies in a reflective, interactive and dynamic way. This forum creates improved cognizance of competencies and other teaching strategies. At MSCHONY our project has been well received by all groups involved.

Poster 18 (Abstract 1150)

How Are We Teaching? A Program Audit using the Ambulatory Pediatric Association Guidelines for Pediatric Residency.

James Bale, MD; Deirdre Caplin, PhD; Jaime Bruse, BS; Wendy Hobson, MD, University of Utah, Salt Lake City, UT

Background: The Ambulatory Pediatric Association Educational Guidelines for Pediatric Residency (APA-EG) is a web program designed to assist in rotation planning, integrating the ACGME competencies, assessing learning objectives, building evaluations, and conducting exercises in faculty development. **Objective:** To audit and evaluate the

pediatric residency curriculum for content and structure, using the APA-EG. **Methods:** The audit was completed for each of the required (17 ambulatory and 4 inpatient) rotations for a medium sized pediatric residency program with 57 categorical trainees. Faculty responsible for each course completed a structured response form that compared APA-EG content to their rotation's educational priorities. Content, context, and rotation structure were summarized and evaluated across rotations. **Results:** The content taught on inpatient rotations was primarily taught in rounds (90%) and patient encounters (95%). Ambulatory rotations reported a wider variety of contexts for teaching. 89% of content was taught at least partially in patient encounters. Some rotations, such as Endocrinology, Gastroenterology, and Outpatient Medicine relied heavily on patient encounters for determining content. Others, such as Behavior and Development, Surgery, and Neurology relied heavily on didactics (31%), readings (40%), and nontraditional activities such as agency or school visits (8%) to supplement patient encounters. We found that 100% of the ACGME competencies were taught across inpatient and ambulatory teaching. Faculty reported that role modeling and discussion were the preferred methods of teaching competencies. **Conclusions:** The program audit provided us with a comprehensive summary of the residency curriculum. This approach enabled our program to standardize objectives, structure, and content throughout the curriculum. This will facilitate the creation of rotation-specific tools to evaluate resident learning, faculty teaching, and the effectiveness of teaching methods and content.

Poster 19 (Abstract 1151)

Longitudinal Child Advocacy Curriculum Improves Resident Knowledge

Jonathan Gold, MD; Peter Jennings, MD, Michigan State University Pediatric Residency, East Lansing, MI

Background: In order to meet ACGME requirements to teach systems-based practice, many pediatric residency programs have instituted curricula in child advocacy. However, little data is available regarding their effectiveness in improving resident knowledge. **Purpose:** To demonstrate the effectiveness of a longitudinal, stepwise approach to teaching child advocacy to pediatric residents in improving their knowledge in how to effectively advocate for children. **Methods:** Pediatric residents at a university-sponsored, community-based program undergo a three-year longitudinal curriculum in child advocacy. All residents attend seminars addressing systems of care affecting children such as special education, child protection and health care financing, as well as workshops on advocacy skills such as grant-writing, culturally competent care and legislative advocacy. Second year residents access community resources to advocate for an individual, at-risk patient. Third year residents create a yearlong community-based advocacy project. All residents complete a yearly survey assessing their knowledge of child advocacy and their current and expected future participation in advocacy. We analyzed survey responses by resident year and looked for changes over time. **Results:** Residents improved their knowledge of local, state, national and international advocacy organizations for children after institution of the curriculum. Residents were better able to identify barriers to care and were better able to identify methods to contact legislators about child health issues. Foreign medical graduates particularly improved their knowledge with this curriculum. **Conclusions:** A longitudinal stepwise approach to teaching child advocacy can improve residents' knowledge and give them skills needed to become effective advocates.

Poster 20 (abstract 1154)

Benchmarks for Support of Internal Medicine-Pediatrics Programs

Michael Aronica, MD, MS, SUNY Buffalo School of Medicine, Buffalo, NY; Brett Robbins, MD, University of Rochester School of Medicine and Dentistry, Rochester, NY

Objective: To understand the level of support of combined internal medicine-pediatrics residency program directors. **Design:** A survey of internal medicine-pediatrics residency program directors from May 2004- August 2005 in eight domains included: demographics, support of directors and faculty, chief resident, fiscal and personnel support, curricula and continuity clinic. **Results:** Of 89 eligible programs surveyed, there were 71 directors from 71 programs (80%) with surveys returned. Most were med-peds trained (80%), male (64%) and in their positions for an average of five years. The average salary of directors was \$134,000 and varied by program type (university \$129,000 vs. community \$156,000 p=0.007) but not by gender, primary departmental appointment or region. 98% of combined directors were dual board certified. Directors reported 0.32 FTE administrative time and programs where there was an assistant director (35%) an additional 0.34 FTE was dedicated to administrative time. Most programs (71%) reported having either a fourth year chief resident (87%) or fifth year chief resident (13%). Less than half reported a separate med-peds budget and 32% had a separate recruiting budget. Twenty-four programs (34%) received an average of \$2715 from pharmaceutical companies. Increased first time ABP board pass rates were higher in those programs employing more med-peds FTE_s, while first time ABIM board pass rates were higher in programs filling in the NRMP. Pharmaceutical financial support was a marker for lower first time pass rates on both board exams. **Conclusion:** The study results identify current support of combined med-peds programs and correlates of first time board-passing rates.

Poster 21 (Abstract 1155)

Factors that Influence Pediatric In-Training Examination (ITE) Score Improvement and Pediatric Certifying Examination (CE) Pass Rates

Susie Buchter, MD; Angela Highbaugh-Battle, MD, Emory University School of Medicine, Atlanta, GA

Introduction: The American Board of Pediatrics ITE and CE are objective measures of a pediatrician's knowledge acquisition during residency. While the examinations do not measure all skills that may contribute to becoming a successful pediatrician, they do provide standardized means for assessing a certain fund of knowledge. For the Pediatrics Residency Program of Emory University School of Medicine in Atlanta, Georgia, unpublished data from 1988-2005 demonstrate that a resident who achieves a score of 350 or better on the ITE has an 83% likelihood of passing the CE. The factors that influence an increase in score have not been described. The goal of this study is to determine the extent to which measurable factors of resident training experience contribute to improvement of ITE and CE scores. **Methods:** ITE scores for the intern class of 2003 (n=17) were compared. Regression analyses were used to determine if inpatient hospital admissions performed (general and/or subspecialty), Core Curriculum lectures attended, Acute Care topics heard, Grand Rounds attended, continuity clinic patients encountered, and procedures performed correlated with improvement of ITE and CE results. **Results:** The mean ITE score change from PL-1 to PL-3 was 216. The mean third year score was 424. The number of general pediatric admissions was the only factor found to influence an increase in ITE score (p=0.04). Similar analyses for CE scores will be performed once available. **Implications:** While all of the exposures of pediatric residents likely contribute to professional competence, some exposures are more influential to a resident's success on ITE and CE. By determining which factors are the strongest contributors to improved ITE scores, a residency program could enhance experiences in these areas. Similarly, if particular factors are not contributing to improved ITE scores, interventions could be created to enhance these experiences.

Poster 22 (Abstract 1161)

The Hospital as a Learning Lab: A Hands On Quality Improvement Curriculum

Michelle Thompson, MD, Geisinger Medical Center, Danville, PA

Introduction: Why Do Quality? This is an important question facing physicians in medicine as the healthcare system continually evolves. Current changes in the healthcare landscape necessitating a quality culture include: a paradigm change to patient-centered care, a high-exposure information environment, and a new value-based, pay-for-performance payment concept. To prepare for these changes, residents must learn and incorporate necessary knowledge and skills to facilitate quality improvement. **Background:** The Quality Institute at Geisinger Medical Center developed a "Quality Short Course" to disseminate the principles of quality improvement to interested staff. Teams, consisting of attendings, residents, medical students and nurses, representing distinct Microsystems within the hospital, were enrolled. The group attended 1 week of ½ day didactic sessions to learn the fundamental skills and concepts for Quality Improvement. After the course, the residents are immersed in a longitudinal improvement initiative. **Project:** The Pediatrics group focused on declining patient satisfaction with the discharge process, centered on incomplete and inconsistent instructions. The global aim was patient centered care and the specific aim was to improve patient and family communication at the time of discharge by 10%. Data is obtained by phone survey, 3 days after discharge. Utilizing the PDSA method, a new discharge procedure was created whereby the nurse and physician discharge the patient together. This procedure was instituted for 1/3 of the patients during a 1month period. Survey results comparing the intervention group to the non-intervention group, demonstrated a 14% improvement in clarity and completeness of discharge instructions and a 23% increase in consistency of instructions. **Outcomes:** As a result of participation in the course, residents acquired knowledge of Quality Improvement principles. Through immersion in an active multidisciplinary improvement group, residents applied their new knowledge and skills, while improving patient care, thus demonstrating competence in systems based practice.

Poster 23 (Abstract 1164)

Teaching the ACGME Core Competencies in a Morbidity and Mortality Review Conference

Hank Farrar, MD; Jill Fussell, MD; Laura Sisterhen, MD, University of Arkansas, Department of Pediatrics, Little Rock, AR

Morbidity and Mortality Review (MMR) is a frequently used venue to teach a systematic approach to improving patient care. As such, it is also an ideal setting to systematically review the ACGME core competencies and provide explicit examples of their application to patient management. We are describing an approach to MMR which focuses on three key components: (1) a consistent review of the core competencies and their application to a clinical case, (2) a regular review of the factors which define high quality patient care, and (3) a focused discussion of Practice-Based Learning and Improvement (PBLI). This approach is an adaptation of the Healthcare Matrix developed by Bingham and Quinn of Vanderbilt University. Our MMR occurs monthly with 1 or 2 cases selected from those inpatients which require readmission within 5 days of discharge or unexpected transfers to the PICU. MMR begins with the case presentation by the resident caring for the patient. The facilitator then leads a discussion of issues which may have affected patient outcome. Management of the patient is discussed in the context of the core competencies of Medical Knowledge, Communication, Professionalism and Systems-Based Practice. Patient Care is

then summarized using each of the Institute of Medicine's descriptors of quality patient care (safe, timely, effective, efficient, equitable and patient-centered). The final core competency, PBLI, is then discussed by identifying specific strengths and weaknesses in the other competencies and describing opportunities for improvement. The presenting resident then documents a reflective summary of the PBLI learning points. This adaptation results in greater applicability to a general pediatric setting while providing a systematic approach to the review of patient care issues. At the same time this method provides a systematic review of the core competencies and their relevance to clinical decision making, medical teamwork and professional interactions, with the ultimate goal of improving patient care.

Poster 24 (Abstract 1166)

An Intern Procedure Retreat for Teaching Basic Procedural Skills to Pediatric Residents

William Graessle, MD; Shonola DaSilva, MD; Sandra Nairn, DO; Gary Stahl, MD, UMDNJ Robert Wood Johnson, Camden, NJ

Background: The RRC requires that procedures be taught to pediatric residents. This has traditionally been done using the see one, do one, teach one method. **Objective:** To improve the education of pediatric procedures for the residents using a formal teaching session. **Design/Methods:** In 2003, the program held an intern retreat for procedure education. Faculty from pediatric emergency medicine, neonatology and pediatric critical care instructed residents in the following procedures: vascular access and venipuncture, urinary catheterization, lumbar puncture, umbilical artery and vein catheterization, airway management and intubation, suturing and intraosseous placement. Methods used included lectures and hands-on sessions using mannequins, umbilical stumps and pigs feet. The retreat was held again in the following 2 years and residents completed an evaluation of the retreat for the past 3 years. **Results:** The residents rated the overall retreat 4.6 on a 5 point Likert scale. Average ratings for the individual sessions ranged from 3.6 for the airway lecture to 4.7 for the suturing and intraosseous sessions. Overall, the hands-on sessions received higher scores than the more didactic sessions. Residents rated the overall experience as useful, that it improved their confidence and that it must be repeated every year with average scores of 4.6, 4.0 and 4.8 respectively. **Conclusions:** The procedure retreat has been rated highly by the residents. It offers them an opportunity to feel comfortable with procedures prior to performing them on patients. They prefer the hands-on experiences as compared to the didactic sessions. Future improvements in this experience are planned, including the addition of more hands-on simulation for vascular access, lumbar puncture and urinary catheterization using mannequins.

Poster 25 (Abstract 1179)

Structured Clinical Observations: Implementing the 360-Degree Evaluation in a Pediatric Resident Continuity Clinic

George Siberry, MD, MPH; Janet Serwint, MD; Barry Solomon, MD, MPH, Johns Hopkins University, Baltimore, MD; Karen Zimmer, MD, MPH, Johns Hopkins University, Baltimore, MD

Background: Pediatric residency programs are required to develop, implement and evaluate tools to assess resident performance in the six core competencies. We developed an instrument, the Structured Clinical Observation (SCO) tool, and conducted a 360-degree evaluation to assess residents in the areas of patient care, interpersonal and communication skills, and professionalism. **Objective:** To assess pediatric resident performance in continuity clinic using direct observation, and to compare evaluations between residents, preceptors and their patients/families. **Design/Methods:** Between August and December 2005, pediatric residents in a large urban primary care clinic participated in the project. The SCO tool was adapted from a previously used instrument and included 46 items in the following 6 domains: opening interview, history-taking, relationship skills, personal manner, negotiation/management, and physical examination. Each resident was directly observed in one full patient encounter during a continuity clinic session. After the observation, the preceptor, patient/family, and resident completed evaluations by selecting one of four possible answers (0 =no, 1=partial, 2 =yes, and not applicable). Two additional patient/family SCOs were obtained sequentially for each resident to maintain confidentiality for the patient/family involved in the direct observation (total of 5 SCO evaluations). The preceptor provided direct feedback to the resident after the observation. We dichotomized the responses and compared SCO scores for individual items and domains between the three evaluators. **Results:** Fifty-six of the 57 eligible residents had direct observations performed. Forty-nine (87%) had all 5 SCO evaluations completed and the remainder had four. Overall, there were very few statistically significant differences in evaluations when comparing preceptors with residents. Items with the most discordance fell in the history-taking domain. In contrast, there were many differences at the individual item level which spanned across domains when comparing preceptors with patients/families and residents with patients/families. All evaluators scored the resident lowest in the domain of negotiation/management. **Conclusions:** Future research in this area should focus on improving our abilities for eliciting family feedback on resident performance. Educational interventions with residents may wish to enhance skills in the area of negotiation/management.

Poster 26 (Abstract 1180)

Shifting Away from Use of the Likert Scale for Resident Evaluation

Thomas George, MD; Stacy McConkey, MD, Children's Hospital of Iowa, University of Iowa, Iowa City, IA

Background: Evaluation and feedback are challenging aspects of resident education. Before 2002, resident evaluations utilized a 9 point Likert scale with the expectation being that a resident at the expected level of performance receives a 5. In reviewing evaluations of residents before 2002, scores typically ranged between 5 and 9, with most scores being above 6. This 'grade inflation' has been well recognized in several educational settings and impedes a program's ability to separate that resident who is excelling versus those performing at or falling below the expected level of performance (competent). Further, this evaluative method with a Likert scale limits the ability to give effective feedback in the face of score inflation. **Challenge:** To develop an evaluation system that more accurately reflects attainment of competence and to more effectively give feedback on areas for improvement and areas of excellence. **Initiative:** A new evaluation tool was developed with options for the evaluator being: Did not evaluate=0, Unsatisfactory Level of Performance=1, Needs Improvement=2, Expected Level of Performance=3. Additionally, residents can be commended for performance in specific competency areas. **Result:** Changing to this evaluation system has allowed the program to give more specific and timely feedback when a resident needs improvement or is at an unsatisfactory level of performance. Cumulative average data allows the program to quickly identify residents whose mean scores are 2 or less in any competency area. Comments are required if a resident is graded at either 1 or 2 with an immediate note to the program if a resident receives a score of 1. If > 4 commendations are made in a specific competency area, specific positive feedback is provided. **Conclusion:** As opposed to the Likert scale, the new evaluative scale enables the program to determine if a resident is performing at the expected level of performance, allows for effective feedback if a resident is at an unsatisfactory level of performance or if improvement is needed in a specific competency area. Residents also receive positive feedback for competency areas in which they excel.

Poster 27 (Abstract 1181)

Professionalism and Practice-Based Learning and Improvement (PBL&I) Competencies: A New Metric

Thomas George, MD; Jefri Palermo, MA, C-TAGME; Stacy McConkey, MD, Children's Hospital of Iowa, University of Iowa, Iowa City, IA

Background: Resident behaviors in Professionalism and PBL&I competencies go beyond patient care. Other resident responsibilities require extraordinary program effort to track and include complying with institutional requirements (eg annual TB tests), reporting work hours, program evaluations, conference attendance, delinquent dictations, presenting at morning (AM) report, maintaining PALS/NRP certification with new requirements in 2005 including involvement in Continuous Quality Improvement projects and Individualized Learning Plans. **Challenge:** To facilitate resident compliance with all program and institution requirements. **Initiative:** A new metric was created with resident and faculty input. Points are allotted for the above and other issues and a benchmark score created for each resident level. **Result:** In resident-preceptor meetings, progress towards the benchmark required is reviewed with specific remediation plans made in areas where little/no points are being gained e.g. if a resident has not presented at AM report or has lost points for delinquent dictations. Scores at the end of the year 04-05 were used in determining achievement of competence in these 2 areas and residents below the benchmark received 'unsatisfactory' in these areas. While this did not preclude advancement to the next year based on achieving competency in the other competency areas and professionalism related to patient care, a remediation plan for how to address these issues in the next year is created. If a resident subsequently fails to achieve benchmark scores in the following years, consideration for marking the resident as 'Unsatisfactory' on the final American Board of Pediatrics verification of training form will be given. **Conclusion:** Tracking and measuring competence in Professionalism and Practice-Based Learning and Improvement is challenging, particularly when measuring behaviors not directly related to patient care. This new metric enables more objective capturing of resident performance, and can target areas for remediation such that graduates recognize the importance of these competency areas in their lifelong practice.

Poster 28 (Abstract 1190)

Use of a Tablet Computer Parent Survey for Assessment of Resident Communication Skills

John Patrick Co, MD, MPH; James Perrin, MD; Susan Edgman-Levitan, PA; Hodon Mohamed, BS; Mary Louise Kelleher, RN, MS, Massachusetts General Hospital, Boston, MA

Background: The Accreditation Council for Graduate Medical Education recommends using patient surveys for assessing resident competency in interpersonal and communication skills. Despite the existence of several validated patient surveys for communication assessment, no system has been developed by residency programs for their efficient collection and sustained use in resident assessment. **Design/Methods:** We developed and tested a system to collect surveys from parents of hospitalized children around the time of discharge. We used a 28-item tablet computer based survey that measures individual provider and team communication. The computer displays resident photographs to ensure accurate identification and offers the survey in multiple languages. Survey responses are stored in Microsoft Access, with reporting capability at both the aggregate and resident levels. After

pilot testing the survey and the survey collection system, we fielded the survey once per week from July to October 2006. We assessed parental acceptance and analyzed survey responses. **Results:** Of the 75 eligible parents that were approached, 59 (79%) completed the survey. Parents completed surveys on 24 different residents during the study period, with a maximum of six surveys returned for a single resident. Ninety-three percent of parents rated the resident as either very good or excellent. Ninety-five percent of parents reported the resident usually or always communicated with them in a way they could understand. However, 19% of parents reported not receiving clear communication about who the doctor in charge was, and 47% reported receiving conflicting information. **Conclusions:** Our system utilizing a tablet computer parent survey for resident assessment is feasible, with a high response rate and a large number of residents receiving parent feedback. While residents were generally rated highly on measures of individual performance, many problems were identified regarding communication within the context of the team.

7:00 - 8:00 p.m. **MPPDA Reception**
Sheraton Hall C (#3, Lower Concourse)

Saturday, May 5

7:00 - 8:00 a.m. **Continental Breakfast**
Grand Ballroom Foyer (Lower Concourse)

8:00 a.m. - 1:00 p.m. **Coordinators Session**
Essex Ballroom (Mezzanine Level)

8:00 - 8:45 Accreditation Council for Graduate Medical Education (ACGME) Data Systems Update

Rebecca Miller, Director, Operations and Data Analysis

8:45 - 9:30 The ABC's of AAP Resident Membership

Terri Howard, Director, Member Services; Shirley Daley, Resident Program Specialist

Learn how you can help your residents gain the most from their AAP membership. Join us for a Q&A session with Shirley for all Pedialink questions

9:30 - 10:00 Break

10:00 - 10:45 News from the American Board of Pediatrics (ABP)

Esther Foster, Tracking and Evaluation Coordinator

10:45 - 11:30 Life After Residency: Ways in Which Coordinators Can Support and Help Graduating Residents

Mary Gallagher, C-TAGME, Long Island College Hospital/Beth Israel Medical Center, Brooklyn, NY

11:30 - 12:15 Juggling 101- A Prerequisite For Balancing Time Between Your Professional and Personal Activities

Marlene Keawe, MBA, University of Hawaii Pediatric Residency Program, Honolulu, HI; Melodie Parker, BS, C-TAGME, Baylor College of Medicine, Houston, TX; June Dailey, C-TAGME, Indiana University School of Medicine, Indianapolis, IN

Balancing our personal and professional lives is a constant juggling act that can lead to substantial internal distress. However, proper planning and attention to this juggling act can result in clarity of purpose and effective results. As a result of this workshop, through individual and group activities, participants will learn to identify important roles in their life (both professional and personal), and how to schedule activities within these priorities in order to achieve balance and a satisfying sense of accomplishment. Participants will learn skills that enhance their ability to work collaboratively in identifying each other's priorities, thus enhancing overall productivity and satisfaction. Participants will gain added insight through learning perspectives on time management with other residency program coordinators from a variety of programs.

12:15 - 1:00 Training Administrators for Graduate Medical Education (TAGME) Update 2007
Jeri Whitten, C-TAGME, Program Coordinator, West Virginia University (Charleston Division), President, TAGME

8:00 a.m. - 11:00 a.m.

Forum for Associate Directors

2 CME Credits Available

Grand Ballroom Centre (Lower Concourse)

Keith J. Mann, MD, Associate Director, Pediatric Residency Program, Children's Mercy Hospital, Kansas City, MO; Nancy Spector, MD, Associate Director, Pediatric Residency Program, St. Christopher's Hospital for Children, Philadelphia, PA

The objective of the Associate Residency Program Director SIG is to identify and discuss common issues that affect Associate Residency Program Directors and to promote our role, both individually and collectively, within the APPD.

In an initial SIG session, we would like to do the following in order to achieve our objectives:

- 1) Introduce the facilitators and review their professional backgrounds and interests
- 2) Provide an overview of the structure of the APPD, including a review of the annual meetings, leadership structure and task forces
- 3) Review the pre-SIG Associate Residency Program Director's survey results with the group and open the floor for discussion
- 4) Discuss four key areas within the life of an Associate Program Director:
 - a. Personal Involvement/Growth - Academic promotion, Administrative promotion
 - b. Local Roles/Involvement - Curriculum development, Evaluation development, Faculty development
 - c. Regional Roles/Involvement - Leadership within the region, opportunities for sharing ideas/completing projects within regions
 - d. National Roles/Involvement - Task forces, presentations at national conferences, collaboration with colleagues from other institutions, gaining board membership, gaining a vote
- 5) Discuss ideas for future collaborative projects
- 6) Discuss ideas for future workshops
- 7) Discuss role of the Associate Residency Program Directors (as a group) within the APPD.

8:00 a.m. - 1:00 p.m.

Forum for Small Programs/Chairs

3.5 CME Credits Available

Grand Ballroom West (Lower Concourse)

Steven P. Shelov, MD, MS, Department Chair, Maimonides Medical Center; Surendra Varma, MD, Program Director, Texas Tech University (Lubbock); Lynn Campbell, MD, Program Director, University of Kentucky Medical Center

8:00 - 9:30

Discussion / dialogue of Hot Topics

9:30 - 9:50

Break for refreshments

9:50 - 10:30

ACGME issues (new PIF, logs, documentation of competence)

10:30 - 11:00

RRC citations and program closures with Edwin Zalneraitis, MD

11:00 - 11:30

Report on the R3P Project and ABP issues with M. Douglas Jones, Jr., MD

11:30 - noon

Discussion of above or additional Hot Topics

8:00 a.m. - 3:30 p.m.

Forum for Fellowship Directors

2.5 CME Credits Available

Grand Ballroom East (Lower Concourse)

8:30 - 10:30

The ACGME and the ABP: Changes in Pediatric Subspecialty Education

Jerry Vasilias, PhD, Executive Director, Residency Review Committee (RRC) for Pediatrics; Caroline Fischer, MBA, Associate Executive Director, Residency Review Committee (RRC); Gail McGuinness, MD, Senior Vice President, American Board of Pediatrics (ABP); Joseph Gilhooly, MD, Pediatric Residency Program Director, OHSU

10:30 - 11:00

Break

11:00 - 11:10

Update from the Council of Pediatric Subspecialties (CoPS)

Victoria Norwood, MD, Vice Chair, CoPS

11:10 - 12:00

Open Forum Discussion to get feedback to CoPS on issues to be addressed within the subspecialties

12:00 - 1:00

Boxed Lunch Provided

1:00 - 3:30

Implementing ACGME Competencies into Fellowship Training Programs: Initial Steps in Curriculum Development

Cynthia Ferrell, MD, MEd, Associate Program Director, OHSU; Dr. John Mahan, MD, Pediatric Residency Program Director, Children's Hospital/Ohio State University; Joseph Gilhooly, MD, Pediatric Residency Program Director, OHSU

- 8:00 a.m. - 5:00 p.m. **Forum for Chief Residents**
6.5 CME Credits Available
Sheraton Hall A (#1, Lower Concourse)
 Planning the year to come, while making sense of the year that is passing.
Edwin Zalneraitis, MD, Program Director, University of Connecticut; Monica Sifuentes, MD, Associate Program Director, Los Angeles County-Harbor UCLA Medical Center; Vincent Chiang, MD, Associate Program Director, Children's Hospital/Boston Medical Center
 This will be an interactive forum bringing together rising Chief residents to plan their year, finishing Chief Residents to consider how to use their experience going forward and program directors to facilitate the activities and consider the position of Chief Resident in their own programs. It will be in a workshop format with activities that will be based on an attendee survey. Offerings include: planning of the Chief resident year, leadership skills, teaching a skill or a group or on the fly, evaluation, feedback, the problem resident and conflict resolution. **Boxed Lunch Provided**
- 8:00 a.m. - 5:00 p.m. **MPPDA Meeting**
Osgoode Ballroom (Lower Concourse)
- 8:00 - 8:15 Introductory Remarks and Review of Agenda
LuAnn Moraski, DO, President elect and Meeting Chair
- 8:15 - 9:30 Session 1: Professional Development Across Residency Program Leadership
Karen Marcante, MD, Vice Chair, Education, Medical College of Wisconsin
- 9:30 - 9:45 Intersession: Promotion and Advancement at Home Institutions
- 9:45 - 10:00 Break
- 10:00 - 11:15 Session 2: Preparing for your Accreditation Site Visit
Keith Boyd, MD, Program Director, Rush University; Brett Robbins, MD, Program Director, University of Rochester
- 11:15 - 11:30 Intersession: PIF Questions and Challenges
- 11:30 - 1:00 Working Lunch/Business Meeting
- 12:00 - 12:15 President's Remarks
Eric Ayers, MD, MPPDA President
- 12:15 - 12:20 Secretary-Treasurer's Report
Brad Benson, MD, MPPDA Secretary-Treasurer
- 12:20 - 12:30 NMPRA Update
Ken Remy, MD
- 12:30 - 12:45 Committee Restructure and Summary
LuAnn Moraski, DO, MPPDA President Elect
- 12:45 - 1:00 Election Results and Awards
Eric Ayers, MD; Allen Friedland, MD; Niraj Sharma, MD
- 1:00 - 1:15 Reflection and Future Directions
- 1:15 - 1:50 Accreditation: Process, Performance, Lessons Learned
 Moderator: *LuAnn Moraski, DO, Program Director, Medical College of Wisconsin*
- 2:00 - 3:30 Accreditation: The Next Steps
 Panel Discussion: ACGME, RC-IM, RC-Peds
Eric Holmboe, MD ABIM; Debra Dooley, ACGME; Gail McGuinness, ABP
- 3:30 - 3:45 Break
- 3:45 - 5:00 Session 3: Tools for Measuring Competency:
 Dialing Down on Real MP Outcomes
Mary Ciccarelli, MD, Indiana University; Lori Wan, MD, Program Director, UCSD
- 5:00 - 5:15 Closing remarks
- 6:00 p.m. - 11:00 p.m. **MPPDA Dinner (additional fee required)**
Alice Fazooli's Restaurant
(294 Adelaide Street W at John Street)

Exhibitors

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

*Be sure to visit them in
Sheraton Hall E
(#5 on the Lower Concourse Level)*

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Jane Bassewitz, MA

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Booth Personnel:
Dan Nelson
Jeff Kirk

Association of Pediatric Program Directors



11th Annual Fall Meeting
October 3-5, 2007
Arlington, VA

***ORIENTATION AND TRAINING
FOR NEW PROGRAM DIRECTORS AND COORDINATORS***

PREPARATION FOR A SUCCESSFUL SITE VISIT

Who Should Attend?

- ❖ *New Program Directors and New Coordinators*
- ❖ *Fellowship Directors*
- ❖ *Associate Program Directors*
- ❖ *Individuals Considering Becoming a Program Director*
- ❖ *Individuals Interested In a Comprehensive Update*
- ❖ *Individuals Preparing For an RRC Site Visit*
- ❖ *Individuals Assisting Program Directors*

Keynote Speaker & Dinner: *October 3*
Meeting: *October 4-5*