2009 Combined Meeting

Association of Pediatric Program Directors

AND

Council on Medical Student Education in Pediatrics

Education Across the Continuum

April 28 – May 2, 2009

Baltimore, MD

Hilton Baltimore Convention Center Hotel

and

Baltimore Convention Center

*This activity has been approved for AMA Category 1 Credit™*
CONTINUING EDUCATION CREDIT

Physicians
This activity has been planned and implemented in accordance with the Essential Areas and Policies of the Accreditation Council for Continuing Medical Education through the joint sponsorship of the Institute for the Advancement of Human Behavior, A Medical Education Company (IAHB-AMEDCO) and Association of Pediatric Program Directors. IAHB-AMEDCO is accredited by the ACCME to provide continuing medical education for physicians.

AMA PRA Statement
IAHB-AMEDCO designates this educational activity for a maximum of 29.5 AMA PRA Category 1 Credit(s)™. Physicians should only claim credit commensurate with the extent of their participation in the activity.

A special appreciative note of thanks...

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

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Abhay Dandekar, MD ~ Joseph Marc Majure, MD ~ Surendra Varma, MD

Nominating Committee
Robert McGregor, MD ~ Heather McPhillips, MD, MPH
# Schedule-at-a-Glance

## Tuesday, April 28

12:00 pm – 5:00 pm  
Registration  
*Key Ballroom East Foyer*

3:00 pm – 5:00 pm  
APPD Pre-Conference Workshop  
(separate registration)  
*Key 11/12*

4:00 pm – 6:00 pm  
Midwest Region Meeting  
*Key 9*

## Wednesday, April 29

7:30 am – 4:30 pm  
Registration  
*Key Ballroom East Foyer*

8:00 am – 8:30 am  
Continental Breakfast  
*Key Ballroom South Foyer*

8:30 am – 11:00 am  
Grassroots Session for Program Directors  
*Key 8/11/12*

Grassroots Session for Associate Program Directors  
*Key 10*

Coordinators’ Assembly  
*Key 6*

11:15 am – 1:15 pm  
Plenary Session  
*Key 8/11/12*

1:15 pm – 2:30 pm  
Lunch (on your own)  
Regional Chairs Luncheon  
*Douglass*

2:30 pm – 4:30 pm  
Task Force Meetings  
(see page 5)

## Thursday, April 30

**APPD/COMSEP COMBINED MEETING**  
at Baltimore Convention Center

6:45 am – 8:00 am  
Continental Breakfast and Exhibits  
*Ballroom I*

7:00 am – 7:50 am  
Flexible Training and Work-Life Balance: What is Really Important to Our Learners?  
*Ballroom III*

8:00 am – 10:00 am  
Combined Session; Miller/Sarkin Lectureship  
*Ballroom III*

10:30 am – 12:00 pm  
Combined Workshops  
(see page 6)

12:15 pm – 2:00 pm  
Combined Research Presentations w/ boxed lunch (provided)  
*Ballroom III*

2:15 pm – 4:15 pm  
Combined Task Force Meetings  
(see page 13)

2:15 pm – 4:30 pm  
APPD Coordinators’ Session (at Hilton Hotel)  
*Key 8*

5:00 pm – 7:00 pm  
Combined Poster Session and Reception  
*Ballroom I*

## Friday, May 1

7:30 am – 9:00 am  
Regional Breakfasts  
(see page 39)

9:00 am – 10:00 am  
The Milestones Project: Competencies - Applying Lessons Learned  
*Key 8/11/12*

10:15 am – 12:15 pm  
Workshops  
(see page 40)

12:15 pm – 2:00 pm  
Lunch (on your own)  
Council of Task Force Chairs Luncheon  
*Peale C*

2:00 pm – 4:00 pm  
Workshops  
(see page 43)

4:00 pm – 5:00 pm  
Plenary/Regroup from Wednesday Grassroots Session  
*Key 8*

Coordinators’ Task Force Meetings  
*Key 11/12*

4:00 pm – 6:00 pm  
MPPDA Subcommittee Meetings  
(see page 46)

6:00 pm – 7:30 pm  
MPPDA Reception  
(separate registration)  
*Holiday 4*

## Saturday, May 2

7:00 am – 5:00 pm  
Registration  
*Key Ballroom East Foyer*

7:00 am – 8:00 am  
Continental Breakfast  
*Key Ballroom South Foyer*

8:00 am – 1:00 pm  
Coordinators’ Session  
*Key 5*

8:00 am – 5:00 pm  
Forum for Chief Residents  
*Key 11*

Forum for Fellowship Directors  
*Key 7*

7:00 am – 5:00 pm  
MPPDA Business Meeting  
(separate registration)  
*Key 6*

6:00 pm – 10:00 pm  
Dinner Off-site  
(additional fee)
APPD / COMSEP
2009 Combined Meeting ~ April 28 - May 2
Baltimore, MD

Education Across the Continuum

APPD Meeting Schedule

Tuesday, April 28

Sessions located in the Hilton Baltimore Convention Center Hotel

12:00 pm – 5:00 pm Registration Key Ballroom East Foyer

3:00 pm – 5:00 pm APPD Pre-Conference Workshop
(additional charge of $45 to attend this workshop)
Followership: The Lost Art of Playing Second Fiddle
Fred A. McCurdy MD, PhD, MPA, Professor & Chairman & Pediatric Residency Program Director, Texas Tech University, Health Sciences Center
While many of us are or aspire to be leaders and managers, we all - at one time or another - have been followers. And we all will be so many more times in the future! It takes the proper skills and attitudes to be an effective follower. Poor followership can make good leadership virtually impossible. This workshop is devoted to the art of following. Learn here how to make the second fiddle sound as sweet as the first violin!

2:00 pm – 7:00 pm Coordinators TAGME Exam Key 10
(prior application and registration required)

4:00 pm – 6:00 pm Midwest Region Meeting Key 9

Wednesday, April 29

Sessions located in the Hilton Baltimore Convention Center Hotel

7:30 am – 4:30 pm Registration Key Ballroom East Foyer

8:00 am – 8:30 am Continental Breakfast Key Ballroom South Foyer

8:30 am – 11:00 am Grassroots Session for Program Directors Key 8/11/12
Rukmani (Roni) Vasan, MD, MSEd, University of Southern California; Brian Youth, MD, Maine Medical Center; Cynthia Ferrell, MD, MSEd, Oregon Health Sciences University

Grassroots Session for Associate Program Directors Key 10
Nancy Spector, MD, St. Christopher’s Hospital for Children, Keith J. Mann, MD, Children’s Mercy Hospital; Aditee Narayan, MD, MPH, Duke University; Marsha Anderson, MD, University of Colorado

8:30 am – 11:00 am Coordinators’ Assembly Key 6
8:30 – 9:00am Welcome/Opening Remarks
APPD Coordinators Executive Committee Members
9:00 – 10:00am Got a Monkey On Your Back? Daily Challenges Facing Fellowships & Residency Coordinators
Deb A. Parsons, C-TAGME, Robin D. Hawkins, June Dailey, C-TAGME, Indiana University School of Medicine, Indianapolis, IN
This workshop will demonstrate how to keep the “monkeys” off your back. The “monkey” being deadlines and regulations that we want to intercept ahead of time to keep the monkey off your back. We will explain the differences between fellowships and residencies, the different timelines and challenges facing each. We will go over web sites where you can find resourceful information, as well as stressing the important advantages of working together in the department.

During our interactive time, we will have a “barrel of monkeys” game to help you identify acronyms in your everyday life as a fellowship or residency coordinator. There will be networking time for coordinators to share their own “monkeys on their backs” and useful tools for handling them.

10:00 – 11:00am Supervising with a Smile
Marlene L. Keawe, MBA, University of Hawaii Pediatric Residency Program, Honolulu, HI, Cynthia A. Parrish, University of Texas Health Science Center, San Antonio, TX, Bonnie P. Kulp, University of Michigan Department of Pediatrics, Ann Arbor, MI
This workshop will involve Program Coordinators in a team building activity sharing skills of leadership. A discussion will follow with the entire group to discuss the qualities of management and leadership and help the audience recognize qualities within themselves. As some coordinators are also supervisors, they will learn a few tips using case studies to encourage positive performance. This will simply give the Coordinators an introduction to the many duties of being a supervisor. Although not all Coordinators are supervisors, it will still be valuable to those working independently as they develop their own leadership qualities in advancing their career as Program Coordinators.

11:00 am – 11:15am Beverage Break

11:15 am – 1:15 pm Plenary Session - Includes updates from the organizations listed below
11:15 – 11:30 Association of Pediatric Program Directors (APPD) – Susan Guralnick, MD
11:30 – 11:40 APPD Share Warehouse / LEARN – Ann Burke, MD
11:40 – 11:45 APPD Coordinators Section – Judy Behnke and Valarie Collins, C-TAGME
11:45 – 11:55 Residency Review Committee (RRC) – Marcia Hutchinson, MD
11:55 – 12:05 American Board of Pediatrics (ABP) – Gail McGuinness, MD
12:05 – 12:10 Federation of Pediatric Organizations (FOPO) – Theodore C. Sectish, MD
12:10 – 12:15 Initiative for Innovation in Pediatric Education (IIPE) – Stephen Ludwig, MD
12:20 – 12:25 AAP Section on Medical Students, Residents and Fellowship Trainees – Amy Jost Starmer, MD
12:25 – 12:30 Council of Pediatric Subspecialties (CoPS) – James Bale, MD
12:30 – 12:35 TAGME Certification – Jeri Whitten, C-TAGME
12:35 – 12:40 APPD Financial Update – Joe Gilhooly, MD
12:40 – 1:00 APPD Awards – Susan Guralnick, MD and Carol Berkowitz, MD
1:00 – 1:15 Recognize Outgoing Leaders/Welcome New Leadership – Susan Guralnick, MD and Robert McGregor, MD

1:15 pm – 2:30 pm Lunch (on your own)
Regional Chairs Luncheon

2:30 pm – 4:30 pm Task Force Meetings
Curriculum Task Force
Evaluation Task Force
Faculty Development Task Force
Learning Technology Task Force
Research Task Force

Combined 2009 Meeting • April 28 – May 2 • Baltimore, MD
THURSDAY, APRIL 30

APPD/COMSEP COMBINED MEETING at Baltimore Convention Center
6:45 am – 8:00 am Continental Breakfast and Exhibits Ballroom I

7:00 am – 7:50 am Flexible Training and Work-Life Balance: Ballroom III
What is Really Important to Our Learners?
Ann E. Burke, MD, Wright State University, Dayton, OH, Mary Beth Gordon, MD, Boston Combined Residency Program, Boston, MA, Nancy Spector, MD, St. Christopher’s Hospital for Children, Philadelphia, PA, Robin Deterding, MD, University of Colorado, Denver, CO

BACKGROUND: The Federation of Pediatric Organizations (FOPO) released a report in 2005. This “Report of the Task Force on Women in Pediatrics” is a document that outlines specific recommendations through the whole spectrum of pediatrics from medical students to senior faculty. The recommendations are aimed at goals that address issues of “family balance in the lives of pediatricians during training and practice, including concerns regarding productivity, career advancement and individual fulfillment.” One of the recommendations focuses on flexible/part-time training, another aims to better educate and counsel pediatric learners regarding work-life balance issues. Both the APPD and COMSEP memberships should be actively involved in this dialogue to explore flexible training and work-life balance, as these topics have significant impact on both organizations’ trainees. DESCRIPTION: A very brief overview of the work of the FOPO Task Force and a literature update regarding the current state of flexible training and work life balance will be shared. Subsequently, there will be a 20 minute open and engaging discussion of various points of view from participants. After this segment of lively interaction, workshop participants will self-select to one of four break out groups for 35 minutes. The groups topics will be: 1) barriers to part-time training, 2) strategies for counseling and mentoring learners in exploring work-life issues, 3) logistic concerns to navigating part-time training schedules, and 4) perception of work-life balance needs of learners. Each group will have a workshop co-leader with specific questions for each group to discuss. These groups will summarize their discussions and report back to the larger group. One overall goal of the workshop will be to engage and excite participants into working with each other in a collaborative manner in the future to ask some of the questions raised during this exercise at their own institutions. The discussions and conclusions of this session will be reported to the FOPO task force.

8:00 am – 10:00 am Combined Session: Miller/Sarkin Lectureship Ballroom III
Dr. Kenneth Roberts, Associate Program Director, Moses Cone Health System
Dr. Roberts will address the potential synergy of APPD and COMSEP collaboration to achieve mutually desired goals and assure that “the whole is greater than the sum of its parts.”

10:00 am – 10:30 am Beverage Break and Exhibits Ballroom I

10:30 am – 12:00 pm Combined Workshops

C1. Introduction to Educational Scholarship: From Ideas to Scholarship Room #344
Robin English, MD, Louisiana State University Health Sciences Center, New Orleans, LA, Su-Ting T. Li, MD, MPH, Lavjay Butani, MD, UC Davis, Sacramento, CA, Jocelyn H. Schiller, MD, University of Michigan, Ann Arbor, MI, Sherilyn Smith, MD, University of Washington, Seattle, WA, Carrie A. Phillipi, MD, PhD, OHSU, Portland, OR, Joseph Gigante, MD, Vanderbilt Children’s Hospital, Nashville, TN, April O. Buchanan, MD, University of South Carolina School of Medicine, Greenville, SC, Linda Tewksbury, MD, NYU School of Medicine, Department of Pediatrics, New York, NY, Susan Guralnick, MD, Stony Brook University Medical Center, Stony Brook, NY, Ben Siegel, MD, COMSEP, Boston, MA, Lynn M. Manfred, MD, EdD, Medical University of South Carolina, Charleston, SC, Robert S. McGregor, MD, St. Christopher’s Hospital for Children, Philadelphia, PA, Heather McPhillips, MD, MPH, Richard P. Shugerman, MD, University of Washington, Seattle, WA

Academic faculty are increasingly faced with the challenges of balancing their time between patient care, teaching, administration, and research. Unfortunately, for many educators, this means traditional research becomes a low priority because of the time demands involved in teaching future health care providers. Lack of this type of scholarly activity is a major obstacle to academic promotion. In 1990, Ernest Boyer addressed the changing climate in higher education institutions and outlined definitions of scholarship that expand beyond traditional research. With an understanding of the criteria for effective scholarship, academic faculty members can approach their educational ideas and responsibilities with the components of scholarship in mind. The resultant innovations, products, and projects can
Faculty development is an important function of medical education leadership. Ideally, we want our faculty to understand our curricula, participate in the teaching process and contribute new ideas to their own teaching.

C2. Case-Based Approach to Teaching and Evaluating Proficiency in Evidence-Based Medicine Across the Continuum of Medical Education

Hans B. Kersten, MD, Nancy D. Spector, MD, E. Douglas Thompson, MD, St. Christopher’s Hospital for Children, Philadelphia, PA; John G. Frohna, MD, MPH, University of Wisconsin, Madison, WI; Erin Giudice, MD, University of Maryland, Baltimore, MD; Susan Guralnick, MD, MPH, Stony Brook University, Stony Brook, NY; Rani S. Gereig, MD, MPH, University of South Florida, Tampa, FL

Educators are faced with the challenge of developing a comprehensive curriculum and evaluation system for Evidence-Based Medicine (EBM) for learners across the continuum of medical education. Currently, most medical schools, residency and fellowship programs have EBM curricula. However, a more coordinated approach is needed to teach and evaluate EBM knowledge, skills, and behaviors. The facilitators have created a library of portable case-based EBM scenarios built on their collective experiences teaching medical students, residents, fellows and faculty. Each case-based scenario has an accompanying evaluation tool, which can be used to teach and assess EBM proficiency at each educational level, and is linked to the EBM goals and objectives from the APA Educational Guidelines. The companion evaluation tools assess searching skills, EBM knowledge, oral EBM presentations, and Critically Appraised Topics (CATs) and can be used in a variety of venues. A framework to evaluate EBM skills along the continuum of medical education will be provided: from medical school through residency and fellowship to faculty level. The workshop will emphasize interactive, small-group sessions where participants will discuss how to teach and evaluate an EBM curriculum for different levels of learners. Participants will have the opportunity to work through and evaluate several cases in order to illustrate how they can be incorporated into different teaching programs. Finally, participants will have the opportunity to develop their own cases and will also be provided with a CD-ROM containing EBM cases, curricular material, and evaluation tools.

C3. Improving Competence in Managing Cultural and Linguistic Barriers:

Tara S. Williams, MD, Case Western Reserve University School of Medicine, Cleveland, OH; Phyllis Nsiah-Kumi, MD, University of Nebraska Medical Center, Omaha, NE; Larrie Greenberg, MD, George Washington University School of Medicine, Potomac, MD; William V. Raszka, MD, University of Vermont College of Medicine, Burlington, VT

RATIONALE: Pediatric providers often care for children whose caregivers have limited English proficiency (LEP). Providing culturally and linguistically effective care for children with LEP caregivers requires that trainees successfully utilize professional medical interpreters. Measuring effective interpersonal and communication skills in encounters with pediatric LEP caregivers provides unique challenges. Designing an effective curriculum to address these challenges will benefit both trainees and patients. AIM: This interactive workshop will expose participants to a variety of tools designed to improve trainee competence in managing linguistic and cultural barriers. Participants will review a successful multi-modal curriculum that incorporates professionalism, patient care, interpersonal and communication skills and systems-based practice and discuss means by which this curriculum or portions of it can be implemented in their own institution. We will discuss methods to assess trainee competence and the effectiveness of the curriculum.

OBJECTIVES: At the end of this workshop participants will be able to: 1) Recognize barriers to providing culturally and linguistically effective care. 2) Describe curricular tools and programs that enhance the ability of learners at all stages of training to provide appropriate care to LEP patients. 3) Implement a variety of methods to assess trainee competence and curriculum effectiveness. METHODS: 1) In large group format, we will briefly review the current literature addressing trainee competence in providing culturally and linguistically appropriate care and barriers to improving care for LEP patients. We will demonstrate several tools that have been developed to improve skills in this area. 2) In small groups, participants will discuss mechanisms to implement tools and assess trainee competence and curriculum effectiveness. 3) In an interactive large group session participants will practice using assessment tools.

C4. Faculty Development Across the Educational Continuum:

Jennifer G. Christner, MD, Hilary M. Haftel, MD, University of Michigan, Ann Arbor, MI

Faculty development is an important function of medical education leadership. Ideally, we want our faculty to understand our curricula, participate in the teaching process and contribute new ideas to their own teaching.
environment as well as to the program at large. However, leading faculty along this path has numerous pitfalls and frustrations. This workshop is intended to both guide and equip medical educators with the ability to implement a vigorous faculty development program. Through a mixture of audience participation and small group breakout sessions, we plan to accomplish the following objectives: 1) Discuss process details of how to implement a faculty development program, 2) Identify appropriate tools for both a core and advanced faculty development curriculum and 3) Formulate unique and innovative strategies to maintain faculty enthusiasm for teaching. At the end of our workshop, each participant will leave with a hard copy of faculty development resources (sample needs assessments, curricula and newsletters, listings of articles, etc.) in addition to those they develop during the workshop itself. We encourage participants to email us ahead of time at jchristn@med.umich.edu with specific faculty development challenges they have had in the past. We will incorporate these into our workshop to make it as relevant as possible for the participants.

C5. Competence: A Developmental Task

Linda O. Lewin, MD, Carol L. Carraccio, MD, MA, University of Maryland, Baltimore, MD

INTRODUCTION: We will introduce participants to the concept of developmental acquisition of clinical competence by comparing it to the predictable developmental milestones of children. We will present three developmental assessment models that can be used to document professional development: the R.I.M.E. evaluation method, the Dreyfus model of skill acquisition, and the Kegan model of identity development. We will also introduce the work of the National Portfolio Collaborative, which, based on these models, created competencies for medical education, with benchmarks that describe the stages of development starting with medical school and continuing through residency and practice. SMALL GROUP WORK: Participants will work in small groups and practice applying the developmental models to specific competencies that are critical to medical learners and physicians across the entire medical education continuum from UME through CME. DISCUSSION: The large group will discuss the strengths and weaknesses of each model and how each might be best used in creating useful teaching and assessment tools. SMALL GROUP WORK: Clerkship and program directors will work together in small groups to review two to four competencies developed by the Collaborative and define the points along the educational continuum (i.e., first two years of medical school, before graduation, during internship) that learners should be expected to meet each benchmark. DISCUSSION: The large group will discuss the challenges to defining the timing of benchmark acquisition and any discrepancies between the expectations of clerkship directors and those of program directors. Take home materials will include the models and benchmarks created by the Collaborative. The latter represent an integration of the ACGME and Medical School Objectives Project competencies to better address the educational continuum.


Robert P. Drucker, MD, Duke University, Durham, NC, Glen A. Medellin, MD, Univ. of Texas Health Science Center, San Antonio, San Antonio, TX, Pradip D. Patel, MD, University of Louisville School of Medicine, Louisville, KY

Audience Response Systems (ARS) are frequently utilized in undergraduate education, but use in medical education has been far more limited. This workshop will demonstrate and allow active exploration of ARS technology for pediatric education. Much of the use of ARS has been to promote interaction between a speaker and students in large, lecture-based classes. However, these systems can be just as, or more, effective in smaller group settings, such as the size of a clerkship or residency program. The first part of the workshop will introduce participants to the ARS technology available and allow hands-on use. Examples of how the ARS are already being used at several medical centers will be shared. These include: 1) team based learning; 2) distance learning; 3) pre- and post-clerkship testing; and 4) facilitating discussion of sensitive topics such as mistreatment or barriers to compliance with duty hour requirements. Participants will work in teams to discuss and develop their own ideas for uses of ARS and will have an opportunity to use the equipment in the workshop to try some of their ideas. Sponsored by the COMSEP Learning Technologies Task Force.

C7. Keeping the Flame Alive: Rekindling Humanism In Medical Education

John Kunzer, MD, Jerry L. Rushton, MD, MPH, Mary R. Ciccarelli, MD, Indiana University Pediatrics, Indianapolis, IN

BACKGROUND: Medical students and residents routinely begin their training with aspirations to practice humanistic medicine. Burnout, decreased empathy, and cynicism often occur as learners progress through their medical training. Clerkships and residency programs must create a learning environment that recognizes these emotional changes in learners and then promotes personal growth. GOAL: Provide participants a tool kit to nurture a medical trainee’s commitment to practice humanistic medicine. OBJECTIVES: 1) Describe standardized tools to measure burnout, empathy, mindfulness, and personal growth. 2) Discuss and practice strategies to promote humanism. 3) Identify opportunities within clerkships and residency programs to implement curricula to rekindle humanism in trainees. METHODS: The workshop is designed to promote interaction and the exchange of information amongst participants. Workshop leaders, who cover all aspects of the educational continuum (students-residents-faculty), will present specific tools that can be used to help measure the more abstract concepts of humanism, professional empathy, and burnout. Participants will complete one of these instruments - the Maslach Burnout Inventory. Individual reflection and group discussion will focus on how these tools can be used in retreats, lectures, and other educational sessions to identify needs and begin to address individual and systems issues to intervene. Participants will then be divided into small groups to do a fly-on-the-wall professionalism exercise. Participants will view a vignette and discuss how subtle displays of cynicism can impact daily work activities, interactions with others, and teamwork. Additional exercises and
workshop ideas to promote humanism will then be presented. The workshop will conclude with a review of some of the multiple methods to approach interventions at a program/institutional level. Large group discussion will focus on identifying key times to institute these curricular changes in clerkships and residency programs.

C8. Designing Pediatric Simulation Scenarios  
Dawn S. Tuell, MD, East Tennessee State University, Martin P. Eason, MD, JD, Center for Experiential Learning, Quillen College of Medicine, Kristin T. Farr, MD, East Tennessee State, Johnson City, TN  
Pediatric simulation has been demonstrated to be a valid tool to improve training. Nevertheless, many institutions do not use simulation in their pediatric curriculum. Our institution has used simulation in pediatric training for residents and third year clerks for three years using a substantial library of cases. The training sessions are run on a regular basis and are considered to be a positive aspect of training. To aid those interested in incorporating simulation into their curriculum, we propose an interactive workshop designed for novices that demonstrates the basics of creating a simulation scenario for pediatrics. The goal is to help the participants gain both competence and confidence in creating and implementing pediatric simulation in their program by taking the participants through the steps for developing a simulation. The participants will then run a trial of some of the designed scenarios. WORKSHOP FORMAT: 1) A discussion with the moderators and participants as to the steps necessary for successful scenario creation, including choosing the right cases, developing learning objectives, deciding on participants, determining needed assets, scenario design and implementation, and debriefing. The discussion may also include the choice of simulation platforms. 2) Using our simulation template, the participants will break into groups and each group will create a simulation scenario. The goal of this section is to have the participants use the knowledge learned in the first section to create their own scenarios and improve confidence in scenario development. The facilitators will work with the groups to assist and resolve any difficulties. 3) We will choose one or two of the simulations created by the groups and run the scenario. The entire group will then debrief the components of the scenario itself. This will provide the participants with feedback to improve their scenario design skills. At the end of the workshop the participants will be able understand the process of scenario design for pediatric simulation and be able to design and implement their own scenarios.

C9. Mirror, Mirror on the Wall...Self-Assessment in the Health Professions  
Stacey E. Bernstein, MD, FRCPC, Paediatrics, Toronto, Ontario, Diane M. Moddemann, MD, FRCPC, Pediatrics, Winnipeg, Manitoba, Anne E. Drover, MD, FRCPC, Memorial University of NL, St. John’s, NL, Milena Forte, CCFP, Faculty at University of Toronto- Dept of Family and Community Medicine, Education Director, Mount Sinai Hospital, Toronto, ON  
BACKGROUND: Self-assessment involves the ability to reflect on strengths and weaknesses in one’s performance in order to identify learning needs and reinforce skills and behavior to improve performance. “Nowhere is self-directed learning and therefore self-assessment more essential than in the professions whose self-regulating autonomy is based on the competent exercise of self-assessment” (Gordon, 1991). However the literature shows that trainees often have difficulty in self-assessing. Methods exist for faculty to teach and evaluate this critical skill in trainees. METHODS AND CONTENT: Participants will have the opportunity to review the use of self-assessment as a method as providing effective feedback. This dialogue will highlight “the double you” of self-assessment- How do You think that You did. The importance and the challenges of fostering and incorporating self-assessment into feedback will be discussed with reflection on the relevant medical education literature. Finally the relative ranking model will be presented. This very innovative model provides a framework for providing feedback that includes self-assessment. Participants will have an opportunity to apply and practice the model in an engaging, creative activity using mangoes! Evidence of the application of the relative ranking model will be discussed. Methods employed in this highly interactive workshop will include small group discussion, audience participation and role play. There will be a focus on practical, relevant material that participants will be able to try out in their home institutions. This workshop will be of interest to all who provide feedback to undergraduate and postgraduate trainees.

C10. Navigating a Successful Mentoring Relationship  
Miriam E. Bar-on, MD, University of Nevada School of Medicine, Las Vegas, NV, Maryellen E. Gusic, MD, Penn State University College of Medicine, Hershey, PA  
Mentoring and being mentored are critical in the academic environment. The literature demonstrates very clearly that successful faculty at all levels have or have had mentors. This workshop will focus on the key components of the mentoring relationship: identifying and selecting the right mentor, defining the tasks involved in the relationship, strategies of negotiating a successful relationship, and problem solving potential issues that may occur. This workshop has been designed using a train the trainer methodology so that participants will be able to reproduce some or all of the workshop at their home institutions if desired. Participants will leave with a framework for planning and implementing an instructional session at their institutions as well as with tools for use in their own session. The workshop will start with facilitated brainstorming during which the whole group will establish a definition of what a mentor is and what mentoring encompasses. The audience will be challenged to differentiate mentoring from teaching, and from role modeling and advising. Once the definition has been established, the larger group will divide into four small groups: two representing mentors and two representing mentees. The small groups will describe the tasks and expectations involved in the mentoring relationship. Next the small groups will address selecting and inviting an individual to be
INTRODUCTION: A typical academic medical center has great generational diversity in its workforce and learners. This diversity can lead to significant conflict when the values shared by each generation are incongruent. Understanding generational attributes, behaviors and values is only the first step toward a more successful work and educational environment. Far more difficult is the task of translating this into practice by offering effective solutions to generational challenges that arise in everyday situations. By viewing conflicts that arise through a generational lens, pediatric medical educators at all levels will be better equipped to actively design productive and satisfying educational and work experiences for every member of the multigenerational team.

GOAL: To understand and respect the values of the four generations present in a typical academic medical center in order to improve the educational and work environment for multigenerational learners at every level. METHODS: This interactive workshop will begin with an overview of the common characteristics and values of the four generations, followed by small group breakout discussions. Participants will engage in a discussion of generational conflicts. Trigger tapes will be used to facilitate small group discussions. Participants will practice developing solutions to these challenges, designing generationally-sensitive curriculum, and identifying effective ways to improve collaboration amongst faculty. Large group discussion will highlight successful solutions as well as common pitfalls and ensure participants will leave with practical tools to improve the academic environment.

C11. Transforming Your Web-Based Curriculum Manager: From Passive Knowledge to a Robust and Interactive Learning Platform for Medical Students and Residents

Room #339

Overview of Blackboard™. Small groups, Components of an effective module and “Interactivity and assessment.” Demonstration of an active module with interactive components for medical students and residents. Small groups, Blackboard™ in your curriculum, advanced applications. Our experience and some preliminary data. Questions and answer period.

C12. A Practical Approach to Assessing and Teaching the Difficult Learner

Room #342

Difficult learners are a challenge to teach in the clinical setting. Most medical students and residents have succeeded in their prior educational efforts, and have trouble accepting the need for help. It can be quite challenging to sort through the affective issues, inadequate preparation, learning disorders, dyslexia and/or preceptor mismatch that can affect learner performance. Preceptors need tools to assess the nature of the problem, and strategies to allow them to help learners overcome these obstacles to clinical training. In this workshop, we will share the approach to the difficult learner developed by the UMass Community Faculty Development Center over the last 15 years. This practical approach can be used by generalist and sub-specialty faculty to improve medical student and resident performance in a variety of settings. 1) Interactive lecture: Using a case-based approach, we will outline an approach to the assessment of problem learner in a clinical setting, introducing a variety of assessment tools. 2) Small group role-play: Participants will use case-vignettes to practice using the tools. 3) Large group discussion: Participants will debrief the small group discussions and discuss barriers and solutions to the use of these methods in their own programs. 4) Interactive lecture: Using a “train-the-trainers” model, participants will develop a plan for introducing similar faculty development program to their home institution. Participants will receive handouts on disc that can be adapted to their home institutions for faculty development.

C13. Generational Differences and Beyond: Are We There Yet?

Room #350

INTRODUCTION: A typical academic medical center has great generational diversity in its workforce and learners. This diversity can lead to significant conflict when the values shared by each generation are incongruent. Understanding generational attributes, behaviors and values is only the first step toward a more successful work and educational environment. Far more difficult is the task of translating this into practice by offering effective solutions to generational challenges that arise in everyday situations. By viewing conflicts that arise through a generational lens, pediatric medical educators at all levels will be better equipped to actively design productive and satisfying educational and work experiences for every member of the multigenerational team.

GOAL: To understand and respect the values of the four generations present in a typical academic medical center in order to improve the educational and work environment for multigenerational learners at every level. METHODS: This interactive workshop will begin with an overview of the common characteristics and values of the four generations, followed by small group breakout discussions. Participants will engage in a discussion of generational conflicts. Trigger tapes will be used to facilitate small group discussions. Participants will practice developing solutions to these challenges, designing generationally-sensitive curriculum, and identifying effective ways to improve collaboration amongst faculty. Large group discussion will highlight successful solutions as well as common pitfalls and ensure participants will leave with practical tools to improve the academic environment.

Laura Smals, MD, Nancy D. Spector, MD, Paul S. Matz, MD, Robert S. McGregor, MD, Michael Blair, MD, Raj Munshi, MD, Katherine Garguilo, MD, St. Christopher’s Hospital for Children, Philadelphia, PA

The advances in technology in recent years have revolutionized medical education and changed the methods of communication in the medical community. While these advances have increased access to the newest data, they also have created new challenges in professional behavior for medical students, residents and faculty. The use of e-mail, text messaging, blogs, smart phones, and social networking sites have changed the speed and ease of communication between members of the medical community, but have the potential to create conflicts not previously encountered. The questions of how to monitor, instruct and remediate behavior with these electronic interfaces is a new challenge to the medical educator. In this workshop, the presenters will review some of the current technology and its potential pitfalls. They will discuss the unique aspects of these methods of communication including topics such as: content, language, tone, timing, distribution, rate of response and appropriate mode utilized. Real-life examples will be used for discussion and a curriculum developed by the presenters will be shared with the group. The participants will have the opportunity to discuss issues in electronic professionalism and to create guidelines and develop possible solutions. The participants will leave with an understanding of the current issues in electronic professionalism and have resources to address these issues and anticipate conflicts in the future.

12:15 pm – 2:00 pm Combined Research Presentations w/ boxed lunch Ballroom III

1. Training in Delivering an Unexpected Diagnosis

Lynn R. Campbell, MD, Harold L. Kleinert, EdD, Carol A. Lunney, PhD, James E. Ferguson, MD, MBA, University of Kentucky, Lexington, KY

This study is directed towards improving medical information and support to families as they receive the unexpected diagnosis of Down syndrome (DS). Using a Web tutorial integrating prenatal and postnatal information into virtual patient scenarios, the study assessed pediatric residents’ knowledge and comfort in delivering a diagnosis of DS. It also measured residents’ perception of need for this training. STUDY DESIGN: A team of physicians, parents, and educational specialists designed a Web-based interactive tutorial in which resident physicians read information about DS and viewed virtual patient-doctor sessions. Before and after viewing the tutorial, resident physicians were asked to respond to situations related to DS diagnoses both in utero and at the time of birth. Outcome variables included factual knowledge, attitudes about DS, and feedback about the perceived value of the tutorial as a part of residents’ curricula. Subjects included 88 pediatric residents from 10 programs. RESULTS: The tutorial yielded significant improvement in knowledge (Pre-test Mean = 8.18, Post-test Mean = 12.00; p<.01) and a decline in the level of discomfort (Pre-test Comfort Mean = 23.13, Post-test Comfort Mean = 17.21; p<.01) that residents expressed related to counseling about DS. In addition, across all pediatric resident groups, residents strongly agreed that this type of training was beneficial for residents, for practicing physicians, and for other medical professionals (p<.03). Residents indicated that their regular curricula do not offer similar instruction in teaching communication skills that are required in clinically difficult and sensitive situations. CONCLUSION: A Web-based tutorial can help pediatricians impart accurate information in a supportive framework about DS. The training modules can be viewed at www.brighter-tomorrows.org. From a broader perspective, this study suggests that Web-based communication training strategies can be effective not only for resident physician communication with families about the unexpected diagnosis of DS, but also for pediatricians communicating with parents about unexpected diagnoses of other life-altering illnesses and disabilities.

2. Students’ Reflections on a Self-Directed Module Method of Learning in a Third-Year Pediatric Clerkship

Angela M. Allevi, MD, Lindsey Lane, MD, Thomas Jefferson University/A.I. duPont Hospital, Philadelphia, PA

PURPOSE: To understand students’ experience with a self-directed learning method used during a third year pediatric clerkship. BACKGROUND: Newer active learning methods like problem-based learning, team-based learning, and case-based learning are increasingly used to augment traditional teaching methods. Despite widespread adoption of these new methods we found no qualitative studies that examined “what actually happens” during these educational processes. Eight years ago we replaced traditional lectures with a module method of learning in our pediatric clerkship. Each topic module consists of 10 case vignettes that students research and prepare for group discussion facilitated by a faculty member. Our goal was to understand the student experience and identify the important factors/features of the module method. METHODS: We conducted an ethnographic study over one year. Sixty-eight students participated. We used multiple data sources: participant observation, written reflections, semi-structured interviews and focus groups. After initial data review a working coding schema was devised, tested, and verified. Data was coded and analyzed for themes. RESULTS: The main themes that emerged were: Constructivist learning, Effective learning, Real-life learning, Importance of time, and Importance of faculty. Students spoke and wrote about and we observed ‘construction’ of knowledge. Although time consuming, students placed value on the module method and high value on their interactions with faculty who were responsible for ‘real-life’ learning in the module sessions. There was a shift in attitude towards modules as third year progressed, with some students more focused on what they needed to know to do well on the exam rather than real-life learning. CONCLUSION: Students see modules as an interactive process that is educational and worthwhile. Learning is built or constructed in modules, with faculty interactions the most valuable part. Faculty play a key role in making the learning effective and real-life. Time is an overriding issue for students as they struggle with the time commitment required to gain the educational benefit achieved.

COMBINED 2009 MEETING ● APRIL 28 - MAY 2 ● BALTIMORE, MD
3. Assessing the Learning Environment of a Clinical Clerkship
   Janice L. Hanson, PhD, Virginia F. Randall, MD, Uniformed Services University, Bethesda, MD
   BACKGROUND: The LCME requires medical educators to evaluate the learning environment and ensure it promotes
   professionalism. Other researchers have defined learning environment primarily from educators’ perspectives and have
   included positive role models; teacher-learner relationships; student self-efficacy; atmosphere. Purpose: To identify factors
   that influence medical students’ views of their learning environment, examined exclusively from students’ perspectives.
   METHODS: Students (N=316) responded to an end-of-clerkship questionnaire (6 pediatric clerkship sites; anonymous to
   clerkship faculty; required by Dean’s office). All free-text responses from AY 2005-2006 (158 of 165) and AY 2006-2007
   (161 of 161) were analyzed using the constant comparative method. Two researchers analyzed the text independently, then
   discussed and compared coding decisions until reaching agreement on labels for themes, organization as three major
   themes with subthemes, and placement of all text in the themes. RESULTS: Three major themes emerged: 1) Structure
   and organization of the clerkship—physical conditions; learning activities; organization. 2) Teacher-learner interactions
   for education—facilitated learning; clinical medicine at the MS3 level; feedback, evaluation, clear expectations; students
   included on the team. 3) Faculty attributes and professionalism—attitude about teaching and medical students; role model;
   expertise of faculty. DISCUSSION: Qualitative analysis of students’ free-text responses to a questionnaire described the
   learning environment in terms of organization, teacher-learner interactions and faculty attributes and professionalism.
   While developed in a pediatric clerkship, the themes may apply to other clerkships or residencies. Themes, subthemes
   and descriptors will form the basis of a questionnaire to assess clinical clerkships and assist faculty in identifying elements
   that promote a positive learning environment and professionalism and those that need improvement. Both qualitative
   analysis of free-text responses and a targeted questionnaire can assist clerkships in addressing the LCME requirement.

4. Self-Directed Learning and Individualized Learning Plans: Implications for Program Directors
   Su-Ting T. Li, MD, MPH, Daniel J. Tancredi, PhD, UC Davis, Sacramento, CA, John Patrick T. Co, MD, MPH, Massachusetts
   General Hospital, Boston, MA, Daniel C. West, MD, University of California, San Francisco, San Francisco, CA
   OBJECTIVES: To determine which resident- or program-related factors are associated with effective self-directed learning
   of residents. METHODS: National cross-sectional web-based surveys of pediatric and med/peds residents and program
   directors. Self-directed learning efficacy was measured by resident self-reported progress on a 5-point Likert scale toward
   achieving learning goals from most recent Individualized Learning Plan (ILP). Learner- and program-level characteristics
   were assessed using multilevel linear regression. RESULTS: The response rate was 100% (45/45) from program directors
   and 58% (972/1684) from residents. Most (76%) residents had written an ILP previously. Most residents reported little (25%)
   or some (50%) progress (mean 2.6; SD: 0.9) on achieving their learning goals. Resident characteristics associated with more
   progress included having a method for tracking progress, being further along in training, feeling that ILPs help align learning
   goals with needs, having greater propensity for lifelong learning, and having more time to work on current ILP. (Table)

<table>
<thead>
<tr>
<th>Regressor or Factor contrast</th>
<th>Adjusted mean difference (95% CI) for 1 s.d. change in regressor or for contrast</th>
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<tbody>
<tr>
<td>Track progress on achieving learning goal</td>
<td>0.19 (0.13 to 0.25)</td>
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<tr>
<td>PGY3+ vs. PGY1</td>
<td>0.21 (0.04 to 0.38)</td>
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<tr>
<td>PGY2 vs. PGY1</td>
<td>0.17 (0.03 to 0.30)</td>
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<tr>
<td>Felt that ILP helped them align learning goals with learning needs</td>
<td>0.12 (0.05 to 0.29)</td>
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<tr>
<td>Propensity toward lifelong learning</td>
<td>0.11 (0.04 to 0.17)</td>
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<tr>
<td>Time since last ILP written</td>
<td>0.10 (0.03 to 0.17)</td>
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<tr>
<td>Confidence in self-directed learning abilities</td>
<td>0.06 (-0.02 to 0.14)</td>
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<tr>
<td>Female vs. Male</td>
<td>-0.14 (-0.27 to -0.01)</td>
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<tr>
<td>“Creator” vs. “Decision maker” learning style</td>
<td>-0.21 (-0.38 to -0.03)</td>
</tr>
<tr>
<td>Undecided in career area vs. Generalist</td>
<td>-0.36 (-0.57 to -0.16)</td>
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CONCLUSIONS: Residents who tracked their progress toward achieving their learning goals and those with more advanced
training and greater propensity toward lifelong learning reported more progress toward achieving their learning goals.
Residency programs should consider helping residents develop measurable goals and systems for tracking progress toward
attaining them. Since propensity toward lifelong learning is associated with greater self-directed learning efficacy, medical
schools and training programs should try to develop this in their learners.

Funding for this study provided through an APPD Special Project Grant in 2008.

5. Paving the Way to Practice-Based Learning and Improvement: Students’ Experiences with a Competency-Based
Sub-Internship Curriculum
   Michele Long, MD, Elizabeth Stuart, MD, Stanford, Palo Alto, CA
   BACKGROUND: Pediatric residency training requirements mandate that all residents maintain an Individualized
   Learning Plan (ILP). Previous work suggests that residents have difficulty identifying learning goals to include in ILPs
BACKGROUND: Computerized Physician Order Entry (CPOE) has been shown to have several beneficial outcomes, including reduction in medication errors, reduced test ordering, improved medication turn-around time, and reduction in length of stay. It has also been shown, however, to increase physician front-end work time. Residents are the physicians primarily responsible for order entry and the subsequent increased physician work time falls to them. Residents are also expected to conform to Duty Hour Regulations that limit the amount of time any resident may spend on patient care activities. It is possible that adding the task of computerized order entry to a resident's workload may result in an increase in duty hour violations. OBJECTIVE: This study analyzed the effect of CPOE on Duty Hour compliance in multiple inpatient and intensive care settings. DESIGN/METHODS: Duty hour logs for Pediatric and Medicine/Pediatrics Residents on inpatient and intensive care services prior to and following the initiation of CPOE were analyzed for duty hour violations. Descriptive statistics and t-tests were employed for data analysis. RESULTS: There was no significant increase in the number of duty hour violations subsequent to the initiation of CPOE, including total work hours and violations of the 24+6 hours rule in the Pediatric ICU and general inpatient services. Duty hour noncompliance was significantly increased, however, in the Neonatal ICU, the first unit to implement CPOE. These violations persist, but may be attributable to other factors. DISCUSSION: CPOE can be successfully implemented in multiple settings without additionally contributing to duty hour violations. In busy intensive care units with other factors contributing to increased physician workload, however, CPOE can contribute to physician work time sufficient to cause noncompliance with duty hour regulations, thus putting institutions at risk for ACGME penalty.
learned as a coordinator for 5 distinct fellowship training programs over the past 5 years. Specific areas of instruction will include: (1) Ways to get organized now! (2) Simple keys to completing the PIF! (3) Important documentation - what do we really need? (4) Keys to effective communication with your site reviewer and (5) Analyzing your successes and deficiencies after the site visit - how to better prepare for the NEXT site visit.

3:30 - 4:30

10 Steps for Effective Presentations
Aida K. Velez, MEd, University of Connecticut Pediatric Residency Program, Hartford, CT
The purpose of this workshop is to introduce participants to a basic structure and approach for developing and delivering presentations or workshops. It will provide a template to follow in creating presentations and will address presentation skills. After presenting the foundation for developing and delivering a workshop, participants will be asked to break into groups, develop a topic, and use the template to identify the goals/objectives, format and structure of the presentation or workshop. The session will end with a reporting out session. This workshop will provide the program coordinators with the groundwork for using creativity in developing presentations and being an active participant in educational activities.

5:00 pm – 7:00 pm

Combined Poster Session and Reception

Ballroom I

APPD Research Posters

1. Workplace Violence: A Survey of Pediatric Residents
Karen Judy, MD, Loyola University Medical Center, Maywood, IL
OBJECTIVE: Pediatric Residents are often exposed to verbal abuse and/or physical assaults from patients and patients’ families during the course of their Residency training. The objective of this study is to determine the prevalence of workplace violence in Pediatric Residency Training Programs. We hypothesize that residents are poorly trained to handle such workplace violence and that they would benefit from further training in how to prevent and respond to workplace violence. PATIENTS AND METHODS: In 2007, a 25 item web-based questionnaire was distributed to 1211 Pediatric Residents of all training levels from 25 Pediatric Programs around the country about their experiences with verbal and/or physical abuse while on duty. Participation in the study was voluntary. RESULTS: We received 541 return surveys, a 45% response rate. Many pediatric residents who responded to our survey (33%) had been verbally abused or physically assaulted by patients and/or patients’ families during their residency program. Verbal abuse was much more common than physical assaults. 71% of pediatric residents reported having no teaching about workplace violence during their residency training. The majority (74%) would like to receive more training in managing angry patients and families. CONCLUSIONS: We conclude that Pediatric Residents are often exposed to verbal threats during the course of their patient care. They are also at risk of physical assaults by angry patients and/or families. Pediatric Residents require more training on how to prevent and respond to workplace violence. This important topic should be incorporated into the Pediatric Residency Curriculum.

2. Community Health and Advocacy Curricula: Poised to Capture ACGME Competencies
Christine L. Bottrell, BA, University of California School of Medicine, Lynne Lamontagne Drouin, MPH, Department of Pediatrics, University of California San Francisco, Anda K. Kuo, MD, Pediatric Leadership for the Underserved, San Francisco, CA
BACKGROUND: The Accreditation Council for Graduate Medical Education (ACGME) has identified 6 core competencies for all GME specialties. Of those, systems-based practice (SBP), practice-based learning and improvement (PBLI), interpersonal and communication skills (ICS), and professionalism (PR) may not be traditionally captured by standard clinical rotations. Community health and child advocacy (CHCA) experiences that are required of pediatric programs by the Residency Review Committee may provide an opportunity to address these competencies as they broaden resident education beyond the bedside. The University of California San Francisco pediatric residency requires a one-month, PGY-2 rotation, titled Physician in Society (PIS), that includes didactic and experiential components in CHCA. No study in our literature review has directly measured perceived improvement in ACGME competencies after CHCA curricula. OBJECTIVE: To demonstrate that CHCA curricula such as PIS can capture ACGME competencies. METHODS: A retrospective pre- and post-rotation self-assessment of residents’ perceived effectiveness in sub-competencies of SBP, PBLI, ICS, and PR was conducted, using a scale of 1-4 (1 = not effective, 4 = very effective). Paired t-tests were used to detect significant differences. Effect sizes were calculated to quantify change. Open-ended questions were utilized for qualitative analysis. RESULTS: Significant differences (p<0.05) in pre- and post-rotation perceived effectiveness were found across all sub-competencies of SBP, PBLI, and ICS and in 3 of 8 sub-competencies of PR. Effect sizes ranged from 0.53-2.12 for SBP, 0.24-1.77 for PBLI, 0.27-1.04 for ICS, and 0.36-0.57 for PR. Qualitative resident data revealed improved knowledge of: social factors that impact health, community-based resources, and the integration of advocacy into clinical practice. CONCLUSION: Community health and child advocacy experiences such as the Physician in Society rotation can improve residents’ perceived effectiveness in SBP, PBLI, ICS, and PR competencies. Greatest perceived change is evident in SBP.
3. Self Perceived Leadership Behaviors Among Pediatric Residents  
Maureen G. Leffler, DO, MPH, AI duPont Hospital for Children, Wilmington, DE, Lynne M. Lamontagne Drouin, MPH, UCSF Pediatric Leadership for the Underserved, San Francisco, CA, Steven Selbst, MD, Glenn Stryjewski, MD, MPH, Robert Doughty, MD, PhD, AI duPont Hospital for Children/ Thomas Jefferson University; Wilmington, DE, Anda K. Kuo, MD, UCSF, Pediatric Leadership for the Underserved, San Francisco, CA  
BACKGROUND: Strong leadership skills are paramount to mastering the core competencies identified by the ACGME. In the changing culture of medicine, physicians must lead new medical systems. To prepare residents for leadership roles, we must first identify their baseline strengths and weaknesses. The Leadership Practices Inventory (LPI) is a well validated instrument that measures behaviors in five domains of leadership: model the way, inspire a shared vision, challenge the process, enable others to act, and encourage the heart. To date, there is no data regarding self-perceived leadership behaviors among pediatric residents. The objective of this study is to provide descriptive data regarding self-perceived leadership behaviors among pediatric residents at two residency programs. METHODS: We administered the Leadership Practices Inventory (LPI), a thirty item self-report survey, to 109 pediatric residents (50 PL1s, 41 PL2s and 18 PL3) from two training programs. Data collection was completed within the first 4 months of the 2008-2009 academic year. Class averages are presented for each leadership behavior. The non-parametric one way ANOVA Kruskal-Wallis test was used to detect differences between the classes. RESULTS: There was no statistically significant difference between class rankings in each leadership behavior (Inspire p-value 0.081, Challenge p-value 0.146, Enable p-value 0.813, Encourage p-value 0.422, Model p-value 0.435). Every class felt that their strongest behavior was Enabling, followed by Encouraging, Challenging, Modeling and Inspiring. CONCLUSIONS: Senior residents did not report increased competencies in leadership skills. Future research should be directed towards correlating observer evaluations of resident leadership behaviors with self-reported behaviors and identifying if similar trends occur in other physician-residents. Finally, this data may provide a tool for framing the discussion about needed changes in medical leadership training.

4. Do Parents Understand the Roles of Physician Trainees?  
Priti Bhansali, MD, University of Connecticut, Carol K. Barrett, MA, Connecticut Children’s Medical Center, Kate Cunningham, College of the Holy Cross, Melissa Held, MD, University of Connecticut, Hartford, CT  
BACKGROUND: Many physician trainees care for patients in an academic hospital. The objective of the study is to survey parent understanding of the roles of medical students, interns, residents and attending physicians in the inpatient setting of a children's hospital. METHODS: Surveys were given to parents after 24 hours of a hospital stay on a medical service. The questionnaire contained 11 statements about the responsibilities and education of physicians and physician trainees. RESULTS: Of 282 surveys, 169 responded (response rate of 57%). 92% knew that medical students were not doctors, could not write prescriptions, or supervise residents or attendings. 60% with a high school education or less thought a medical student could not obtain a history compared to 31% with a college education (p=0.001). 82% did not know that an intern had completed medical school, 70% did not know an intern was a doctor, and 83% did not know an intern could write prescriptions. 27% did not know a resident was a doctor, and 37% did not know a resident could write prescriptions. 74%-78% knew that attendings had graduated from medical school, were doctors, could obtain a history, write orders, and supervise interns and students. 56% with a high school degree or less knew an attending had graduated from medical school versus 90% of those with a college degree (p=.001). There was no significant relationship between knowledge of physician roles and length of hospital stay, exposure to medical television programs, or working in a medical setting. Only 52% of parents who had roles explained to them were able to correctly identify the experience levels of physicians on the healthcare team. Factors identified as affecting understanding of these roles included the parent's level of education and race. Discussion: There is confusion among parents of pediatric patients about the different roles of physicians and physician trainees. This finding is pronounced in parents who have not attained education beyond high school, and in those who identify as being non-white. Appropriate methods of educating parents about the roles of providers caring for their child should be pursued.

5. 360 Degree Evaluations in the Outpatient Setting: Is Family Input Really Necessary?  
Nicole L. Chandler, MD, University of North Carolina, Durham, NC, Gavin J. Henderson, MD, PhD, Brittany Park, BS, Julie Byerley, MD, MPH, Wallace D. Brown, MD, Michael Steiner, MD, UNC, Chapel Hill, NC  
BACKGROUND: Faculty have traditionally evaluated resident professionalism and interpersonal skills without input from other perspectives. Programs are now required to institute 360 degree evaluations which include multiple evaluators. OBJECTIVE: To determine if nurse (RN), patient or family (P/F), and resident (self) ratings differ from faculty ratings of resident professionalism and interpersonal skills in an outpatient setting. METHODS: Pediatrics residents were enrolled on consecutive days over a 4-week period in the continuity clinic. During this period, P/F, MD, RN and self completed evaluations after each clinic session using a validated 10-item questionnaire. Five-point Likert scales for each question were averaged and became the summary rating from that questionnaire. Mean Likert scale scores between types of raters were compared using mixed ANOVA with random subject effects and pairwise comparisons when appropriate. Pearsons correlation was used to measure agreement between raters. RESULTS: Eight hundred and thirty-six evaluations were completed for 66 residents (total eligible=69). All raters scored residents highly (mean Likert scale range 4.4 to 4.9). However, P/F scored the residents lower than MD and RN (respective mean scores; P/F 4.53, SD 0.53; MD 4.77, SD 0.32; and RN 4.85, SD 0.30; p < 0.0001). The resident self-evaluation scores were also lower than the MD and RN.
scores, but did not differ from the P/F scores (average resident self score: 4.44, SD 0.43; p<0.0001 compared to MD and RN; p=0.19 compared to P/F). Correlation coefficients between all combinations of raters ranged from -0.21 to 0.21 and were not statistically significant. There was no significant difference between average scores for each resident training year (PL1 4.75, SD 0.44; PL2 4.76, SD 0.47; PL3 4.77, SD 0.45, p=0.92). CONCLUSION: Ratings of resident professionalism and interpersonal skills were high; however, different members of the healthcare team rated residents differently, and in ways that were not correlated. These results provide evidence for the potential value of 360 degree evaluations.

6. Resident Perceptions of Individualized Learning Plans
Amy Jost Starmer, MD, Children's Hospital/Boston Medical Center, Brookline, MA, Ann E. Burke, MD, Wright State University, Dayton, OH
INTRODUCTION: Individualized Learning Plans (ILPs) are required by the Pediatric Review Committee. This form of self-directed learning is relatively new to residents, as well as program directors and faculty. There is a paucity of information on resident attitudes regarding ILPs and the perceived effectiveness of this exercise in residency training. OBJECTIVE: To ask residents questions regarding their perceptions about and participation in ILPs and thus determine if a majority of residents surveyed have outstanding common opinions. DESIGN/METHODS: In 2008, during the redesign of Pedialink, a survey was developed to ascertain estimates of residents’ perceptions of ILPs in order to assist program directors (PD) with strategies to assist in making the resident ILP experience useful and positive. The majority of questions were asked on a five-point Likert scale with the anchors being agree strongly, agree somewhat, neutral, disagree somewhat, and disagree strongly. The survey was vetted with the Pedialink Resident Center Working Group, comprised of PDs and residents, and evaluated for face validity. The 10-item survey was sent to program delegates of the AAP resident section (n=316). The survey was sent three times over 2 months. RESULTS: One hundred-sixty four residents completed the survey (52%). Of the respondents 37%, 48% and 5% were in their third, second and first year of residency, respectively. The remaining 10% of respondents were either in practice, fellowship or chief resident positions. When asked if the ILP is a potentially valuable career development tool, 81% answered that they either “agree somewhat” or “agree strongly”. When asked if ILPs were well implemented at their residency program, 39% agreed and 33% disagreed; 26% remained neutral. Inquiry into format preference for ILPs was made: 77% prefer online ILPs, 8% prefer paper, and 19% stated they had no preference. CONCLUSIONS: There is a wide range of resident opinion regarding ILPs. The majority felt ILPs to be potentially useful as a career development tool and preferred online ILPs. These opinions and the reasons behind them need further investigation.

7. An Innovative 360-Degree Assessment Instrument: Using a Relative Ranking Model to Enhance the Appraisal Performance
Satid Thammasitboon, MD, MHPE, Karen Breets, MD, John Phillips, MD, Renee Moore, MD, West Virginia University, Morgantown, WV
BACKGROUND: In order to minimize appraisal errors (i.e. central tendency, halo and ceiling effects), we developed an innovative 360-degree assessment instrument using a relative ranking model. The instrument integrates input from faculty, nurses and resident peers, and then produces an intra-individual assessment profile that characterizes areas of strengths and weaknesses within individual residents. PURPOSE: To compare discriminative performance of a 360-degree assessment instrument using a relative ranking model with a conventional 3-point likert scale system. DESIGN AND METHOD: A cross-sectional comparison of two Web-based competency assessment instruments. The 360-degree assessment instrument (360°) produces intra-individual assessment profiles for 6 core competencies. The 3-point likert scale system (likert-3) yields profiles with an individual average rating for 26 elements representing core competencies. The expert evaluators, selected by program directors, completed six tests matching the residents’ names with their assessment profiles from the two instruments using three tests for each instrument. The discriminative performance of both instruments, represented by proportions of correct matches, were compared and analyzed. Residents were asked the extent to which the profiles represented actual performance. RESULTS: Twenty-one expert evaluators completed the test. The evaluators reported higher levels of confidence when comparing matching items from the 360° with the likert-3 profiles (means, 48.5 vs. 27.7%, p<0.001). Discriminative performance was also higher using profiles from the 360° rather than those from the likert-3 instruments (means, 6.4 vs. 0.4%, p<0.005). On a scale of 0 to 100%, residents reported that profiles were reasonably representative of themselves (mean, 65%, 95% CI, 60-72%). CONCLUSION: Our innovative 360-degree assessment instrument produces competency assessment profiles that are more informative (discriminative and representative) than those from the 3-point likert scale system.
INTRODUCTION: Adults learn a subject best when they see its relevance and perceive a need for improvement. For

11. We Need to Talk: Discrepancies Between Resident Perceptions of their Communication Skills and those of Faculty

Thanakorn Jirasevijinda, MD, Weill Cornell Medical College, New York, NY, Richard Neugebauer, PhD, Bronx-Lebanon Hospital Center, Bronx, NY

INTRODUCTION: Adults learn a subject best when they see its relevance and perceive a need for improvement. For communication skills (CS), little is known about resident self-perceptions on areas of weakness. Even less is known
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BACKGROUND: ACGME Duty Hours Standards have been in place since July, 2003. The effects on knowledge acquisition during pediatric residency training are unknown, as no pediatric studies to date have looked at concrete differences in education and performance before and after duty hour implementation. In the present study, we sought to compare resident education pre- and post-duty hours using change in examination scores over the course of residency as an indicator. METHODS: We compared the standardized test scores (in-training examination and certifying examination) of cohorts of Emory pediatric residents trained before (PGY-1 years 1997-2000) and after (PGY-1 years 2003-2006) the institution of work hour restrictions. We documented the change in exam score, from PGY-1 to PGY-3 year, and from PGY-1 year to certifying exam, between the two cohorts and then compared the change using a t-test of means. Residents without both a PGY-1 and PGY-3 in-training examination score were excluded from analysis. Certifying exam scores were not yet available for the 2005 and 2006 PGY-1 classes and thus not included. RESULTS: There was no significant difference between the mean change in examination scores pre- and post-duty hours (PGY-1 to PGY-3 pre-: 200 vs. post-: 210, p=0.51; PGY-1 to certifying exam pre-: 284 vs. post-: 318, p=0.08). There was a significant difference between the mean scores of the before and after duty hour cohorts in every residency year (PGY-1 year pre.:239 vs. post.:175, p<0.01; PGY-2 year pre.:382 vs. post.:326, p<0.01; PGY-3 year pre.:439 vs. post.:384, p<0.01). Certifying examination score means, however, were similar (pre.:521 vs. post.:526, p=0.82). CONCLUSIONS: While less exposure to the hospital, because of duty hour restrictions, might produce untoward results in pediatric resident education, no such relationship was shown. Alternatively, there seems to be no enhancement of education after the institution of duty hour standards. Ongoing studies, incorporating multiple programs’ experiences and using a variety of surrogate markers, such as patient outcome data and resident/faculty opinion, are needed to confirm our results.
14. The Impact of Combined Pediatric Residency Programs on the Educational Experience of the Categorical Pediatric Residents

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BACKGROUND: Current program requirements for pediatric residency programs and for med-peds programs have raised concerns about the possibility of a negative impact of combined residency training programs on pediatric programs. There are no published data on this subject. METHODS: A random sample of 500 graduating third-year categorical pediatrics residents were surveyed as part of an annual pediatric survey in 2004. The responses were merged with the Accreditation Council for Graduate Medical Education (ACGME) database on residency program size and with the American Board of Pediatrics (ABP) categorical-pediatrics-only pass rates. RESULTS: Responses were received from 303 graduating residents (62%). Among the 184 respondents who trained in programs with a combined training program the majority (60%) reported that the combined programs enhanced their educational experience. Another 39% thought the combined programs had no effect on their experience. Combined programs did not negatively affect self-reported outcomes variables or board pass rate. Graduates of small and medium categorical pediatrics programs were more likely than residents from large programs to report that the combined programs enhanced their experience (69% v. 50 %, p = .011). CONCLUSIONS: Our data do not support concerns that combined programs may negatively impact the educational experience of residents in the categorical pediatrics program but suggest a subjective enhancement of their experiences.

APPD Descriptive Posters

15. Field Trip: A Novel Way to Improve Anticipatory Guidance for Resident Physicians and Medical Students

Allen R. Friedland, MD, Christiana Care Health System Med-Peds Program, Hayley Rintel-Queller, MD, David Paul, MD, Christiana Care Health System, Newark, DE

INTRODUCTION: Pediatric health care providers are routinely asked to give advice on child health products in addition to guidance on feeding and safety issues. We introduced a new method of teaching anticipatory guidance and child product recognition using a field trip approach. METHODS: Residents and students were brought to a local Babies R Us store where they were given a narrative, tour and product demonstration of the products sold using American Academy of Pediatrics (AAP) recommendations as the basis of discussion. Each participant completed a 20 question pre and post test related to common pediatric feeding and safety issues just before and after the tour. RESULTS: Sixty-seven resident physicians and medical students from pediatrics, med-peds and family medicine participated in the study. The mean score on the pretest was 9.94 +/- 2.6 and on the post test 15.5 +/- 2.2 (p-value <0.05). Analysis of individual questions showed that twelve of the twenty questions showed a statistically significant improvement after the field trip. There was not a statistically significant difference in improvement based upon the participant’s sex, whether the participant had children, student or resident status, residency program type or program year. 97% of participants thought this session was valuable and should be continued in our curriculum. CONCLUSIONS: Exposure of residents and students to child products through an interactive field trip is helpful to increase awareness about these products in addition to improve knowledge of feeding and safety guidelines set forth by the AAP.

16. ACGME Outcomes Project-Direct Observation Requirement: A Difference Among Evaluators?

Nirali H. Patel, MD, Michael L. Forbes, MD, Douglas Moses, MD, Children’s Hospital Medical Center of Akron, Akron, Ohio, Michael Hewit, MS, Northeastern Ohio Universities Colleges of Medicine, Rootstown, OH

BACKGROUND: In 2006, the ACGME RRC issued amended requirements that included direct observation in 6 core competency domains (CCD). This study was conducted to test 2 hypotheses. H1): There is a difference among faculty evaluator (FE) scoring within each CCD. H2): This difference has an impact on the composite score. METHODS: Using ACGME language, Akron Children’s Hospital developed the SOAP-PIC (Subjective, Objective, Assessment/Plan, Professionalism, Interpersonal/Communication Skill) tool. Using SOAP-PIC, 8 pediatricians served as FEs and scored 56 encounters by 7 interns in each CCD. For each subject, mean (+SD) scores were obtained in each CCD. Individual subject and FE scores for each CCD were analyzed using descriptive statistics. Differences among FE CCD-scoring were analyzed using one-way ANOVA. Significance was defined as p<0.05. RESULTS: For each subject’s CCD score, there was no difference among FEs. Faculty evaluators consistently scored each subject in each CCD. However, there was a difference among FEs in scoring each CCD. There was significant variability across subjects in FE expectation in each CCD. Their assessment of the subjects’ performance differed in all domains. Composite scores among FEs, however, showed no difference. DISCUSSION: This pilot study confirmed H1: There is a difference among FE scoring in each CCD. Faculty evaluators appear to differ in domain-specific expectations of an intern’s performance. Whether this variability is a strength or weakness of the evaluation process remains unanswered. H2 was not confirmed by this pilot. There was no difference in the final, composite score of each subject when FEs were compared. This small, pilot study has yielded provocative results and has been expanded to incorporate more FEs and housestaff. We have speculated that there is a critical number, and possibly specialty mix, of FEs necessary to optimize fairness and equity in residency performance evaluation. The importance of domain-specific variability among FEs and the impact on resident evaluation requires further study.
• 17. IV Bootcamp: An Innovative Approach to Training Residents in the Placement of Intravenous Lines
   Lynne Karlson, MD, Tufts Medical Center, Marc A. Lieberman, MD, Josh Borus, MD, Patricia Catudal, RN, Tufts Medical Center/ Floating Hospital for Children, Boston, MA
   According to the ACGME Program Requirements for Graduate Medical Education in Pediatrics, pediatric residents must have “sufficient training” in the placement of intravenous lines (IVs). The placement of IVs can be one of the most traumatic aspects of a child’s hospital stay, and in this era of duty hour restriction, it is difficult to find adequate time to teach this skill. For many years at the Floating Hospital, IV placement skills were taught in a workshop during PL-1 orientation. The residents practiced this skill on each other. Follow up interviews with the residents and our IV nurse, revealed that this experience was inadequate and that the residents did not feel comfortable attempting IVs on children with so little experience. We therefore designed a program to respond to the challenges of teaching IV placement, coined “IV Boot Camp”. Our interns spend one week under the tutelage of our IV nurse. The week consists of didactics and readings focused on proper technique and complications of IV placements. In addition to didactics, our residents spend time practicing on a synthetic arm. Once comfortable, under the direction of the IV nurse, our residents spend time taking “IV call” and placing IVs on floor patients. Finally, interns spend time in the pediatric endoscopy suite, placing IVs in sedated patients. Interns are taught the IV scoring system which assists in determining the difficulty of IV placement in specific patients. Once completing “IV Boot Camp” residents maintain their skills in a variety of ways. They are expected to attempt initial catheter placement on all inpatients unless deemed too difficult according to the IV scoring system. In addition, opportunities are available to maintain IV skill in the newborn nursery and the ED. At the end of the year our IV nurse presents one rising PL-2 with an award for best IV skill. This program has decreased the burden on our IV team, and has increased resident comfort in placing IVs. Our program produces residents that are competent in IV placement, exceeding the ACGME requirement of “sufficient training” in the placement of IVs.

• 18. Evaluating Pediatric Resident Mentorship - Preparing Residents for Their Future
   Aditee P. Narayan, MD, MPH, Debra L. Best, MD, Duke University Department of Pediatrics, Durham, NC
   BACKGROUND: The goal of pediatric residency training is to create successful pediatricians. Most of residency is spent in learning the basics of pediatric medicine. Little time is spent on preparing residents for conducting a job search, participating in contract negotiations and maintaining an adequate work life balance. There is a paucity of data in the literature on how to best prepare residents to address these issues as well as how to teach senior physicians how to mentor. Our residency program conducted a needs assessment through retreats and exit interviews and found that there was a lack of attention to this during their training. Residents requested more individualized attention and direction in terms of their career progression. This prompted the development of our two-tiered mentorship program, including provision of specific mentoring resources to guide the mentor-mentee pair. PROGRAM DESCRIPTION: Created in 2007, our Pediatric Mentorship Program matched all residents with a total of 31 faculty mentors based on mutual interest and specific mentorship needs. Mentor-mentee pairs were given written job expectations, an article on mentorship, and a mentoring goals template. Pairs were encouraged to meet at various times during the year. Group mentorship workshops were also held. These covered finding a career in general pediatrics, exploring careers in academic pediatrics, and maintaining work-life balance. PROGRAM EVALUATION: The mentorship program was evaluated using faculty-mentor surveys, exit interviews and resident focus groups. Overall, this two-tiered program was very successful. Mentors found the mentoring resources to be helpful in guiding their relationship (job description 62%, goals template 69%, mentoring article 67%). Seventy percent of mentors met mentees more than twice per year. Residents felt that this filled a niche that was otherwise empty. We feel that mentoring resources may improve the mentoring experience for residents and faculty. This innovative program could be easily generalized to fit any pediatric residency program’s need.

• 19. Resident as Coach: Teaching Clinical Skills
   Kimberly A. Gifford, MD, CHaD Pediatric Residency, Leslie H. Fall, MD, Dartmouth Medical School, Lebanon, NH
   To address ACGME competency standards, recent efforts have been made to formalize resident instruction in teaching skills. Many published resident-as-teacher and faculty development curricula focus on didactic teaching or the teaching setting, rather than on specific clinical teaching tasks. Our goal was to improve our existing resident-as-teacher program by including all tasks required for clinical teaching and by giving busy residents tools to more easily incorporate the tasks into everyday clinical teaching. We defined our core teaching tasks through integrating concepts from both the medical and non-medical literature. The curriculum views the resident as a clinical coach and involves a cycle of assessment, feedback, goal setting, and practice. The curriculum is grounded in adult learning theory and utilizes resident learning contracts to enhance personal motivation. The longitudinal series of didactics are linked through self-reflection activities to capture and build on the rich daily teaching encounters that residents already experience. Rather than using a pre-established order, the topic for each session is chosen from a curriculum index, such that it offers tools and strategies to address the needs that surface through the self-reflection exercises. To help residents become more comfortable with performing the skills that they are teaching, we use clinical skills sessions to improve resident physical exam, procedural and critical thinking skills. The clinical skills sessions also model effective use of the teaching tools and strategies introduced in the didactics. Residents then have the opportunity to implement the tools and strategies with students clinically and return to the next session to reflect on those teaching encounters. Program evaluation is multidimensional and assesses resident satisfaction by survey, resident learning through self-reflection and learning contracts, resident behavior through the clinical application of tools, and, most importantly, student impact through
All pediatric residency programs must incorporate training in advocacy and community pediatrics. Legislative
Benjamin D. Hoffman, MD, Christopher Fink, MD, Tito Monge, MD, Teresa Vigil, MD, University of New Mexico,
Gretchen A. Matthews, MD, Marcie L. Billings, MD, Jason (Jay) H. Homme, MD, Robert G. Voigt, MD, Prathibha

In 2000, the Surgeon General described a “silent epidemic of dental and oral diseases...” This was a call to arms for
Melinda B. Clark, MD, Albany Medical Center, Albany, NY
change, developing a campaign including an information campaign and media tools, and testifying before a mock

Their tasks include learning the basic process of legislation in the state, including the timelines

The University of New Mexico Pediatric Residency Program has developed a unique 2 day retreat to help teach these skills. During the retreat, pediatric interns work

advocacy is a crucial means for improving child and community health. In order to effectively work with legislators,

How To Be Heard: A Curriculum on Legislative Advocacy for Pediatric Residents
Benjamin D. Hoffman, MD, Christopher Fink, MD, Tito Monge, MD, Teresa Vigil, MD, University of New Mexico, Albuquerque, NM

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It can help to standardize oral health education and perhaps produce the first generation of pediatricians adequately

PACT, so additional data is being collected. We urge pediatric residency programs to use PACT because it can help to standardize oral health education and perhaps produce the first generation of pediatricians adequately trained in oral health.

The ACCME common program requirements state that residents must “advocate for quality patient care and optimal
care systems”. The Pediatric specific program requirements refine this further to indicate that residents must
know how to advocate for the promotion of health and the prevention of disease and injury”. A strong public health

curriculum aids in achieving these objectives. In a 1991 survey by the Ambulatory Pediatric Association, general
academic pediatricians reported that the most significant threats to the future health of American children include
poverty, the American value system, and the harmful environment. Furthermore, academic pediatricians responded that
to address these health threats, community involvement and community-based residency training are key strategies
for training pediatricians. Many traditional residency training programs do not offer a public health view that takes into
account the broader health systems and support structures that affect patients and their families. Working in concert,
education leaders from the Pediatric and Adolescent Medicine residency and Preventive Medicine and Public Health
fellowship programs identified five content needs for enhancement as aligned to preventive medicine and public
health pediatrics training. They include: 1) A structured longitudinal public health educational experience, combining
integrated didactic and experiential opportunities, 2) Child advocacy and the legislative role of pediatricians,
CME accreditation should be available by Dec 2008. As PACT is online, trainees can proceed at their own pace, and minimal effort by their program is required. The 13 chapters of PACT encompass all of the oral
health information a pediatrician needs in general practice. All text was reviewed by members of the AAP Section on
Pediatric Dentistry and Oral Health. Each chapter contains specific learning objectives, a key-points summary page
and a photo gallery. PACT has a 170+ picture gallery, a glossary, and references. Pre- and post-tests were created based
on the individual chapter objectives. PACT was piloted at Albany Medical Center and pre and post-test comparisons
demonstrate an average improvement of 20.6%. On the pre-test, only 30% of trainees knew to recommend an initial
dental visit by age 1 and only 35% could identify the proper management of an avulsed tooth. Other programs have
begun using PACT, so additional data is being collected. We urge pediatric residency programs to use PACT because
can help to standardize oral health education and perhaps produce the first generation of pediatricians adequately
trained in oral health.

The Genesis of a Longitudinal Public Health Curriculum for Pediatric Residents
Gretchen A. Matthews, MD, Marcie L. Billings, MD, Jason (Jay) H. Homme, MD, Robert G.Voigt, MD, Prathibha

20. Protecting All Children’s Teeth (PACT): A Pediatric Oral Health Training Program for Physicians
Melinda B. Clark, MD, Albany Medical Center, Albany, NY

Gretchen A. Matthews, MD, Marcie L. Billings, MD, Jason (Jay) H. Homme, MD, Robert G. Voigt, MD, Prathibha

22. How To Be Heard: A Curriculum on Legislative Advocacy for Pediatric Residents
Benjamin D. Hoffman, MD, Christopher Fink, MD, Tito Monge, MD, Teresa Vigil, MD, University of New Mexico, Albuquerque, NM

2009 Meeting • April 28 - May 2 • Baltimore, MD
INTRODUCTION: Medical educators have used the Jeopardy!© game as a teaching tool, especially for medical
\hspace{1cm} Thanakorn Jirasevijinda, MD, Weill Cornell Medical College, New York, NY, Lauren C. Brown, BA, Bronx-Lebanon
\hspace{1cm} Hospital Center, Bronx, NY

22. Jeopardy!©: An innovative approach to teaching psycho-social aspects of Pediatrics
\hspace{1cm} Thanakorn Jirasevijinda, MD, Weill Cornell Medical College, New York, NY, Lauren C. Brown, BA, Bronx-Lebanon
\hspace{1cm} Hospital Center, Bronx, NY

23. Development of Low-Fidelity Simulation Cases for a Night Float Curriculum
\hspace{1cm} Toni A. Wakefield, MD, UTMB- Austin Pediatrics, Austin, TX

CONTEXT: High fidelity simulation programs are being adopted in pediatric programs to provide effective learning
\hspace{1cm} opportunities that safeguard patient safety, but require a substantial commitment of financial resources. OBJECTIVE:
\hspace{1cm} We developed a low-fidelity case-based curriculum to create innovative educational opportunities with limited
\hspace{1cm} resources. METHODS: Fifteen PGY2 residents at our UTMB-Austin pediatric residency program participated. Three
\hspace{1cm} pediatric simulation cases were created, and reviewed by at least two faculty members each. Case topics were chosen
to represent common pediatric causes of acute decompensation. The following case topics were chosen: asthma, respiratory
distress and neonatal sepsis. The cases utilized materials available in house: nurse educators cooperated by role-playing,
instructors used simple AHA PALS mannequins, and obtained videos of clinical examples from existing patients (with appropriate consent). Radiologic images from patient cases were de-identified as were other diagnostic materials such as EKGs. Mock versions of the resident's sign out sheets were utilized. Skills emphasized included the following competency areas: Telephone Communications, Patient Care, Interpersonal Communication and Systems-Based Practice. Checklist rating instruments were developed concurrently with the cases. The checklists were discussed by the team as a whole at the conclusion of each case in order to provide immediate and specific feedback. RESULTS: The residents were administered pre- and post-session surveys to evaluate their confidence in patient assessment and assess the perceived utility of the sessions. The surveys demonstrated improved confidence in their ability to assess ill patients and communicate with the medical team. The sessions were uniformly felt to be useful. CONCLUSION: We were able to develop a curriculum that was felt to be effective by the residents and improved their confidence in their ability to assess patients with acute status changes.

\hspace{1cm} Thanakorn Jirasevijinda, MD, Weill Cornell Medical College, New York, NY, Christina M. Alex, MSW, Bronx-Lebanon
\hspace{1cm} Hospital Center, Bronx, NY

INTRODUCTION: Communication skills (CS) and cultural competence (CC) are two ACGME domain components that are difficult to teach and assess. With the premise that teaching is the highest form of understanding, we piloted a project utilizing teaching as an opportunity for residents to reinforce skills and for program directors to assess proficiency in these areas. OBJECTIVES: 1) To study how teaching CS and CC reinforces residents' skills in these areas; 2) To pilot tools for assessing CS and CC using teaching activities of these areas. DESCRIPTION: The Interactive Workshops on Communication & Cultural Sensitivity (IWOCCS) Program at the Bronx-Lebanon Hospital Center trains residents in cross-cultural communication using interactive and peer-education models. The program piloted Learning by Teaching (LxT) Project, whereby PGY-3 residents taught IWOCCS sessions to PGY-1 residents. Sample topics include basic communication skills, adolescent patient, psychosocial model of care, difficult patients, and giving bad news. Faculty mentored PGY-3 residents through the process, from preparation to implementation to assessment. Assessment strategy for LxT included 1) Faculty Assessment completed by faculty as they mentored residents through the activities, with focus on PROCESS; 2) Peer Assessment completed by PGY-1 learners, with focus on CONTENT & DELIVERY; and 3) Self Assessment completed by PGY-3 facilitators, with focus on SELF-REFLECTION. RESULTS: Twenty-eight residents participated in LxT during the 2006-08 academic years. All reported improvement in their knowledge, attitude and/or skills in the topics they taught, as well as in their teaching skills. They also reported that the project helped reinforced self-directed learning in CS and CC. Faculty, peer and self-assessment tools as well as preliminary data analysis and narrative comments will be shared. CONCLUSION: Teaching activities in CS and CC provide an excellent opportunity for reinforcement of skills and assessment of competencies in these areas, and should be incorporated into residency training curricula.

25. Jeopardy!©: An innovative approach to teaching psycho-social aspects of Pediatrics
\hspace{1cm} Thanakorn Jirasevijinda, MD, Weill Cornell Medical College, New York, NY, Lauren C. Brown, BA, Bronx-Lebanon
\hspace{1cm} Hospital Center, Bronx, NY

INTRODUCTION: Medical educators have used the Jeopardy!© game as a teaching tool, especially for medical
\hspace{1cm} knowledge. We piloted the Jeopardy!© format to teach psycho-social aspects of Pediatrics in our residency program.
OBJECTIVE: To pilot an edutainment tool to educate trainees about the diversity, resources and challenges of the community they serve. DESCRIPTION: The Bronx-Lebanon Hospital Center (BLHC) is located in one of the most diverse and underserved areas in the US. The Interactive Workshops on Communication & Cultural Sensitivity (IWOCCS) Program trains residents in cross-cultural communication using interactive and peer-education models. Sample topics include basic communication skills, health disparities, role of culture/religion/spirituality in health, adolescent sexuality, difficult patients, and giving bad news. As part of the IWOCCS program, we piloted "Bronx Jeopardy!©" and focused its content on the various aspects of the community. Mirroring the popular game, ours explored five categories: Roots...
The PURPOSE of this project is to enhance resident understanding and utilization of the six ACGME competencies.

**26. Novel Professionalism Curriculum for a Pediatric Residency Program**

*Rachel L. Dawkins, MD, Simone Fogarasi, MD, Louisiana State University Health Sciences Center, New Orleans, LA*

Designing a curriculum and demonstrating competency in the domain of professionalism is of utmost importance, as it is mandated by ACGME. Effectively teaching professionalism in pediatric residency programs has proven to be a challenging task. Many obstacles exist when trying to design such a curriculum. Our program designed a novel, longitudinal curriculum that has introduced important themes from the professionalism literature as well as provided our residents with a forum to share their thoughts and experiences about professionalism in a safe, supervised setting. Due to residents’ busy schedules, multiple clinical sites, and a busy cadre of clinical professors, we knew that we needed to overcome significant obstacles. We opted to integrate this curriculum into the noon conference time, and to offer it quarterly. We divided all of our residents into groups of ten, spanning all levels of training. Each group is paired with one or two faculty members who went through a faculty development seminar introducing this curriculum. Using cases provided in the Teaching and Assessing Professionalism: A Program Director’s Guide, we aimed to address the following topics: Introduction to Professionalism, Professionalism and Clinical Care, Professionalism and Stress, and Professionalism and Society. Each session opens with a short description of the day’s topic. The faculty mentors are given a syllabus with themes for discussion and cases that can be addressed. The residents are encouraged to bring up their own cases and experiences for discussion. Additionally, each resident is encouraged to write a reflective piece that they may choose to share or keep private. During the first year of this course, participants were asked to write down what they took away from each session, which is in the process of analysis. Each year the curriculum for the professionalism small groups will stay the same with the hopes that residents and faculty have the opportunity to continue this dialogue over time. We have already received verbal feedback that both the residents and faculty have found these sessions valuable for their professional growth.

**27. A Model for Teaching Evidence Based Medicine: A Toolbox for Training, Documentation and Evaluation**

*Kathy L. Perkins, MD, PhD, Lee T. Miller, MD, M. Virginia Barrow, MD, UCLA Pediatric Residency Training Program, Los Angeles, CA*

The Pediatric RRC requires that residents must have didactic experiences to critically evaluate and apply current medical information and scientific evidence for patient care. More specifically, faculty must document a resident's ability to access, appraise and apply knowledge from the medical literature, and the program must evaluate the competence of residents in performing an evidence-based exercise. The exercise may include a journal club presentation or other structured exercise in which best evidence is applied to a focused clinical question, and the evaluation should be based on predetermined criteria. This poster will share a strategy to meet the curricular requirements to teach residents the principles and applications of evidence-based medicine (EBM). More specifically, we demonstrate teaching models that emphasize: 1) How to access best evidence, 2) How to assess validity, strength and precision of published literature by applying EBM principles, 3) How to assess the applicability of the medical literature to patient care. We also share a rubric for evaluating resident competence in performing an evidence-based exercise. Review of the evaluation during feedback sessions fosters resident self-reflection and may contribute to development of an action plan. In addition, this evaluation tool satisfies programmatic requirements for documentation of resident participation. Finally, we share survey data on the ways in which our residents access the medical literature, both before and after participation in EBM training, as well as information about the EBM tools that they bring to residency training from their undergraduate medical educations. These data may also have significant implications for curriculum development at the clerkship level.

**28. Using Resident Portfolio to Understand the ACGME Competencies**

*Ralitsa B. Akins, MD, PhD, Gilbert A. Handal, MD, Texas Tech Pediatrics El Paso, El Paso, TX*

The PURPOSE of this project is to enhance resident understanding and utilization of the six ACGME competencies through development of a structured portfolio. METHODS: In 2007, a 15-section portfolio structured format was developed following the 6 ACGME competencies and the resident training requirements as specified in the PIF. Residents are encouraged to reflect on their experiences with the competency areas and include examples from own practice. The portfolio is used by faculty advisors in guiding resident progress and by the PD in resident evaluations in a quality improvement manner to identify areas for improvement and guide training emphasis. Portfolios are not compared between residents; each portfolio is reviewed for individualized areas of learning and competency understanding. RESULTS: 40 residents in the El Paso pediatric residency program participated in this project. The
INTRODUCTION: Evidence suggests current training in neonatal resuscitation is not transferring to the real environment.

Douglas T. Leonard, MD, JoDee M. Anderson, MsEd, Neonatology-OHSU, Portland, OR
Jamie Warren, MD

31. Expert Modeling Improves Acquisition of Technical Skills in Neonatal Resuscitation Training

Douglas T. Leonard, MD, JoDee M. Anderson, MsEd, Neonatology-OHSU, Portland, OR, Jamie Warren, MD, Thomas Anderson, MD, Kit Leaning, MD, Judy Leflore, PhD, RN, OHSU-Pediatrics, Portland, OR

INTRODUCTION: Evidence suggests current training in neonatal resuscitation is not transferring to the real environment. Video analysis of resuscitations shows that NRP guidelines are not followed more than 50% of the time. Decreased skill retention during the 2-year interval recommended for re-certification has also been documented. Current literature on medical expertise suggests that modeling may facilitate the acquisition of expert technical skill sets. By observing, learners selectively take in information about performing to create a mental image that provides a cognitive reference for the learner. This image then becomes a reference for future performance. We instituted the addition of an “expert model” video to simulate NRP training to test the hypothesis that learners will better acquire and retain technical skills needed to successfully manage newborn emergencies. METHODS: A video was created using a Delphi process to demonstrate expert skills, behaviors, and thought processes during newborn resuscitation. 31 interns in a simulated NRP course were studied via a post-test only control group design. Baseline demographics, NRP cognitive test scores, and a subjective measure of confidence were collected. Both groups received comprehensive NRP training. The groups were randomized by a table of random numbers: the intervention group reviewed the expert model video while the control group practiced megacodes with instructor feedback. All participants then individually underwent a videotaped megacode in the simulator. The videos were scored by a blinded reviewer using a validated megacode score.
The goal of practice based learning and improvement (PBLI) as set forth by the ACGME is for residents to identify their needs and work towards improvement. Pediatric Resident Leadership Series-A Novel Practice Based Learning and Improvement Seminar for Our residents' in-service exam scores always showed steady improvement but were often not better than the peer average. In light of a poorly organized and insufficient learning effort, we developed a Knowledge Improvement Project (KIP). The KIP is intended to be one of the corners of what we consider the resident's "Triangle of Learning," the other corners being case-based (patient-related) and rotation-specific studying. Our goals were to systematically cover the knowledge base required of a pediatrician, provide some studying autonomy consistent with adult learning, and exert some positive pressure on resident performance. We hope to teach the tools for life-long learning and to provide continuity from the medical student with an interest in pediatrics to the pediatric senior ready to graduate. Every month, three pages of the "American Board of Pediatrics Content Specifications" are distributed to all residents, enabling the entire content to be covered in three years. Every two months, a multiple-choice quiz is distributed. Questions refer to the "Content Specifications" as well as topics covered during noon conferences and morning report. Residents have 48 hrs to complete this open-book test, with an expectation of 80% correct. All residents start the KIP in September. Residents scoring higher than the 70th percentile for peers nationwide on the in-service examination may opt out of the KIP. Residents who score less than 80% on a KIP quiz can retake the quiz or are put on a remediation plan. Preliminary data suggest that the KIP has had an impact on overall in-service examination scores as well as the amount of improvement between PGY-levels (Exhibits 1 and 2).

Knowledge Improvement Project (KIP)
Divya-Devi Joshi, MD, FAAP, Kathleen Finta, MD, Marshfield Clinic, Marshfield, WI

The Intern Lecture Series: How to Survive, Thrive, Learn, and Teach as a Pediatric Intern
Greg A. Harlan, MD, MPH, Dedee Caplin, PhD, James F. Bale, MD, Univ of Utah Pediatrics, Salt Lake City, UT

The Intern Lecture Series is a semi-structured, longitudinal, intern-specific curriculum entitled the "Intern Lecture Series" (ILS) to prepare pediatric interns for simultaneous roles as learners, teachers, and practitioners. METHODS: Intern needs (fears/goals for intern year) were assessed via survey in June 2008. Fears included: errors, helplessness, lack of knowledge, and trouble with relationships. Goals included: gaining knowledge, improving communication, improving efficiency, exploring research, and finding balance. The ILS curriculum was developed in four segments (Survive, Thrive, Learn, and Teach) to address these fears/goals and to facilitate learning of professionalism, medical knowledge, and communication. ILS meets weekly for one hour for the entire intern year. ILS was evaluated by the same group of interns (n=19) at the conclusion of their intern, second, and third years of residency (in June 2006, 2007 and 2008). RESULTS: Residents identified sustained improvements over three years in intern cohesion (79-91%), communication skills (73-93%), and pediatric knowledge (70-86%) as a result of ILS. Survive gives interns concrete skills and covers basic pediatric topics. Thrive delves into psychosocial and emotional aspects of medicine. Learn allows interns to become more comfortable with preparing and delivering medical presentations. Teach improves their comfort with teaching overall. The transition from medical student to intern is difficult for all (means= 4.00 at end of 1st year, 3.43 at end of 2nd year, 3.60 at end of 3rd year; based on 1-5 likert scale with 5= “very difficult”). Support from the residency program as a whole and from individuals is helpful. Supervising residents still have fears regarding the need for increased medical knowledge, leadership skills, and teaching skills. CONCLUSIONS: ILS is a meaningful way to incorporate communication, knowledge, and professionalism into resident curricula, while also increasing intern cohesion. Identifying and addressing interns' needs may improve their experience and ease the transition to senior residency roles.

Pediatric Resident Leadership Series-A Novel Practice Based Learning and Improvement Seminar for Supervisory Residents
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The goal of practice based learning and improvement (PBLI) as set forth by the ACGME is for residents to identify their strengths and weaknesses, their limits in knowledge and skill in regards to patient care. The overriding aim of PBLI is to foster self-evaluation and life-long learning in trainees that can be carried forward into their careers. At the Boston Combined Residency Program at the Boston Medical Center we have initiated an innovative program in leadership that fosters this life-long skill of self-assessment and learning. The Leadership Series is designed for residents on supervisory rotations during their junior and senior year. At the supervisory level, housestaff are placed in leadership positions for the first time. This critical period in training represents an important opportunity to address the need for leadership development. The main purpose of this series is to address this need and to allow residents to self-reflect on their leadership style. The seminars are facilitated by a chief resident and faculty member and are deemed 'protected' to create a safe environment for self-reflection and assessment. Sessions are held weekly over a four week period. The series is divided into rotating modules. Our modules consist of emotional intelligence, conflict resolution, giving feedback, identifying leadership strengths, and managing your attending. Within the modules, educational tools are used to foster group discussion, role-play, and case studies.
used to foster active learning. These include a strengths assessment survey, an emotional intelligence evaluation, direct observation, role-playing, and a video recording of residents giving feedback. Residents are expected to actively assess their leadership styles with a goal toward integrating leadership strategies discussed during the seminars into their team management. By implementing the Leadership Series into our residency, our supervisory residents learn how to continually reflect on their style of team leadership. This opportunity provides our residents with life-long skills that address the main aim of the PBLI competency.

35. Training Pediatric Residents in the Cognitive, Technical and Behavioral Skills Required for Management of Acute Life Threatening Events: Methodology
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   Serena Kelly, PNP, Oregon Health & Science University, Portland, OR
   BACKGROUND: Pediatric residents are often the first responders to life-threatening events in hospitals; therefore,
   resident training in resuscitation has direct impact on patient care. Because patient events are relatively infrequent
   and residents are spending less time in hospital, completion of a pediatric residency alone does not ensure residents
   will achieve the cognitive and behavioral skills required to respond to emergencies, nor the technical skills required
   by the Pediatric Review Committee (RC). METHODS: We surveyed residents on their experience with mock codes
   and the perceived effectiveness of various educational strategies in preparing them to manage resuscitations. The
   survey included a self-assessment of competency with managing stress in real and actual codes, and applying PALS,
   NRP, and crisis resource management principles. We developed a curriculum including didactic instruction on crisis
   resource management and a collection of simulated pediatric emergency scenarios incorporating the cognitive
   and technical skills of PALS and NRP, as well as RC technical skills. We implemented monthly mock codes utilizing
   simulated patients in actual clinical environments. Each mock code is videotaped and the footage used in structured
debriefing. Achievement of objectives is documented using a skills checklist. Objectives are reinforced via a follow
up email. RESULTS: Resident response to the mock code curriculum has been positive and residents have been
enthusiastic participants. Informal feedback of the curriculum indicates residents perceive an improvement in their
ability to manage pediatric resuscitations. CONCLUSIONS: Relying on patient events alone to train residents in
pediatric resuscitation is unreliable. Simulation can be used as an educational strategy within a curriculum to improve
resident comfort in managing life threatening events. Ongoing assessment through self evaluation, video review, and
documentation of resident performance is needed to formally evaluate residents’ skill acquisition and its impact on
patient care.

36. Enhancements to the Educational Format of Pediatric Morning Report at the Medical University of South Carolina (MUSC)
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   The pediatric chief residents at MUSC assessed the prior format of morning report and recognized an opportunity
to enhance educational productivity and attendance. A needs assessment was performed and multiple, innovative
educational and technological strategies were implemented. Evaluation of the effectiveness of these interventions is
ongoing. Our needs assessment process began with an appraisal of the previous format by a dedicated committee of
residents and faculty that generated a list of improvement goals. These goals were successfully instituted and included:
selection of cases in advance for presentation from different divisions, encouraged attendance from subspecialists, and
brief presentations to highlight educational pearls of the cases. Each case is immediately uploaded to an interactive
Wiki site, important discussion points are summarized, and direct links to the educational presentations and references
are provided. For physicians unable to attend, additional teaching comments may be posted at any time. Attendance
data comparing the 2007-2008 academic year to that of 2008-2009 is still being compiled. Preliminary data shows mean
resident attendance for July-September 2007 to be 30.3% compared to 41.5% for the same time period in 2008. This
is a significant increase of 11.2% (p=0.009). We are currently gathering data on the number of visits to our internet
Wiki site to better understand the educational interests of our residents and faculty and the ease of accessibility to case
information. The MUSC pediatric morning report conference has experienced multiple educational enhancements in
this academic year. There has been a significant increase in attendance and it is now standing room only. Additionally,
the Wiki site provides an expansive, interactive catalog of de-identified pediatric teaching cases. Ongoing assessment
will allow better understanding of the benefits these changes have on resident education.

37. Two Half-Days of Continuity Clinic Provide Opportunity for Advocacy and Research
   Wendy L. Hobson-Rohrer, MD, MSPH, Angelika Valdez, MD, Chad Cox, MD, MPH, Elizabeth Vukin, MD, Jaime Bruse,
   Patricia Sharp, James F. Bale, MD, University of Utah, Primary Childrens Medical Center, Salt Lake City, UT
   BACKGROUND: The University of Utah Pediatric Residency provides comprehensive ambulatory pediatric resident
education by having two half-day continuity clinics per week in all years of training. Beginning in 2005 PL-2s and PL-
3s could apply to use their second half day to pursue mentored advocacy or research projects. To participate in this
program, residents must create educational objectives, identify a mentor, describe the proposal, and create a project
timeline. Residents are required to submit a final report. As the need for subspecialists grows, this novel program
allows our residents enhanced research experience to assist in fellowship application. This alternative day option
potentially provides residents with educational flexibility and opportunities for scholarly activity. OBJECTIVE: To review
demographics and outcomes of the alternative day program. DESIGN/METHODS: We reviewed resident participation, project types, and scholarly products associated with participation in the alternative day program from 2005 to the current academic year. RESULTS: In 2005-2006, 7 of 33 (21%) PL-2s and PL-3s participated in the program. Program participation has increased; by 2008-2009 17 of 42 (41%) elected to participate. The latter includes 50% of the current PL-2 class. Of the projects, 35 of 45 (78%) were research and 10 of 45 (22%) advocacy (the majority of which also had a research component). From 2002-2004, 11 residents (4 residents/year) presented abstracts at the Pediatric Academic Societies (PAS) meetings. From 2005-2008, 22 resident participants (6 residents/year) have presented PAS abstracts (7 residents in 2008) and three residents in the program have submitted successfully-funded American Academy of Pediatrics Community Access to Child Health (CATCH) grants. A PL-3 participant received the Society for Pediatric Research House Officer Research Award in 2008. Residency Review Committee requirements for continuity clinic days and patient numbers were met by all participants. CONCLUSIONS: Resident participation has increased steadily in each year of the program, as have resident presentations at PAS. Utilizing a two-half day continuity clinic program can not only be used to provide an enhanced clinical educational opportunity for residents entering primary care, but also allows educational opportunities for residents anticipating careers in research or advocacy. This approach allows programmatic flexibility without creating a track system.

38. Expert Modeling Improves Behavioral Skills Acquisition in Simulation-based Training
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INTRODUCTION: In 2004 JCAHO published a report of 71 newborns with poor outcomes; issues with behavioral skills were identified as the root cause. JCAHO recommended team training, mock emergency drills, and debriefings aimed at evaluating team performance to address these problems. Many educators have added simulation-based training to resuscitation training to improve team training and teach the behavioral skills requisite to effective crisis management. For learners to develop expert behavioral skills, the expert’s thought process needs to be demonstrated or modeled. This study was done to determine whether expert modeling enhances behavioral skill acquisition in simulation-based resuscitation training. METHODS: An expert model video was created by a Delphi process to demonstrate expert skills, behaviors, and thought processes during newborn resuscitation. 31 incoming interns in a simulated NRP course were studied via a post-test only control group design. Baseline demographics, NRP cognitive test scores, and a subjective measure of confidence were collected and both groups underwent comprehensive NRP training. The groups were randomized to an intervention group that viewed the expert model video while the control group practiced megacodes with an instructor. All participants individually underwent a videotaped megacode in the simulator. Three blinded reviewers then scored the videos with a validated delivery room behavioral skills assessment tool. Mean scores were calculated and compared for each group using a two tailed t-test. RESULTS: There was no significant difference between the groups in age, gender, simulation experience, NRP experience, cognitive knowledge, or confidence. The intervention group scored significantly higher in behavioral skills than the control group (p<0.001). The Cronbach’s alpha was 0.97 and the inter-rater reliability was 0.8. CONCLUSION: The addition of an expert model video to a simulated NRP course improved the acquisition of behavioral skills. Expert modeling allows the educator to teach the behavioral component of crisis management (CRM) more effectively.

39. Developing a Curriculum for Family-Centered Rounds at an Academic Children’s Hospital
Carmen M. Coombs, MD, Janet R. Serwint, MD, Johns Hopkins, Baltimore, MD

BACKGROUND: Family-centered rounds (FCRs) are recognized by the American Academy of Pediatrics and the Institute of Medicine as an opportunity for information exchange between the medical team and family. DESCRIPTION: FCRs were initiated in March 2008 on two general inpatient services at an academic children’s hospital where senior residents serve as team leaders. The chief resident and a nurse organized an initial meeting where a FCRs video was shown to a multidisciplinary group. A decision was made to pilot FCRs on the infant-toddler unit, residents and nurses were notified, cards were made to identify families who wished to participate, and a bedside communication folder was developed. Despite initial enthusiasm, rounding practices were inconsistent and concern was expressed over lack of clarity of expectations. In June 2008, a structured approach to FCRs was undertaken. A multidisciplinary team including physicians, nurses, social workers, child-life specialists, and a parent representative was created. Meetings were held every 1-2 weeks to review the status of FCRs, and revisions were made according to input from different disciplines. This process led to the development of a standardized curriculum for FCRs. Key features include: 1) defined roles for care team members, 2) monthly resident orientations, 3) ongoing nursing education, 4) multidisciplinary noon conferences, 5) introductory letter for families, 6) inclusion of translators in rounds, 7) written daily plans for families absent during rounds, and 8) family feedback questionnaires. FCRs were expanded to the school-age, adolescent, and clinical research units. The next phase will focus on evaluating the impact of FCRs on patient experience, resident and medical student education, and multidisciplinary communication. Ongoing challenges include sustainability, time constraints, patient confidentiality, and multidisciplinary communication. CONCLUSIONS: Successful implementation of FCRs requires a standardized multidisciplinary approach with ongoing education, monitoring, evaluation, and revision.
40. Evaluating Pediatric Resident Procedural Skills  
Gretchen A. Matthews, MD, Grace Arteaga, MD, Mark S. Mannenbach, MD, Robert G. Voigt, MD, William A. Carey, MD, Christopher E. Colby, MD, Mayo Clinic Rochester, Rochester, MN  
The ACGME Program Requirements for Pediatrics include a list of procedural skills for which residents must receive sufficient training. A challenge facing nearly every residency program is the ability to reliably evaluate residents’ competence in procedural skills. Issues that affect the determination of procedural competency are multifactorial. There is a paucity of objective criteria upon which we can determine if a resident is truly competent. Additionally, reduced work hours potentially limit the number of procedures a trainee may encounter during residency. At some tertiary centers, residents compete with many other medical team members for the opportunity to perform procedures. The procedures that need to be evaluated also commonly occur at night when senior residents, who may not be technically competent themselves, are asked to evaluate the junior residents’ competence. To address these challenges, we have incorporated into our curriculum a half day session, which is repeated annually, where residents are evaluated on their abilities to perform a variety of RRC-required procedures. Using high fidelity mannequins, simulators and task trainers with attending physician level supervision, we assessed procedural competency in eight domains. We developed standardized objective criteria to document the level of achieved competency. The Eight Procedural Domains include: Arterial Puncture, Venipuncture, Airway management of the neonate Bag Mask Ventilation, Endotracheal Intubation, Lumbar puncture, Umbilical Catheter placement, Radiographic Interpretation. We also compared the observed level of competency with resident self assessment, number of previously performed procedures, and the evaluation of resident procedural skills by attending physicians. We compared the strength of correlation between these four areas, (current objective technical evaluation, self assessment, previous number of procedures performed, and previous attending evaluation of resident). The assessments and evaluations are then stored in the residents’ portfolios. We will present data regarding which of these assessments correlated most strongly with actual performance.

41. Career Guidance Across the Continuum: A Workflow Approach  
Abhay S. Dandekar, MD, Kaiser Permanente Oakland, Oakland, CA  
This Poster will highlight: 1) An approach to help facilitate career guidance for the pediatric medical student, intern, and resident. 2) An approach to complementing bi-annual feedback sessions with concrete career guidance goals and individual progress reports. 3) An approach to help facilitate student and resident self reflection by integrating the resident ILP (or a similar student based exercise) with an individualized career guidance workflow. The goal of this poster will be to share an approach to formalizing the career guidance process for the advisor guiding a medical student and resident through career counseling sessions. A career guidance worksheet will be introduced that will enable the faculty advisor to use a uniform approach to incorporate an Individualized Learning Plan tool to help guide the student and resident in a personalized manner. The worksheet is designed to help create a uniform workflow that can also be individualized to needs of the student or resident based on their own dynamic interests, situation, and level of training. This poster session will demonstrate the contents of the career guidance worksheet, which includes a review of the student/resident’s personal and professional goals, a networking portfolio of resources (including student/resident peers, alumni, and faculty and community members), timelines for developing a CV, review of the fellowship application process, timelines for job searching and application, review of the job interviewing and acquisition process, checklist of required/anticipated experiences and exposures, and resources for refinement/redefinition and achievement of career goals. Finally, this worksheet can ideally be used by the advisor to complement formal feedback sessions with the student or resident and allow the advisor to help facilitate further self-reflection, highlight links between competency based training and career guidance, emphasize the process of life-long learning, and provide a platform for additional feedback in a more individualized environment.

42. A Training Pathway for Child Health  
Alice A. Kuo, MD, PhD, Victor H. Perez, MD, MPH, Alma D. Guerrero, MD, MPH, Moira Inkelas, PhD, UCLA, Los Angeles, CA  
BACKGROUND: The current health care workforce does not reflect the racial/ethnic demographic of the population in the U.S. In addition, promising minority students who enter health professions training often do not return to their communities. OBJECTIVE: To develop a training pathway in which minority students are exposed to rewarding community-based experiences in child and family health at multiple levels of training. CURRICULAR INNOVATIONS: Over the past eight years, we have developed a training pathway for students at multiple levels to learn about child health and participate in service-learning community-based experiences. We now have programs for undergraduates (Pathways for Students into Health Professions), medical students and public health students, and pediatric and med-peds residents (Community Health and Advocacy Training). Each program provides knowledge through didactic curricula and experiential learning through community-based service activities. Faculty mentoring is an important component, both from a career development perspective and for role modeling. As each program has developed, linkages between the programs have occurred. For example, pediatric residents have partnered with undergraduates to provide a Youth Empowerment program for 4th graders living in a public housing development. Medical students and undergraduates deliver a fitness/nutrition curriculum to 5th graders at three elementary schools in underserved areas. These leveraged experiences not only provide a valuable service to the community, but also develop camaraderie and mentoring experiences, and pediatric and med-peds residents to students. CONCLUSIONS: New community and
advocacy curricula are developing in pediatric residency programs. While these curricula fulfill RRC requirements and address ACGME competencies, these programs can also address workforce development issues in pediatrics and child health. Providing fulfilling, valuable experiences in the community can increase the likelihood that trainees will consider a career working with underserved children and families.

43. **Teaching Med-Peds Residents about Transition Care for YSHCN**  
**Alice A. Kuo, MD, PhD, Emery Chang, MD, Debra S. Lotstein, MD, MPH, UCLA, Los Angeles, CA**  
**BACKGROUND:** Youth with special health care needs (YSHCN) need to prepare for the transition to adulthood, including transferring to the adult health care system. Currently, systematic processes for transitioning these patients are not widely used in pediatric practice. **OBJECTIVE:** To develop a Transition Program for YSHCN that provides the following: 1) a clinical service for YSHCN run by med-peds faculty and residents that facilitates the transition from pediatrics to adult health care, and 2) an educational opportunity for med-peds residents to learn both the aspects of successful transition processes and the “business” of starting a clinical program. **CURRICULAR INNOVATIONS:** Our Med-Peds program has undertaken the project of developing a Transition Program within our department of pediatrics. From the inception, med-peds residents have been involved in the planning of the program. Using a clinical model, med-peds residents spent a second half-day-a week during electives in “Transition Team Planning” sessions in order to accomplish the following: 1) develop the business plan for the program, 2) survey stakeholders for a needs assessment, 3) determine referral criteria, and 4) plan the menu of services to be provided. After 6 months of planning, the med-peds residents will staff the Transition Clinic during the second-half day a week during electives. **CONCLUSIONS:** Transition Programs for YSHCN are necessary and developing in many departments of pediatrics throughout the country. Med-Peds physicians are a natural fit as providers of care for youth in these programs. Involving med-peds residents in the development of these programs builds the capacity for them to develop new programs in other departments after they graduate.

44. **A Morning Report Curriculum: Waking up to this Need in a Community Pediatric Residency Program**  
**Katie McCarthy, DO, MS, Beth Moughan, MD, Justin Lynn, MD, Crozer -Chester Medical Center, Upland, PA**  
**BACKGROUND:** Morning report (MR) exists within most training programs and is often a discussion of cases admitted. General pediatrics cases comprise the majority of admissions to our hospital requiring us to draw on cases from our tertiary care affiliate to increase the diversity of topics. **OBJECTIVE:** Conduct a needs assessment of MR and develop a curriculum aimed at board preparation. **METHODS:** We conducted a needs assessment as follows: 1) MR schedules from July 2007 through September 2008 were reviewed for subject matter of case presentations. 2) PL-2 and PL-3 residents were surveyed about their satisfaction with MR over the preceding year. 3) A focus group comprised of 5 generalist attendings and 3 residents met twice to review the content specifications from the 2008 Pediatrics Review and Education Program (PREP) as a guide to developing topic areas to cover in a MR curriculum. **RESULTS:** There were 111 MR cases from July 2007-September 2008. Subject categories were identified in 95.3% of cases. Seven categories accounted for 64.7% of cases with Infectious Diseases (28%) accounting for most. To date, 9 of 12 residents completed surveys and reported satisfaction with MR including an appropriate emphasis on differential diagnosis, management, and didactics; resident participation; and attending input. They also perceived an adequate variety of subspecialty topics covered. The focus group determined that 16 of 31 subject categories from PREP would be appropriate for MR. Subject categories eliminated were believed to be well covered outside of MR. Five subheadings within each PREP subject category were identified as most important. Therefore, 80 topics form the basis of a new MR case curriculum. For each topic, at least 3 objectives are being developed using the knowledge statements from PREP. **CONCLUSIONS:** Though MR may be well received and perceived to cover an adequate variety of topics, critical analysis of MR in one program revealed a limited variety of topics covered. Developing a MR curriculum can ensure a broad variety of case discussions which is particularly important in community-based programs.

45. **Improvement in Medicine-Pediatrics Residents Ambulatory Training and Patient Outcomes**  
**Rita M. Rossi-Foulkes, MD, MS, FAAP, FACP, Sara Platte, MD, MS, FAAP, FACP, University of Chicago, Chicago, IL**  
The ACGME requires that residents gain competence in systems based practice and practice based learning and improvement. Our Med-Peds residents rated these areas, along with ambulatory training in general as needing improvement. The ambulatory training site is an ideal setting to combine quality improvement in patient care and resident education. **OBJECTIVES:** 1) Improve resident satisfaction with and quality of ambulatory training, 2) Improve patient satisfaction at the Med-Peds ambulatory site, 3) Improve the quality of care delivered at the ambulatory Med-Peds clinical site. **METHODS:** 1) Resident survey, patient chart review, and patient satisfaction data was collected in 2006-2007 with comparison data from 2008. 2) Quality improvement initiatives were implemented by resident and attending physicians and office staff. **RESULTS:** 1) Resident satisfaction with ambulatory training: A) clinic curriculum improved from 50% to 75% B) resident comfort with general outpatient issues improved from 69% to 87.5% C) resident comfort with QI knowledge improved from 44% to 75%. 2) Patient satisfaction: A) Satisfaction with registration staff improved from 82.1% to 90% B) Satisfaction with nursing staff improved from 75% to 87.5% C) Satisfaction with the clinical provider improved from 75% to 91.7%. 3) Physician performance: Physicians improved in completion of problem list, documentation of results review, evidence of reviewing the prior progress note, documentation of the foot examination, aspirin use, and depression screening in patients with diabetes, pneumovax administration, and BMI documentation.
CONCLUSIONS: The resident ambulatory training site is an ideal setting for improving resident education and patient care. By combining curriculum changes with practice quality improvement, the learning environment as well as patient care and satisfaction can be improved.

46. A Guided Tour of Camden: Helping Residents Understand Their Patients
Deborah Meilisch, MD, Renu Doshi, MD, Ramonita Ortiz, William R. Graessle, MD, UMDNJ/Cooper University Hospital, Camden, NJ
BACKGROUND: As part of orientation for the past several years, a lecture providing an overview of Camden has been given to our residents. This lecture has included an overview of the history of Camden as well as resources available to our patients. We wanted to provide our residents with more first-hand experience with the community.
OBJECTIVES: To provide the pediatric residents with a better understanding of the community where their patients live. DESIGN/METHODS: During a retreat in July, all eight first-year pediatric residents were taken on a guided tour of the city of Camden. The tour included an overview of different sections of the city including some history of Camden, locations of housing, schools, grocery stores, community resources and important buildings. Shortly after completing the tour, residents were asked to complete a short answer survey about the experience. RESULTS: The residents felt the tour provided them with a unique experience. They had a new appreciation for the circumstances under which the patients live and the resources available to them. They have a greater understanding of the conditions of housing and the surrounding communities and most felt it would change how they give anticipatory guidance to their patients in continuity clinic. CONCLUSIONS: A guided tour of the community served by a continuity clinic can be very helpful to the residents in understanding their patients and their patient’s circumstances. Based on the feedback from our first year residents, this tour has been requested by the senior residents who did not participate and will be included as part of the curriculum annually.

47. A Home Visit Curriculum Integrated into a Pediatric Resident Continuity Clinic
Janet R. Serwint, MD, Rheanna E. Platt, MD, Megan M. Tschudy, MD, Johns Hopkins, Baltimore, MD
BACKGROUND: Despite its decline in pediatric residency training, home visits are an important means to establish a medical home, especially in at-risk populations. The newborn period is an ideal time to establish the primary provider as a source of support, strengthen the physician-family relationship, and implement early preventive care measures.
OBJECTIVE: To introduce a newborn home visitation curriculum into pediatric resident continuity clinics. METHODS: Mother-infant dyads are recruited from the nurseries at Johns Hopkins Hospital and Johns Hopkins Bayview Medical Center. Inclusion criteria include gestation > 35 weeks, <4 hour NICU stay, and parent desires primary care at one of the two resident clinics. The POY 1 or 2 level resident who will be the primary care doctor conducts the home visit with an experienced visiting nurse. This partnership provides educational value and safety. Residents complete a home visit curriculum including an orientation on essential information about home visits and a self-directed learning module about the surrounding community. However, the main emphasis of the visit is to allow the resident to get to know the family on their turf. Institutional Review Board approval and informed consent were obtained. OUTCOMES: Resident outcomes include pre and post home visit assessment of attitudes, knowledge and behavior. Reflections on the experience will be assessed at focus groups. Mother-infant dyad outcomes include the Pediatric Trust in Physician Survey (Pedi-TiPS), parental perception of the visit value, breastfeeding rates and infant receipt of recommended health supervision services. Home visits and data collection began in September 2008 and continue through June 2009. At the time of the meeting we will present qualitative data on resident and family experience. CONCLUSIONS: We propose that integrating home visits as part of the formal continuity clinic education will improve the health of children in the catchment area, increase family trust in providers and improve resident ability to provide comprehensive medical care while emphasizing the true concept of the medical home.

48. Promoting Scholarly Activity in a Community Residency Program Using a Quality Improvement (QI) Rotation: Two for the Price of One
Beth Moughan, MD, Maria Farias, MD, Crozer-Chester Medical Center, Upland, PA
BACKGROUND: The ACGME requires residents to participate in scholarly activity. This poses a challenge to community programs in which research opportunities are limited. OBJECTIVE: To describe a rotation that provides an opportunity to engage in research while promoting competence in Practice-based Learning and Improvement (PBLI). METHODS: Third-year residents are required to complete a QI rotation. Before the start of the rotation they read The Model for Improvement; meet with an advisor to refine ideas for Plan-Do-Study-Act (PDSA) cycles; complete a literature search; and submit a proposal to the IRB committee if appropriate. During the rotation they implement and analyze results from PDSA cycle(s). After the rotation they submit an abstract to the program director; give an oral presentation of their findings; and create a poster for the institutional research day. The program director evaluates the quality of the QI project and that of the formal presentation. Residents that completed the rotation were given a survey that addressed confidence in their research and PBLI skills. RESULTS: To date, 3 of 7 Pl-3 residents are in a late stage of their QI block activities; all submitted IRB proposals and received approval; 2 completed the rotation. The projects include: 1) Analysis of changes in infant back to sleep practices in our hospital after an educational intervention with nurses. 2) Analysis of pediatric resources available in a community hospital and knowledge/perceptions of stakeholders regarding resource availability. Education about resources and recommendations for change is planned. 3) Analysis of adherence to Group
49. An Approach to Outcomes Evaluation

Rukmani Vasan, MD, MPH, MSEd, Jennifer Saenz, MD, MSEd, USC Pediatrics, Los Angeles, CA

The ACGME requires residency programs to use outcome assessment data to improve the educational effectiveness of their program. The assessment is intended to facilitate continuous improvement of the educational experience, resident performance and program performance. Our objectives are to describe a comprehensive framework for outcomes evaluation and discuss a curricular intervention. The three elements of our outcomes evaluation include: a) resident performance measures: content analysis of in-training exams (ITE), rotation evaluations, knowledge assessments through multiple choice quizzes (MCQ), clinic provider logs, direct observations, breaking bad news, scholarly activity, 360 evaluations, patient satisfaction surveys, individualized learning plans, chart reviews and resident portfolios; b) program quality: resident evaluations, faculty evaluations and content analysis of the ITE; c) graduate performance: certifying exam results and surveys for programmatic feedback. Following analysis of aggregated results of our outcomes, the continuity clinic curriculum was restructured using the PDSA quality improvement model. The goal was to deliver well-child care and core ambulatory topics aligned with the ABP content specifications across all clinics through a structured three-year curriculum with MCQ’s to measure resident knowledge. Topic of the Week curriculum was implemented with topic selection guided by programmatic needs identified on the ITE, group learning needs and new practice guidelines. Curriculum format included didactics, case-based presentations and interactive discussions. Quarterly MCQ reviews promoted resident discussion and self-reflection on learning needs. In-training outcomes have improved significantly. The quality of resident presentations has improved significantly as evidenced by content and resident surveys. Based on outcome assessments, our recent curriculum updates have included the new health maintenance recommendations. Thus our curriculum improvement projects continue to evolve as dynamic processes that meet the ongoing learning needs of our residents.

50. UCSF Pediatric Primary Care Residents’ Community-Based Projects to Improve Local Child Health

Kathryn R. Davis, MD, MPH, Emily J. Roth, MD, UCSF Primary Care Pathway, San Francisco, CA

TARGET POPULATION: The children of the Western Addition neighborhood of San Francisco, a neighborhood with high rates of poverty and childhood obesity. With their distinct demographic profile, the residents likely face a unique set of obesity-related risk factors and barriers. DESCRIPTION: Primary Care Pediatrics residents spend project time collaborating with local community groups and schools to address child health problems. They intensively work on their projects for a month during their third year. They teach each other about their projects in seminars and work together to sustain programs. METHODS: Residents felt ineffective in treating obesity in the clinic and decided to work together to address this health problem within the context of a community. Residents partnered with school and community groups to improve access to good nutrition (with a school-based garden project) and exercise (with an after-school running program and a program to improve park safety). RESULTS: Residents developed several community-based projects that are improving community access to fitness and nutrition. The running program has 50-70 students running with volunteer coaches twice a week, in addition to family runs and nutrition seminars. In collaboration with a local high school, residents built an organic garden to teach about healthy, natural foods. High School students run nutrition events for younger students. Regular community events help build and maintain the garden. Residents are collaborating with local parks and recreation councils to help build safe playgrounds that will improve access to fitness. Residents report feeling empowered and amazed by the responsiveness of local community groups and quality of resources available to help address pediatric health problems. CONCLUSIONS: Residents are learning their potential role in working in communities to collaboratively affect child health problems. This program may serve as a model for how to train pediatric residents to work with community organizations to impact local child health outside the clinic.

51. Prepared for Pediatric Practice? Collaboration by a Consortium of Programs to Obtain Former Pediatric Residents’ Perspective on the Current Content of Residency Education

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The Residency Review and Redesign in Pediatrics Project plans to invite proposals from programs and consortium of programs to develop innovative changes in curriculum to address challenges in residency education. The GA/SC+ APPD Group is a subgroup of the Southeast Region of the APPD consisting of the five residency programs in Georgia, three in South Carolina and the program at Chattanooga, TN. The GA and Chattanooga programs have met annually for the past five years to discuss common challenges and share solutions in residency education. The SC programs joined this group at their annual meeting in August 2008 and the potential for collaboration to develop a proposal for an innovative change in curriculum was explored. The group decided that a better understanding of the current outcomes for these programs was needed to determine where best to focus efforts for changing curriculum. Using e-mail for communication among programs, a post residency survey was developed to obtain feedback from the 400 former residents who completed their residency at the nine programs in the years 2004-2008. The survey includes items that identify practice patterns for those engaged in general pediatric practice (e.g. hospital based vs outpatient; newborn nursery experience; attendance...
at deliveries; full time vs part time; number and types of procedures performed; rural vs urban, etc). The survey aims to identify how well the current residency curriculum prepared individuals for these varied practice patterns. This poster will present the results of this survey with discussion of how feedback from former residents informs the process for proposing changes to the current residency curriculum. We conclude that 1) collaboration across programs is feasible and 2) a post residency survey can provide important outcome information to assess the success of current residency curriculum in preparing general pediatricians for a variety of available practice opportunities.

COMSEP Research Posters

52. CORRELATION OF SELF-REPORTED READING WITH END-OF-CLERKSHIP PEDIATRIC NBME (SHELF) EXAM SCORES
Jennifer L. Goralski, MD, Surbparkash Singh, MD, Susan G. Mautone, MD, UMDNJ-New Jersey Medical School, Newark, NJ
OBJECTIVES: Self-directed learning via the reading of textbooks is an accepted and common form of learning in the medical education setting. Students are often told to increase their reading. However, what is not known is how the amount of time spent reading corresponds with performance on the end-of-clerkship Pediatric NBME (Shelf) exam. METHODS: A mid-clerkship review is undertaken by the site director at each of two clinical sites associated with the UMDNJ-NJMS Pediatric Clerkship. Students are asked to approximate the number of hours per week they spend reading during this 6 week clerkship. Data from the last 18 months of the clerkship were collected in a retrospective manner. The scores of 233 students were reviewed, eliminating three due to insufficient data. Student’s T-test and Pearson’s Correlation Coefficient were performed to assess clinical significance. RESULTS: 92% of students reported using one of the recommended texts during their studying (Nelson Essentials of Pediatrics, Rudolph’s Fundamentals of Pediatrics, or Woodhead’s Pediatric Clerkship Guide). Time spent reading ranged from 5 hours per week to 44.5 hours per week. There was no correlation between number of hours spent reading and the final Shelf scores (Pearson’s Correlation Coefficient 0.12). A small subset (10 students) were self-described “slow readers”, with a mean NBME score of 72.7 compared with a score of 74.4 for the other students. This difference did not reach statistical significance (P>0.5). CONCLUSIONS: These results do not support the widely-held belief that simply increasing the number of hours spent reading leads to better exam scores. Other factors must be at play, potentially including poor study habits, lack of proficiency in English, or unidentified learning disorders. There exists a potential for bias in that the data were all self-reported; time spent reading may have been over- or underestimated and is subject to recollection bias. Nonetheless, these results should prompt discussion amongst clerkship directors regarding adult learning theory and its role in preparing students for the NBME exam.

53. DOES A WEB-BASED ORAL PRESENTATION MODULE IMPROVE MEDICAL STUDENT ORAL PRESENTATION SKILLS: RESULTS FROM A PILOT RANDOMIZED CONTROLLED TRIAL
Su-Ting T. Li, MD, MPH, UC Davis, Sacramento, CA, Daniel J. Tancredi, PhD, UC Davis, Sacramento, CA, Stephanie N. Mateev, MD, University of California, Davis, Sacramento, CA
OBJECTIVE: To determine whether a web-based oral presentation module improved medical student oral presentation skills compared to a written oral presentation guide. METHODS: A pilot randomized controlled trial of third-year pediatric medical students supported by a 2006 grant from COMSEP. After students consented, they were randomized to an interactive oral presentation website or a written oral presentation guide. Students were videotaped giving a 5-minute oral presentation based on a videotaped standardized patient interview and physical exam on orientation day (baseline) and on week 7 of the 8 week clerkship. Students randomized to the intervention were given access to the website after they had recorded their baseline oral presentation. We rated the students’ oral presentations with an oral presentation evaluation instrument we developed. Inter-rater and intra-rater reliability were determined using the Pearson product-moment correlation. Repeated measures regression models were used to assess and compare over-time gains in the two groups. RESULTS: 64 students consented to be enrolled in the study. Due to technical difficulties, 18 students’ first oral presentation was not recorded. 6 students did not record a second oral presentation, leaving a total of 40 students who recorded both oral presentations. The evaluation instrument’s inter-rater (0.89; 95% CI: 0.79-0.94) and intra-rater reliability (0.82; 95% CI: 0.75-0.90) were high. Students improved the overall quality of their oral presentation by 2.8 points (p=0.003) by the end of their pediatric clerkship. Students randomized to the website trended toward further improving the quality of their oral presentation by 2 points (p=0.14). A larger randomized controlled trial with 104 total students enrolled would have 80% power to detect a similar difference in effect size. CONCLUSIONS: A web-based oral presentation trainer has promise to improve the oral presentation skills of third-year medical students above that of an 8-week pediatric clerkship.

54. REFLECTIVE EDUCATION AND SIMULATION IN PEDIATRIC MEDICAL STUDENT EDUCATION
Maria N. Kelly, MD, Nicole Paradise Black, MD, University of Florida, College of Medicine, Gainesville, FL, Meredith K. DiPietro, PhD, University of North Carolina at Charlotte, Charlotte, NC, Erik W. Black, MA, School Teaching and Learning, University of Florida, Maureen A. Novak, MD, University of Florida, College of Medicine, Gainesville, FL
OBJECTIVE: Medical simulators teach technical skills without the logistical, legal and emotional concerns associated with real patients. Additionally, utilizing reflective practice to critically analyze one’s practice promotes the development
of expertise. Together these educational modalities have minimal exposure in pediatric research. We aim to evaluate the impact of simulators, specifically the pediatric hip and lumbar puncture (LP) simulators, on key areas of medical student education: 1) procedural knowledge 2) technical skill and 3) reflective assessments. METHODS: Cohort design at a large academic medical center using 3rd-year medical students (n = 147). They participated in a 5-phase design: 1) pre-test knowledge assessment 2) technical skill instruction: handout with video demonstration (intervention group also received simulator instruction and practice) 3) post-test knowledge assessment 4) technical skills assessment and 5) reflective assessment. Data analyses included comparison of pre/post-test scores, technical skills assessment (ANOVA, within-subjects t-test, Cohen’s-d) and qualitative reflective assessments (triangulation of analysis). RESULTS: Simulator instruction and practice improved students’ pre-test (6.3, possible 10) to post-test (8.0) scores (p < 0.01, Cohen’s effect: large, d = 1.03) and acquisition of technical skills (LP 18.2 p = 0.01, Hip 18.9 p < 0.01). Reflective responses demonstrated 100% positive comments with ‘confidence’ as the major self-reported outcome in two categories: lowering anxiety/apprehension and positive self-assurance for perceived technical ability. Participants reflected more robustly on the LP simulator experience due to perceived complexity, technicality and invasiveness of the procedure as compared to the hip simulator. CONCLUSIONS: Instruction and practice on technical ability LP and hip simulators improved students’ procedural knowledge, self-perceptions of technical ability, competence, and confidence in conjunction with actual improved technical abilities. Simulators and reflective practice should be considered as supplemental learning tools in pediatric medical education.

55. **EFFECT OF MEDICAL STUDENT TOBACCO EDUCATION ON DOCUMENTATION PRACTICES OF TOBACCO IN PEDIATRIC PRIMARY CARE**

* Maria N. Kelly, MD, Teresa A. Lynch, MD, Lindsay A. Thompson, MD, Maureen A. Novak, MD, University of Florida College of Medicine, Gainesville, FL

**OBJECTIVE:** Tobacco is a global cause of morbidity and mortality. Physicians must be competent to address this epidemic but medical curricula inconsistently include tobacco. This study aims to evaluate the impact of tobacco educational modules on medical student knowledge, guidance, and documentation practices. METHODS: Cohort design at a large academic medical center using 3rd-year medical students (n = 43, intervention group) and pediatric residents (n = 48, control group). They participated in a 4-phase design (students: phases 1-4, residents: 1, 4 only). Phases included: 1) pre-test knowledge assessment, 2) tobacco education modules (EPA’s Smoke-Free Homes), 3) post-test knowledge assessment, and 4) chart audit of randomly selected clinical encounters (n = 488) for tobacco-related documentation. Data analyses included comparison between students and residents of pre/post-test scores (within subjects t-test, Cohen’s-d) and tobacco documentation practices. RESULTS: There was no difference (p = ns) in pretest knowledge scores between students (10.1, possible 12) and residents (10.1), yet students’ post-test scores were higher following tobacco education modules (mean 11.2, p = 0.000, Cohen’s effect: large d = 1.1). Compared to residents, modules improved student documentation of tobacco cessation/prevention practices (OR 2.0, 95% CI 1.2-3.1, p = 0.004), but did not improve documentation of tobacco use (p = ns) or exposure (p = ns). Unexpectedly, if child had a tobacco-related condition, students’ documentation was lower compared to residents’ for tobacco use (OR 0.5, 95% CI 0.3-0.8, p = 0.004), exposure (OR 0.6, 95% CI 0.4-0.9, p = 0.018), and prevention/cessation practices (OR 0.4, 95% CI 0.2-0.6, p = 0.000). CONCLUSIONS: Tobacco education improved students’ knowledge and documentation of tobacco prevention/cessation compared to residents. However, the modules did not improve documentation of tobacco use and exposure, especially when tobacco-related conditions existed. In an era of increased need for documentation, future studies must promote recording in addition to knowledge and skills.

56. **INTEGRATION STRATEGIES FOR THE USE OF VIRTUAL PATIENTS IN THE CLINICAL CLERKSHIP**

* Norman Berman, MD, Leslie Fall, MD, Dartmouth, Lebanon, NH, Sherilyn Smith, MD, University of Washington, David Levine, MD, Morehouse School of Medicine, Christopher Maloney, MD, PhD, University of Utah School of Medicine, Michael Potts, MD, U of Illinois College of Medicine at Rockford, Benjamin Siegel, MD, Boston University School of Medicine*

**PURPOSE:** The purpose of the study is to explore student perceptions of virtual patient use in the clinical clerkship, including learning effectiveness and satisfaction, and to develop a conceptual framework to evaluate the effects of different integration strategies on student perceptions of this innovation. METHODS: A prospective, multi-institutional study was conducted at 6 Pediatric clerkships using the Computer-assisted Learning In Pediatrics Program (CLIPP) virtual patients over 2 academic years. Integration strategies were designed to meet the needs of each school, and integration was scored for components of virtual patient use, and elimination of redundant teaching. A student survey instrument was developed and validated, and administered to students at the end of the clerkship. Data were analyzed using confirmatory factor analysis and structural equation modeling. RESULTS: Overall student satisfaction with CLIPP was high and students reported that CLIPP was more effective than traditional methods. The structural model demonstrated that elimination of redundant teaching was directly associated with perceived effectiveness of the integration strategy (p < 0.00001). A higher use score had a significant negative effect on perceived integration (p < 0.0001), but positively impacted perceived knowledge gain (p < 0.0001) and skills gain (p < 0.001). Positive student perceptions of integration directly and powerfully affected satisfaction (p < 0.00001) and perceived knowledge (p < 0.00001) and skill (p < 0.0001) gain. CONCLUSIONS: An integration strategy balancing use of virtual patients with elimination of some other requirements was significantly associated with student satisfaction and with their perceptions...
of the effectiveness of the program in improving their knowledge and skills. Obtaining a positive student perception of integration is critical in achieving the desired outcomes of computer-assisted instruction.

57. PHACES (PHOTOGRAPHS OF ACADEMIC CLINICIANS AND THEIR EDUCATIONAL STATUS): THE IMPACT ON FAMILY-CENTERED CARE
Robert A. Dudas, MD, Hanna A. Lemmeran, MPH, Janet A. Serwint, MD, Johns Hopkins, Baltimore, MD
BACKGROUND: An academic medical team may include medical students, interns, residents, fellows and an attending. Extant literature suggests that patients and their families are frequently confused by the roles and responsibilities of different members of the medical team. The purpose of this study was to determine if an information sheet containing photographs and explanations of the training of each provider would enhance a parents ability to identify their providers and understand their roles as well as increase satisfaction with care. METHODS: This was a prospective study of 100 parent-child dyads admitted to a general pediatric service. The control group received standard admission protocol while the intervention group received an additional information sheet with the names, photographs, list of the roles and training of the medical students, housestaff and attending that were providing care. Outcomes included parental ability to match names with faces from a sheet of scrambled photographs and names. Parents completed the Patient Satisfaction Questionnaire (PSQ) and answered questions regarding the roles of providers and attitudes towards trainees. RESULTS: Ninety four percent of parents in the intervention group were able to identify at least one provider compared to 41% of the control group (p<.01). Parents who received the intervention were more likely to correctly identify, by matching picture to name, the attending (80% vs 24%;p<.01), intern (55% vs 14%;p<.01) and medical student (67% vs 14%;p<.01). Parents in the intervention group demonstrated an improved understanding of the roles of the providers and their scores on the PSQ were higher (mean: 48.3 vs 45.4;p<.01). Qualitative data suggested that parents valued knowing the roles of providers. CONCLUSIONS: An information sheet containing the photographs of the healthcare providers along with an explanation of their roles and training improves satisfaction with care delivered by physicians-in-training and improves recognition of the healthcare team members.

COMSEJP Descriptive Posters:
58. SOMA’S INNOVATIVE CURRICULUM ACROSS THE CONTINUUM
Noel John M. Carrasco, MD, SOMA, A.T. Still University, Mesa, AZ
OBJECTIVE: To create an online Education Delivery System (EDS) to facilitate student learning in the clinical presentation (C-P) curricular model (establishing a curriculum through modeling the cognitive process used by physicians to make clinical diagnosis, c.f. University of Calgary Medical School). BACKGROUND: In the late 1990’s it was suggested that integrating both basic and clinical science in the first two years of medical school would obviate the need for students to restructure their knowledge upon entering their third- and fourth-year clinical clerkships (1). Currently available online EDS fail to facilitate structured integration. SOMA’s delivery system, Medical Learning Online, is being developed in collaboration between SOMA, Dr. Henry Mandin, and Essential-Talk Software, towards optimizing such integration beyond that which can be pragmatically achieved in-classroom. METHODS: Our C-P model is organized around the various ways patients present to physicians, spanning over 120 key symptomatic presentations (c.f. (2)). In support of this, we designed our EDS to be decision-point focused, from the point of view of a clinician diagnosing patients. RESULTS: Our online program, launched September 2008, engages over 100 second year students across eleven clinical campuses. The feedback received from both students and facilitators has been overwhelmingly positive. While too early to attempt correlation with clinical-clerkship performance, preliminary Mini-CEX results will be discussed. CONCLUSION: Contemplative application of technology is allowing a fuller integration between basic and clinical science pedagogy, thereby more rapidly developing ‘expert reasoning.’ 1) Mandin, H. et al Academic medicine 70(3) 186-193, 1993. 2) Mandin, H. et al. Helping Students Think Like Experts When Solving Clinical Problems. Academic Medicine 72 (3)172-179 1997.

59. USING IPHONES FOR I(MMEDIATE) FEEDBACK AND I(NSTANTANEOUS) TEACHING IN A PEDIATRIC CLERKSHIP
Jennifer G. Christner, MD, University of Michigan, Ann Arbor, MI, Terence Joiner, MD, University of Michigan, Ypsilanti, MI, Chris M. Chapman, Media Services Manager, University of Michigan, Ann Arbor, MI
BACKGROUND: Medical students are unfortunately rarely observed in direct patient care encounters such as history taking and performing physical exams, yet, faculty are expected to evaluate students’ skills in these domains (1). Faculty preceptors often cite time constraints as a factor when teaching students in ambulatory settings (2). Our goal is to develop tools to facilitate teaching, feedback and student self-assessment in the outpatient setting using iPhones. Teaching Tools development: In January 09 we are conducting an electronic needs assessment of our primary care facuty regarding their current use of various curricular items and smart phones. Using these results, we will select teaching materials to pilot on smart phones. One preceptor from each of our 9 ambulatory sites will then receive a smart phone loaded with various curricular materials. In addition to piloting the curricular material, we also want these preceptors to practice using the smart phones to videotape short segments of student history taking and physical examinations. We are creating a student self assessment form for the student to complete after viewing the video of their patient interaction. The preceptor will have also filled out a feedback form (in development) regarding the same
encounter and will review this with the student once they have completed their self-assessment form. We will pilot these tools and assess the best way to distribute and collect this data. The selected faculty will receive faculty development sessions on both the technical aspects of how to use a smart phone (i.e. accessing curricular materials, video taping student-patient interactions) and also the principles of effective feedback. Throughout the course of this pilot phase, we will conduct focus groups with the faculty to gather information about the acceptability and possible barriers of the above interventions. RESULTS/CONCLUSIONS: By the time of the meeting, we will be able to provide actual student video clips, examples of our assessment tools, and pilot data from student self assessments and preceptor feedback forms. In addition, we will be able to provide examples of the curricular material on our smart phone devices. 1) Pulito, AR et al. What Do Faculty Observe of Medical Students’ Clinical Performance? Teaching and Learning in Medicine 2006; 18(2): 99-104. 2) Vinson DC et al. The Effect of Teaching Medical Students on Private Practitioners’ Workloads. Academic Medicine 1994; 69(3): 237-238.

60. A NOVEL EAR MODEL FOR TEACHING CLINICAL SKILLS
Meg G. Keeley, MD, University of Virginia, Charlottesville, VA
BACKGROUND: Acute otitis media is the most common infection for which antibiotics are prescribed for children in the U.S. generating a well documented and substantial social and economic burden. The AAP/AAPF practice guideline recommends that, instruction in the proper examination of the child's ear should begin with the first pediatric rotation in medical school and continue throughout postgraduate training. Continuing medical education should reinforce the importance of and retrain the clinician in the use of pneumatic otoscopy. Teaching these skills is a challenge in unwilling pediatric patients with joint viewing limited to video otoscopy and no existing models to simulate pneumatic otoscopy. The objective of this project was to develop a model to simulate common ear pathologies and how to perform related diagnostic techniques. METHODS: This project began as the development of an anatomical model to teach myringotomy and ear tube insertion. Prototyping was accomplished via 3-D software and hand sculpting with removable cartridges simulating the tympanic membrane and middle ear space. The interdisciplinary team of researchers from the Departments of Pediatrics, ENT and Biomedical Engineering at the University of Virginia then adapted this model for broader applications. Engineering and medical students have been involved in all stages of development. The head support has been modified for optimal positioning, more realistic materials have been incorporated to compose the soft tissue, an umbo/malleus was created to improve realism and a pressure gauge has been added to monitor pneumatic otoscopy. Replaceable cartridges with photos of normal and abnormal findings have been added to the teaching kit as well as foreign bodies to practice removal. CONCLUSIONS: The development and modification of this novel ear model has resulted in a versatile diagnostic and procedural teaching and assessment tool. The model has a broad target audience including students, residents and practicing physicians in many specialties. Additionally, this process has been a successful example of collaborative and translational research.

61. BEING A REFLECTIVE PRACTITIONER: A MEDICAL STUDENT CURRICULUM TO ENHANCE LEARNING AND REFLECTIVE THINKING ON A PEDIATRIC CLERKSHIP TO REACH EXCELLENCE IN PRACTICE.
Maria L. Marquez, Georgetown University, Washington, DC
BACKGROUND: Reflective practice enables learners to develop critical thinking skills. OBJECTIVE: Implement a Reflective Practice Program to determine the impact on professional learning. DESIGN/METHODS: Twenty-four third-year medical students on a pediatric clerkship were randomly assigned to participate in morning report sessions. Twelve students, the intervention group, received a 2 hour participative orientation. The instructor had experience about reflection. The other 12-students group, the control, didn’t receive orientation about reflection, and the instructor didn’t have experience about reflection. RESULTS: The characteristics were similar in both groups, including fund of knowledge about the cases. Four recorded morning report sessions were analyzed. Control set-First Morning Report: had 283 entries of which 32 % were questions, and 68 % were statements. It showed 71.4 % data gathering, 28.2 % data analysis, 0.4 % conclusion drawing level. Control set - Second morning report: had 180 entries of which 28 % were questions and 72 % were statements. It showed 70.2 % data gathering, 25.5 % data analysis, 4.3 % conclusion drawing level. Intervention Set - First morning report: had 301 entries of which 41 % were questions and 59 % were statements. Data gathering was 41.5 %, data analysis was 39.6 %, and conclusion was 18.9 %. Intervention set-Second morning report: had 182 entries of which 34 % were questions and 66 % were statements. It showed 37.9 % data gathering, 44.4 % data analysis and 17.7 % conclusion drawing. There was significant difference between the groups in the level of cognitive processing. CONCLUSIONS: Reflective Practice curriculum provides a baseline for a deeper thinking.
by two focus groups of medical student educators across clinical disciplines at the University of Maryland School of Medicine to identify 10-12 items from previous tools and new items suggested by the participants to include in a new assessment tool. Next, the tool will be tested for its ease of use by applying it to recordings of oral presentations made by faculty members for this purpose. Modifications will be made and the tool will then be used to assess recorded patient presentations of a subset of third year medical students on their pediatrics and internal medicine clerkships. Assessors will be experienced teachers who will be trained to use the new tool. Analysis will be done to determine the inter-rater reliability and construct validity of the tool as well as its practical utility. RESULTS: By the time of the meeting the inter-rater reliability of the instrument will be evaluated, and ratings of students’ presentations using the new tool will be compared with other presentation skills assessments to assess tool validity. CONCLUSIONS: A new tool to assess medical student oral case presentation skills is being developed and will add to the current tools to address this important physician competency.

63. UTILIZING A CLERKSHIP WIDE ORIENTATION PROGRAM FOR A MULTI-SITE CLERKSHIP TO IMPROVE STUDENT PERCEPTION OF CLERKSHIP PREPAREDNESS AND STUDENT PERFORMANCE ON OSCE TESTING
Lee T. Miller, MD, Kathy L. Perkins, MD, PhD, Deborah Lehman, MD, LuAnn Wilkerson, EdD, Angelika Rampal, MD, David Geffen School of Medicine at UCLA, Los Angeles, CA

BACKGROUND: In the middle of the 2007-08 academic year a new orientation program was introduced to our core pediatric clerkship to insure that students in a multi-site clerkship received a comprehensive and consistent introduction to fundamental principles that would serve as a foundation for their subsequent clerkship experience. The Orientation Program highlighted aspects of the history and physical examination that are unique to pediatric medicine, with an emphasis on the organization and structure of the pediatric history. By introducing this Orientation Program in the middle of the academic year, we were able to compare student performance on a senior OSCE between groups receiving the orientation and groups that didn’t. Specifically, we focused on the following outcomes: history taking skills and physician/patient interaction skills in a pediatric OSCE case. We were also able to compare the students in the two groups on their self-reported preparation for the clerkship.

METHODS: The responses of third-year students in evaluating the pediatric clerkship and their scores on the pediatric components of a year-end OSCE were compared using multiple analysis of variance controlling for the total OSCE score. RESULTS: 1. Students rated their preparation for the clerkship higher if they had participated in the orientation than if they had not. 2. Students who had participated in the Orientation Program scored significantly higher on history taking in the pediatric case during the OSCE (p<.05) than those who did not participate in the program. There was no effect on the physician/patient interaction score.

CONCLUSION: In addition to the above, while the OSCE demonstrated improvement in history taking, analysis of oral presentations made after the pediatric patient encounter revealed that many students had significant difficulties organizing and synthesizing clinical information. These data will be shared, along with implications for program evaluation, curricular change and subsequent study.

64. IMPLEMENTING A PEDIATRIC SENIOR STUDENT CURRICULUM: COLLABORATION, CHALLENGES AND LESSONS LEARNED
Lisa E. Leggio, MD, Valera L. Hudson, MD, Leila E. Stallworth, MD, William P. Kanto, MD, Medical College of Georgia, Augusta, GA

BACKGROUND: The Residency Review and Redesign in Pediatrics (R3P) Project urges a continuum of pediatric education beginning in medical school. We believe the senior year should bridge the undifferentiated student and focused postgraduate trainee. Management of this bridge year requires collaboration between undergraduate and postgraduate education directors. Both have vested interest in creating a curriculum that assure undergraduates are well prepared. The objective of this project is to create a senior student curriculum that prepares students for pediatric residency. METHODS: Directors of undergraduate and postgraduate education collaborated to create a pediatric senior student curriculum. Competency-based objectives focus on knowledge and skills expected from post-graduate trainees on day one. Focus groups with trainees gave insight about what students need to be prepared for internship. Curriculum changes include a portfolio, direct observation, group meetings, and a discussion series. The portfolio encourages goal-setting and self-reflection. Direct observation of student notes, orders, and physical exam are documented with a predetermined checklist. Facilitated group meetings with seniors and advisors cover curriculum, electives, curriculum vitae, personal statements, and interviews. Small group discussion topics include ethics, prioritization and organization, teaching, feedback/evaluation, nutrition, resuscitation, dehydration, shock, respiratory distress, and anaphylaxis.

RESULTS: Evaluation of the curriculum has been positive. Attendance at small group sessions varied, but improved after timing was revised. Collaboration between undergraduate and postgraduate education directors improved. Challenges to implementation included 1) determining optimal timing, 2) dedicated faculty time, 3) perception of senior year being easy and 4) evaluating effect of curricular change when outcome is preparedness for internship. CONCLUSIONS: Challenges remain, but collaboration between undergraduate and postgraduate education directors is helpful when creating a pediatric senior curriculum.
65. PEDIATRIC JUNIOR CLERKSHIP STUDENTS: DO THEY DO WHAT THEY DOCUMENT? DO THEY DOCUMENT WHAT THEY DO? A FOLLOW-UP REPORT.

Marlene M. Broussard, MD, Pat F. Bass, MD, MPH, Joseph A. Bocchini, MD, LSUHSC-Shreveport, Shreveport, LA

PURPOSE: The primary purpose of this study is to determine if inconsistencies exist between the examination maneuvers and documentation of these maneuvers as documented by junior medical students. An additional purpose is to see whether documentation errors decrease as students progress throughout the clinical 3rd year. METHODS: Funding was secured through a COMSEP educational grant. IRB approval was obtained. Junior medical students on the outpatient clinic rotation of the Pediatric Clerkship were recorded performing examinations on patients younger than 5 years old with appropriate consent. Each videoed encounter was reviewed independently and results were recorded on a standard physical exam checklist. Exam elements performed incorrectly were also noted on the form. A separate investigator reviewed copies of clinic notes for each patient encounter and recorded results from the clinic note on the checklist. Both checklists were compared to determine if any discrepancies between performed physical examination skills and the corresponding documentation existed. RESULTS: Twenty-five student-patient encounters have been recorded and reviewed. All encounters have been performed by junior medical students (n=20) with varying amounts of clinical training. On the 25 videos, 296 physical exam maneuvers were performed; only 73% were documented. There were 302 items documented in the 25 corresponding clinic notes, 28% of which were not clearly performed on the video. The most common elements documented but not performed were eye and neck examinations. The video reviewer did not see any physical exam elements that were incorrectly performed. CONCLUSIONS: No encounters were completely and accurately documented. Limitations include a single-institution study with a small number of encounters. Data are still being collected to determine whether documentation errors decrease as students progress throughout the clinical 3rd year.

66. THE INTEGRATION OF THE HIGH FIDELITY SIMULATOR IN THE THIRD YEAR PEDIATRICS CLERKSHIP

Yasmin Pedrogo, MD, UPR School of Medicine, San Juan, Puerto Rico, Nerian Ortiz, MD, UPR School of Medicine, Puerto Rico, Nydia Bonet, MD, UPR School of Medicine, San Juan, Puerto Rico

BACKGROUND: Simulation in medicine is a useful tool for assessing competencies. Scenarios range in complexity depending on trainee level. Some are used to review assessment skills. LCME expects students to have simulation experiences in medical school curriculum. 40% of US medical schools use simulators. AAMC reported that the number of schools using standardized patients in courses increased to 50% but still fail to employ evaluation methods that specifically assess student’s achievement of the skills. At the UPR School of Medicine the simulator has been used during clinical correlations. Integration of these simulators have been encouraged for clinical clerkships. The Pediatrics Clerkship has incorporated an activity using the pediatric simulator. The objective is to provide students the opportunity to demonstrate knowledge relevant to pediatrics practice using the human simulator. METHODS: During the academic year 2007-08 a formative activity using the high fidelity simulator was implemented in the Pediatrics Clerkship. Two scenarios were designed with stated objectives. Third year medical students were required to participate in the activity. The simulator presented with respiratory distress. A group of six students worked the scenario, which was discussed by a faculty member. Students completed an evaluation form. RESULTS: One hundred twenty four students participated in the activity during the academic year 2007-08. 94% expressed that the objectives were clearly stated and that adequate orientation was offered before the activity. 98% percent agreed that the level of difficulty was adequate for the educational level. 98% agreed that the use of the simulator in an scenario with relevant general pediatric issues such as the one presented allowed a better understanding of clinical concepts studied in the clerkship. More than 85% of the students recommended the integration of the simulator in other major clinical clerkships. CONCLUSIONS: The use of the high fidelity simulator during the pediatrics clinical clerkship has been an excellent tool to reinforce learned skills. The activity has served to strengthen history taking, physical exam and critical thinking skills.

67. SECOND YEAR MEDICAL STUDENT ELECTIVE IN CHILD LIFE SERVICES

Jocelyn Schiller, MD, Jennifer Christner, MD, U of Michigan, Ann Arbor, MI

BACKGROUND: Exposure to pediatrics in the first two years medical school is often minimal. To increase second year students’ exposure and interest in pediatrics, an elective was created in collaboration with Child Life Services. Child Life services are an essential component of quality pediatric health care and are integral to family-centered care and best-practice models of health care delivery for children, according to the American Academy of Pediatrics 2006 Policy Statement. A literature search revealed no publications on Child Life services in medical education. OBJECTIVES: A multidisciplinary committee developed and implemented an elective for second year medical students. Goals were to: 1) increase preclinical students exposure to pediatrics, 2) increase students comfort with children 3) develop students’ skills in communication with children and in patient relaxation. Description: Three 2-hour sessions were planned for October 2008. Prior to each session, students were assigned a small task such as exploring how a child might react in certain scenarios regarding illness. Developmental milestones were reviewed, particularly how children of various ages interpret illness and death. The interactive sessions with Child Life staff utilized a multitude of techniques to teach a variety of relaxation and coping skills. Examples of this include: 1) art therapy to explore children’s feelings in the hospital and the impact of hospitalization on child development, 2) music therapy 3) medical play to demonstrate procedures such as central line placement 4) use of cookies and candy to explain bone marrow. Results/CONCLUSIONS: Surveys before and after the course and final course evaluations will be used to analyze the impact of the course on
student interest in pediatrics, perceived skills learned and overall content and delivery of the course. Child life staff may be underutilized as potential teachers in our pediatric student and resident programs. Programs that involve these staff may be another mechanism of exposing learners to key concepts in the Systems Based Practice competency.

68. REFLECTIVE EXERCISE ABOUT VIOLENCE IN A THIRD YEAR PEDIATRIC CLERKSHIP
Nydia Bonet, MD, Brenda Mirabal, MD, MPH, UPR School of Medicine, Department of Pediatrics, San Juan, PR

BACKGROUND: Homicides are the first cause of death for youths > 15 years in PR. Males are affected 14 times more than females. Thousands of youths are incapacitated physically, mentally or emotionally by intentional injuries in PR every year. In order to prevent intentional injuries and reduce costs to society it is necessary to identify the risks and protective factors of intentional injuries in this population. The LCME expect students to be prepared for their role in addressing the medical consequences of common societal problems. At the UPR SOM Pediatric Clerkship, a new requisite was begun in academic year 2008-09 were students completed a reflective exercise on this topic in order to increase awareness. OBJECTIVES: Provide the students the opportunity to recognize that intentional injuries and homicides are a serious public health problem in the youth population in PR and motivate reflection in order to develop plausible preventive measures. Strategy: Students are required to read the article entitled “Homicides Among Children and Young Adults-Puerto Rico, 1999-2003, MMWR” and write a reflective essay describing their thoughts and ideas about this problem. RESULTS: Thirty-six students out of a 106 have completed the Course. All students recognized youth violence and homicides as a serious public health problem. Common themes discussed in the students’ exercises were: the role of families, government programs, schools and communities in teaching youths about positive values and pro-social skills; and the role of physicians and health professionals in early identification of risk factors and patient education in clinical interventions. Students also expressed the need for collaboration between different sectors of society to reduce and prevent this problem. CONCLUSION: Reflective exercises promote introspection, critical thinking and analysis and are helpful when dealing with complex social problems. It is essential that future physicians become aware of their role in the identification of risk factors and the importance of promotion of preventive strategies to address the social problems prevalent in their community.

69. INITIATING A BASIC SCIENCE CURRICULUM IN THE PEDIATRIC 4TH YEAR CLERKSHIP
Irene Hong-McAtee, MD, Hubert O. Ballard, MD, Chris Nelson, MD, University of Kentucky, Lexington, KY

BACKGROUND: Only 19% of US medical schools offer “capstone courses” to refresh their senior medical students in the basic sciences (Spencer et al, Acad Med, July 2008). To our knowledge, our curriculum is one of the first attempts to integrate basic science knowledge in understanding clinical pediatrics. The objectives were to 1) To re-introduce 4th-yr med students who have chosen pediatric careers to basic science concepts that lead to a deeper understanding of pediatric cases, so that they may become more astute clinicians, and 2) to foster independent learning and development of teaching skills through preparation of weekly presentations to their peers and professors. STRUCTURE: 4 different cases were presented, 1 case per week of a 4-wk 4th-yr pediatric clerkship. Each weekly topic included a Tuesday and a Friday session, and was taught by a different pair of professors. On Tuesdays, 1st a clinical vignette was presented by a Clinical Pediatrician, during which students formulate differential diagnoses and recommendations for treatment. Then, a Basic Science Faculty presented physiology of the disease and mechanisms of treatment. Finally, students and faculty brainstormed about further questions that were raised by the faculty presentations. These led to assigned or chosen topics that students researched for the remainder of the week. On Fridays, the basic scientist, clinical pediatrician, and students reconvened to listen to the student-led PowerPoint presentations, which were expected to be concise and evidence-based. Evaluation (data collection ongoing): 1) Each student received a written summary of the weekly evaluations by each faculty pair. 2) Evaluation of the effectiveness of the curriculum was based on A) student evaluations of the curriculum and teachers, using Likert scales, and B) increase in individual student knowledge of the 4 pediatric topics, i.e., change in score from pre- to post-test. FUTURE DIRECTIONS/CONCLUSIONS: include expanding to a free-standing elective and fostering interdisciplinary interaction by recruiting graduate students in the basic sciences, pharmacy and nursing.

70. USING DISTANCE LEARNING TO TEACH AND ASSESS THIRD-YEAR MEDICAL STUDENT PERFORMANCE OF ADOLESCENT PSYCHOSOCIAL INTERVIEWING
Michael A. Pelzner, MD, Uniformed Services University, Bethesda, MD

BACKGROUND: Ensuring comparable clinical experiences, instruction and assessment methods for learners who are spread across remote training sites presents a continuing challenge for medical schools. (Functions and Structure of a Medical School, Liaison Committee on Medical Education, 2008.) DESCRIPTION: We demonstrate how distance-learning technology can help teach and assess an adolescent medicine curriculum to remote third-year medical students. We use videoconferencing technology to administer two standardized patient encounters (SPE) to students at six training sites, up to 4835 miles a part (Honolulu, HI to Washington, DC). Performance is measured with post-encounter forms, and students receive formative feedback from a faculty observer. After the second SPE, students and standardized patients complete a satisfaction survey. EVALUATION: Students and standardized patients were satisfied with the realism of the encounter (65% and 95% respectively). Students were satisfied with the learning experience (17/28, 65%), and recommended continuing to use it as teaching tool. 96% of students felt that they received detailed and quality feedback over the VTC system. Standardized patients were satisfied that the VTC-based SPE was an effective
way to assess interviewing skills (28/28, 93%). Analysis of the student performance data is in progress. CONCLUSIONS: Modern videoconferencing technology and standardized patient encounters provide one option to ensure comparable experiences for learners at distant sites.

71. PATIENT SAFETY EDUCATION: EVALUATING A CURRICULUM INTEGRATED INTO A BASIC PEDIATRIC CLERKSHIP

Robert A. Dudas, MD, Michael A. Barone, MD, David G. Bundy, MD, Hanan Aboumatar, MD, MPH, Marlene R. Miller, MD, Johns Hopkins University, Baltimore, MD

INTRODUCTION: The AAMC Medical School Objectives Project recommends that medical students learn the principles of quality improvement that maximize patient safety. Few curricula address this learning need in a clinical setting. We developed a curriculum to teach the systems-based process of identifying and remediating potential medication administration errors. METHODS: Students viewed an online video introducing system safety concepts. Faculty presented an example of a medication administration error using the Learning from Defects tool (LFD). Fifteen groups of students identified a medication error during their pediatrics rotation and used the LFD tool to analyze it. Each group presented their defect analysis and recommendations for system improvements. Students were also asked to shadow a nurse through the process of medication administration. We measured attitudinal changes towards safety and system improvement using questions from the Safety Attitudes Questionnaire (SAQ). RESULTS: Seventy students completed this curriculum. Fifteen groups presented findings on safety events and some uncovered issues that would not have otherwise been discovered. Changes in student attitudes were assessed by comparing pre/post mean Likert scores (1=strongly disagree - 5=strongly agree). All were found to be statistically significant: Medical errors are handled appropriately in hospitals 3.64/3.27; I will see others make errors that may harm patients 3.61/4.30; Disruptions in continuity of care can be detrimental 4.17/4.51; I will make errors that have the potential to harm patients 3.80/4.14; I feel comfortable reporting issues to appropriate authorities 3.42/3.99; My suggestions on safety would be acted upon if I expressed them 2.68/3.07. Curriculum content was rated as relevant and 70% of students recommended that the sessions continue. CONCLUSIONS: Our curriculum was well received by students and effective in changing attitudes about patient safety. This exercise may also serve to identify patient safety concerns not currently addressed through other means.

72. ASSESSING THE VALUE OF PEER EVALUATIONS DURING THIRD YEAR PEDIATRIC CLERKSHIPS

James R. Stallworth, MD, Sara F. Lindsey, MD, University of South Carolina School of Medicine, Columbia, SC

BACKGROUND: Reports on the use of peer assessment for constructive feedback are limited in the medical education literature. No reports isolate peer assessments from students on their pediatric rotation. Furthermore, the impact of these evaluations on students and whether they change behavior has been minimally explored. The Department of Pediatrics has obtained anonymous peer evaluations within clerkships groups for the past four years. Students are supplied with an open ended forum whereby they provide evaluations on each member of their group. The responses are collected by the clerkship director, formalized constructively, and become part of the overall course evaluation but do not affect the final grade. Objectives of this work is to determine if: 1) Do students value the content of peer evaluations? Has the impact of peer evaluations caused a change in behavior? Are medical students accepting of peer evaluations? METHODS: During the summer of 2007, 234 students who completed the pediatric clerkship within the prior four years were mailed surveys. 110 students responded anonymously by year of graduation. A sixteen question Likert scale questionnaire with one open ended comment section was used. RESULTS: Selected student responses of the peer evaluations reported as “agreed” or “strongly agreed” were: Beneficial 64%, Accurate 67%, Changed behavior 30%, Positively impacted communication with peers 41%, Positively impacted communication with patients 17%, Made me anxious 35%, Content of peer and faculty evaluations were similar 58%, Popularity impacted the peer evaluation process 53%, and Peer evaluation should impact the clerkship grade 18%. CONCLUSIONS: Our project assessed open ended peer feedback and its impact on self awareness and change in behavior. Two thirds of students found them beneficial. From these data, we have developed a quantitative peer evaluation form. This will be a more objective measure and will allow the students to compare themselves to their peers. This tool may be utilized as part of a clerkship’s 360 degree evaluation process.
Friday, May 1

Sessions located in the Hilton Baltimore Convention Center Hotel

7:30 am – 9:00 am

Regional Breakfasts

Mid-America

West PA, OH, WV, KY, IN, MI (Raheel Khan, MD, Hilary Hafitel, MD and Jean Ashley)

Mid-Atlantic

South NJ, East PA, DE, MD, Wash DC (Paul Bellino, MD, Nancy Spector, MD, and Stephen Schraith)

Midwest

IL, WI, MN, IA, MO, KS, NE, OK (James Nocton, MD, Keith Mann, MD and Tara Shirley)

New England

ME, NH, MA, CT, VT, RI (Aida Velez and Edwin Zalneraitis, MD)

New York/New Jersey

NY, Northern NJ (Joel Forman, MD and Beth Woolf)

Southeast

VA, NC, SC, GA, FL, AL, MS, LA, AR, TN (Karen Ariemma and Mark Bugnitz, MD)

Southwest

TX, AZ (Judy Behnke and Surendra Varma, MD)

Western

CA, NV, OR, WA, HI, CO, NM, UT (Cynthia Ferrell, MD, Adam Rosenberg and Laurie Ashenbrenner)

9:00 am – 10:00 am

The Milestones Project: Competencies - Applying Lessons Learned

Susan Guralnick, MD, Stony Brook University Medical Center, Stony Brook, NY; Carol L. Carraccio, MD, MA; Erin L. Giudice, MD, University of Maryland, Baltimore, MD; Robert Englander, MD, MPH, University of Connecticut, Hartford, CT; Gail A. McGuinness, MD, American Board of Pediatrics, Chapel Hill, NC

The new millennium brought a shift in the focus of training toward outcomes of teaching and assessing the six ACGME competencies. We responded by developing a set of learning objectives for each of these six competencies. To determine expected levels of performance for each objective at each level of training, we surveyed the membership of APPD. Eighty (40%) program directors responded, with 95% agreement at the PL2 level and 100% at the PL3 level. Over the next 3 years we measured actual resident performance in the patient care competency against expectations established by APPD. We will set the stage with results of this study and introduce a similar initiative, the Milestones Project, which is a joint venture of the ACGME and ABP to develop a set of learning objectives for pediatrics that will inform the next iteration of residency accreditation requirements. With this background in mind the major objectives for the workshop participants will be to: 1) understand the charge given to the pediatric community by ACGME and ABP and define the role and strategies for APPD membership involvement, and 2) understand and apply the lessons learned from the previous set of learning objectives and performance expectations to the project at hand. The workshop leaders will introduce the session with a presentation of the comparison data between expectations and actual performance of learning objectives pertaining to the patient care competency, collected at the University of Maryland. There will be an opportunity to discuss the findings and their interpretation. This discussion will be followed by an overview of the Milestones Project including the details of the charge, the key role played by APPD, and the progress to date. The larger group will break down into small groups for discussion of strategies to garner input from the entire membership of APPD, as well as strategies for ongoing dissemination of future progress. The essence of these discussions will be captured in a large group debrief. We will conclude by having the group define a concrete set of next steps.

10:15 am – 12:15 pm

Workshops

1. Individualized Learning Plans: A Primer with Tools and Concepts for Success!

Ann E. Burke, MD, Wright State University, Dayton, OH, Amy Jost, MD, Children’s Hospital/Boston Medical Center, Brookline, MA, Ann P. Guillot, MD, University of Vermont, Burlington, VT, John D. Mahan, MD, Nationwide Children’s Hospital/Ohio, Columbus, OH

BACKGROUND: There is increasing emphasis on self-directed learning (SDL) in graduate medical education.
Individualized learning plans (ILPs) are a tool reported to have theoretic educational benefits. Educators in pediatrics are now mandated to have trainees accomplish one ILP per year. Many faculty members, including program directors, who are newly responsible for facilitating development of resident ILPs may feel unprepared for the task. While the definition of ILPs is given to us in the RRC Companion Document, the details of this approach to practice based learning and improvement is a challenge for many. Program directors have found barriers to implementation of successful ILP curricula such as lack of faculty familiarity with the process, lack of faculty buy-in, waning enthusiasm by resident learners, difficulties of time constraints and misunderstanding about the goals of ILPs. Some programs are utilizing Pedialink, while others have developed various written formats for ILPs. There are many examples of programs with successful ILP processes. DESCRIPTION: This workshop will begin with a 15 minute introduction and delineation of what an ILP actually is as defined by the Pediatric RRC and the medical education literature. The theoretic need and purpose for an ILP in a resident's training experience will also be discussed. Participants will subsequently be divided into small groups to discuss misconceptions about, barriers to and questions regarding ILPs. The groups will report back to the whole group and invigorating, interactive group discussion will follow. A Fellow will then report her interesting data from a survey of residents regarding their thoughts on the utility of ILPs. The remainder of the workshop will be a showcase of a number of “Best Practices” to implementing useful learning experiences for residents via the ILP. Two successful, but different, approaches to the ILP will be presented. Each presentation will be 10 minutes long with an additional 10 minutes for discussion of the presentation. Material, examples of learning strategies, and an ILP reference list will be distributed to all participants.

2. Fostering Humanism and Professionalism in Pediatric Residency Training
   Jennifer C. Kesselheim, MD, Katharine C. Garvey, MD, Theodore C. Sectish, MD, Robert J. Vinci, MD, Boston Combined Residency in Pediatrics, Boston, MA
   RATIONALE: The many challenges faced by pediatric residents conspire to suppress key humanistic attributes such as compassion and empathy, and residents are known to be at risk for moral erosion, depression and burnout. Moreover, the teaching of professionalism, which is closely linked to humanism, is required by the Accreditation Council for Graduate Medical Education (ACGME) and encouraged by the American Board of Pediatrics (ABP). Pediatric educators must seek new curricular elements to foster both humanism and professionalism. The Boston Combined Residency in Pediatrics (BCRP) has developed a small group discussion curriculum for interns and junior residents, which uses case vignettes to explore barriers to humanism and professionalism in residency training. Sessions aim to support residents and allow them time to develop strategies and coping skills to apply to their work. This workshop aims to promote dialogue on the teaching of humanism and professionalism in pediatrics while sharing and refining BCRP strategies. FORMAT: After reviewing key concepts and relevant literature, workshop participants will divide into two groups. In a case simulation station, participants will work through case vignettes from the BCRP discussion curriculum and reflect on issues raised for residents, teaching goals and facilitator roles. In a second station, participants will focus in depth on the challenges of discussing depression and burnout with residents in a confidential group setting. Finally, as a large group, participants will summarize their discussions, brainstorm other curricular efforts and explore how these might be coordinated at a regional or national level to strengthen this crucial area of resident training. BCRP curricular materials will be distributed, and participants will be encouraged to share other curricula and evaluation tools.

3. Spinning Your Web: Creating a Web Site as an Effective Educational Tool
   Paul S. Matz, MD, St. Christopher's Hospital for Children, Andrew McInnes, MD, Children's Hospital of Philadelphia, Michael Blair, MD, Nancy D. Spector, MD, St. Christopher's Hospital for Children, Philadelphia, PA
   BACKGROUND: Residency and fellowship programs are faced with the challenge of creating new educational programs and evaluation tools. The task of disseminating background information and resources to develop these new tools can be a daunting task for faculty and program directors. Creating a web site can be a useful way for faculty and trainees to access clinical information, research data, and administrative policies, as well as an effective way to develop innovative educational programs. Graduate medical trainees are familiar with using these electronic resources in their educational and clinical endeavors, yet faculty members and residency and fellowship 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) Identify specific curricular objectives that may be enhanced by innovative web-based tools; 2) Research and select a location to house web-based educational programs (including purchasing a domain name and hosting services); 3) Design and build an effective web site using commonly available software; 4) Secure electronic data; and 5) 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 web-based resources encompassing clinical care, faculty development, and graduate trainee education. 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. This workshop is designed for individuals with beginning to intermediate computer skills and knowledge of Microsoft Office.
4. **Curriculum Task Force: Interactive Symposium of Curricular Tools for Professionalism**
   
   Susan B. Bostwick, MD, NYU-Cornell, NY, NY, Karin Hillenbrand, MD, East Carolina University / Pitt County Memorial Hosp, Greenville, NC
   
   **BACKGROUND:** Curricula in pediatric graduate medical education cover a wide range of material in the traditional competencies of medical knowledge and patient care areas. There are additional competencies that need to be taught to pediatric residents. These additional competencies are possibly more difficult to define, and therefore increasingly time consuming to develop curriculum around. One of the more difficult to teach competencies is Professionalism. The Curriculum Task Force originally addressed Practice Based Learning and Improvement for 3 years in this symposium. However, given input from members, we feel that more information about Professionalism curriculum is needed. Additionally, outcome measures regarding professionalism curriculum are starting to be identified. There continues to be a need for disseminating ideas and strategies about curricula in Professionalism. **OBJECTIVE:** To share and disseminate curricular ideas and methods utilized in various programs to teach Professionalism. These ideas and methods will be conveyed to participants via practical examples of curricular practices in real programs. **DESCRIPTION:** The session will follow the style of a platform session with moderators. The time will consist of 5 program directors presenting 15 minute condensed explanations of their curricula to teach the domain of Professionalism. These will be solicited prior to the meeting from the program directors on the curriculum task force and poster proposals received by the APD pertaining to Professionalism. After each presentation there will be a 5-10 minute question and answer session. Each participant will leave the workshop with new ideas for Professionalism that can be practically and easily implemented into their own local program curricula.

Five Selected Presentations:
- **NOVEL PROFESSIONALISM CURRICULUM FOR A PEDIATRIC RESIDENCY PROGRAM**
  Rachel L. Dawkins, MD, Simone Fagarasi, MD, Louisiana State University Health Sciences Center, New Orleans, LA
- **HOW TO TEACH CULTURAL SENSITIVITY TO PEDIATRIC RESIDENTS**
  Ralitsa B. Akins, MD, PhD, Gilbert A. Handal, MD, Cecilia Carigma, MD, Texas Tech Pediatrics El Paso, TX
- **HOW TO BE HEARD: A CURRICULUM ON LEGISLATIVE ADVOCACY FOR PEDIATRIC RESIDENTS**
  Benjamin D. Hoffman, MD, Christopher Fink, MD, Tito Monge, MD, Teresa Vigil, MD, University of New Mexico, Albuquerque, NM
- **DEVELOPING A CURRICULUM FOR FAMILY-CENTERED ROUNDS AT AN ACADEMIC CHILDREN’S HOSPITAL**
  Carmen M. Coombs, MD, Janet R. Serventi, MD, Johns Hopkins, Baltimore, MD
- **THE INTERNS LECTURE SERIES: HOW TO SURVIVE, THRIVE, LEARN, AND TEACH AS A PEDIATRIC INTERN**
  Greg A. Harlan, MD MPH, Dedee Caplin, PhD, James F. Bale, MD, University of Utah Pediatrics, Salt Lake City, Utah

5. **Using Behavior Based Interviewed to Assess Residency Applicants**
   
   Christine Skurikis, MD, Aida Velez, MBA, Priti Bhansali, MD, Edwin Zalneraitis, MD, University of Connecticut, Hartford, CT
   
   **BACKGROUND:** Behavior based interviewing (BBI) focuses on experiences, behaviors, knowledge, and skills that are job related. BBI employs the concept that the best indicator of future performance is past performance. This technique is commonly utilized by industry because of its proven merit in identifying applicants with desirable skills. Employers determine specific skills that are needed by their future employee, based on the expectations for the position. The employer then creates questions inquiring about the past experiences of the applicant that may demonstrate successful aptitude in the desired areas of competency. Questions specific to the applicant’s experiences and background are developed based on the details provided in their application. Responses are evaluated based on accepted criteria, and the result is included in the overall assessment of the applicant. This interview technique has the potential to better assess important characteristics of residency applicants during their interviews, and to aid programs in the resident selection process. **WORKSHOP FORMAT:** The basis and implementation of BBI will be presented. Attendees as a group will create a list of competencies by generating qualities that are desired of pediatric residency applicants. Next, participants will review a sample application, and practice creating specific questions for that applicant. Attendees will then divide into smaller work groups and develop specific behavioral based questions for each identified competency, generated from sample applications. After each group practices interviews using BBI, including scoring of responses using a 5-point scale, the work groups will share the outcomes of their efforts. Strategies for implementing behavior based interviews at local institutions, including faculty interviewer development, will be discussed at the conclusion of the session.

6. **Resident Retreats: Developing Core Competency Skills through Fun and Games**
   
   Kelly R. Leite, DO, Penn State Hershey Children’s Hospital, Hershey, PA, Susan Curalnick, MD, Stony Brook University Medical Center, East Setauket, NY
   
   **BACKGROUND:** For years, many residency programs have used workshops and retreats to focus on developing resident skills in the core competencies. Two programs in the Mid-Atlantic region have collected data from resident retreats for 14 years. Our data show that 100% of residents view retreats as an important component of their education. Despite the
typical retreat format of role play and open discussions with peers, 95% of residents rate their retreats as outstanding or very good. In addition, over 93% of residents report that retreats lead to a more positive representation of their program to new applicants. While evidence indicates retreats improve resident skills and overall resident morale, many program directors have little experience in preparing a structured and effective resident retreat. PURPOSE: This workshop offers strategies for incorporating structured retreats into a program curriculum with the goal of refining resident skills in a longitudinal format. Focused core competencies include professionalism, interpersonal communication and practice-based learning. METHODS: In the first hour, participants will acquire the necessary tools to set the stage for a successful retreat. A review of setting ground rules, using introductory games and creative exercises to enhance resident skills will be discussed in an interactive format. Participants will share strategies used in their programs, providing a broad variety of ideas. The concept of using retreats to develop resident skills in a longitudinal format will also be included. Workshops for senior residents on topics such as leadership skills, conflict management and career development will complete the experience. In the second hour, participants will take part in a workshop on developing support systems to show how experiential learning can be an effective educational tool. Qualities of an effective facilitator will also be reviewed. Participants will receive copies of introductory games, creative exercises and retreat agendas that outline a longitudinal approach to developing core competency skills throughout residency training.

7. First “SIPS” And Then “GULPS”: Utilizing Standardized Individual Patient Scenarios (SIPS) to Promote the Generation of Unique Learning Plans (GULPS)

James J. Nocton, MD, Jennifer Mckanry, MSED, Diane Dettinger, PNP, Karen Marcdante, MD, Lynn Sheets, MD, Paola Palma-Sisto, MD, Shonu Das, MD, Michael Weisgerber, MD, Medical College of Wisconsin, Milwaukee, WI

Residents are now required to develop individual learning plans (ILPs). Most residents feel unprepared to develop meaningful plans, and many program directors find it challenging to develop a process to help residents accomplish this task. Many barriers may hinder the development of an effective ILP, including a lack of understanding of the purpose, lack of tools that promote self-assessment, lack of time, lack of faculty guidance, and difficulty developing measurable goals. This workshop will describe a hands-on curriculum that permits residents to reflect and self-assess their skills in the core competencies. Utilizing standardized individual patient scenarios (SIPS), residents are directly observed and videotaped through several stations. Residents then view recordings of their performance and scores from an objective checklist.

This process promotes reflection upon their current skills and development of specific goals for improvement (generate unique learning plans:GULPS). All residents repeat this process at a later time and review their progress. We will present aggregate data on the performance of our residents at baseline and at follow-up. Participants in the workshop will then divide into 6 groups and develop standardized individual patient scenarios and checklists designed to evaluate specific competencies. Examples of case scenarios, checklists, and aggregate data will be distributed to all participants to help generate ideas. In small groups, participants will discuss how to implement a similar process within their own programs, potential barriers to implementation, and solutions to these barriers. Each small group will present a summary of their discussion to the entire group for further discussion. At the conclusion of this workshop, attendees will be better prepared to develop systems within their own programs that will permit the development of more meaningful resident ILPs.

8. What Can Advocacy Do For You: How to Design and Implement Sustainable Competency-Based Curricula in Advocacy and Community Pediatrics

Benjamin D. Hoffman, MD, University of New Mexico, Albuquerque, NM, Lisa Chamberlain, MD, Stanford, Palo Alto, CA, Anda Kuo, MD, UCSF, San Francisco, CA, Jeffrey Kaczorowski, MD, University of Rochester, Rochester, NY

The ACGME requires that all pediatric residency training programs must incorporate training in advocacy and community pediatrics, but this “unfunded mandate” makes finding curricular time and resources a challenge. Clearly linking community pediatric training to ACGME competencies is the “currency” that can be used to secure and enhance rotation time. Beyond fulfilling requirements, pediatric training programs, departments, faculty and residents also have many rewards to gain from this training. This workshop will: 1) provide a brief overview of data demonstrating the importance of community pediatrics and advocacy training in medical education, 2) use examples of sustainable curricular approaches and curricular tools successfully employed in medical education and residency programs to demonstrate how training can empower trainees to become effective advocates for children from the individual to the systems-level, 3) demonstrate with these examples how such curricula can document learner competence in ACGME core competencies, 4) share lessons learned from trainees and faculty. Participants will work with facilitators to: 1) develop strategies for implementing new or enhanced experiences for learners in advocacy and community pediatrics 2) practice applying tested curricular tools to their institution, 3) identify areas within their own programs where ACGME competencies can be demonstrated and apply tools to better document these competencies. Finally, we will share best-practice competencies developed for community pediatrics and advocacy training by the AAP Community Pediatrics Training Initiative.
9. The I’s Have It - Incorporating and Integrating a Quality Improvement Curriculum into a Residency Program
   Kerry K. Sease, MD, MPH, Jonathan E. Markowitz, MD, MSCE, Jennifer A. Hudson, MD, Greenville Hospital System/Univ of SC School of Medicine, Greenville, SC
   Formal Quality Improvement activities give residents experience in systematically analyzing practice and implementing change with the goal of practice improvement. The Plan-Do-Study-Act (PDSA) cycle described by Berwick, et al. provides a model for use in a residency training program to teach fundamentals of the change concept as well as offer practical experience for trainees and faculty alike. GHS-UMC Children’s Hospital has been engaged in Quality Improvement (QI) projects within its Pediatric Residency program for the past three years. During this time we have implemented a successful curriculum that includes the completion of a QI project for every resident, and it has encouraged the formation of trainee-faculty mentor relationships. Our trainees’ projects are submitted to state and national scholarly meetings and have resulted in awards and recognition both for our program and for several individual trainees. In this workshop, we will introduce the PDSA model for change as an example of one QI methodology and highlight its advantages when used in residency training. We will briefly describe our program’s method for incorporating the PDSA model into the pediatric curriculum, and highlight our approach for integrating the results of the PDSA cycles into actual clinical practice. The workshop will then focus on specific IRB issues that we have encountered, with particular emphasis on the differences between QI and Clinical Research. During this time, we will also discuss our strategies for bringing an entire residency program up to speed with a variety of regulatory issues and for developing quality presentations. The final phase of the workshop will be a breakout session where we will work in small groups to brainstorm ideas and identify potential barriers to action so that attendees will be able to implement the PDSA model into their individual programs. Following the breakout session, we will take some time to wrap-up and field questions from the entire group.

10. Managing from the Middle: Improving Leadership Skills for Associate Program Directors
    Aditee P. Narayan, MD, MPH, Duke University Department of Pediatrics, Durham, NC, Marsha Anderson, MD, The Children’s Hospital, Aurora, CO, Glenn Stryjewski, MD, MPH, Thomas Jefferson University, Wilmington, DE, Priti Bhansali, MD, University of Connecticut School of Medicine, Hartford, CT, Sadiq Thammasitboon, MD, MPH, West Virginia University School of Medicine, Morgantown, WV, Sherry Sakowitz, MD, Brookdale University Hospital and Medical Center, Brooklyn, NY, Nancy Spector, MD, St. Christopher’s Hospital for Children, Philadelphia, PA, Keith J. Mann, MD, Children’s Mercy Hospitals and Clinics, Kansas City, MO, Christiane Corriveau, MD, MA, Children’s National Medical Center, Washington, DC
    INTRODUCTION: In 2005-2006, the Association of Pediatric Program Directors (APPD) addressed the career needs of Associate Program Directors (APD) and included, for the first time, APDs in the organization’s strategic plan. From that effort, the Associate Program Directors’ Special Interest Group was established and a needs assessment was conducted through both an online survey, as well as through the Spring APPD meetings in 2006-2007. We found that many APDs are new to the role (50% have been APDs < 2 years) and a core concern was how to lead a wide array of people from a middle management position. Our workshop is intended to address these needs by teaching APDs to assess, develop, and apply their leadership skills within their unique position. WORKSHOP FORMAT: Participants will begin the workshop by completing the Leadership Practices Inventory (a validated tool in leadership evaluation) as a self-assessment tool, followed by self-scoring to identify their leadership tendencies. This will be followed by a large group discussion on leadership practices commonly used when managing from the middle. This discussion will be interactive, and we hope to identify participants’ perception of leadership and compare and contrast that to common practices of effective leaders. Leadership concepts will be reinforced through use of an instructional video, which will translate the principles into practice. Lastly, participants will break into small groups to discuss application of leadership skills through case-based scenarios. Participants will leave the workshop with a self-assessment of their personal leadership style, knowledge of effective leadership practices, strategies for enhancing specific leadership skills, and plans for integrating these leadership practices into their current roles to further their career development and satisfaction.

11. SIMULATING A DAY IN THE LIFE: MAKING INTERN ORIENTATION RELEVANT
    WITH SIMULATION MODULES
    Debra Boyer, MD, Boston Combined Residency Program, Boston, MA, Marie Clark, MD, MPH, Children’s Hospital of Pittsburgh, Pittsburgh, PA, Stacey Cook, MD, PhD, Rebecca Ruebner, MD, Juliette Hunt, MD, Margaret Wolff, MD, Ari Wassner, MD, Boston Combined Residency Program, Boston, MA
    For many pediatric training programs, intern orientation has become a to-do list focused upon the completion of hospital-mandated courses and computer trainings. While completion of these tasks is essential for new hospital employees, the main goal of intern orientation, preparing interns for the challenging year ahead, has been buried. This year the Boston Combined Residency Program experimented with a new orientation format to focus on preparing interns for the day-to-day life of internship. The format involves a series of Simulation Modules, each designed to simulate a different aspect of intern life. The scenarios were chosen with an emphasis on the most common and/or most anxiety-provoking settings for new interns. For example, modules focus on rotating in the ED, Inpatient Ward and NICU, as well as on performing procedures.
and handling difficult communications. Each module has a similar format: a) Didactic session b) Group discussion and question/answer c) Computer application d) Group skill practice session. The workshop will focus on three main objectives: 1) Understand challenges in creating an effective pediatric intern orientation. Following a didactic introduction, the group will discuss the challenges faced by their programs in meeting the needs of the programs, hospitals and trainees during orientation. 2) Learn to create simulation modules to address these challenges. We will present components of a successful simulation module. The group will experience a sample simulation module and then break into small groups to create their own simulation modules. 3) Learn to assess the effect of changes implemented. A brief presentation on the BCRP experience with survey follow-up will be followed by a discussion on different strategies to assess effect.

12. Virtual Reality: The New Age of Using Simulation to Assess and Teach  
Sharon Calaman, MD, Nancy D. Spector, MD, St. Christopher’s Hospital for Children, Philadelphia, PA; Joseph O. Lopreiato, MD, National Capital Area Medical Simulation Center, Bethesda, MD, Clifton E. Yu, MD, National Capital Consortium Pediatric Residency; Washington, DC; Glenn Stryjewski, MD, A.I. duPont Hospital for Children, Wilmington, DE; Laura Smals, MD, Raj Munshi, MD, Michael Blair, MD, St. Christopher’s Hospital for Children, Philadelphia, PA

With work hour limitations, changes in staffing models, and more sophisticated learning needs, there is a greater need to efficiently utilize trainees’ time and control their learning experiences. Simulation can be a useful means of such control as it is not dependent upon the randomness of most training experiences. Simulation methodologies have been used to teach and assess several competencies including Communication skills, Patient Care skills, integration of Medical Knowledge, Professionalism and Teamwork skills. Simulation programs can be structured to allow learners to receive feedback on their performance and repeat a situation (Practice Based Learning and Improvement). In this workshop we will review the spectrum of tools available for simulated learning: human patient simulators, task trainers and standardized patients. A team of expert facilitators from three institutions will give examples of innovative ways that simulation is already being applied in competency based curricula for the purposes of teaching and assessment. After the overview, we will break into three small working groups: simulators, task trainers and standardized patients. Participants can self-select a group to join. With the assistance of the facilitators, participants will construct an outline of their plan for using simulation at their institution based on their resources, time and interest. Handouts, spreadsheets and practical examples will be distributed to foster creativity within groups. Participants will leave with an understanding of the various tools for simulated learning and ways to utilize them in their own curriculum.

13. Expanding Your Web: Advanced Web Site Tools to Enhance Your Educational Goals  
Paul S. Matz, MD, St. Christopher’s Hospital for Children, Andrew McInnes, MD, Children’s Hospital of Philadelphia, Michael Blair, MD, Nancy D. Spector, MD, St. Christopher’s Hospital for Children, Philadelphia, Pa

BACKGROUND: Residency and fellowship programs are faced with the challenge of creating new educational programs and evaluation tools. Developing internet-based programs can be an innovative approach to reaching educational goals. Graduate medical trainees now expect educational technology to be a significant part of their pediatric education.

OBJECTIVES: This workshop will be a hands-on, interactive presentation that will provide participants with a framework to develop advanced web-based educational programs. Participants will be able to: 1) Create multimedia website quizzes and Case of the Week scenarios; 2) Develop a web-based curriculum, including the use of audio, video, and lecture components; 3) Use Microsoft Sharepoint to create and build a document, image, or video library; 4) Create a virtual clinical practice in Microsoft SharePoint; 5) Track web site use; and 6) Develop an academic portfolio for individuals or an entire program.

DESCRIPTION: The workshop will begin with a short didactic presentation that will review the facilitators’ experience in implementing advanced web-based educational tools. The large group will work through the process of developing these resources. Small groups will have the opportunity to use software to implement these tools in a variety of mock web sites. Participants will leave with resources that will assist them in producing creative web-based tools at their own institution. This workshop is designed for individuals with intermediate to advanced computer skills and knowledge of Microsoft Office, as well as experience developing web sites. Microsoft Front Page will be highlighted, although experience with any web-building software will be helpful. Participants do NOT need to understand computer programming languages.

14. Improvement Science Applied to Medical Education: From the ACGME to Your Residency  
Javier A. Gonzalez del Rey, MD, MEd, Carole M. Lannon, MD, MPH, Stephen E. Muething, MD, Cincinnati Children’s Hospital Medical Center, Cincinnati, OH

BACKGROUND: Program directors are responsible for ensuring compliance with ACGME regulations in a complex healthcare system that appropriately emphasizes patient care and service. Integrating these educational requirements into busy and clinically focused programs can be challenging, in part, because the training program often exists as a parallel system. This session will strive to link the systems by providing program directors with the tools to improve the daily operations of their educational systems while also providing excellent training and meeting ACGME requirements. We will illustrate how the use of improvement science can enable residency programs to focus efforts as well as use rapid cycle learning to more effectively integrate changes into training. OBJECTIVES: Participants will learn practical improvement skills and how to apply them to improve an educational issue or process within their local training setting.

FORMAT: We will provide a brief and useful overview of the Model for Improvement (MFI) using interactive activities to teach key principles. Specific examples from the Cincinnati Childrens Hospital Medical Center Pediatric Residency
Program will be used to demonstrate the application of MFI to training program processes (Direct observation, 360 Evaluations, and Communication to improve patient safety). Participants will then have the opportunity to consider their own local educational environment and develop a plan for testing improvements using the MFI method. These skills will be helpful for program directors to address not only local training issues but also the integration of the competencies of systems thinking and performance improvement into residency training.

15. No Learner Left Behind: Identifying, Diagnosing, and Remediating “The Problem Learner”

Wendy L. Hobson-Rohrer, MD, MSPH, University of Utah, Primary Childrens Medical Center, Salt Lake City, UT; Rebecca L. Blankenburg, MD, MPH, Michele E. Long, MD, A. E. Stuart, MD, MSEd, Lucile Packard Children's Hospital, Stanford Univ, Palo Alto, CA; Maryellen E. Gusic, MD, Penn State University College of Medicine, Hershey, PA

When was the last time you encountered a problem learner? With defined core competencies for medical students, residents, and fellows, medical educators must design methods to evaluate these competencies and strategies to remediate learners who are not meeting these benchmarks for performance. In particular, professionalism, communication, and medical knowledge/clinical synthesis are challenging to effectively remediate. In this interactive workshop using role-played clinical vignettes, video clips, and facilitated small group discussions, participants will learn how to identify, diagnose, and remediate problem learners. The presenters will discuss tools and strategies used at their institutions, and participants will build upon these resources by sharing their own issues, solutions, and experiences. At the end of the workshop, participants will receive a summary of the discussion and a toolbox of these methods for use in their own programs.

16. Perspectives on Curriculum Reform: Different Approaches to the Same Goal

Brad G. Olson, MD, John S. Andrake, MD, Jay Peacock, MEd, SUNY Upstate Medical University, Syracuse, NY; Greg A. Harlan, MD MPH, Dedee Caplin, PhD, Angelika Valdez, MD, Wendy Hobson-Rohrer, MD, MSPH, James F Bale, MD, University of Utah Pediatrics, Salt Lake City, UT; Susan Guralnick, MD, Robyn J. Blair, MD, Jennifer Fahner, DO, Taylor Starr, DO, Stony Brook University Medical Center, Stony Brook, NY

The Departments of Pediatrics at SUNY Upstate Medical University, University of Utah, & Stony Brook University Medical Center have recently undertaken robust curriculum reform efforts aimed at achieving an improved curricular scope, as guided by the American Board of Pediatrics content specifications, the ACGME core competencies, and need for improved conference attendance. SUNY Upstate has partnered with Syracuse University in a collaborative effort to create a global curriculum that integrates a comprehensive online core lecture series with an interactive, case-based, face to face discussion series. The result is a rich blended learning environment. Stony Brook has restructured both the timing and content of their core conference series through an evaluative and analytical process, applying the information learned to inform the ongoing curricular reform effort. A robust 3 year conference curriculum, supplemented by a comprehensive web-based core reading program, has been developed. The University of Utah has developed a model for the creation of a longitudinal, customizable, training-year specific curriculum that addresses several ACGME competencies (communication, professionalism, and medical knowledge), as well as unforeseen needs of residents. During this interactive workshop, curriculum developers and educators will explore ideas, develop content, and resolve barriers associated with the approaches taken by each program to address their distinct educational challenges, as well explore ways in which these methods can be applied in their home institutions. Workshop leaders will include both faculty and residents in order to provide different perspectives on the curricular change process. The workshop will begin with a brief overview of the curricular reform processes at each institution. There will be an opportunity for active discussion of choices made and obstacles encountered. Participants will spend the majority of their time in highly interactive, small group sessions around three phases of curriculum development (implementation, content challenges, and evaluation): 1) Implementation - Develop strategies to overcome real and perceived barriers (such as duty hours, clinics, didactics and other existing obligations) - We ask that participants bring their own programs’ resident schedules as a basis for small group activities; 2) Content Challenges - Differentiate ideal from necessary content elements - Determine how residents’ needs may change through the year, themes to address longitudinally, and potential teachers for specific content areas - Use elements of the ACGME competencies/ABP Content Specifications as a basis for content; 3) Evaluation - Benefits of informal and formal feedback and evaluation - Determine outcomes of curricular changes and methods of measurement for evaluating change. The session will conclude with a group discussion of content, novel ideas, and possible solutions for implementation challenges. Conference participants will come away with useful ideas/methods for curriculum reform and materials shared by the workshop leaders.
4:00 pm – 6:00 pm  MPPDA Subcommittee Meetings

- Accreditation Committee  Blake
- Curriculum Committee  Calloway A
- Recruitment Committee  Calloway B
- Research Committee  Poe A
- Transition Committee  Poe B

6:00 pm – 7:30 pm  MPPDA Reception – separate registration required  Holiday 4

SATURDAY, MAY 2

7:00 am – 5:00 pm  Registration  Key Ballroom East Foyer

7:00 am – 8:00 am  Continental Breakfast  Key Ballroom South Foyer

8:00 am – 1:00 pm  Coordinators Session  Key 5

8:00 – 8:30  Introduction – Coordinator’s Executive Committee

8:30 – 9:00  American Board of Pediatrics (ABP) – Esther Foster

9:00 – 9:30  Accreditation Council on Graduate Medical Education (ACGME) – Rebecca Miller

9:30 – 10:00  American Academy of Pediatrics (AAP) – Doris Santos

10:00 – 10:15  Break

10:15 – 10:45  Electronic Residency Application System (ERAS) – Renee Overton

10:45 – 11:15  ECFMG Update – Marlene Keawe

11:15 – 12:15  Best Practice Strategies for Coordinators

  - Laurie Ashenbrenner, Oregon Health & Science University, Portland, OR
  - Louise Kadane, University of California, San Diego, San Diego, CA
  - Cindy Colpitts, University of Nebraska Medical Center College of Med, Omaha, NE
  - Caleen Froelich, Oregon Health & Science University, Portland, OR

The role of residency program coordinator is unique in medical education. Most coordinators learn the job through trial and error, with a fortunate few benefiting from the wisdom and experience of their predecessors and mentors. This interactive workshop will help coordinators at all levels of experience by outlining examples of “Best Practices” regarding specific components of the Coordinator’s job. We will discuss strategies for learning the basics of the job, getting through major events in the yearly timeline, and recent changes in program requirements and how we can work with the program and the program directors to meet those requirements. In addition, we will address opportunities to incentivize residents to complete those “not so exciting” tasks that coordinators must continually hound them over. At the end of this session, participants will have gained insight into the challenges of maintaining professional satisfaction in the role of a coordinator and will return to their respective program with skills to incorporate such “Best Practices” to incorporate into their respective programs.

12:15 – 1:00  Jeopardy Game - Coordinators Presentation

8:00 am - 1:00 pm  Forum for Directors of Small Programs / Affiliate Chairs  Key 8

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

1.  RRC Update -- To meet all RRC requirements small programs may not have all resources. This interactive forum helps in exchanging ideas and learning methods to comply with RRC guidelines.

2.  AMSPDC Survey

  1) Members will become aware of the AMSPDEC survey of Affiliate Chairs and Programs and the decision process regarding consideration of potential membership in some capacity.
2) Participants will discuss their interests and expectations of potential membership in AMSPDC.
3. Match Analysis -- For Program Directors and Affiliate Chairs to appreciate the nature of this year’s match and implications for workforce planning.

8:00 am – 5:00 pm Forum for Chief Residents
Planning the year to come, while making sense of the year that is passing
Edwin Zalneraitis, MD, Program Director, University of Connecticut; Priti Bhansali, MD, Associate Program Director, University of Connecticut; John Mahan, MD, Program Director, Children’s Hospital/Ohio State University; Vincent W. Chiang, MD, Associate Program Director, Boston Combined Residency Program in Pediatrics
This will be an interactive forum bringing together rising Chief Residents to plan their coming year, finishing Chief Residents to consider how to use their experience as Chief Residents 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 introductory didactic material applied in work groups. Selected activities will be determined by 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.

8:00 am – 5:00 pm Forum for Fellowship Directors
8:00 – 9:00 American Board of Pediatrics (ABP)
Gail McGuinness, MD, Executive Vice-President, ABP
This session will present an update on the American Board of Pediatrics training requirements for subspecialty certification. There will be ample opportunity for questions from participants.
9:00 – 10:00 Accreditation Council for Graduate Medical Education (ACGME)
Jerry Vasilias, PhD, Executive Director, RRCs for Family Medicine and Pediatrics
This session will present an update on the ACGME requirements for training in Pediatric Subspecialties. There will be ample opportunity for questions from participants.
10:15 – 11:15 National Resident Match Program (NRMP)
Mona Signer, Executive Director, NRMP
The National Resident Matching Program’s Specialties Matching Service manages nearly 40 fellowship matches, including 7 for Pediatric subspecialties. In this session NRMP staff will explain how a match eliminates pressure and optimizes the preferences of applicants and training program directors, fosters a spirit of fairness by ensuring all participants adhere to the policies governing the matching process, and provides feedback to the profession by means of detailed data reports.
11:15 – 12:15 Electronic Residency Application System (ERAS)
Renee Overton, Director, ERAS
The electronic resident application system is a service that transmits applications, letters of recommendation, medical school transcripts, USMLE transcripts, and other supporting credentials to program directors using the Internet. This session will focus on plans for bringing on the remaining pediatric sub-specialties, the ERAS reengineering efforts and probe participants for suggested changes they’d like to see in the new ERAS.
12:30 – 1:15 Using the APPD Share Warehouse (session includes a working lunch)
Ann Burke, MD, Program Director, Wright State University
Learn about this virtual, web-based, collaborative project that will provide a place for pediatric graduate medical educators to find and share resources, including curricula and evaluation tools.
1:30 – 2:30 Individualized Learning plans: What are they?
Ann Burke, MD, Program Director, Wright State University
Participants will become familiar with ILP and Portfolio concepts, philosophy, and practicality.
2:30 – 3:30 Update from the Council of Pediatric Subspecialties (CoPS)
Victoria Norwood, MD, President, CoPs
The CoPS mission is to integrate approaches to subspecialty education, research and patient care by providing a forum for members and other organizations and by serving as the common voice for the pediatric subspecialties.
3:45 – 4:45 Survivor RRC: The PIF and Your Site Visit
Susan Guralnick, MD, Program Director, Stony Brook University Medical Center
This workshop will walk fellowship directors through the process of an RC site visit, from preparation of the Program Information Form (PIF) to logistics of the on-site visit, including practical steps, realistic timelines and pitfalls to avoid.

7:00 am – 5:00 pm MPPDA Business Meeting -- separate registration required
7:00 – 8:00 Registration
8:00 – 8:15 Welcome, Member Introduction and Meeting Overview
All participants introduce themselves/institution.
Suzanne Woods, President-elect
8:15 – 8:30 President Address - Brad Benson
8:30 – 9:00 Healthcare Matrix: the Intersection of ACGME Core Competencies and Quality Improvement - Waldon Garriss and Sandra Moutsios
9:00 – 9:15 Break-out Session 1
9:15 – 9:45 Medical Student Electives - Allen Friedland and others
9:45 – 10:00 Break
10:00 – 10:30 Accreditation – Lessons Learned - Jimmy Stewart and others
10:30 – 11:00 Innovations / Tool Sharing - Prep time for ACGME and the Board
11:00 – 11:45 MPPDA Distinguished Lecture - Dr. James Stockman III
11:45 – 1:15 Lunch and Business Meeting
  President Elect – Sue Woods
  MPPDA Membership Update and Treasurer's Report – Rita Rossi-Folkes
  NMPRA update - Jessica Wilson
  Walter Tunnessen Award – LuAnn Moraski
  MPPDA Election results – Eric Ayers
  AAP update – Tommy Cross
  Poster winner
1:15 – 1:30 Break
1:30 – 3:15 Question and Answer Session with the Boards and Review Committees
  Bill Lobst, MD Director, Academic Affairs
  American Board of Internal Medicine
  Gail A. McGuinness, MD
  American Board of Pediatrics
  Felicia Davis, Associate Executive Director
  Review Committee for Internal Medicine, ACGME
  Jerry Vasilias, PhD, Executive Director
  Review Committee for Pediatrics, ACGME
3:15 – 3:30 Break
3:30 – 3:45 Breakout Session
3:45 – 5:00 Committee updates and discussion
  Accreditation Committee
  Curriculum Committee
  Recruitment Committee
  Research Committee
  Transition Committee
6:00 pm – 10:00 pm Dinner Off-site (additional $50 fee)
APPD Would Like To Thank The Following Companies For Their Participation As Exhibitors At This Year’s Meeting

Be sure to visit them on Thursday, April 30th in Ballroom 1 at the Baltimore Convention Center

MedStudy Corporation (Table 1)

Publishers of Peds & IM board review Core Curriculums, board-style Q&As, video board reviews on DVD, and board prep conferences (Peds conference August 29 - September 5, 2009 in Dallas, TX). AMA PRA Category 1 Credits™ available on all.

MedStudy Corporation
1455 Quail Lake Loop
Colorado Springs, CO 80906
Tel: 1-800-841-0547; Fax: 810-963-8264
Email: mferguson@medstudy.com ~ Web address: www.medstudy.com

Booth Personnel: J. Thomas Cross, Jr., MD, MPH

Hospital Corporation of America (HCA) (Table 2)

HCA Kids is a one stop recruitment office for pediatric opportunities in 20 states, a great resource for help in finding a great opportunity.

Hospital Corporation of America (HCA)
3 Maryland Farms, Suite 140
Brentwood, TN 37027
Tel: 937-235-5890; Fax: 937-235-5897
Email: kathleen.kyer@hcahealthcare.com ~ Web Address: http://hca-kids.com/

Booth Personnel: Kathy Kyer, Manager - Ped Subs Recruitment

HSoft Corporation (Table 3)

HSoft’s mission is to improve the teaching quality of your program by providing efficient, easy to use web based tools, bringing medical residency management to a higher level.
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HSoft Corporation
364 W. Trenton Avenue, Suite 4
Morrisville, PA 10967
Tel: 215-337-9080; Fax: 215-337-9233
Email: info@hsoft.org ~ Web Address: www.Meditrek.com

Booth Personnel: Frank Jakab, President and Izabella Zathureczky, MD
PediaLink Online/American Academy of Pediatrics (Table 4)

Come visit the PediaLink Resident and Program Director Center.

PediaLink Online/American Academy of Pediatrics
141 Northwest Point Blvd.
Elk Grove Village, IL  60007
Tel:  847-434-4723;  Fax: 847-434-8000
Email:  dkurpiewski@aap.org ~ Web address:  www.pedialink.org

Booth Personnel: Scott Bradbury and Charlette Nunnery

American Academy of Pediatrics Publications (Table 5)

The AAP, an organization of 60,000 primary care pediatricians, pediatric medical subspecialists, and pediatric surgical specialists, is the leading publisher in the field of Pediatrics, providing both professional and patient educational materials.

American Academy of Pediatrics
141 Northwest Point Blvd.
Elk Grove Village, IL  60007
Tel:  847-434-4000;  Fax:  847-434-8000
Email:  phlos@aap.org ~ Web Address:  www.aap.org

Booth Personnel: Jean Wesloski and Maureen DeRosa

Challenger Corporation (Table 6)

Challenger provides learning and testing tools for program directors and institutions to quantify the skill sets of residents and PAs in training. Challenger’s reporting system yields compliance, performance and remediation data on individual users, program years, and for your entire program. These statistical outputs permit client institutions to prove compliance and effectiveness to certifying organizations.

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5100 Poplar Avenue, Suite 1410
Memphis, TN  38137
Tel: 1-901-762-8499;  Fax:  1-901-767-7019
Email:  anitra.arcenaux@chall.com ~ Web Address:  www.chall.com

Booth Personnel: Lauren McGinnis
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Email: Terry.DeFelice@abbott.com ~ www.abbottnutrition.com

Booth Personnel: Terry DeFelice and Bob Dahms
Hotel Floor Plan

Level 3

Pratt Street

Open to Key Ballroom Below

Paca A
Paca B

South Foyer

Marshall
Carroll B
Carroll A
Tubman B
Tubman A

East Foyer

Open to Holiday Ballroom Below

North
ASSOCIATION OF PEDIATRIC PROGRAM DIRECTORS

13TH ANNUAL FALL MEETING
SEPTEMBER 9 - 11, 2009

THE WESTIN ARLINGTON GATEWAY
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: Wednesday evening, September 9
Meeting: Thursday and Friday, September 10-11

*CME Offered*