

2011 ANNUAL MEETING

ASSOCIATION OF PEDIATRIC
PROGRAM DIRECTORS

CELEBRATING
25 *years of*
 Educational
Excellence!

EDUCATIONAL BEST PRACTICE AND
CREATIVE PROGRAM MANAGEMENT
FOR THE FUTURE

MARCH 31 - APRIL 3, 2011
MIAMI, FL

INTERCONTINENTAL MIAMI
100 CHOPIN PLAZA, MIAMI, FL

*THIS ACTIVITY HAS BEEN APPROVED FOR AMA PRA CATEGORY 1 CREDIT™

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SCHEDULE-AT-A-GLANCE

THURSDAY, MARCH 31	FRIDAY, APRIL 1	SATURDAY, APRIL 2	SUNDAY, APRIL 3
<p>7:30am Registration Begins</p> <p>8:00 – 11:00am Forum for Directors of Small Programs/Affiliate Chairs</p> <p>10:00am – 3:00pm Coordinators' TAGME Exam (prior registration necessary)</p> <p>11:00am – 3:30pm Pre-Conference QI Workshop (separate registration required)</p> <p>3:45 – 5:45pm Grassroots Forum for Program Directors</p> <p>Grassroots Forum for Associate Program Directors</p> <p>Grassroots Forum for Fellowship Directors</p> <p>Coordinators' Assembly</p> <p>6:00 – 8:00pm Dinner on Own</p> <p>8:00 – 10:00pm 25th Anniversary Celebration / Salsa Night</p> 	<p>7:45 – 9:00am Breakfast and Platform Presentations -- Best of Research and QI Abstracts</p> <p>APPD Hospitality Room (see schedule of hours posted outside Trinity)</p> <p>9:00 – 10:35am APPD Awards, History and Annual Reports</p> <p>10:45am – 12:00pm Task Force Meetings</p> <p>12:00 – 1:15pm Lunch on Own</p> <p>1:15 – 2:30pm Innovation Presentations/ Q&A with ABP, RRC, AAMC/ NBME Project, LEARN, IIPE, Milestones</p> <p>2:30 pm – 3:45 pm Key Stakeholders in Education/ Interactive Q&A with representatives from the following organizations: AAP, AMSPDC, APA, FOPO, COMSEP, CoPS, MPPDA, SOMSRFT</p> <p>3:30 – 5:30pm Coordinators' Workshops</p> <p>3:45 – 5:30pm Mentoring Session (for Physicians) 3:45-4:30 Skill Development (OPEN to all) 4:30-5:30 Pre-Existing Groups</p> <p>4:30 – 6:00pm LEARN Workshop on IRBs and Educational Research</p> <p>6:30pm Coordinators' Social (separate arrangements)</p>	<p>7:00 – 8:30am Regional Breakfast Meetings</p> <p>APPD Hospitality Room (see schedule of hours posted outside Trinity)</p> <p>8:45 – 10:15am Workshop Session I for Physicians</p> <p>8:45am – 12:00pm Coordinators' Session</p> <p>10:15 – 10:30am Break</p> <p>10:30am – 12:00pm Workshop Session II for Physicians</p> <p>12:00 – 1:30pm Lunch on Own</p> <p>Council of Task Force Chairs (COTFC) Lunch</p> <p>Council of Regional Chairs (CORC) Lunch</p> <p>1:30 – 3:00pm Poster Session</p> <p>3:00 – 4:00pm Task Force Meetings Redux</p> <p>3:00 – 5:00pm Coordinators' Session</p>	<p>7:30am – 3:00pm Forum for Chief Residents see page 24 for details (includes breakfast and lunch)</p> <p>8:00 – 9:00am Wrap-Up Session from Grassroots Forums / Continental Breakfast</p> <p>9:15 – 10:45am Workshop Session III for Everyone</p> <p>10:45 – 11:15pm Break / Check out of hotel</p> <p>11:15am – 12:45pm Workshop Session IV for Everyone</p> <p>MPPDA Meeting Begins see page 26 for details</p>

WELCOME TO MIAMI!

Following our first very successful stand-alone meeting last year in Chicago, the APPD 2011 Annual Meeting promises to be even better! As we celebrate 25 years of Educational Excellence, we will continue to highlight top educational research and QI projects with platform presentations (Friday, 7:30-9:00am), focus on quality improvement with our Pre-Conference Workshop (Quality Improvement 101: Tools for Change), encourage task force activities and participation, provide 30 excellent workshops during four sessions on Saturday and Sunday, feature nearly 70 research/descriptive/QI abstracts as posters (Saturday, 1:30-3:00 pm), continue to train mentors (Friday, 3:45-4:30 pm), and offer a superb track for coordinators.

This year, we have added sessions (including Q&A) on Innovation and Key Stakeholders in Education (Friday, 1:15-3:45 pm) and will feature a lively presentation on the 25 year History of the APPD by Dr. Ken Roberts during the APPD Awards/History/Annual Reports session on Friday morning from 9:00-10:35 am. In addition, the Forum for Chief Residents has been enhanced this year to include more interactive workshops for both rising and graduating chiefs (Sunday, 7:30 am – 3:00 pm).

Just in case you're wondering, the 25th Anniversary Meeting won't be all work and no play! We hope that you will join the anniversary celebration on Thursday evening from 8:00-10:00 pm when we'll party by the pool (weather permitting)! Become part of the Miami scene as we dance to a live band and enjoy Salsa Night!

Our sincere hope is that you will share the good ideas that you brought with you to this forum and take away many more. This is your chance to learn and network. Please take advantage of every opportunity!

ANNOUNCEMENTS

Special Ribbons and Pins

It is always a pleasure to welcome first time attendees to the APPD Annual Meeting and this year we have a significant number. We urge you to look for their "First Timer" ribbons (white with blue lettering) so that you may "show them the ropes" and help ensure that their first experience is a pleasant and successful one. Please also look for ribbons and pins that note APPD leadership, staff and donors who have contributed to the APPD Fund the Future Campaign during our 25th Anniversary year.

APPD Hospitality Room

We invite you to stop by the APPD Hospitality Room (*Trinity*, second floor) on Friday and Saturday to grab a beverage and learn more about the Milestones Project, APPD LEARN (Longitudinal Education Assessment Research Network), IIPE (Innovation in Pediatrics Education) and the Share Warehouse. A schedule of specific times when the room will be open will be posted outside the room each day.

APPD Luggage Storage on Sunday

As a courtesy to those who will be checking out of their hotel room on Sunday morning, we have set aside *Michelangelo* (2nd floor meeting room) from 7:30 am-3:30 pm where you may leave your luggage. Please note that luggage will be left at your own risk. APPD cannot assume responsibility for your belongings.

CONTINUING EDUCATION CREDIT

Accreditation Statement

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 (IAHB), the Association of Pediatric Program Directors (APPD) and the Medicine-Pediatrics Program Directors Association (MPPDA). The IAHB is accredited by the ACCME to provide continuing medical education for physicians.

Credit Designation Statement

The IAHB designates this live activity for a maximum of 25.5 AMA PRA Category 1 Credit(s)TM. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

SESSIONS FOR COORDINATORS

This year, there are four stand-alone sessions blocked out for coordinators. These include Thursday afternoon's "Coordinators' Assembly," the Coordinators' Task Force Meetings on Friday morning and coordinator-specific workshops on Friday afternoon. In addition, a "Coordinators' Session" filled with important information will be offered during two time slots on Saturday. These sessions have been blocked and shaded in the program to assist in locating them. Coordinators should also note that they are encouraged to attend sessions during all other time slots on Friday and Saturday, and all Sunday sessions with physicians. Workshops of general interest to coordinators are being offered during Sunday's Workshop Session III and Workshop Session IV. Please mark your choices for those workshops on your registration form and plan to stay throughout the meeting.

APPD LEADERSHIP

President - Ann Burke, MD (2010-2012)

President-Elect - Patricia Hicks, MD (2010-2012)

Secretary-Treasurer - Adam Pallant, MD, PhD (2010-2013)

Past-President - Susan Guralnick, MD (2010-2012)

Executive Director - Laura Degnon, CAE

Associate Director - Kathy Haynes Johnson

Board of Directors

Debra Boyer, MD (2008-2011)

Grace Caputo, MD, MPH (2008-2011)

Cynthia Ferrell, MD, MEd (2010-2013)

Lynn Garfunkel, MD (2009-2012)

Javier Gonzalez del Rey, MD, MEd (2010-2013)

Jerry Rushton, MD, MPH (2008-2012)

Coordinators Executive Committee

Deb Parsons, C-TAGME, Co-Chair (2008-2011)

Elizabeth Sanchez-Rocca, C-TAGME, Co-Chair (2008-2011)

Jaime Bruse, C-TAGME (2009-2012)

Avis Grainger, C-TAGME (2009-2012)

Patricia Jacobi, (2010-2013)

Kathryn Miller, C-TAGME (2010-2013)

Nominating Committee

Susan Guralnick, MD, Chair

Joel Forman, MD (2009-2011)

Richard Shugerman, MD (2010-2012)

2011 Annual Meeting Program Committee

Executive Planning Committee

Rob McGregor, MD - Program Chair

Keith Mann, MD - Program Co-Chair

Susan Guralnick, MD

Marsha Anderson, MD

Members

James Bale, MD

Ann Burke, MD

Suzette Caudle, MD

Alex Djuricich, MD

Patricia Hicks, MD

Karin Hillenbrand, MD

Dena Hofkosh, MD

Diane Kittredge, MD

Heather McPhillips, MD

James Moses, MD

Erin Stucky, MD

Franklin Trimm, MD

Clifton Yu, MD

JOIN AN APPD TASK FORCE!

The APPD Task Forces are seeking new members. Please attend one or more task force meetings and plan to become an active part of these important groups. Task Force meetings will be held on Friday, April 1 from 10:45 am – 12:00 pm and on Saturday, April 2 from 3:00-4:00 pm. All are welcomed!

CURRICULUM

The Curriculum Task Force works to ensure that the APPD takes a lead role in promoting and developing a training curriculum that meets ACGME requirements, prepares residents for certification and, most importantly reflects the current needs of children in our society. Members have the opportunity during meetings and throughout the year to participate in the infrastructure for curriculum development, contributing in areas ranging from needs assessment and content development to implementation and dissemination. Current initiatives of the Task Force are addressing curricular needs including bioethics, pediatric surgery, global health, night float, the medical home, and quality improvement.

EVALUATION

The APPD Evaluation Task Force is charged with developing goals with measurable objectives that can be achieved in a 3-year time period to assist pediatric residency programs in improving their evaluation procedures. Such procedures may include evaluation and feedback to individual trainees and faculty, as well as encompassing curricular or programmatic evaluation issues

FACULTY AND PROFESSIONAL DEVELOPMENT

The APPD Task Force on Faculty and Professional Development proposes APPD programs and activities that promote the professional development, educational scholarship, and career success of pediatric residency program directors. It also addresses ways that APPD can help pediatric program directors to develop and improve faculty teaching skills at their institutions and in their region.

LEARNING TECHNOLOGY

The APPD Learning Technology Task Force is charged with the responsibility of identifying and evaluating technology, including software, computers, personal digital assistants, telecommunication devices, and wireless technologies that support training and education of pediatric residents. Areas of particular importance include technologies that assist in the measurement of the ACGME competencies; promote self-directed learning; and enable training to be more efficient and cost-effective.

RESEARCH

The charge to the APPD Research Task Force is to establish an organizational framework that will promote the APPD (or its individual members) to conduct research projects that will contribute knowledge to the APPD or to the field of pediatric postgraduate medical education. Such research projects may include study of program operations, as well as projects designed to study novel curricular or evaluation instruments that will allow programs to address and measure ACGME competencies.

APPD Task Force Leadership

Javier Gonzalez del Rey, MD, Chair, Council of Task Force Chairs

Curriculum Task Force:

Karin Hillenbrand, MD, Chair

Becky Blankenburg, MD, Vice Chair

Evaluation Task Force:

Suzette Caudle, MD, Chair

Ann Guillot, MD, Vice Chair

Faculty and Professional Development Task Force:

Clifton E. Yu, MD, Chair

Nancy Spector, MD, Vice Chair

Learning Technology Task Force:

Joel Forman, MD, Chair

Franklin Trimm, MD, Vice Chair

Research Task Force

Linda Waggoner-Fountain, MD, Chair

Heather McPhillips, MD, Vice Chair



2011 ANNUAL MEETING MARCH 31 - APRIL 3 ~ MIAMI, FL

EDUCATIONAL BEST PRACTICE AND CREATIVE PROGRAM MANAGEMENT FOR THE FUTURE

APPD MEETING SCHEDULE

THURSDAY, MARCH 31

7:30am Registration Begins
Mezzanine

8:00 – 11:00am Forum for Directors of Small Programs/Affiliate Chairs
Bayfront Ballroom

This forum plans to review the impact of new ACGME duty hours on small programs and ways to implement them. The goal is to have a more interactive session with the audience rather than formal presentations. Topics and speakers will include:

Problem Solving for Small Programs – Diane Kittredge, MD

RRC Update Related to Small Programs – Edwin Zalneraitis, MD

Night Float Model for Interns under New Common Program Requirements – Tammy Camp, MD

Dealing with Cultural Diversity Issues in Small Programs – Surendra Varma, MD

("Small programs" have been defined as having 10 or less residents per year. However, many programs consider themselves "small" as compared to other larger programs in their vicinity. Any program that feels they may be having difficulty attaining programmatic goals due to the fact that their program is "small or medium" in size is welcome to attend. No numeric cutoff is necessary.)

11:00am – 3:30pm Pre-Conference QI Workshop
(additional fee applies; includes boxed lunch)
Versailles

Quality Improvement 101: Tools for Change

Javier Gonzalez del Rey, MD, MEd, Director, Pediatric Residency Program, Cincinnati Children's Hospital Medical Center/University of Cincinnati College of Medicine; Keith Mann, MD, Associate Program Director, University of Missouri at Kansas City; Terri Byczkowski, PhD, Assistant Professor, Div of Emergency Med, Cincinnati Children's Hospital Medical Center/University of Cincinnati College of Medicine; Rajesh Donthi, MD, Program Director, Nationwide Children's Hospital / Doctors' Hospital; Cynthia Ferrell, MD, MEd, Program Director, Oregon Health Sciences University; Lynn C. Garfunkel, MD, Associate Directors of Pediatric and Med-Peds Training Programs, University of Rochester; John D. Mahan, MD, Program Director, Nationwide Children's Hospital / Ohio State University; Heather McPhillips, MD, MPH, Associate Program Director, University of Washington; James Moses, MD, MPH, Associate Director, Children's Hospital/Boston Medical Center

Through workshop participation, individuals will gain general knowledge to understand change principles, framework to create improvement teams, skills to navigate through an improvement project related to any patient care, education, or administrative area, and understanding to apply these concepts towards curriculum development in their home institution. Participants will bring a current problem from their residency or fellowship program and utilize the knowledge and skills gained to set in motion a plan of improvement based on sound quality improvement methodology and science. Audience: Program Directors, Associate Program Directors, Chief Residents, and anyone else interested in initiating change. *Limited to the first 125 participants.*

1:30am – 3:00pm Midwest Region Meeting
Flagler

3:45 – 5:45pm

Grassroots Forum for Program Directors

Trianon

This relatively unstructured part of the meeting is designed for the membership to raise their concerns or questions which they want to vet or bring to the APPD Board for further attention. Hot Topics of interest and importance will be addressed at this lively session, divided into small group break-outs based on survey results and facilitated by Drs. Diane Kittredge, Robert Vinci and Dan West.

Grassroots Forum for Associate Program Directors

Sevilla

The Forum for Associate Program Directors will review timely and important topics of interest to the APPD and will discuss organizational and career development needs specific to our group. Additionally, there will be short, peer-reviewed presentations from Associate Program Directors. The session will conclude with a presentation, Create Your Future with Professional Development Planning, introducing the steps of effective professional development planning (presentation by Nancy Spector MD and Theodore Sectish MD) We hope to build upon five years of successful meetings and invite you to bring your ideas to this energetic group session. Leaders: Drs. Marsha Anderson, Aditee Narayan, and Jerry Larrabee.

Grassroots Forum for Fellowship Directors

Sandringham

The forum for subspecialty program directors will be an open discussion of hot topics raised by the participants. Potential topics might include, response to new duty hour regulations, program accreditation, improving fellow scholarship, faculty development, and use of ERAS and the match. In addition, we will discuss the growing needs of subspecialty program directors within the APPD. Facilitation will be by subspecialists on the APPD Board.

Coordinators' Assembly

Chopin Ballroom

3:45-4:15

Intro Activity

Kathryn M. Miller, BS, C-TAGME, Johns Hopkins University, Baltimore, MD and Patricia Jacobi, St. Louis Children's Hospital/Washington University, St. Louis, MO

4:15-4:45

Mentoring: It's a 2-Way Street

Avis Grainger, C-TAGME, Carolina Medical Center, Jean Ashley, MSBC, C-TAGME, University of Louisville, Louisville, KY, Aimee Levy-Page BS, HAS, Our Lady of the Lake RMC, Baton Rouge, LA

An introduction to the benefits of the Coordinators' Mentor/Mentee (protégé) relationship and an opportunity for mentors and mentees to meet with each other.

4:45-5:45

SOCIAL MEDIA: YOU BE THE JUDGE

Avis I. Grainger, C-TAGME, Carolinas Medical Center, Charlotte, NC, Jean Ashley, MSBC, C-TAGME, University of Louisville, Louisville, KY, Kathryn M. Miller, BS, C-TAGME, Johns Hopkins University, Baltimore, MD

Exploration and investigation of means of social media in GME. This will be expanded upon and addresses professionalism in the GME environment.

6:00 – 8:00pm

Dinner on Own

8:00 – 10:00pm

25th Anniversary Celebration / Salsa Night!

Pool Terrace

You won't want to miss this very special dance party where we'll celebrate APPD's 25th Anniversary! For your entertainment, we'll have a live Latin variety band and beautiful salsa dancers. Come join us for dancing and dessert (we won't be eating salsa, just dancing it!) as we open the 2011 Annual Spring Meeting in Miami-style!

About the Band and Dancers: This group is more than just a band, they are pure energy! Having performed together for many years, they deliver a variety

of musical selections including Latin, big band, top 40, reggae, calypso and more -- all with style and flair! They have performed at Super Bowl XXIX and have opened for the Spin Doctors, Harry Connick, Jr. and K.C. and the Sunshine Band. They were also honored to be chosen to perform for the President of the United States at the Summit of the Americas.



Beautifully costumed dancers will perform choreographed dance routines throughout the evening and teach us the hottest moves in salsa and merengue.

FRIDAY, APRIL 1

7:00am

Registration
Mezzanine

7:30 – 9:00am

Breakfast and Platform Presentations - Best of Research and QI Abstracts
Grand Ballroom

Platform Presentation 1

SLEEPLESS IN HOUSTON: SLEEP HABITS OF ENTERING PEDIATRIC RESIDENTS

Teri L. Turner, MD, MPH, MEd, John A. Turner, MD, Diagnostic Clinic, Mark A. Ward, MD, Baylor College of Medicine, Houston, TX

Background: Sleep deprivation among resident physicians has been an issue of much focus and debate over the past decade. Numerous studies have analyzed the deleterious effect of sleep deprivation on medical house officers. Much less is known about incoming residents' daytime sleepiness, sleep behaviors and attitudes just prior to beginning clinical work during residency. Objectives: To determine baseline sleep habits/attitudes of entering interns and measure the level of daytime sleepiness prior to initial full-call responsibility. Methods: All interns entering the Baylor College of Medicine pediatric residency program were surveyed anonymously prior to the start of training. The survey was part of the Sleep Alertness/Fatigue Education in Residency Curriculum developed by the American Academy of Sleep Medicine. Survey questions addressed measures of daytime sleepiness, sleep behaviors, and sleep attitudes. Within the questionnaire was the Epworth Sleepiness Scale (ESS), a validated tool for the measurement of average sleep propensity (scores can range from 0-24). Results: 28% of all entering residents (n=43) had a score > 10 on the ESS suggesting excessive daytime sleepiness; 26% scored 8-9 (range for all residents 1-15, mean = 7.72). 75% of all residents averaged < 7.5 hours of sleep on weekdays and 24% felt rested after only 6-7.5 hours of sleep. ~50% of interns agreed/strongly agreed - "sleep loss/fatigue have a major impact on my personal life" and 41% agreed/strongly agreed these factors "have a major impact on my work." Conclusions: Three fourths of all interns in our survey were not getting the recommended amount of sleep (~8 hours/night) before residency began. More than 1/4 of all residents had ESS scores outside the range of normal, suggesting a significant proportion have an inadequate amount of sleep prior to residency training and may be at risk for a variety of conditions related to fatigue. Future efforts need to focus on identifying when these habits develop and helping residents develop priorities for sleep during off duty hours.

Platform Presentation 2

RESIDENT SIGN-OUT PRACTICES: RESULTS FROM A MULTI-SITE NEEDS ASSESSMENT

Amy J. Starmer, MD, MPH, Children's Hospital Boston, Boston, MA, Nancy Spector, MD, St. Christopher's Hospital For Children, Philadelphia, PA, Christopher P. Landrigan, MD, MPH, Theodore Sectish, MD, Children's Hospital Boston, Boston, MA, Maitreya Coffey, MD, Hospital for Sick Children, Toronto, Ontario, Canada, F.S. Cole, MD, Washington University in St. Louis, St. Louis, MO, Jennifer Hepps, MD, National Capital Consortium, Bethesda, MD, Madelyn Kahana, MD, Lucile Packard Children's Hospital at Stanford, Palo Alto, CA, Jennifer O'Toole, MD, Cincinnati Children's Medical

- *Center, Cincinnati, OH, Glen Rosenbluth, MD, University of California, San Francisco, San Francisco, CA, Adam*
- *Stevenson, MD, James F. Bale, MD, University of Utah, Salt Lake City, UT*
- Background: Transitions in care are a potential source of communication failure. Limited data exist on current practices for handoffs (“sign-outs”) in pediatric residency training programs. Objective: To determine current practices for resident handoffs at nine pediatric residency training programs. Design/Methods: As part of a multi-site initiative to improve resident handoffs, semi-structured focus groups were conducted at nine pediatric training programs to determine current practices. Residents and Program Directors identified the structure and content of resident handoffs as well as environmental factors and current handoff curricula. Results: Nine focus groups were conducted (n=85 participants). “Sign-out” was the most common term used for the handoff process. Very few sites routinely had attending physicians or faculty present at handoffs of care, and only 2 of 9 sites (22%) had multiple team members present. Most (5/9; 55%) used a standardized written handoff tool that auto-imported patient information from the electronic medical record, but only one program used a standard verbal mnemonic to facilitate verbal handoffs. All written handoff tools displayed patient name and diagnosis, but other medical and demographic elements were variable among sites. Only two programs (22%) had protected time to perform handoffs of care, and most conducted handoffs in common spaces, such as resident workrooms or lounges. While some programs devoted time during intern orientation to teach handoffs, no program had a formal curriculum to teach residents best practices for verbal and written handoff skills. Conclusions: Residents receive limited training in handoffs. Handoffs occur in environments prone to distraction and interruption with little attending supervision. Pediatric residency programs will benefit from implementation of a formal handoff curriculum that trains residents in the best methods of safe and effective transitions of care.

Platform Presentation 3

IMPROVING TIMELINESS OF HEPATITIS B VACCINE ADMINISTRATION FOR NEWBORNS

Erin M. Bailey, MD, Jennifer A. Hudson, MD, Kerry K. Sease, MD, Greenville Hospital System/USC School of Medicine, Greenville, SC

BACKGROUND: Early administration of the initial dose of hepatitis B vaccine is associated with reduced perinatal transmission of hepatitis B as well as with higher rates of completion of all primary vaccine series. **OBJECTIVE:** To vaccinate all infants (with parental consent) on our Mother-Baby Unit against hepatitis B virus within 12 hours of delivery, using the PDSA method for quality improvement over the course of one year. **METHODS:** Chart reviews, in groups of 200 patients, were performed periodically between March 2009 and March 2010 to determine baseline levels of early vaccine administration and then effectiveness of PDSA cycle interventions. The first intervention implemented was a standardized order set calling for immunization of all infants within 12 hours of birth, after parental consent. Subsequent interventions involved meetings with nursing staff to educate regarding the importance of early vaccination, to identify and remove perceived barriers for obtaining parental consent, and to identify the best individual to assume responsibility for obtaining consent and administering the vaccine. **RESULTS:** On initial chart review, prior to interventions, 52.5% of newborns received the vaccine within 12 hours of delivery. Once a standardized order set was in place, 65.5% were immunized within 12 hours. Following nursing education and removal of additional perceived barriers, 74% of infants were vaccinated within 12 hours of birth. After formal chart reviews were completed, this initiative was added to the Mother-Baby unit’s “quality scorecard.” Chart reviews by nursing staff in July, August, and September of 2010 documented 90-93% early vaccination rates. Statistical analysis using Fisher’s exact test revealed a p value <0.0001. **CONCLUSIONS:** We found that a standardized order set alone did not ensure timely vaccine administration. Education of the nursing staff, however, resulted in further improvement in timely vaccination rates. Turning the project into a sustainable quality initiative by adding it to the unit’s “quality scorecard” led to additional marked improvement in early vaccination of newborns.

Platform Presentation 4

PEDIATRIC MILESTONES: INITIAL EVIDENCE FOR USE AS LEARNER-CENTERED ROADMAPS

Daniel J. Schumacher, MD, Kadriye O. Lewis, EdD, Cincinnati Children’s Hospital Medical Center, Cincinnati, OH, Ann E. Burke, MD, Wright State University, Dayton, OH, Patricia J. Hicks, MD, Children’s Hospital of Philadelphia, Philadelphia, PA, Susan Guralnick, MD, Winthrop University Hospital, Mineola, NY, Robert Englander, MD, MPH, University of Connecticut, Hartford, CT, Bradley J. Benson, MD, University of Minnesota, Minneapolis, MN, Carol L. Carraccio, MD, MA, University of Maryland, Baltimore, MD

BACKGROUND: The Milestone Project is a national initiative to redefine the Accreditation Council for Graduate Medical Education competencies in the context of specialties and set performance standards by training level. The Pediatrics Milestones focus on a synthesis of relevant literature (background) and a series of behavioral descriptors of development along the educational continuum (developmental milestones, DM). Cognitive interviews (CI) were used as a method to study the way residents understand, process, and respond to the Milestones. **OBJECTIVE:** Identify threats to and support for the use of Milestones among PL2s and PL3s. **METHODS:** 16 CI were conducted with one Milestone, chosen for range of complexity and length, from each of 4 core competencies (clinical reasoning, handovers, self-directed learning, and supervision), each representing a different primary author. CI were conducted with 2 PL2s and 2 PL3s for each Milestone, using a protocol of think aloud questions and verbal probes. CI were transcribed and coded using a modified QAS-99 and successive rounds of inductive (focusing on clarity, knowledge, and attitudes) and deductive methods. **RESULTS:** Participants offered specific comments to ensure clarity, including mixed thoughts on the use of education/new terms in backgrounds and support for use of examples in backgrounds and bolding in DM. All participants were able to summarize the backgrounds and DM well in their own words, citing personal experiences. They identified the developmental progression of the Milestones in themselves and others, noting the importance of experience in development. Demonstrating deep understanding, some participants

felt DM were context dependent, had elements that may not develop together, and represented a continuum rather than discrete categories. Finally, most thought the DM served as learning roadmaps, but could not replace specific feedback from supervisors. CONCLUSIONS: While offering comments for improving future iterations of Milestones, all participants demonstrated sufficient, often deep, understanding of the Milestones studied, supporting their use among PL2s and PL3s.

9:00 – 10:35am	<p>APPD Awards, History and Annual Reports Grand Ballroom</p> <p>9:00-9:10 Welcome/Brief Overview: <i>Ann Burke, MD, APPD President</i> 9:10-9:40 APPD History - The First 25 Years: <i>Kenneth Roberts, MD</i> 9:40-10:10 Award Presentations (Holm, Tunnessen, Berkowitz): <i>Susan Guralnick, MD, APPD Immediate Past President; Carol Berkowitz, MD</i> 10:10-10:15 Election Results/Farewell to Leaders: <i>Susan Guralnick, MD, APPD Immediate Past President; Ann Burke, MD, APPD President</i> 10:15-10:20 Special Projects: <i>Javier Gonzalez del Rey, MD, APPD Chair, Council of Task Force Chairs</i> 10:20-10:25 Finance Report: <i>Adam Pallant, MD, APPD Treasurer</i> 10:25-10:35 Introduction of Task Force Chairs: <i>Ann Burke, MD, APPD President</i></p>										
10:35 – 10:45am	<p>Break Grand Ballroom Foyer</p>										
10:45am – 12:00pm	<p>Task Force Meetings (open to all interested attendees) <i>see page 4 for details</i></p> <table border="0" style="width: 100%;"> <tr> <td style="width: 70%;">Curriculum</td> <td style="text-align: right;">Chopin Ballroom</td> </tr> <tr> <td>Evaluation</td> <td style="text-align: right;">Trade Room</td> </tr> <tr> <td>Faculty Development</td> <td style="text-align: right;">Sevilla</td> </tr> <tr> <td>Learning Technology</td> <td style="text-align: right;">Sandringham/Windsor</td> </tr> <tr> <td>Research</td> <td style="text-align: right;">Balmoral</td> </tr> </table>	Curriculum	Chopin Ballroom	Evaluation	Trade Room	Faculty Development	Sevilla	Learning Technology	Sandringham/Windsor	Research	Balmoral
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	<p>Coordinators' Task Force Meetings (open to all interested attendees)</p> <table border="0" style="width: 100%;"> <tr> <td style="width: 70%;">Management/Supervision</td> <td style="text-align: right;">Tuttle</td> </tr> <tr> <td>Professional Development</td> <td style="text-align: right;">Flagler</td> </tr> <tr> <td>Tools</td> <td style="text-align: right;">Gusman</td> </tr> </table>	Management/Supervision	Tuttle	Professional Development	Flagler	Tools	Gusman				
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Tools	Gusman										
12:00 – 1:15pm	Lunch on Own										
1:15 – 2:30pm	<p>Innovation Presentations/Q&A Grand Ballroom</p> <p>American Board of Pediatrics (ABP): <i>Gail McGuinness, MD, Executive Vice President</i> Pediatric Review Committee (RC): <i>Joseph Gilhooly, MD, Incoming Chair</i> Introduction of IIPE/LEARN/Milestones: <i>Ann Burke, MD</i> Initiative for Innovation in Pediatrics (IIPE): <i>Carol Carraccio, MD, IIPE Director</i> APPD LEARN: <i>Hilary Haftel, MD, Director of LEARN (Longitudinal Education Assessment Research Network)</i> Pediatric Milestones: <i>Susan Guralnick, MD</i> Pilot Project for APPD LEARN: <i>Patricia Hicks, MD and Robert McGregor, MD</i> Q&A: <i>Ann Burke, MD (moderator)</i></p>										

2:30 – 3:45pm

Key Stakeholders in Education

Grand Ballroom

American Academy of Pediatrics (AAP): *Robert Perelman, MD*

AAP Section on Medical Students, Residents and Fellowship Trainees (SOMSRFT): *Sarosh “Shawn” Batlivala, MD*

Association of Medical School Pediatric Department Chairs (AMSPDC): *Bonita Stanton, MD*

Academic Pediatric Association (APA): *Janet Serwint, MD*

Federation of Pediatric Organizations (FOPO): *Theodore Sectish, MD*

Council on Medical Student Education in Pediatrics (COMSEP): *Jerold C. Woodhead, MD*

Council of Pediatric Subspecialties (CoPS): *James Bale, MD*

Medicine-Pediatrics Program Directors Association (MPPDA): *Alex Djuricich, MD*

Q&A: *Adam Pallant, MD* (moderator)

3:30 – 5:30pm

Coordinators' Workshops

Chopin Ballroom

3:30 - 4:30

THE RESILIENT PROGRAM COORDINATOR

Teresa D. Flournoy, BGS, Children's Mercy Hospitals and Clinics, Kansas City, MO

Coordinating fellowships and residency programs requires an enormous amount of flexibility and the ability to manage many competing demands. “The Resilient Program Coordinator” will enable Program and Fellowship coordinators to learn about resilience. Coordinators participating in the workshop will be able to define resilience and expound upon the various components that make up the resilient coordinator. Participants will be able to identify limiting behaviors that might be inhibiting their ability to be resilient. Once identified, participants will learn ways to limit the interference of negative behaviors and develop skills to improve their resiliency. The coordinator will be able to use these skills to increase their ability to manage the multiple daily priorities they face. This will promote their ability to accomplish their personal and professional goals.

4:30 - 5:30

RECRUITMENT SUCCESS: MORE THAN MATCH RESULTS

Ambrosya Amlong, BA, University of Iowa, Iowa City, IA

Participants of this workshop will be given an overview of one institution's recruitment process, then break out into small groups to share recruitment ideas, finally coming back together to share ideas with the whole. This workshop will allow attendees to see one program's approach to improving recruitment satisfaction. The desire for improvement did not arise from poor match results, as the program had an unprecedented year in the match, but rather a coordinator's goal to be better tomorrow than we were yesterday. The improvement process started with a pediatric intern focus group and evolved to include all levels of pediatric residents. Results of this focus group were shared with members of the Graduate Medical Education Office, who expressed a desire to expand exploration beyond just pediatric residents. A GME representative, the pediatric residency coordinator, the internal medicine residency coordinator, College of Medicine representatives and Information Management representatives conducted a focus group with fourth year medical students interested in various specialties to determine what is typically looked for in a recruitment package. From this a comprehensive overhaul of the pediatric residency website, as well as our approach to recruitment changed. A permanent resident recruitment committee was formed, with the pediatric program coordinator and 8 pediatric residents providing input and decision-making regarding the entire recruitment process. A variety of strategies are employed to persuade applicants that the University of Iowa is not in the middle of a corn field, but rather, a thriving academic medical center providing exceptional education in a diverse community. The residents have taken ownership of recruiting excellent colleagues, instead of the program coordinator making decisions unilaterally. Some of the fresh and innovative ideas provided by this work group have been used for the basis of an institution wide template for all residency and fellowship programs to utilize. Participants will leave this workshop with concrete ideas that can be implemented in their own program.

3:45 – 5:30pm

Mentoring Session (for physicians)
Keith Mann, MD and Nancy Spector, MD
Bayfront Ballroom

The mentoring session will occur in 2 parts. The first 45 minutes will be an OPEN session focusing on Skill Development for Mentors. The last hour will be an opportunity for existing mentor - mentee dyads and peer facilitated groups to meet in person.

3:45-4:30

Skill Development for Mentors- OPEN to all

4:30-5:30

Existing peer facilitated groups/dyads meet together

4:30 – 6:00pm

Be Not Afraid: Educational Research and your friendly neighborhood IRB
Hilary Haftel, MD and Heather McPhillips, MD

Concourse 1

This workshop will provide an opportunity for anyone interested in educational research to learn about the role of your Institutional Review Board in educational research. Different IRB classifications and strategies for submission will be discussed for local investigator initiated research, as well as collaborative research projects, such as those which will be facilitated through APPD LEARN (Longitudinal Educational Assessment and Research Network). The workshop will include an interactive venue for anyone, at any level, to learn how not to be afraid of the big bad IRB. Come and join us!

6:30pm

Coordinators' Social

Please join your fellow coordinators for dinner at a nearby restaurant (separate arrangements).

SATURDAY, APRIL 2

6:30am

Registration
Mezzanine

7:00 – 8:30am

Regional Breakfast Meetings

(Please note that several programs have crossed state boundaries and participate in a different region than the one designated below for their state.)

Mid-America

Western PA, OH, WV, KY, IN, MI

Raphael/Michelangelo

Mid-Atlantic

Southern NJ, Eastern PA, DE, MD, Washington DC

Flagler

Midwest

IL, WI, MN, IA, MO, KS, NE, OK

Isles

New England

ME, NH, MA, CT, VT, RI

Balmoral

New York

NY, Northern NJ

Escorial/Alhambra

Southeast

VA, NC, SC, GA, FL, AL, MS, LA, AR, TN

Bayfront B

Southwest

TX

Gusman

Western

CA, NV, OR, WA, AK, CO, NM, UT, AZ, HI

Concourse 2

• 8:45 – 10:15am Workshop Session I for Physicians

• Workshop 1

Tuttle/Dupont

• **SAVE THE PATIENTS! STOP THE CITATIONS! EMPOWERING RESIDENTS THROUGH EXPERIENTIAL LEARNING IN SYSTEMS ERROR**

• *Robyn J. Blair, MD, Stony Brook University, Stony Brook, NY, Susan Guralnick, MD, Winthrop University Hospital, Mineola, NY, Loren Murphy, MD, Stony Brook University, Stony Brook, NY*

• Citations are the bane of a residency program's existence. Patient care error clearly has a very serious impact in the hospital world. Recognition that patient care errors are most often the result of a systems problem, more than individual practice, is a relatively new and important concept if we are to improve health care quality and patient safety. At Stony Brook University we recognized that our pediatric training program could use the resident curriculum to attack both problems at once, preventing a citation in the area of systems-based practice/systems error experiential learning while improving systems in patient care. In this workshop we will present our quality improvement approach to teaching systems-based error analysis and intervention. This practice has now moved beyond the residency program into the department of pediatrics and is becoming incorporated throughout the institution. Prior to this interactive session each participant will be asked to come to the workshop prepared to discuss a case in which a patient care error occurred. The session will begin with a short presentation about the Vanderbilt Healthcare Matrix, a systems-based and competency-based approach to analyzing error and creating systems-based action plans for error prevention. The session leaders, one of whom is a pediatric resident, will discuss how this practice was implemented including outcomes and barriers. In small groups the participants will analyze a case utilizing the Vanderbilt Healthcare Matrix, and develop an action plan for preventing future similar error. The large group will reconvene, and one or two of the small groups will present the outcomes of their analysis and action plans. The leaders will facilitate a discussion of how this method of systems-based analysis and quality improvement can be applied at their home institutions, what barriers they will face, and how these might be overcome. Participants will leave the session with a didactic session for use at their institution, post-workshop evaluation materials, and a useful validated tool for experiential learning in systems-based error.

• Workshop 2

Windsor

• **ACCULTURATION OF INTERNATIONAL MEDICAL GRADUATES**

• *Ernie Guzman, MD, White Memorial Medical Center - Pediatric Residency, Los Angeles, CA, Ashweena Gonuguntla, MD, MSU Pediatric Residency Program, Lansing, MI, Auxford Burks, MD, Albert Einstein Coll of Med, Jacobi Med Ctr, Bronx, NY*

• Acculturation of International Medical Graduates. International Medical Graduates (IMGs) without US citizenship made up 25% of the applicant pool in 2009. This number has been rising from year to year for some time. The number of non-US IMG applicants is expected to continue to rise in the years to come, particularly in the eastern seaboard residency programs. This workshop is intended to highlight the many facets of acclimatization the IMG needs to engage in order to adjust to language, traditions, rules and regulations in the US which can be quite different from medical education in their various home countries. Central to this workshop is a presentation by the Dr. Gerald Whelan, from the Educational Commission for Foreign Graduates (ECFMG) who will be discussing their Acculturation Program. Their web-based program is designed to assist IMGs with the transition to working and living in the United States. As part of this program, the ECFMG is developing a spectrum of resources designed to help IMGs as they learn about the U.S. medical system in which they will be learning and training during their GME and about living in the United States. Many residency programs may be opening their doors to the IMG applicant or have newer program directors. Even the most experienced program directors may learn about new resources they may have not been aware of previously. Participants can share their individual experiences and their best practices for all to gain from.

• Workshop 3

Sevilla

• **"AND THE SURVEY SAYS..." DESIGNING AND COLLECTING SURVEYS TO OPTIMIZE PROGRAM OUTCOMES**

• *Timothy W. Kelly, MD, Daniel C. West, MD, University of California, San Francisco, San Francisco, CA*

• Surveys are likely familiar to us (from the iconic Family Feud game show, for instance) and may appear deceptively easy to construct. In graduate medical education, surveys are an increasingly important quality improvement tool to enhance curriculum, improve residency recruitment, or identify strengths and weaknesses in virtually ANY program element. In fact, a well executed survey can yield specific, reliable and valid data that can inform a meaningful action plan for any QI project. In addition, a data-driven, evidenced-based approach to optimizing our own educational programs intuitively makes sense as we embody the ACGME Competencies. And yet, formal training in survey design is rarely part of the background of individuals responsible for program management. Optimal survey design can be challenging as there are numerous common pitfalls that can be encountered, yielding data that may not be valid, reliable or even useful. This workshop will give participants the basic tools needed to create more useful surveys for a myriad of program needs. The workshop will be in several parts. Initially, participants will receive instruction as a group on concepts (brief introduction to validity and reliability as it relates to survey design and collection) and skills (question formulation, response scales, and data collection methods). This will be followed by a small group activity where participants will practice using these tools and a survey design worksheet to make design improvements on a survey of their own making. The workshop will end with a large group session to discuss challenges encountered during the small group activity and identify potential solutions. Participants will leave the workshop with a basic understanding of optimal survey design, a worksheet that provides a step-by-step guide to developing surveys, and an improved version of their own survey. All workshop attendees will also be encouraged to participate in a

pre-conference survey that will itself be analyzed by the group during the session and serve as an example of the concepts, methods and skills taught during this workshop.

Workshop 4

Sandringham

THE CRITICALLY ILL CHILD: PALLIATIVE CARE, STAFF CARE, AND SELF CARE IN THE 21ST CENTURY

Colette Mull, MD, Evan Weiner, MD, Sabina Singh, MD, Christopher Haines, DO, Emily Nichols, MD, Arun Chopra, MD, St. Christopher's Hospital for Children, Philadelphia, PA

Currently, residency and fellowship programs have at least one token didactic on How to Break Bad News to the parent or guardian of a deceased child. There is typically little or no teaching provided on interacting with the parents of a critically ill child, custom designing our interactions to the family's culture, spiritual beliefs, and level of education, or how to introduce the concept of palliative care to a family. Similarly, there is little purposeful training on how physicians can care for themselves and their staff in the setting of a patient's critical illness or death. Using small group role playing of assigned scenarios, a checklist evaluation tool (CET), and large group discussions, workshop leaders and small group facilitators will provide evidence-based, interactive, education on 1) laying a socio-behavioral framework in which a physician-family dialogue can thrive, 2) communication skills needed to have difficult conversations with family in a culturally, spiritually-sensitive, compassionate, and accessible manner, 3) introducing parents and staff to the option of palliative care, 4) identifying short- and long-term self care tools for oneself and one's medical team as a way of promoting wellness and career longevity. Workshop leaders and facilitators will model debriefing techniques for each small group role play. Prior to the close of the workshop, each small group will have the opportunity to incorporate lessons learned in a repeat role play of their originally assigned scenario in front of the other small groups. Pre- and post-workshop CET results will be compared and discussed. A comprehensive resource list for trainees and training program directors will be provided to workshop participants.

Workshop 5

Trade

GLOBAL HEALTH TRAINING IN RESIDENCY PROGRAMS TODAY, PART I: CREATING A FOUNDATION UTILIZING CURRENT BEST PRACTICES

Sabrina M. Wagner, MD, University of Wisconsin School of Medicine, Madison, WI, Cliff M. O'Callahan, MD, PhD, Middlesex Hospital/AAP, Middletown, CT, Charles J. Schubert, MD, Cincinnati Children's Hospital, Cincinnati, OH, Cynthia Howard, MD, MPHTM, University of Minnesota, Minneapolis, MN, Suzinne Pak-Gorstein, MD, PhD, MPH, University of Washington, Seattle, WA

This workshop offers residency program leaders the opportunity to understand and utilize current best practices in global health education. The workshop will be led by directors of pediatric global health tracks, creators of a new and innovative set of interactive global health modules, and leadership from within the AAP Section on International Child Health. The workshop can serve as a stand-alone workshop or may be paired with workshop #700 "Global Health Training in Residency Programs Today, Part II: Overcoming Hoops and Hurdles When Developing High Quality Global Health Experiences for Trainees." The workshop will review current best practices in global health curriculum building and will introduce to participants a series of interactive web-based teaching modules designed to support competency-based global health training. The modules are aimed at broadening resident perspectives on the social determinants of health, introducing them to standards of clinical care in developing countries, and preparing them to care and advocate for underserved children in the US and abroad. These modules will be used in the workshop to engage participants in a formative process of building effective GH programs within a residency, including curriculum development and preparation for offsite rotations. The workshop begins with a demonstration of the new on-line modules with a short didactic session. Participants will then split into groups. Group 1 will target programs in the nascent stages of developing GH education by sharing best practices and resources for future program development including the AAP GH Toolkit currently under development and discussing how the modules and other elements of global health education can be integrated into a residency curriculum. Group 2 will target those from more established GH programs and use small group exercises to explore in-depth curriculum development, evaluation techniques and solutions to unique issues encountered by each program.

Workshop 6

Chopin Ballroom

HOW TO BECOME A BLOCKHEAD: A PRACTICAL APPROACH TO MOVING FROM NOON CONFERENCE TO BLOCK CONFERENCES FOR PEDIATRIC RESIDENCIES

Benjamin D. Hoffman, MD, University of New Mexico, Albuquerque, NM, John G. Frohna, MD, MPH, Lindsay M. Geier, MD, University of Wisconsin, Madison, WI, Amy O. Staples, MD, Walter N. Dehority, MD, Emily Macdonald, DO, University of New Mexico, Albuquerque, NM, Melissa A. Cercone, MD, Jeff Yaeger, MD, University of Wisconsin, Madison, WI

The Pediatric Residency Review Committee mandates that all programs have "regularly scheduled didactic sessions." The traditional model for most programs is to present the core pediatric topics in a 1-hour daily conference, held generally over the lunch hour. While this model has predominated for many years, recent changes in residency training, including limits on duty hours and the increased emphasis on education over service have led to a change in paradigm. Several pediatric residency programs have changed from daily conferences to a protected weekly block of time. This engaging workshop will utilize interactive and hands-on small group activities to share the experiences of programs that have recently made the transition to block conferences. Topics for discussion will include: 1) Building the capacity for change: who must be involved, what factors must be considered, and how to assess potential risks and benefits. 2) Identifying and addressing barriers to

- implementation, including patient care coverage, curriculum development, and faculty resistance. 3) Sharing tips for success from two programs that have made the transition with very positive outcomes. 4) Discussing evaluation opportunities at both the program and individual resident levels. The workshop leaders will also share specific examples about scheduling block sessions and designing the overall curriculum. Participants will receive sample curricula and evaluation tools.

Workshop 7

Concourse 1

THE “MACGYVER” APPROACH--TEACHING ACGME REQUIRED PROCEDURES WITH MINIMAL TO ROBUST BUDGET, MODERATE TIME, AND UNCOMMON INGENUITY

Brian E. Wagers, MD, Daniel Schumacher, MD, Mia Mallory, MD, Carolyn Holland, MD, Ryan Baker, MD, Cincinnati Children’s Hospital Medical Center, Cincinnati, OH

Have you ever experienced the following scenario? You are working in a busy pediatric ward/emergency department/clinic when a patient requires what you believe is a simple procedure such as a lumbar puncture, an IV placement, a bladder catheterization, or even more advanced skills such as intubation or suturing. Thinking this should be a slam dunk for your residents you call one over and ask them to perform the procedure, only to be met with an apprehensive look and a nod of the head. Sensing the discomfort in your resident, you ask them if they are comfortable with performing this procedure. They refreshingly admit that they are not comfortable because they have not had much opportunity to perform this procedure. Later in your office, as you reflect on this encounter, you daydream about how you could improve your residents’ proficiency and comfort level with performing ACGME required procedures. You wish that you had some sort of a clinical skills lab where you could have your residents practice and perfect these skills in low stress environments so that they would have the necessary confidence when faced with this situation. During our workshop, you will learn both high fidelity, robust budget and low fidelity, minimal budget ways to set up your clinical skills lab and other strategies to improve the performance and competence of your residents for several ACGME required pediatric procedures. We will also give several resources to attendees that they can take back to their programs to implement clinical skills labs regardless of their budgetary and time restraints. Our workshop will even equip you with the knowledge to build your own task trainers in a few minutes! Whether you have the ability to spend thousands of dollars on task trainers or fifty dollars at the local hardware store, you will leave our workshop with the necessary blueprints to start and maintain a clinical skills lab that will engage your residents and improve their performances on routine pediatric procedures!

Workshop 8

Bayfront A

SO MUCH MORE THAN JUST THE NUMBERS! UTILIZING EFFECTIVE TEACHING METHODS IN THE CONTINUITY CLINIC SETTING

Cynthia L. Ferrell, MD, MEd, Oregon Health & Science University, Portland, OR, Sharon K. Riesen, MD, Loma Linda University, Loma Linda, CA, Diane Kittredge, MD, Dartmouth Medical School, Lebanon, NH, Lynn C. Garfunkel, MD, University of Rochester, Rochester, NY, Janet R. Serwint, MD, Johns Hopkins University, Baltimore, MD

At the heart of the continuity clinic experience is the development of resident competence in longitudinal care of both healthy children and those with chronic conditions. Resident knowledge and skill are optimized when provided with structured learning experiences, direct observation, and preceptor feedback while caring for patients. This workshop will be a lively, interactive introduction into three areas of teaching and learning in continuity clinic: didactics, clinical teaching, and direct observation with feedback. Best educational practices will be shared and participants will begin the process to implement innovative teaching methods in their continuity clinic. A systematic review of data on educational methods in the ambulatory setting will be presented. To follow will be a review of curricular options for the didactic continuity conference. Available material, common sense approaches for programs of various sizes and resources, and decision-making about content and implementation of the didactic curriculum will be discussed. Participants will discuss implementing a number of clinical teaching methodologies including SNAPPS, the One-Minute Preceptor, and professorial questions to enhance the clinical decision making skills of residents. Lastly, the groups will experiment with direct observation methods for use in the continuity setting. The longitudinal nature of the continuity clinic experience makes it a unique opportunity to teach at multiple levels with individual residents over time. Participants of this workshop will leave with a toolkit of possibilities for implementation at their home institution. Agenda 1. Introductions and goals - Didactic - 15 min 2. Systematic review of literature - Didactic - 15 min 3. The continuity conference - Didactic and small group - 30 min 4. BREAK - 15 min 5. Clinical teaching - small groups - 45 min 6. Direct observation - small groups - 45 min 7. Summary - 15 min

8:45am – 12:00pm	Coordinators’ Session
	Trianon
8:45-10:15	WHERE WERE YOU WHEN THE LIGHTS WENT OUT, WHAT HAPPENS IF I GET HIT BY A BUS, AND OTHER PROGRAM ALTERING EVENTS <i>Jeri L. Whitten, C-TAGME, West Virginia University, Charleston Division, Charleston, WV, Rosemary Munson, C-TAGME, Maine Medical Center, Portland, ME</i> The program coordinator faces a myriad of events daily which can impact his/her ability to perform the daily management of the program. However, there are program or life-altering events which can have a profoundly negative impact on

the program, such as major injury or death of a resident or faculty member, severe illness or injury of the program coordinator or program director, sudden departure of the program director or coordinator. This presentation will include several case scenarios of program-altering events and interactive discussion of solutions. The presentation will also provide discussion of the need for and tips for creating a program coordinator management manual to assure uninterrupted program function in case of serious negative events.

10:15-10:30

Break

10:30-11:15

Report from the Electronic Residency Application Service (ERAS)
Angelique Johnson, Manager of ERAS Training Programs

11:15-11:45

Information on the Educational Commission for Foreign Medical Graduates (ECFMG)

Deb Parsons, C-TAGME, Indiana University School of Medicine

10:15 – 10:30am

Break

Grand Ballroom Foyer

10:30am – 12:00pm

Workshop Session II for Physicians

Sevilla

Workshop 9

THE BUSINESS OF MEDICINE: HOW DO WE TEACH IT AND HOW DO WE TRACK OUR PROGRESS?

Joan Y. Meek, MD, MS, Nicole R. Bramwell, MD, MBA, Odett Stanley-Brown, MD, Nicole M. Fields, DO, MS, Elizabeth L. Tatum, MD, Orlando Health, Orlando FL

The competency of systems based practice is critical to success in the practice of medicine for both general pediatricians and pediatric subspecialists. The physician of the future must be able to navigate an increasingly complex health care system. This workshop will provide a brief overview of the curriculum which has been implemented in the pediatric residency program at Orlando Health and Arnold Palmer Hospital for Children. This curriculum incorporates principles of medicine into didactic resident conferences, daily family centered rounds, and in the continuity clinic and ambulatory pediatric rotations. Residents practice billing and coding scenarios, complete a check off list with specific objectives for aspects of practice management, including patient appointment templates, physician scheduling, patient registration, billing and coding, vaccine and supply ordering, nurse triage calls, staffing and human resource management, managed care and insurance plans, interpreting a financial statement, and facilitating patient referrals. Residents rotate in the role of physician office manager during their continuity clinic to manage patient flow, problem solve and resolve patient or staff complaints. In addition, a 3-week elective offers a “mini-MBA” exposure to residents who desire additional expertise. Participants will receive tools to use in implementing their own business of medicine curriculum. Workshop participants will work in small groups to inventory their own local faculty and institutional resources to develop a business curriculum and will devise activities which can be incorporated in their own programs. Opportunities to share ideas and collaborate with other programs will be facilitated.

Workshop 10

Trade

GLOBAL HEALTH TRAINING IN RESIDENCY PROGRAMS TODAY, PART II: OVERCOMING HOOPS AND HURDLES WHEN DEVELOPING HIGH QUALITY GLOBAL HEALTH EXPERIENCES FOR TRAINEES

Sabrina Wagner, MD, University of Wisconsin School of Medicine & Public, Madison, WI, Nicole E. St Clair, MD, Children’s Hospital of Wisconsin, Milwaukee, WI, Christiana M. Russ, MD, Boston Combined Residency Program, Boston, MA, Donna M. Staton, MD, MPH, American Academy of Pediatrics, Los Altos Hills, CA, Maneesh Batra MD, MPH, University of Washington - Seattle Children’s Hospital, Seattle, WA

The workshop can serve as a stand alone workshop or may be paired with workshop #634, Global Health Training in Residency Programs Today, Part I: Creating a Foundation Utilizing Current Best Practices. The workshop will be led by directors of pediatric global health tracks and leadership from within the AAP Section on International Child Health. The workshop will utilize a case-based approach with real examples from other programs to engage the participants in discussion about potential pitfalls (and solutions) in global health programs and rotations. Topics covered will include preparation, safety and evacuation insurance, legal issues and malpractice coverage, professionalism and communication, and partnership development. An expert panel will be available to assist the audience in developing potential solutions to their global health rotation dilemmas. Additionally, tables will be provided with a facilitator for small group discussion of frequently encountered scenarios. Given this small group format, the workshop will have the ability to be tailored to different groups within the audience. For those contemplating incorporating global health rotations into their residency program, the workshop will give a complete picture of the details involved in implementing a safe, ethically sound, and educationally valuable experience. For those with currently available global health rotations the workshop will provide a forum to address issues of concern or improve on their current practices. Participants will be provided with access to policies and procedures that are currently in use at various institutions with well-established global health elective rotations. These resources will be available to workshop participants for adaptation and use at their home institution.

- **Workshop 11** **Sandringham**
- **TEACHING QUALITY IMPROVEMENT AND SYSTEMS BASED PRACTICE WHILE IMPROVING PATIENT SAFETY USING A SYSTEMS IMPROVEMENT CONFERENCE**
- *Priya S. Garg, MD, Elisabeth Schainker, MD, MSc, Julia Aquino, MD, Elena Aragano, MD, Floating Hospital for Children at Tufts Medical Center, Boston, MA*
- Improving patient safety and quality of care is an important focus in our health care system but faculty, trainees, and health care providers have limited experience translating an event where a medical error or near miss occurred into a change in the system of care. ACGME and ABP have instituted requirements for competency in Practice-based Improvement, System-based Practice and Quality Improvement (QI) as a part of training and Maintenance of Certification. There is a need to develop ways to teach these skills and attitudes so faculty and trainees are prepared to effectively engage in improving the health care system in which they practice. At our institution, we have used Systems Improvement Conference (SIC) as a strategy to improve patient safety in our hospital and train residents, faculty and hospital staff in QI methods. These conferences are a multidisciplinary forum to discuss cases where a patient safety event occurred, teach how to analyze the root cause of an error and identify ways to change our system to prevent recurrence of the event. The case presentations and discussions are led by a resident who is mentored by pediatric hospitalists. Previous SICs have resulted in reduced delay in antibiotics and safer dosing of nephrotoxic drugs. During these conferences specific patient safety and QI methods such as patient safety walk rounds and PDSA cycles have been discussed. The workshop will begin with a brief explanation of the SIC method and how it has been used at our institution. The learners will participate in a simulated SIC. We will also teach participants how to mentor a trainee to present a SIC using this method. Finally, we will distribute vignettes of challenging scenarios we have encountered during our own SICs. In small groups, facilitators will help participants brainstorm strategies to address these scenarios and share with the larger group.

- **Workshop 12** **Concourse 1**
- **SURVIVING AND THRIVING WITHOUT 24-HOUR CALL: THE ART AND SCIENCE OF SCHEDULE RE-ENGINEERING**
- *Susan G. Mautone, MD, UMDNJ-New Jersey Medical School, Newark, NJ, Tina A. Leone, MD, University of California (San Diego), San Diego, CA, David Cennimo, MD, UMDNJ-New Jersey Medical School, Newark, NJ*
- Struggling with modification of your resident/fellow on-call schedules to achieve compliance with the ACGME's recently-published revised Common Program Requirements? The pediatric and combined internal medicine/pediatrics residency programs at UMDNJ-New Jersey Medical School and the neonatology fellowship program at UC-San Diego have essentially eliminated 24-hour call for all trainees since 2004 and 2007 respectively, while maintaining continuous full accreditation. Workshop leaders (a pediatric program director, a neonatology fellowship director and a 5th-year adult/pediatric infectious diseases fellow) will present a brief summary of the body of literature substantiating the negative effects of sleep deprivation on resident performance, and will review the European Working Time Directive implemented in 2004 as well as current ACGME duty hours regulations and the additional changes effective July 2011. In large group format, workshop participants will identify stakeholders in and barriers to change in resident work hours at their institutions, consider learning objectives and scheduling parameters central to the process, and propose venues through which consensus might be achieved. Workshop leaders will discuss their experience in re-engineering their program's on-call schedules, beginning with the re-design of the annual rotation master schedule and sharing insight into what has and hasn't worked well. Resident and fellow supervision, transitions of care, continuity of learning, and impact on patient outcomes and scholarly activity time will be discussed. Using templates provided by workshop leaders, participants will then work in small groups to develop on-call schedule options for various services, assuring compliance with the new ACGME duty hours regulations using 16 hours as the maximum shift length. Copies of coverage options developed during the workshop, as well as those utilized by the workshop leaders in their programs, will be provided to all participants.

- **Workshop 13** **Chopin Ballroom**
- **THERE'S AN APP FOR THAT**
- *Laura Haubner, MD, University of South Florida College of Medicine, Valerie Panzarino, MD, Sally Coover, Robert Nelson, MD, University of South Florida Health, Pediatrics Residency, Tampa, FL*
- Using a combination of video and real-time demonstrations, learners will become familiar with many capabilities of the Apple iPad in delivering curriculum execution for a residency program. Like many hand-held devices, the Apple iPad tablet provides mobile access to the Internet. It's larger size as compared to typical hand-held devices such as smart phones, however, makes it use more like that of a laptop with superior portability. Advantages of WiFi technology will be reviewed including, connection to university servers, email accessibility, access to search-able databases and one's own learning plans. In addition, access to both patient electronic health record and New Innovations for residency logging of procedures, logging of work duty hours, schedule and document review will be demonstrated. In addition, presenters will demonstrate the capabilities of iPad applications necessary to create and deliver an iPad-centered curriculum, using commercially available applications (apps). Presenters will then describe the process used to develop the iPad-centered curriculum at the University of South Florida College of Medicine. Lastly, resources for application development will be discussed including opportunities for collaborative development specific for medical education. The learners will then be divided into groups of 3-4 by table and will design a component of an iPad-centered curriculum. Each group will have an iPad available for hands on learning during this portion of the presentation. During the small groups sessions, brainstorming will be done to describe ideal applications for medical education. Finally, each group will present "dream" applications to the workshop participants so that collaboration of medical education applications can be explored.

Workshop 14

Windsor

DEVELOPING YOUR SCHOLARSHIP ROADMAP

Patricia J. Hicks, MD, The Children's Hospital of Philadelphia, Philadelphia, PA, Erin L. Giudice, MD, University of Maryland, Baltimore, MD, Aditee P. Narayan, MD, MPH, Duke University, Durham, NC, Janet Serwint, MD, Johns Hopkins, Baltimore, MD

Developing and producing scholarship is one of the most personally gratifying aspects of academic medicine and one which is rewarded by the promotional process. However, fellows and junior faculty are sometimes stalled in their progress and encounter barriers in developing successful scholarship. This workshop will empower participants to develop their individualized roadmap to scholarship. Initial group discussion will focus on the reasons to produce scholarship and the different types of scholarship: scholarship of discovery, integration, application and teaching. Participants will then reflect on their individual opportunities, complete their mind map of scholarship by identifying barriers and solutions for success. Participants will then discuss in a small group setting the project they would like to accomplish and strategies. A toolbox of approaches to common barriers, resources as to mentorship, collaboration, time management and funding will be shared and utilized by the individuals in the small groups. Individual participants will work to complete their roadmap along with a commitment for completion and facilitators will mail this back to them in a 3 month time period. Agenda: 1. Interactive session discussing attendee perspectives on scholarship-10 minutes 2. Didactic session of reasons to do scholarship and types of scholarship- 15 minutes 3. Personal reflection and completion of individual scholarship roadmap- 10 minutes 4. Group discussion of identified barriers and solutions- 45 minutes (Facilitators to implement toolbox during group discussions) 5. Review of Toolbox 20 minutes Group members to make personal commitment to scholarship project

Workshop 15

Bayfront A

MEASUREMENT TOOLS TO SUPPORT EDUCATIONAL INNOVATION AND LEARNER EVALUATION

Su-Ting T. Li, MD, MPH, UC Davis, Sacramento, CA, Daniel C. West, MD, UCSF, San Francisco, CA

How do you know that a resident is ready for practice without direct supervision? How do you know that the innovative program you developed is successful? Evaluating a trainee's clinical competence or an innovative educational program's efficacy is a significant challenge. This workshop is designed to help medical educators design tools to measure these important outcomes. The workshop will begin with interactive presentations on the purpose of measurement tools, with specific illustrative examples from medical education. The presenters will then describe the essential elements of validity and specific steps to ensure the creation of a valid measurement tool. Participants will work in facilitated small groups using a detailed planning worksheet to develop a plan to design their own valid measurement tool. The presenters will then discuss the elements of measurement theory as it relates to establishing reliability and outline specific steps to test the reliability of a measurement tool. In a large group format, participants will then discuss ways to test the reliability of their measurement tool in their home institution. At the conclusion of the workshop, participants will have a basic understanding of the elements of validity and reliability and have a plan for developing their own valid measurement tool and testing its reliability at their home institution. The workshop will close with a question/answer period, summary, and annotated bibliography of references that includes published examples of measurement tools from clinical research and education and books and articles that describe development of measurement tools. Participants should expect a very hands-on workshop requiring their active participation.

Workshop 16

Tuttle/Dupont

DELIBERATE PRACTICE AND MASTER COACHING: GUIDING NOVICE LEARNERS ON THE JOURNEY TOWARDS EXPERTISE

Satid Thammasitboon, MD, MHPE, West Virginia University, Morgantown, WV, William B. Cutrer, MD, MEd, Vanderbilt University, Nashville, TN, Teri Turner, MD, MPH, MEd, Danny Castro, DO, Geeta Singhal, MD, MEd, Baylor College of Medicine, Houston, TX, Mark Quirk, EdD, University of Massachusetts, Worcester, MA

Expert clinicians achieve exceptional performance via experiential learning over an extended period of time. Recent evidence in cognitive psychology, neuroscience and education reveals a new perspective on how one might achieve expertise via deliberate practice. To assure optimal knowledge and clinical skills acquisition in the current residency training environment, we propose learner instruction in deliberate practice augmented with master coaching as a mechanism to expedite the development of expertise. This interactive workshop utilizes a variety of teaching formats based on Kolb's learning cycle to provide educators with practical tools to help their resident learners. The workshop will begin with a role play that illustrates how experts use a blend of intuition (rapid, unconscious thinking) and metacognition (deliberate, conscious thinking) to solve clinical problems effectively. Participants will complete a self-assessment about their cognitive style preferences. A discussion will follow that outlines practical strategies to attain intuitive and metacognitive capabilities using interactive activities such as a jeopardy game and wonderlic testing. A case-based didactic session will address three critical elements of deliberate practice (ignition, deep practice and master coaching). An audience-response question and answer system will be used throughout the workshop to promote reflection and active participation. The workshop leaders will share applications for bedside teaching, morning report and curriculum development at their institutions. In small groups, participants will brainstorm about strategies to incorporate acquired knowledge into the existing clinical teaching. Finally, participants will develop action plans for bringing back knowledge to their institutions.

• 12:00 – 1:30pm	Lunch on Own	
•		
•	Council of Task Force Chairs (CoTFC) Luncheon	
•	Crandon	
•	Council of Regional Chairs (CoRC) Luncheon	
•	Godfrey	
• 1:30 – 3:00pm	Poster Session (see page 29 for poster/abstract details)	
•	Versailles	
• 3:00 – 4:00pm	Task Force Meetings Redux	
•	Curriculum	Escorial/Alhambra
•	Evaluation	Tuttle
•	Faculty Development	Flagler
•	Learning Technology	Dupont
•	Research	Gusman

• 3:00 – 5:00pm

Coordinators' Session

Trianon

3:00-3:30

Report from the American Academy of Pediatrics (AAP)

Charlette Nunnery, Manager, E-Learning Content

3:30-4:00

Update from the American Board of Pediatrics (ABP)

Lee Currin-Director Credentialing and Examination Administration

4:00-5:00

GME PROGRAM COORDINATOR/ADMINISTRATOR: IS IT A BIRD, IS IT A PLANE, IS IT A JOB OR A CAREER?

Kathryn M. Miller, BS, C-TAGME, Johns Hopkins University, Baltimore, MD;

Mark Malachesky, BA, Children's Hospital of Philadelphia, Philadelphia, PA

How long have you been a coordinator/administrator of a GME program? Weeks, months, years, decades even? How many of us said that when we grew up, this is what we wanted to be? How do we approach the responsibilities of our position?

Does it feel like just a job or a professional career with opportunities for growth and advancement? This presentation will address these questions and many others related to professional growth and development as well as career advancement in GME administration by soliciting real examples from your coordinator/administrator colleagues. Participants will be able to set goals and develop plans to obtain career objectives that most suit their personal and professional needs.

• SUNDAY, APRIL 3

• 7:00am

Registration

Mezzanine

• 7:30am – 3:00pm

Luggage Storage for Late Check-Out/Departure

Michelangelo

• 7:30am – 3:00pm

Forum for Chief Residents (see page 24 for session details)

Chopin Ballroom

• 8:00 – 9:00am

Wrap-up Session from Grassroots Forums / Continental Breakfast

Trianon

9:15 – 10:45am

Workshop Session III for Everyone

Workshop 17

Bayfront B

IF YOU BUILD IT, WILL THEY COME?

Melodie Allison, BS, C-TAGME, Baylor College of Medicine, Houston, TX, Dawn Barata, MS, University of Florida Jacksonville, Jacksonville, FL, Dawn Baye', MBA, UT Southwestern/Children's Medical Center, Dallas, TX, Cindy Gibson, C-TAGME, Miami Children's Hospital, Miami, FL, Jodi Graeber, C-TAGME, Michigan State University, Lansing, MI, Pat Jacobi, St. Louis Children's Hospital Washington University, St. Louis, MO

Recruitment has no "best practice". Programs have been required to become more and more creative as they face different and often very difficult challenges especially in the current economic era. Are the challenges programs face so different or do we just assume they are? The workshop team managers will explore recruitment challenges facing small, medium, large and mega programs based on their extensive recruitment experience along with survey "stats" that will be obtained. The target audience will then be asked to participate in a round table "team" discussion focused on a select recruitment challenge provided by the manager of their "home club". Teams will be divided into the following clubs: Small Programs - 25 residents or less Medium Programs - 26-50 Residents Large Programs - 51 to 100 Residents Mega Programs - More than 100 Residents Each team will summarize their "stats" then file a "scout" report back to the manager of their "home club". Open discussion will create many trades over the allotted period for negotiations. Following negotiations, each team will leave the field with many creative "plays" to try out during the next recruitment season. The manager of each home club will summarize what "best practice plays" were developed so they can be placed in the "Share Warehouse Hall of Fame".

Workshop 18

Bayfront A

DEVELOPING 21ST CENTURY CURRICULA FOR 21ST CENTURY LEARNERS: USING MULTIMEDIA MODULES TO TEACH ACGME COMPETENCIES

Amy E. Whittle, MD, Anda Kuo, MD, University of California San Francisco, San Francisco, CA

With increasing demands on learner and educator time such as the new reductions in resident work hours, medical education is faced with finding more and more innovative and efficient ways to meet mandated educational requirements and competencies, particularly Systems-Based Practice and Practice-Based Learning and Improvement. One way to meet these needs in an effective and time-efficient manner is by embedding opportunities for self-guided and self-directed learning via multimedia curricula. This workshop will explore techniques for using multimedia tools to translate traditional group lecture-style courses to ones that are on-demand, standardized and learner-driven. Workshop leaders will provide didactics on the key steps in creating such a curriculum as supported by the medical literature. Leaders will review the advantages, disadvantages, and data around effectiveness of such online curriculum. The leaders will use the University of California San Francisco pediatric residency program's Physicians in Community (PIC) rotation as an example of a course transitioned from a traditional month-long block to a learner-guided longitudinal experience. Leaders will demonstrate specific technology-based education tools in this curriculum such as interactive online (flash-based) presentations, self-directed audio walking tours, interactive quizzes, and electronic portfolio reflections. Participants will share ideas in a large group and workshop leaders will facilitate a discussion on the challenges and potential solutions when utilizing these educational formats.

Workshop 19

Concourse 2

HOW TO MAKE E-LEARNING SING (AND WORK) FOR YOUR TRAINEES!

Kadriye O. Lewis, EdD, Cincinnati Children's Hospital Medical Center, Cincinnati, OH, Cynthia L. Ferrell, MD, MEd, Oregon Health & Sciences University, Portland, OR, Teri L. Turner, MD, MPH, MEd, Baylor College of Medicine, Houston, TX, John D. Mahan, MD, Nationwide Children's Hospital/OSU, Columbus, OH

E-learning (E-L) will certainly come to define more of the learning environment in pediatric medical education (PME) in the next decade. E-L utilizes all forms of electronically supported learning and teaching methods in the computer and network-enabled transfer of skills and knowledge to the learner. E-L processes include Web-based learning, computer-based learning, virtual classrooms and digital collaboration, delivered via the Internet, audio or video tape, TV and CD-ROM. It can be self-paced or instructor-led and includes media in the form of text, image, animation, streaming video and audio. Newer E-L formats, such as E-Learning 2.0, have the potential to dramatically expand educational opportunities and choices for learners. Contrasted with conventional E-L systems, E-L 2.0 places increased emphasis on social learning and use of social software such as blogs, RSS (Really Simple Syndication), wikis, podcasts, virtual worlds, and Second Life. Thus, knowledge (as meaning and understanding) is ultimately socially derived and effective learning occurs through conversations, group activities and interactions. E-L applications in PME are varied and many faculty have limited familiarity with available methods and best practices for E-L. This workshop will help faculty understand and integrate E-L into their curriculum for medical students, residents and fellows. After review of key concepts and methods of E-L in medical education, a variety of practical applications will be presented. These will include examples of interactive web based learning sites (e.g., the Pediatric Nutrition Series and AAP Pedialink modules, the Cincinnati Children's Masters of Education program), and collaborative social learning methods (e.g., Twitter, Wiki, Second Life). Through a series of educational scenarios, participants in small groups will explore potential applications and challenges. Each group will present their work followed by a general discussion that summarizes conclusions. Finally attendees will be organized by themes of interest, allowing groups time to develop specific examples that could be implemented in their own institutions.

Workshop 20

PEDIATRICS MILESTONES 101: AN EDUCATOR'S GUIDE TO WHAT THEY ARE, WHAT THEY AREN'T AND WHAT THEY COULD BE

Bradley J. Benson, MD, University of Minnesota Med-Peds, Minneapolis, MN, Robert Englander, MD, MPH, Connecticut Children's Medical Center, Hartford, CT, Daniel J. Schumacher, MD, Cincinnati Children's Hospital Medical Center, Cincinnati, OH, Patricia J. Hicks, MD, The Children's Hospital of Philadelphia, Philadelphia, PA, Carol L. Carraccio, MD, MA, University of Maryland, Baltimore, MD

In 2009, the Accreditation Council for Graduate Medical Education (ACGME) and the American Board of Pediatrics (ABP) partnered to create the Pediatric Milestone Project. One of the goals of this project was to reframe the six competencies in the context of the specialty, identifying markers of achievement (milestones) along the path of residency training. In this workshop we will utilize multiple large and small group teaching techniques to engage the participants in a discussion of the Pediatrics Milestones Project and to demonstrate practical applications of the work. We will begin with a large group discussion with Audience Response System (ARS) to query participant knowledge and attitudes about the Pediatrics Milestones Project. A short presentation will then detail the history of the Project including the guiding principles, work processes, and work products to date. The presentation will address topics raised in the large group discussion. Thereafter, a trigger tape will be shown of a medical encounter involving a pediatric resident, and participant assessment of the resident performance will be solicited. We will then break into small groups to discuss impressions of the resident performance, and workshop leaders will facilitate the use of a specific Milestone document to assess where the resident is on the proposed developmental spectrum. Thereafter, we will engage in a large group discussion of how the Milestones could add value to the current assessment techniques used in participants' programs. We'll discuss the barriers to their adoption and use and ways of mitigating these barriers. We will finish with a brief overview of the next critical steps in this project which entail expert review and "field testing" with interested members of our pediatric medical education community.

Workshop 21

DOCTOR COACH: TEACHING CLINICAL SKILLS

Kimberly A. Gifford, MD, CHaD Residency, Lebanon, NH, Su-Ting T. Li, MD, MPH, University of California Davis, Sacramento, CA, Rebecca Blankenburg, MD, MPH, Stanford Pediatric Residency Program, Palo Alto, CA, Mark Vining, MD, University of Massachusetts Medical School, Worcester, MA

A coaching framework has been utilized by various professions as a method to teach and improve performance for many different types of skills. While the skills differ, the tasks that a coach performs to teach the skills are similar across disciplines. Doctor Coach is an innovative approach to teaching clinical skills in a resident-as-teacher or faculty development program. Doctor Coach is informed by successful strategies from the sports, art, business and psychological literature and frames the specific coaching tasks involved in clinical teaching within the context of a coach-learner relationship. Unlike many published teaching models which focus primarily on critical thinking skills or the teaching setting, Doctor Coach is based on fundamental coaching tasks, making it widely applicable to teaching all clinical skills in any setting. The Doctor Coach model emphasizes the development of lifelong learning skills through repeated cycles of assessment, feedback, goal setting and facilitated practice. Through this interactive workshop, participants will be introduced to the Doctor Coach curriculum and given primers and tools to better understand the individual coaching tasks. Participants will be introduced to the coaching tasks associated with each of these topics then attend a break out session to give them more in-depth practice with a particular coaching task of their own choosing. Each break out session will start with an interactive presentation that serves as a primer for the task. Each primer is coupled with a practical tool handout to help residents and faculty to translate and integrate the lessons into their clinical teaching practice and facilitate implementation with learners. Participants will then have the opportunity to practice the coaching task, and adapt it for use at their home institution. Finally, participants will create a plan to enhance their own teaching practice or resident-as-teacher program using Doctor Coach principles and will leave the workshop with a toolbox of primers and tools for all of the tasks ready for implementation.

Workshop 22

BRINGING THE PEDIATRICIAN TO THE COMMUNITY: A PRACTICAL GUIDE TO DEVELOPING AND STRENGTHENING A RESIDENT HOME VISIT PROGRAM

Megan M. Tschudy, MD, Johns Hopkins Pediatric Residency Program, Baltimore, MD, Suzinne Pak-Gorstein, MD, PhD, University of Washington Pediatric Residency Program, Seattle, WA, Janet R. Serwint, MD, Johns Hopkins Pediatric Residency Program, Baltimore, MD

Home visits are an archetypical form of family-centered care advocated by the American Academy of Pediatrics in its medical home model. Home visitation can be an excellent means to engage residents in ACGME core competency areas in a meaningful manner by addressing a wide array of concepts including: access to healthcare, environmental health and home safety, family dynamics, cultural/spiritual beliefs and practices, community networks, and the physician-patient relationship. Drawing on the experiences of two academic sites that have incorporated different strategies of home visitation, Johns Hopkins Children's Center in Baltimore, MD and Harborview Medical Center of the University of Washington in Seattle, WA, the workshop will outline home visitation goals, evaluations, challenges, and solutions. Breakout groups will engage in interactive exchange and problem-solving strategies by developing a novel resident home visit program tailored to the goals of their individual sites. Participants will walk through a process map for designing and/or improving their curriculum including: 1) Needs Assessment, 2) Program Planning, 3) Implementation, and 4) Evaluation. Components of these discussions will cover establishing program

goals, designing an educational curriculum, implementing evaluation tools, and creating a structure for sustainability. Practical issues will be discussed such as integrating home visits in resident individualized learning plans (ILPs) addressing community pediatrics, using a home visit program as a residency program recruitment tool, and fitting visits in a curriculum with the realities of restrictive work hours. An electronic format toolbox for developing a home visit program will be provided. Participants will be invited to join a list serve of those interested in home visitation programs to create a network for national collaboration. At the end of this workshop participants should be equipped to design and begin implementation of their own home visit program.

Workshop 23

Sandringham/Windsor

SOCIAL MEDIA AND MEDICAL PROFESSIONALISM: HOW I TWEETED MY WAY OUT OF PEDIATRICS

Michael P. McKenna, MD, Indiana University, Indianapolis, IN, Allison Brindle, MD, Rita Pappas, MD, Cleveland Clinic Children's Hospital, Cleveland, OH

Social media provides an excellent opportunity for pediatricians to network with other physicians, conduct scholarship and teach patients as well as learners. Unfortunately, it can also be an outlet for unprofessional behavior. In this workshop, attendees will debate whether medical professionals should be held to a higher standard on social networking sites and there will be a brief review of the current literature on use of social media by physicians as well as medical professionalism and social media. Participants will break into small groups and dissect cases of unprofessional behavior on social networking sites, including cyberstalking, inappropriate disclosure of patient information on social media, online 'friendships' with patients or their family members, use of discriminatory language on social networking sites and depiction of medical professionals using excessive alcohol or illicit substances. The small groups will then formulate strategies to target these specific infractions, including consequences for unprofessional behavior online and how to prevent these occurrences in the future. At the end of the session, the small groups will present their work to the larger group for discussion. Attendees will leave the session with ideas on how they can utilize social media in the education of pediatric residents. In addition, participants will develop tools they can take back to their institution to educate learners of all levels about unprofessional behavior on social media sites.

10:45 – 11:15am

Break / Late Check-Out from hotel

Please use this break to check out of your room. You may store your luggage in Michelangelo (2nd floor meeting room) for pick-up and departure after your final session. Luggage will be left at your own risk. APPD cannot assume responsibility for your belongings.

11:15am – 12:45pm

Workshop IV for Everyone

Workshop 24

Bayfront A

USING AN ELECTRONIC PORTFOLIO TO CREATE AN INDIVIDUAL DEVELOPMENT PLAN: THE NITTY GRITTY DETAILS

Lee R. Atkinson-McEvoy, MD, Glenn Rosenbluth, MD, UCSF, San Francisco, CA

The Individual Development Plan is a tool that is increasingly being used by mentors and program directors to help their learners identify and document learning goals and objectives, achievement of competencies, and for career development. This flexible tool can be used for students, residents, fellows and junior faculty. Electronic portfolios are an attractive tool to allow a single location to collect evidence of learner progress and they facilitate instantaneous sharing and feedback which can be done remotely allowing more expedient communication between learners and mentors or advisors. This workshop will review the implementation of an electronic portfolio tool used to create e-IDPs for medical students, residents and fellows. Workshop leaders will provide a short didactic session on the background and evidence supporting the use of portfolios in medical education. As part of that session examples of the e-IDP uses at the University of California San Francisco Pediatric Residency Training Program and Pediatric Subspecialty Fellowships Training Program will be reviewed. In addition, how content areas and criteria were established and evaluation of entries will be reviewed. The leaders will then guide group participants through a tool to establish a plan for creation of implementation of an e-IDP within their programs.

Workshop 25

Bayfront B

CURRICULUM TASK FORCE: INTERACTIVE SYMPOSIUM OF CURRICULAR TOOLS FOR TEACHING QUALITY AND SAFETY

Karin M. Hillenbrand, MD, East Carolina University / Pitt County Memorial Hosp, Greenville, NC, Rebecca L. Blankenburg, MD, Lucile Packard Children's Hospital, Stanford, Palo Alto, CA

Presentation 1: QI OLYMPICS: "QUALITY" TIME OUTSIDE THE HOSPITAL

Elizabeth R. Hanson, MD, Lee Atkinson-McEvoy, MD, Katie E. McPeak, MD, Glenn Rosenbluth, MD, University of California San Francisco, San Francisco, CA

Presentation 2: IT CAN BE DONE! ENGAGING PEDIATRIC RESIDENTS IN QUALITY AT THE "101" LEVEL

Paul M. Shore, MD, MS, Robert Bonner, MD, Celeste Chamberlain, BSN, MS, CPHQ, David Cooperberg, MD, Mackenzie Frost, MD, Cheryl Gebeline-Myers, BS, Bryon Lauer, MD, Matthew McDonald, MD, Robert McGregor, MD, St. Christopher's Hospital for Children, Philadelphia, PA

Presentation 3: FUSION OF CHILD ADVOCACY AND QUALITY IMPROVEMENT: A COMBINED CURRICULUM

Jerry G. Larrabee, MD, University of Vermont Pediatric Residency Program, Burlington, VT

- Presentation 4: A RESIDENT-LED MORBIDITY AND MORTALITY CONFERENCE IN THE PICU
- *Chen C. Kenyon, MD, Meredith van der Velden, MD, James Moses, MD, MPH, Boston Combined Residency Program, Boston, MA*

- Presentation 5: MASTERING HAND-OVER: A CURRICULUM FOR EFFECTIVE TRANSFER OF PATIENT INFORMATION
- *Melissa Held, MD, Edwin Zalneraitis, MD, University of Connecticut School of Medicine, Hartford, CT*

• Workshop 26

Trade Room

• HOW MUCH IS YOUR RESIDENCY WORTH?

• *Adam Pallant, MD, PhD, Tracey Wallace, Brown Medical School, Providence, RI*

• Resident trainees are generally the primary base of manpower that supports clinical service in academic hospitals. Resident labor and linked resources are evermore stretched in our current culture of increased regulation and shrinking duty hours. Despite their critical role in health care services, residency directors rarely have significant influence over budget, personnel, and support of their work force. Program Director s negotiations with hospital administration are often hampered by a lack of knowledge and detail regarding GME finances and flow of dollars around resident activities. This workshop will be lead by a team consisting of the Residency Director and the Administrative Director of Pediatric Operations of a busy, urban academic hospital. Participants in this workshop will learn how to model quantitative and qualitative evaluations of their training programs. Topics taught and dissected will include mechanisms to tease apart federal and state dollars that that flow to the hospital associated with their trainees. Additional factual and theoretical models will be introduced and discussed for supplementary methods to capture the value of financial, scholarly, and human resource benefits of residents in the context of a larger hospital complex. Upon completion of the workshop, attendees will be able to begin to create formulations to quantify and describe the value of their training program. This information in turn will support directors to prepare them for the now critical discussions that they face in negotiating for additional resources and support in a setting of increased demand with limited resources. Program directors will complete this workshop with an enhanced capacity to demonstrate the financial worth, intangible value, and potential replacement cost associated with their residency, permitting significantly enhanced negotiating capacity when seeking programmatic improvement.

• Workshop 27

Concourse 2

• PBLIPAD: UTILIZATION OF HANDHELD INFORMATION TECHNOLOGY IN RESIDENCY EDUCATION

• *Alexander M. Djuricich, MD, Indiana University Med-Peds, Indianapolis, IN, Bradley J. Benson, MD, University of Minnesota Med-Peds, Minneapolis, MN*

• The development and maintenance of competence in the use of information technology is vital in the modern practice of medicine and its role will only continue to expand and evolve. In recognition of this fact, the ACGME has mandated that our learners demonstrate competency in the following sub-domain of practice-based learning and improvement (PBLI): Using information technology to optimize patient care and learning. In this workshop we will review the literature on clinical and educational uses of handheld technologies with a focus on the iPad. The facilitators will highlight how the iPad has been integrated into two residency programs, with descriptions of its use for handoffs/sign-out, interactive small-group learning sessions, and traditional didactics; we will also summarize evaluations of iPad use by residents. We will then demonstrate the use of the iPad with the audience members, with a focus on applications useful for residents and preceptors in their education and clinical practice. One approach to facilitating just-in-time learning at the point of care will be highlighted. An Audience Response System (ARS) will be used to increase participation and to demonstrate the ARS functionality of the iPad. Participants will be given the opportunity to use iPads during this session.

• Workshop 28

Sevilla

• HUMANISM IN MEDICINE: FOSTERING THE EXPLICIT AND “UNHIDING” THE CURRICULUM

• *Janet Serwint, MD, Johns Hopkins University, Baltimore, MD, Ann Burke, MD, Wright State University, Dayton, OH*

• Humanism has been a key quality within medicine since Hippocrates. While professionalism has been identified as one of the core competencies, humanism is often considered within the professionalism framework. Jordan Cohen states that “Humanism provides the passion that animates authentic professionalism”. While many organizations and boards have professionalism statements and charters, few have explicitly expressed the distinction and importance of humanism. Further, many stakeholders feel medicine is too technology driven, impersonal, and lacks the appropriate attention to the human dynamics of illness and health. As educators, we must design creative strategies to permeate our medical culture and education with humanism. Humanism is of central and utmost importance for meaningful professionalism as a doctor. Being explicit with this topic will enhance and invigorate trainees’ habits in the humanism realm. This interactive workshop will explore the working definition of humanism within a theoretical framework via dyad reflection, followed by a brief literature review and subsequent small group discussions. After participants gain insight into habits of humanism that occur every day, group activities will occur. Review of videotapes of clinical encounters and discussion of the cases will stimulate more group discussion. Then, participants will review artwork, photography, and poems as they learn some unique strategies for incorporating humanism into their teaching and programs. Ideas and perspectives on self-care, personal nourishment and professional support will be demonstrated and strategies to teach these skills to trainees will be emphasized. With these activities, participants will have both the opportunity to reflect and explore their own ideas about humanism while simultaneously learning practical, take home techniques to teach

and practice humanism. This will thus enhance and bring to the forefront the humanistic abilities of their trainees. "Humanism is an affirmative philosophy...translated into a life devoted to one's improvement and the service of all mankind." Corliss Lamont

Workshop 29

Sandringham/Windsor

TEACHING LEARNERS HOW TO THINK, FEEL AND REFLECT: THE KEYS TO DEVELOPING PROFESSIONAL COMPETENCIES

Satid Thammasitboon, MD, MHPE, Linda Nield, MD, West Virginia University, Morgantown, WV, William Cutrer, MD, MEd, Vanderbilt University, Nashville, TN, Geeta Singhal, MD, MEd, Hilel Frankenthal, MD, Baylor College of Medicine, Houston, TX, Mark Quirk, EdD, University of Massachusetts, Worcester, MA

The goal of medical education is to nurture learners for professional growth in all areas of competency. Many professional behaviors are often taught via hidden curriculum in the form of apprenticeship between learners and expert physicians. Its shortcoming can be that learners become adept at practical procedures without developing deeper conceptual understanding of the clinical experience they are engaging. This workshop will describe a teaching method that brings the unconscious aspect of clinical experience to the conscious level to cultivate metacognitive skills required for optimal learning. The workshop will begin with engagement of participants through reflection on a role play of patient encounters demonstrating learners using a cognitive vs. metacognitive approach. Metacognition refers to higher order thinking which involves active control over one's cognitive processes engaged in learning. A discussion will follow on how metacognitive skills promote critical thinking, effective communication and desired professional behaviors. A case-based, interactive section will introduce principles of metacognition (planning, perspective-taking, regulation and reflection), propose the use of POSE modeling (Preview, Outline, Share and Evaluation), and discuss its relevance to attaining various competencies. An audience-response question and answer system will be used to promote reflection and active participation. In small groups, participants will practice collaborative/facilitative teaching using the POSE to model and promote metacognitive skills with a standardized student. All participants will then reconvene to brainstorm practical strategies for incorporating the concepts of metacognition into various settings at the individual's home institution in order to produce well-rounded clinicians according to core competency guidelines.

Workshop 30

Concourse 1

UPDATE IN MEDICAL EDUCATION: APPLYING THE CURRENT LITERATURE TO EDUCATIONAL PRACTICE AND SCHOLARSHIP

H B. Fromme, MD, MHPE, University of Chicago, Chicago, IL, Shari A. Whicker, MEd, Duke University Pediatrics, Durham, NC, John D. Mahan, MD, Nationwide Children's Hospital/The Ohio State Univ, Columbus, OH, Teri L. Turner, MD, MPH, MEd, Baylor College of Medicine, Houston, TX

For many academic educators, the breadth and volume of educational literature can be intimidating. The sheer number of articles published each year in a variety of journals in diverse professions, as well as the range of relevance to any one educator, makes evaluating and utilizing the literature a challenging task. For any individual not experienced in medical education (e.g. new fellowship directors, new program directors, junior academic faculty), the vast domain can result in paralysis of scholarship. Yet, utilizing the literature to enhance individual educational practice and institutional success represents a very valuable method for improving medical education. This workshop endeavors to facilitate the application of evidence-based education to participants' professional work. Participants will be introduced to the top three "hot topics" in medical education for 2010 as determined by the workshop presenters through a rigorous and systematic literature review method, which they will explain. The significant studies in each topic area will be briefly reviewed for the audience. The participants will then be divided into three small groups, with each group assigned to one of the hot topics. With facilitation by the presenters, each group will brainstorm on how to apply the evidence to their own practice and institutional needs. Small groups will also be asked to consider areas for multi-institutional scholarship within each topic area (i.e. future areas of research, curricular innovations, etc), as well as be encouraged to create collaborative networks for continue discussion and development after the meeting. This workshop will introduce participants to basic tips for educational research as well as aid them in creating a specialty or educational-role specific list of targeted journals for future review.

Sunday, April 3

7:30am – 3:00pm Forum for Chief Residents (from page 18)

Chief residents face a diverse set of challenges as leaders in academic medical centers related to the multiple roles that they assume as leaders, clinicians, educators, administrators, and counselors. To be effective across these multiple domains, chief residents must have a broad skill set and acquire new skills, especially to address the leadership and administrative aspects of the job. The APPD's Forum for Chief Residents is an educational session designed to teach key administrative, academic, and leadership skills in order to facilitate a successful year as a chief resident.

7:30-8:00am

Breakfast and Introductions

8:00-9:30am

McChief Rounds: Facilitating Chief Resident Led Educational Conferences
Matthew McDonald, MD, Assistant Professor of Pediatrics, St. Christopher's Hospital for Children, Bryon Lauer, MD, Assistant Professor of Pediatrics, St. Christopher's Hospital for Children, Robert McGregor, MD, Pediatric Residency Program Director, Bronwyn Carlson, MD and Jennifer Tingo, MD, Graduating Chief Residents, St. Christopher's Hospital for Children

In this session, participants will actively discuss important characteristics of adult learning and teaching strategies that lead to a successful chief resident led educational conference. The rising chief residents will learn how to facilitate "McChief Rounds", an interactive, team based approach to learning, and will have the opportunity to design an original McChief Rounds based on a clinical case of their choosing.* Graduating chief residents will serve as mentors through this design process.

* Rising chief residents should bring a clinical case to this session.

9:30-10:45am

Diagnosing the Problem Resident

Christine Skurkis, MD, Assistant Professor of Pediatrics, Associate Pediatric Residency Program Director, University of Connecticut SOM and Connecticut Children's Medical Center and Marsha S. Anderson, MD, Associate Professor of Pediatrics, Associate Pediatric Residency Program Director, University of Colorado School of Medicine, The Children's Hospital of Denver

This session will help both rising and graduating Chief Residents approach the common and challenging situation of the resident who is experiencing problems in their participation with the program. The session will begin with an overview and systematic approach residents experiencing problems, and a copy of the PowerPoint will be provided to use as a guide in solving case examples identified by participating Chief Residents, and we are sure there are many, or case vignettes that the session leaders can provide. After the case examples have been addressed in small work groups, the recommendations will be reported back to the whole group for further discussion.

10:45am-12:00pm

Conflict Resolution

Maria Ramundo, MD, MS, Director, Pediatric Residency Program, Associate Chair of Pediatrics, Academic Affairs, Akron Children's Hospital, Department of Medical Education, Clinical Professor of Pediatrics & Emergency Medicine, NEOUCOM; Greg Blaschke MD, MPH, FAAP, Associate Professor Pediatrics, Doernbecher Children's Hospital; Amber Hoffman, MD, Assistant Professor of Pediatrics, UMKC School of Medicine, Associate Director, Pediatric Residency Program, Children's Mercy Hospitals & Clinics; and Katherine Mason, MD, Fellowship Director, Division Pediatric Critical Care, Rainbow Babies and Children's Hospital

Chief residents will encounter difficult situations while helping administrate their residency programs. It is important that chief residents learn how to manage conflict constructively by engaging in crucial conversations. As leaders, chief residents must learn how to manage conflict constructively in order to build effective relationships with faculty and residents. In this session, participants will learn techniques to use when engaging in crucial conversations with faculty, residents, and other members of the health care team. Chief residents will have the opportunity to practice engaging in crucial conversations and conflict resolution by role playing situations that they will encounter in their new leadership role. Graduating chief residents will serve as facilitators through this small group role playing process.

12:00-12:30pm	Lunch (courtesy of APPD)
12:30-2:00pm	<p>RISING CHIEFS' TRACK -- Planning the Chief Resident Year <i>Edwin L. Zalneraitis, MD, Professor of Pediatrics and Neurology, Pediatric Residency Program Director, Assistant Dean for Clinical Education, University of Connecticut SOM and Connecticut Children's Medical Center and Sharon Smith MD, Associate Professor of Pediatrics and Associate Pediatric Residency Program Director, University of Connecticut School of Medicine, Connecticut Children's Medical Center</i></p> <p>This session is designed to help rising Chief Residents plan their Chief year in a way that will be most productive and useful for their programs and for their careers. It will begin with a systematic overview and methodology in planning the year. The PowerPoint for the presentation will be provided to the participating Chief Residents, and they will then work together in small groups to do some actual planning, including troubleshooting barriers and using opportunities. The small groups will then report back to the whole group for further discussions of the planning process. The session leaders will provide their contact information, so they can serve as resource for those wishing further advice throughout the year.</p> <p>GRADUATING CHIEFS' TRACK -- Create Your Future with Professional Development Planning <i>Nancy Spector, MD, Associate Chair of Education and Faculty Development, Associate Residency Program Director, St. Christopher's Hospital for Children and Theodore C. Sectish, MD, Program Director, Children's Hospital Boston, Associate Professor, Harvard Medical School</i></p> <p>This informative, reflective, and interactive session will introduce graduating chief residents to the concept of professional development planning by first identifying participants' personal and professional mission, vision, and values. This exercise serves as the foundation for the creation of a professional development plan. Participants will develop their own professional development plans with goals and objectives and strategies to accomplish them. Facilitators will emphasize and elaborate about the importance of two key elements – mentoring and professional networks – as critical strategies to employ in career development.</p>
2:00-3:00pm	<p>RISING CHIEFS' TRACK – Create Your Future with Professional Development Planning <i>Nancy Spector, MD, Associate Chair of Education and Faculty Development, Associate Residency Program Director, St. Christopher's Hospital for Children and Theodore C. Sectish, MD, Program Director, Children's Hospital Boston, Associate Professor, Harvard Medical School</i></p> <p>This informative, reflective, and interactive session will introduce graduating chief residents to the concept of professional development planning by first identifying participants' personal and professional mission, vision, and values. This exercise serves as the foundation for the creation of a professional development plan. Participants will develop their own professional development plans with goals and objectives and strategies to accomplish them. Facilitators will emphasize and elaborate about the importance of two key elements – mentoring and professional networks – as critical strategies to employ in career development.</p> <p>GRADUATING CHIEFS' TRACK -- Charting Your Educational Work Beyond the CV: How to Develop an Academic Portfolio <i>Clifton E. Yu MD, Program Director, National Capital Consortium Pediatric Residency Program; Anna Marie Carr, MD, Associate Program Director, Albert Einstein Medical Center</i></p> <p>This interactive workshop will help graduating chief residents reflect on their past year in academic medicine and introduce them to the concept of an academic or educator's portfolio. Participants will practice writing a reflective statement crystallizing their educational philosophy, and then be introduced to the APA/AAMC educator portfolio template. By familiarizing themselves with these tools through the help of experienced educator/facilitators, graduating chief residents will not only be able to communicate what they have done for greater recognition and potential promotion, but also be able to more deliberately chart the path of their academic future.</p>

MPPDA MEETING

SUNDAY, APRIL 3, 2011

8:00 am – 1:00 pm MPPDA Coordinators' TAGME Certification Exam
Balmoral

1:00 – 4:00 pm MPPDA Coordinators' Meeting
Flagler

2:00 – 5:00 pm MPPDA Conference Registration
Satellite Registration/Mezzanine

4:30 – 6:00 pm MPPDA Committee Meetings
Accreditation Committee
Curriculum Committee
Recruiting Committee
Research Committee
Transitional Care Committee

Oxford
Trinity
Sandringham
Windsor
Balmoral

6:00 – 7:00 pm MPPDA Welcome Reception
Mezzanine West

MONDAY, APRIL 4, 2011

7:00 – 10:00 am MPPDA Conference Registration
Mezzanine

7:00 – 8:00am MPPDA Breakfast and Mingle
Trianon Lobby

All Monday MPPDA Sessions held in Trianon, Second Level

8:00 – 8:30am MPPDA Welcome and Introductions
Scott Holliday, MD

8:30 – 8:45am MPPDA Presidential Address
Alex Djuricich, MD

8:45 – 9:45am MPPDA Presentation 1

Duty Hours Changes: The Rules, the Consequences and the Adjustments (Presentation + Workgroups)
Russ Kolarik, MD & Michael Lukela MD

The revised ACGME Duty Hour Requirements present increasing challenges to Med-Peds residency training programs. It is imperative that we continue to provide outstanding clinical and didactic experiences, while preserving integrated, high-quality, and safe care for our patients. We will describe (1) the unique challenges faced by combined training programs based in both community and academic centers; (2) working with institutional and categorical program leadership to develop integrated educational experiences; and (3) effective strategies to balance fulfilling the ACGME requirements, while preserving education and safe patient care.

9:45 – 10:15am MPPDA Presentation 2

Med Peds and National Health Policy

Niraj Sharma, MD

The speaker will give an update on changes with national health policy and the implication on Medicine-Pediatrics. Particular emphasis will be placed on graduate medical education and the care of youth with special health care needs.

All Monday MPPDA Sessions held in Trianon, Second Level

- 10:15 – 10:30am MPPDA Meet & Greet
- 10:30 – 11:00am MPPDA Presentation 3: Committee Updates
Accreditation Committee
Curriculum Committee
Recruiting Committee
Research Committee
Transitional Care Committee
- 11:00 – 11:30am MPPDA Presentation 4
Residents In Trouble (Remediation in practice and in the literature)
Cynthia Peacock, MD
Competency based assessment of residents has been widely accepted but strategies for remediation of any assessed deficiencies has not been standardized. A review of the literature will describe what is known about remediation practices and what evidence is available to guide best practices for remediation of physicians who are assessed as failing to demonstrate competence in practicing medicine.
- 11:30am – 12:15pm MPPDA Keynote Speaker
Generational Synchronicity: Improving the Medical Teaching Environment
Joseph Gilhooly, MD
Today's medical center has four difference generations working together. The diversity of the values held by each generation can lead to significant conflict which disrupts teamwork and education. Understanding and respecting these values can lead to effective solutions that improves the educational environment and the satisfaction of faculty, residents, and students.
- 12:15 – 1:00pm MPPDA Business Meeting and Lunch
Moderator – Scott
Secretary/Treasurer Report – Rita
Tunnessen Award – Sue
Election Results – Sue
NMPRA Update – Jen
AAP Section Update – Tommy
Bylaw changes
- 1:00 – 2:00pm MPPDA Presentation 5
Milestone Projects – ABIM & APPD
Bill Iobst, MD & Brad Benson, MD
The Milestone Project is the next phase in the ACGME-led movement towards competency based medical education. Dr. Iobst will focus on the definition and implications of IM Milestones. The next phase will be moving from a written document to operationalizing the project through input from the IM communities.
- The Pediatric Milestones Group has now completed the initial work to define the developmental progression of competence across the 6 ACGME Competencies and 53 sub-competencies. Dr. Bensen's presentation will outline the scope of the work, showcase examples, and discuss the next steps for the GME community.
- 2:00 – 2:20pm MPPDA Break and Poster Review
- 2:20 – 3:40pm MPPDA Panel Session (ABIM, ABP, ACGME)
Bill Iobst, Gail McGuinness, and Felicia Davis
- 3:40 – 4:00pm MPPDA Social Interaction Session
Small Group Pride Points & Challenges
Scott Holliday, MD

• **All Monday MPPDA Sessions held in Trianon, Second Level**

• 4:00 – 4:20pm MPPDA Break and Poster Review

• 4:20 – 4:50pm MPPDA Presentation 6

• Improving Care for Patients with Chronic Illness

• *Alice Kuo, MD*

• We implemented a mandatory 2-week rotation in quality improvement in the R2 year to introduce chronic disease management principles and provide the foundation for resident quality improvement projects in continuity clinic. We will provide descriptions of the “nuts and bolts” of the rotation, as well as evaluation data and future plans.

• 4:50 – 5:10pm MPPDA Strategic Mission

• *Alex Djuricich, MD*

• 5:10 – 5:20pm MPPDA Wrap-up

• *Scott Holliday, MD*

• 6:00 – 9:00pm MPPDA Dinner

• YUCA Restaurant, Miami Beach (additional charges apply)

• **TUESDAY, APRIL 5, 2011**

• 8:00am – 12:00pm MPPDA Executive Committee Meeting

• *Godfrey*

POSTER SESSION DETAILS

Saturday, April 2, 1:30-3:00 pm

Descriptive Posters

Poster Number 1

COMPASS CURRICULUM: A CURRICULUM TO FACILITATE IMG ACCULTURATION

Amanda D. Osta, MD, Michelle M. Barnes, MD, University of Illinois at Chicago, Margaret A. Scotellaro, MD, Rush University Medical Center, Chicago, IL, Wednesday Sevilla, MD, Children's Hospital of Pittsburgh, Pittsburgh, PA

Many international medical graduates excel in their medical knowledge, but have had limited exposure to the other ACGME core competencies. In addition to the issues all new residents face, these physicians must adjust to the added challenges of a new medical system, new culture and, in many cases, new language. In our training program, we strive to acculturate our international medical graduates and to provide a supportive environment in which to discuss common challenges faced by new residents. To do this, we developed an educational needs assessment for our incoming and current residents. The majority of residents stated that their greatest priorities during the intern year were to improve their verbal and written communication as well as to increase their understanding of the US health care system. Most respondents thought this would best be accomplished in a small group setting. We created the Compass Curriculum which consists of a longitudinal, primarily didactic, orientation in July followed by monthly meetings of Compass Families in a small group format. Through these educational sessions, residents received an extensive introduction to the roles of various support staff and learned about the systems of health care and education delivery in the US. After the longitudinal orientation, interns were divided into Compass Families, each with 2-3 senior residents and faculty. Every month, residents are given a topic or clinical vignette to serve as a starting point for discussion. The vignettes focus on issues surrounding communication and interpersonal relationships--with colleagues, patients, and families--in a variety of settings. The Compass Curriculum has been used to facilitate acculturation of international medical graduates into the practice of medicine in the US. It also provides a supportive and comfortable environment for residents to voice issues and receive guidance from senior physicians who have faced many of these same issues in their own training. This serves as a means to teach the core competencies, as well as to fulfill a gap in our curriculum as identified by our residents.

Poster Number 2

MASTERING HAND-OVER: A CURRICULUM FOR EFFECTIVE TRANSFER OF PATIENT INFORMATION

Melissa Held, MD, Edwin Zalneraitis, MD, University of Connecticut School of Medicine, Hartford, CT

In 2006, the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO), National Patient Safety goal 2E required that organizations implement a standardized approach to handoff communications, including an opportunity to ask and respond to questions. Although the Joint Commission made "a standardized approach" to hand-over part of its national patient safety goals, it is unclear if pediatric residents or other learners receive the requisite hand-over education, evaluation and feedback to ensure development of competence in this activity. Since then, with increasing restriction of resident duty hours, there are greater numbers of patient information transfers and an even greater need for a resident curriculum to teach and assess resident hand-over of patient information. To address this need, we created a hand-over curriculum for pediatric residents, which may be used for residents and fellows across all disciplines. The goals of the curriculum are: to master transfer of clinical information at hand-over of care, ensure seamless continuum of care as a member of an integrated healthcare team, reduce errors related to transfer of information, and to improve the quality of the patient and family experience around the clock. Achievement of the goals is defined by a set of Entrustable Professional Activities (EPAs) determined by level of performance and need for supervision in the hand-over process. These EPAs are "milestones" for learners ranging from the novice, to competent, to proficient, and finally to mastery of the skill. The hand-over curriculum activities and outcomes are linked to the relevant ACGME general areas of competence and correlative assessment tools.

Poster Number 3

TURNING GRIPES INTO CHANGES

Andrew R. Buchert, MD, Dena Hofkosh, MD, MEd, Children's Hospital of Pittsburgh of UPMC, Pittsburgh, PA

We have designed a curriculum to teach residents about Quality Improvement principles and get them started on meaningful participation in QI projects. Our goal is to create a pervasive atmosphere of quality improvement throughout the residency program: a QI attitude adjustment. The curriculum includes lectures and discussions about important tools of QI: root cause analysis, flow charts, and the PDSA cycle. Residents are engaged in hands-on experience using these tools to effect change, reduce medical errors, and improve patient care. Our To Err is Human sessions, monthly meetings of residents and selected faculty, provide a safe, peer-protected and confidential forum for discussion about the errors, near-misses, adverse events, and system issues that the residents have witnessed or experienced. During these sessions, complaints often arise about the systems of care, including technology, communication, patient flow, and teamwork, and potential solutions are discussed. With some reframing, many of these complaints can be channeled and formed into QI projects in which meaningful change can be effected. We sought to develop a QI curriculum that would teach young physicians how to scientifically and systematically turn their gripes into changes. Starting July 2010, all residents participate in the QI Attitude Adjustment by attending interactive QI learning sessions during noon conference time offered 1-2x per month for residents at all levels of training. PGY-2 residents participate in the hands-on QI experiences during one full afternoon per week for four weeks. This is their dedicated QI time

- during which they work closely with a faculty member experienced in QI who mentors each resident through the selection, planning, design, and ultimately completion of a QI project. Additionally, residents at all levels of training are encouraged throughout their residency to participate in other ongoing QI projects within the department. We will present the specifics of the curriculum, selected projects, and an evaluation of the impact of the curriculum on resident knowledge, skill and attitude as well as changes throughout the workplace and learning environment.

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• **Poster Number 4**

• **CHANGES IN WORK HOUR VIOLATIONS AFTER IMPLEMENTATION OF A NIGHT FLOAT SYSTEM IN A PEDIATRIC RESIDENCY PROGRAM**

• *Lorna K. Fitzpatrick, MD, Deanna S. Richmond, MD, Vicki Ip, MBChB, Danielle Bonnevie, MD, Tara Petroski, MD, State University of New York at Buffalo Pediatric Residency, Buffalo, NY*

• In anticipation of new proposed work-hour regulations, and in response to a work-hour violations study we conducted in 2008-2009, we implemented a night float system. We eliminated all ward 27 hour shifts and limited ED shifts to 10 hours. Objectives: After implementation of a night-float system, we sought to: 1) assess overall compliance with work hour regulations 2) identify assignments prone to violations 3) assess perceived barriers to compliance. Methods: 60 residents at Women and Children's Hospital of Buffalo were asked to record hours using Wardmanager™. Work hours were tracked for 16 weeks. In addition, all 60 residents were polled regarding their perceived barriers to compliance. Results: After changing most of our residents to a night-float system, there was no statistical difference in the overall number of violations. In the 2008-2009 study, 79.6% reported violations, versus 66.7% in the 2009-2010 study (p-value=0.19). Most violations still occurred in the ICUs. The violations for exceeding 27 hours on duty decreased: 31.2% in the 2008-2009 study versus 24.6% in the 2009-2010 study (p-value=0.000). However, the number of residents who did not have a minimum of 10 hours off between shifts increased (p-value=0.005). 85% of residents polled regarding their perceived barriers to compliance returned the survey. 72.5% responded that admissions during sign-out was problematic. 66.7% responded that too many admissions overall limited their ability to comply, and the same percentage responded that being too busy to sign-out on time was problematic. Conclusions: Switching to a night-float system significantly decreased the number of violations of the maximum 27 hour shift rule. However, with switching to shorter shifts, residents more frequently violated the minimum time between shifts. Possible solutions include hiring of additional mid-level providers to alleviate some resident duties; providing protected time during sign-out; instruction in efficient and accurate sign-out; continued education of residents and faculty as to duty-hour policies.

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• **Poster Number 5**

• **SUCCESSFUL DESIGN AND IMPLEMENTATION OF QUALITY IMPROVEMENT (QI) EDUCATION IN AN INTEGRATED HEALTH SYSTEM: LESSONS LEARNED**

• *Michelle A. Thompson, MD, Linda Famiglio, MD, John Boker, PhD, Geisinger Health System, Danville, PA*

• Purpose: Physicians must not only be aware of current healthcare changes (e.g. patient-centered care, systems-based practice, and practice-based learning) but must also be prepared to actively participate and lead QI initiatives. Challenges for clinical educators include how to effectively integrate QI knowledge, skills and attitudes into residency training. We applied QI methodology to identify robust practices and ameliorate obstacles during a five-year experience with integrated QI curricula design and implementation. Method: Recurrent PDSA cycles examined successive longitudinal curricula. Each curriculum varied because of re-design consistent with findings from analysis of prior cycles. Key design elements included: curriculum structures and content; learning objectives, activities and formats; trainee mix and levels; course administration and faculty; and sustainability and linkages to institutional goals. The chain-of-impact model guided curricular evaluations. Results: Each curriculum included didactic sessions to teach core principles, concomitant interspersed learning activities, and a mentored experiential period for application in the real-world health system. Expectations included completion and dissemination of QI projects. Learners variably included attendings, residents, nurses, medical and nursing students. Regardless of faculty, administrative ownership, or amount of didactics, learners acquired knowledge and skill. Sustainability improved when learners experienced high-functioning system committees. Identified needs included faculty development for clinical staff involved in the experiential phase. Evaluations became more robust and gradually populated all four chain-of-impact levels. Conclusions: A high functioning integrated health system provides both opportunities and obstacles for integrating QI education. Successful design and implementation of a QI curriculum requires careful planning, persistent monitoring, and systematic evaluation to ensure educational quality and effectiveness.

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• **Poster Number 6**

• **A RESIDENT DEVELOPED MORBIDITY AND MORTALITY CONFERENCE WITH A PATIENT SAFETY FOCUS: A QI CURRICULUM**

• *Shilpa J. Patel, MD, Stanford University, Stanford, CA, Lauren A. Destino, MD, Stanford University, Palo Alto, CA*

• Context: Morbidity and Mortality conferences (MMC) are required by the ACGME for many specialties. The traditional MMC focused on individual actions and knowledge gaps. However, MMCs present a unique opportunity to focus on quality improvement in the resident setting and teach topics that encompass the six core competencies, particularly systems-based practice and practice-based learning and improvement. Objectives: As part of a longitudinal resident quality improvement project, pediatric residents filled a void by creating a Morbidity and Mortality conference with a focus on systems-based quality improvement. Methods: Pediatrics residents undergoing a mandatory Quality Improvement (QI) rotation performed

the following steps to establish a new MMC: administered a needs assessment; performed background literature review; researched ongoing MMCs at our institution; developed goals and learning objectives for the new MMC; created a MMC case submission process and form as well as a conference evaluation tool; identified and invited key facilitators and the Medical Director of Quality Management; solicited cases and systematically reviewed/prepared the case for presentation. After the MMC, the key systems issues that were identified for further action are followed up by subsequent QI residents in the manner of a Plan/Do/Study/Act (PDSA) project. Conclusion: Residents are capable of developing and maintaining educational conferences that focus on quality improvement and patient safety as a means of broadening their exposure to institutional quality improvement efforts as well as providing first-hand experience in many QI processes.

Poster Number 7

NOVEL SIMULATION BASED ORIENTATION FOR NEW INTERNS: INITIAL ASSESSMENT AND STABILIZATION OF THE ACUTELY ILL PEDIATRIC PATIENT

Rhett H. Lieberman, MD MPH, Brett McAninch, MD, Children's Hospital of Pittsburgh of UPMC, Pittsburgh, PA

Introduction: Interns are often the first physicians to respond to patients acutely decompensating in the hospital, before more experienced providers arrive. As such, a core set of clinical skills is needed. Intern orientation often includes training in these skills, but we believe existing, formal courses do not meet the needs of new interns. PALS is too advanced and time intensive for orientation while PEARS is too basic for providers who often treat critically ill children. This formal curriculum provides standardized training in initial assessment and management, focusing on specific clinical skills needed by interns. Hypothesis: A simulation based curriculum providing hands on, training level specific, practical education in assessment, initiation of management and specific key skills will improve new interns' resuscitation skills and comfort beginning residency training. Methods: 31 pediatric interns (27 categ, 3 med/peds, 2 peds/psych triple brd) participated in a simulation based patient care orientation. Interns rotated in small groups through 5 skill stations and then participated in high fidelity simulated scenarios, reinforcing training acquired in the skill stations. A pre and post-course survey was completed. Results: Participants' perceived preparedness to initiate management of a patient with respiratory distress, cardiovascular compromise and seizure were assessed using a 5 point Likert score. In all cases, participants reported significant improvement in their perceived preparedness (respiratory: $t 8.2, p < 0.001$; cardiovascular: $t 7.3, p < 0.001$; seizure: $t 4.4, p < 0.001$). Participants also reported improvement in resuscitation skills and topics and degree of detail was appropriate for their current knowledge base and level of training. Discussion/Conclusion: This course provides a standardized orientation to patient care skills necessary to function effectively as an intern. Following the course, interns reported increased comfort level, perceived improvement in ability to perform key skills and improved ability to assess and initiate patient management.

Poster Number 8

THE "PICU BOOT CAMP" CURRICULUM: AN ORIENTATION PROGRAM FOR PEDIATRIC CRITICAL CARE FELLOWS

Danny Castro, DO, Baylor College of Medicine, Houston, TX, Satid Thammasitboon, MD, MPHE, West Virginia University School of Medicine, Morgantown, WV

Background: Pediatric critical care (PCC) fellows are expected to perform in a high-pressure, high-risk environment right after residency, where adequacy of clinical/procedural exposure is questioned due to restrictive duty hours. Simulation-based training (SBT) affords educators in this field the opportunity to train and assess the learners performance without risking patient safety. However, it should be integrated into a well-designed curriculum to optimize learning and progression towards competence. Aim: Develop an orientation curriculum incorporating SBT to expedite knowledge and skills acquisition among PCC fellows. Program Description: An orientation and training program previously described in the literature was used as a model to help develop the curriculum. It was a 3-day course incorporated as part of our orientation for first year PCC fellows. The curriculum focused on the core topics of vascular access, airway management, resuscitation and communication. There were pre- and post-intervention assessments that were performed and analyzed. Program Evaluation: Based on a 5-point Likert scale questionnaire, participants gave a mean score of 4.7 and 4.8, when asked to rate overall value of the curriculum and when asked if they felt this curriculum improved or will improve their clinical knowledge, skills and behavior, respectively. Participants reported a significantly higher level of comfort (mean \pm SD) with regards to the core topics after the curriculum. Vascular access [CVL placement: 1.33 ± 0.5 vs. 3.2 ± 0.8 ; Arterial catheterization: 2.0 ± 0.9 vs. 3.7 ± 0.5], Airway management: 2.5 ± 1.1 vs. 3.7 ± 0.5 , Resuscitation: 2.0 ± 0.9 vs. 3.2 ± 0.8 and Communication [Breaking Bad News: 2.2 ± 1.0 vs. 3.3 ± 0.8 ; Rapid Response Team Communication: 2.2 ± 0.4 vs. 3.5 ± 0.6]. Discussion: Participants found the 3-day simulation-based orientation curriculum to be valuable and felt that it improved or will improve their clinical education. Participants also perceived a significantly higher level of comfort in the core topics covered after participating in the curriculum.

Poster Number 9

RESIDENT-NURSING COLLABORATION: A RESIDENT-DRIVEN QUALITY IMPROVEMENT INITIATIVE

Kelly Kelleher, MD, Ellen Hansen, RN, BSN, MS, Ryan S. Bode, MD, Phoenix Children's Hospital/ Maricopa Medical Center, Phoenix, AZ

Several studies have shown a correlation between physician and nursing collaboration and communication and patient outcomes within intensive care units. Within teaching hospitals, resident physicians and nurses interface on a constant basis in the midst of patient care. Residents within this program and teaching hospital recognized an opportunity for quality

- improvement within resident and nursing education, communication and teamwork. Resident and nursing liaison positions were established. A Plan, Do, Study, Act (PDSA) model of quality improvement was utilized. Specific interventions included:
- 1. Resident presentation given at monthly nursing orientations with education regarding resident schedule, rounding and conference times and information on reaching the correct responsible resident and team. 2. Nursing presentation at monthly resident housestaff meeting regarding nursing schedule, change of shift, clinical chain of command, and timeliness and communication of orders. 3. Development of Resident/Faculty Communication Sheet to be placed on the front of the chart identifying all involved members of the health care team with contact numbers for each patient. Additional planned interventions include the formalization of bedside multidisciplinary family centered rounds. Data is currently being collected for this quality improvement initiative and will be reported at the APPD meeting.

• **Poster Number 10**

• **DESIGNING A QUALITY IMPROVEMENT CURRICULUM: OPTIMIZING VALUABLE RESIDENT TIME**

• *Lauren A. Destino, MD, Stanford University, Palo Alto, CA, Shilpa J. Patel, MD, Stanford University, Stanford, CA, Madelyn Kahana, MD, Stanford University, Palo Alto, CA*

• Context: Quality improvement (QI) experience is a relatively new ACGME requirement with which residency programs may struggle due to limits of time and lack of previous training. In our residency program, despite the presence of an advocacy track through which QI experience may be gained, not all participate. Thus, the need for a resident curriculum to address QI concepts and project development was essential. Objective: To demonstrate the development of a quality improvement curriculum mandatory for all pediatric residents. Methods: After an anonymous resident survey and feedback from residents, chief residents and the program directors, the components of a QI curriculum that emerged as being the most engaging, feasible, broadly encompassing, and efficient included an exploration of the background and literature surrounding QI; application of QI methods and processes in the form of learning modules with direct relevance to the resident participant in outpatient and inpatient settings; attendance at a monthly hospital QI meeting for exposure to large improvement initiatives; and lastly, contribution to an on-going, resident-initiated, -sustained, and -evaluated quality improvement project. All of these objectives were felt to be met in a brief one to two week rotation. Conclusion: The QI curriculum developed for this pediatric residency program is easily adaptable to any program interested in initiating a brief rotation in QI. It requires a nominal amount of valuable resident and faculty time but provides a foundation for QI concepts necessary for ongoing patient safety and care improvement in both inpatient and outpatient settings.

• **Poster Number 11**

• **COGNITIVE INTERVIEWING AS A METHOD FOR DEVELOPING AND IMPROVING EDUCATIONAL TOOLS: PEDIATRICS MILESTONES AS AN EXAMPLE**

• *Daniel J. Schumacher, MD, Kadriye O. Lewis, EdD, Cincinnati Children's Hospital Medical Center, Cincinnati, OH, Carol L. Carraccio, MD, MA, University of Maryland, Baltimore, MD*

• Background: Developing educational tools that are clear and understandable among end-users is often under-appreciated when these tools are developed and refined. Cognitive interviewing (CI) has emerged as a prominent method for identifying and evaluating sources of response error in survey questionnaires, and it can be used in the development of other educational tools as well. CI maximizes clarity and minimizes burden and potential error sources by studying the way users understand, process, and respond to materials being developed. This approach is useful in ensuring that end-users capture the intent of the materials. We are applying this unique technique in the development of the Pediatrics Milestones, a national initiative whose goal is to refine the Accreditation Council for Graduate Medical Education competencies in the context of pediatrics and set performance standards by level of training. Intervention Methods: To help ensure the Milestones are learner-centered, CI with pediatric residents is being undertaken. An interview protocol was developed for standardization between participants. This protocol consists of think alouds (TA) and verbal probes (VP). TA are open-ended questions/statements asking participants to describe what they are thinking and sometimes how they are feeling. VP are directed questions, often following a TA, aimed at gaining more information and can be predetermined or posed dynamically based on TA responses. Interviews are transcribed and coded using successive cycles of inductive and deductive methods, identifying themes to inform future iterations. Discussion: In Milestones, a high-stakes material, it is critically important to engage learners to be sure the goal of providing them with a clear and useful roadmap and feedback on their progression is achieved. In our study, we found CI to be useful in understanding how residents interpret, respond to, and understand the Milestones. We believe CI is valuable in the development of other educational tools commonly used by residency programs as well to ensure their optimal, intended use among end-users.

• **Poster Number 12**

• **RESIDENT-DRIVEN CURRICULAR QUALITY IMPROVEMENT**

• *Dominic Moore, MD, Ryan S. Bode, MD, Grace L. Caputo, MD, MPH, Phoenix Children's Hospital/Maricopa Medical Center, Phoenix, AZ*

• The ACGME and Pediatric RRC state that programs must undergo and document formal, systematic evaluation of the curriculum and overall program quality at least annually. Within the competency of Practice Based Learning and Improvement, residents are expected to learn and utilize quality improvement methods. Our residency program has a "Curriculum Committee" with a goal of resident-driven continuous quality improvement with a specific focus on education and training.

Curriculum Committee convenes in July with each academic year and is made up of resident representatives from all 3 years of training, chief residents, program coordinators, directors and core faculty. Potential improvement projects are targeted from the annual faculty and resident program review, anticipated changes in ACGME requirements or from participants at the initial meeting. 3-4 sub-committees are formed based upon voted selected areas with a resident serving as co-chair with a program director or faculty. Meetings are monthly over a lunch hour with 45 minutes dedicated to a sub-committee working session and 15 minutes as a larger group with updates, feedback and discussion. Sub-committees follow the plan, do, study, act (PDSA) model of quality improvement. At the end of the academic year, sub-committees summarize their quality improvement project including results and future action items. Examples of past quality improvement projects include: Addition of 2nd Development block rotation with focus on abnormal development; Creation of Community Advocacy Project; Development of practice management curriculum; Restructuring of traditional noon conference series to include weekly rotation-specific conferences; Duty hour pilots within the NICU and PICU in anticipation of revised requirements. Curriculum Committee has been an innovative and successful resident-driven program-wide curricular quality improvement utilizing a PDSA model. Residents become the drivers of change as well as obtain valuable quality improvement education and experience.

Poster Number 13

BUILDING A CULTURE OF CONTINUOUS IMPROVEMENT: THE ANNUAL ROTATION REVIEW PROCESS

Julie L. Pantaleoni, MD, Amanda A. Sandford, MD, Kathleen Leonard, MD, Madelyn D. Kahana, MD, Lucile Packard Children's Hospital at Stanford Univ, Palo Alto, CA

The Pediatric Residency Program at Stanford University has formalized a process for annual pediatric rotation review, which is directly responsive to resident input and results in prompt curricular improvement. This process starts with the aggregation of standardized resident Medhub evaluations for each rotation. Average numerical scores for rotation elements, including patient volume, skill development, continuity of care, quality of supervision, quality of teaching, adequacy of feedback and overall educational value, are summarized in table format. Program average and standard deviation are computed for each core element thereby allowing clear cross-rotation and cross-year comparison. Written comments regarding strengths and weaknesses of the rotation are categorized and quantified as to the percentage of respondents with like concerns. All data are presented and discussed at an annual rotation meeting with invested parties including the Division Chief, Rotation Director, Residency Program Director, Associate Program Director for Curriculum Development, and Chief Residents. These meetings follow a standardized agenda that addresses both rotation-specific and program-wide curricular issues. Ultimately, each rotation is asked to specify targeted tangible improvements for the upcoming year. Those rotations performing suboptimally or facing specific challenges undergo further discussion at a larger Curriculum Committee meeting. This committee consists of residents at all levels of training and serves as a focus group in which ideas for improvement are vetted. Curricular resolutions are then implemented and tracked to evaluate impact and sustainability. This collaborative annual rotation review process not only provides a standardized procedure for rotation evaluation, but also validates the efforts and concerns of the rotation director and is directly responsive to resident feedback. The benefits of this process include improved response time to educator and resident concerns, improved communication between rotation directors, faculty educators and residents as well as improved rotation performance.

Poster Number 14

UCSF RESIDENT CLINIC QI PROJECT

Elizabeth R. Hanson, MD, Glenn Rosenbluth, MD, Katie McPeak, MD, Natalie Burman, DO, UCSF Pediatrics, San Francisco, CA

Background: There is growing recognition of the importance of Quality Improvement (QI) training as part of the Systems-Based Practice (SBP) and Practice-Based Learning and Improvement (PBLI) competencies. Although QI can be taught in a variety of settings, continuity clinic is ideal because it is where residents feel the most ownership over their patients. UCSF residents have continuity clinic in one of 5 different sites: a university hospital, a university-affiliated community clinic, a county hospital, an HMO, and a private community clinic. Objective: To describe a continuity clinic-based QI curriculum and assess the feasibility of implementing it across a spectrum of clinical settings. Methods: The central feature of the curriculum is a series of didactic and experiential activities that focus on the principles of QI and the Plan-Do-Study-Act (PDSA) model and culminate in a resident clinic QI project. These principles are introduced in the QI Olympics activity held at our annual residency retreat in which residents practice applying the PDSA model to personal QI projects and team-building exercises. This is followed by training for the continuity clinic mentors and a residency-wide lecture focusing on QI in the clinical setting. From January-March 2011 each clinic pod will conduct a QI project of their choosing with the clinic attending as project mentor and the QI Expert Team available for consultation. Results: The QI Olympics have been completed with the remainder of the curriculum to be completed by March 2011. We will present data from feedback sessions with residents and faculty on feasibility, project quality, and the challenges presented by different clinical settings. This data will be used in our own PDSA cycle as we move forward in our SBP and PBLI curriculum development. Conclusions: Training in SBP and PBLI presents a challenge to residency programs, particularly those with multiple training sites. The information from this feasibility study will inform our curricular improvement efforts and provide a model for implementation of resident QI projects in variety of continuity clinic settings.

• **Poster Number 15**

• **PILOTING A CURRICULUM FOR THE PREVENTION AND MANAGEMENT OF CHILDHOOD OBESITY**

• *Sylvia H. Yeh, MD, Harbor-UCLA Medical Center, Torrance, CA, Alma Guerrero, MD, Wendy Slusser, MD, Debra Lotstein, MD, UCLA Center for Healthier Children, Families, and Co, Los Angeles, CA, Esther An, MD, Monica Sifuentes, MD, Harbor-UCLA Medical Center, Torrance, CA*

• Background: Despite the awareness of pediatric obesity at epidemic levels, gaps in knowledge and delivery of care practices persist among healthcare professionals. A primary care residency curriculum ("FIT for Residents") for the prevention and management of childhood obesity, based on the Chronic Care Model, was developed with support of a national expert committee. The objective was to implement the FIT curriculum and identify the changes in knowledge and delivery of care practices among pediatric residents in continuity clinic. Curricular Innovations: The FIT curriculum was implemented with all residents (n=30) in one year. Didactic formats employed include: 1) case-based lectures on epidemiology and evidence-based practices of childhood obesity using an audience response system, 2) lectures on rapid Plan-Do-Study-Act (PDSA) quality improvement strategy implementation, and 3) small group discussions to identify opportunities and resources to improve delivery of care related to childhood obesity in our hospital-based continuity clinic. In addition, web-based interactive modules for motivational interviewing were incorporated into the first year advocacy rotation with direct faculty follow-up. Results: Monthly chart reviews assessed pre-identified measures of evidence-based practices of childhood obesity. Significant changes were noted in assessing dietary practices, physical activity and patient's motivational goals for weight loss. Results of pre- (n=19) and post (n=17) resident surveys to assess changes in knowledge, attitudes, and practices are forthcoming. Qualitative faculty comments suggest that the curriculum served to promote individual changes in practice and supported PDSA strategies to improve use of evidence-based practices within the continuity clinic. Conclusions: A residency curriculum for childhood obesity is needed to improve knowledge and practice among physician trainees. The FIT curriculum provides a framework to implement quality improvement measures and incorporate evidence-based measures to address the obesity epidemic.

• **Poster Number 16**

• **CREATION OF AN INNOVATIVE WEB-BASED CLINICAL PROBLEM-SOLVING AND ASSESSEMENT TOOL**

• *Graeme R. Frank, MD, Howard Seiden, MD, Cohen Children's Medical Center, New Hyde Park, NY*

• Background: Current challenges to medical education include less direct patient contact (work hour restrictions), less independent thinking and problem solving (increased requirements for direct attending supervision), and less teaching and feedback (less protected time for attending physicians). The goal of this project was to address these challenges by creating a web-based, interactive, problem-solving learning tool with robust assessment capabilities. Methods/Results: We developed a web-based program that allows the creation of level-specific Case Studies (CS) and Assessments. During the CS, the learner is provided information (history, physical examination, test results, or clinical course) in a series of steps. For each step, the learner must develop and prioritize differential diagnoses (with rationale), and make decisions how to proceed, including ordering tests (with justification), until ultimately, the learner reaches a final diagnosis. Immediate feedback is provided to the learner in the form of a side-by-side comparison between the learner's responses and the CS creator's "Perfect Path". The scoring system takes into account the differential diagnosis, the appropriateness of tests ordered, and the final diagnosis. The CS ends with a Final Discussion aimed at providing a summary of the topic and clinical practice guidelines. After a predetermined time, the learner is invited to complete an assessment aimed at assessing retention of knowledge acquired. All learners who complete a CS have access to a Bulletin Board for further communication with each other and the CS creator. User-specific reports can be generated to assess learners' performance against peers, and program directors can assess performance of learners, teachers, and the program itself. Conclusions: We developed a web-based, interactive, problem-solving program that can be used as both a learning and assessment tool. It provides immediate feedback, assessment of retained knowledge, and reporting tools. Finally, the program directly addresses most of the General Competencies, satisfying requirements of the ACGME.

• **Poster Number 17**

• **A RESIDENT-LED MORBIDITY AND MORTALITY CONFERENCE IN THE PICU**

• *Chen C. Kenyon, MD, Meredith van der Velden, MD, James Moses, MD, MPH, Boston Combined Residency Program, Boston, MA*

• Morbidity and mortality conferences (MMCs) are traditional educational forums focused on evaluating care and management, but a common framework/structure for these sessions has not been adopted. Recent reports suggest that structured MMCs are useful for assessing quality of care and patient safety. From a residency training perspective, these conferences can provide an opportunity to address the ACGME competency of practice-based learning and improvement (PBLI). Although residents are often invited to these conferences, they are rarely involved in a substantial way. In light of this, we created a monthly resident-led morbidity and mortality conference as part of the Pediatric Intensive Care Unit (PICU) rotation in the Boston Combined Residency Program in Pediatrics at the Boston Medical Center. The PICU is a 6 bed unit and is staffed by an attending physician and a senior resident. Each month, a senior resident assigned to the rotation presents all adverse events that occurred during the month using a structured template that includes assessment of contributory factors categorized into patient, team, environment, task and organizational aspects of care delivery. Assessment of preventability, analysis and recommendations for actions are also included in the resident presentation. Adverse events reported include all mortalities, unplanned extubations, all code blues whether in PICU or on the pediatric inpatient service, all hospital-acquired infections,

24h readmissions to the PICU, and all medication errors. To date, residents have presented cases of each of the above, initiating a critical review of each event and the contribution of system performance in each scenario. We assert that resident leadership of PICU MMCs presents a novel approach to actively address and assess the ACGME competencies of PBLI and Systems-based practice.

Poster Number 18

CLINICAL SKILLS FAIR - AN INNOVATIVE PROGRAM EVALUATION TOOL

Aditee P. Narayan, MD, MPH, Shari A. Whicker, MEd, Kathleen A. McGann, MD, Duke University Pediatrics, Durham, NC
Residency Program Directors are required to perform meaningful program evaluations in order to meet accreditation standards. The authors describe the Duke Clinical Skills Fair (CSF), an innovative tool to evaluate the effectiveness of residency program curricula. The CSF was developed by the Duke Curriculum Committee using a modified Delphi process, an iterative and interactive development process dependent on the insight of a structured group of content experts. Members of the committee, comprised of representative faculty, identified the key level-specific and competency-based goals and objectives to be tested via the CSF for the different PGY levels. Based on this list, the CSF was organized into three separate domains: medical knowledge/patient care, communication, and procedures. The medical knowledge/patient care station is comprised of a computer-based assessment consisting of multiple choice and short answer questions on patient care scenarios. The communication station includes a simulated scenario in which the resident delivers bad news to standardized patient parent actors. This short communication session (4 minute limit) is video-recorded and assessed by trained faculty. The procedure station includes level-specific procedures that are performed using low-fidelity simulators and are rated by trained faculty. The CSF is held at the end of each academic year, to assess how well the residents (in aggregate) met their level-specific goals and objectives for the given PGY level. For baseline comparison, new PGY1 residents complete the PGY1 CSF immediately before starting their residency training. Each station is evaluated based on previously validated scales. Aggregate data analyses are performed annually for each PGY level. These identify how well residents have met their level-specific goals/objectives for the preceding year. These analyses identify areas for improvement in the curriculum, and demonstrate outcome based success in others. The Clinical Skills Fair is a useful and innovative tool that program directors can replicate to provide a meaningful evaluation of their curricula and program.

Poster Number 19

A MULTIDISCIPLINARY EDUCATIONAL CURRICULUM IN CHILD ABUSE: THE PEDIATRICIAN'S ROLE IN RECOGNITION, DOCUMENTATION, MANAGEMENT AND LEGAL ADVOCACY

Tammy M. Camp, MD, Lesley C. Motheral, MD, Kirsten K. Robinson, MD, Patti J. Patterson, MD, MPH, Lara W. Johnson, MD, MHS, Texas Tech University Health Sciences Center, Lubbock, TX

Background: Though most pediatric residents receive a didactic curriculum in child abuse pediatrics, exposure to patients with signs of abuse, especially in the outpatient setting may be variable. Additionally, the residents' exposure to legal aspects of child abuse pediatrics may be limited or of variable educational benefit. Objective: We sought to develop a standardized curriculum incorporating clinical recognition of child abuse, resident documentation, management and communication skills in cases of abuse, and the interface between the pediatrician and the legal system. Methods: We utilized a standardized patient encounter to assess and enhance resident communication, documentation and patient management skills. We created a case with a mother presenting with an infant with suspected maltreatment. Residents were unaware of the purpose of the activity other than to conduct a visit with a standardized patient for evaluation. After the encounter residents wrote a standard visit note including assessment and plan. Standardized patients assessed the residents' communication skills, and faculty physicians performed detailed scoring of their notes. Subsequently, residents received a mock subpoena to appear in court regarding the patient. In the courtroom residents received didactic instruction from an assistant district attorney specializing in child abuse regarding the courtroom process and providing expert testimony, as well as instruction from a general pediatrician. Three months later, key aspects of the experience were repeated with another impromptu standardized patient encounter followed by assessments as before. An attorney provided additional critiques of the residents' written documentation and two residents were chosen for mock testimony. Conclusions: Feedback from the residents was generally positive regarding the utility and implementation of the curriculum. Assessments of documentation indicated residents' skills in recognizing possible abuse, ordering appropriate imaging, laboratory studies and consultations did improve.

Poster Number 20

NIGHT TEAM: A COLLABORATIVE CURRICULUM BETWEEN 2 PROGRAMS

Priti Bhansali, MD, The George Washington University School of Medicine, Washington, DC, Christine Skurkis, MD, University of Connecticut School of Medicine, Hartford, CT, Karin Gray, MD, Aisha Davis, MD, The George Washington University School of Medicine, Washington, DC, Edwin Zalneraitis, MD, University of Connecticut, Hartford, CT

Background: Due to ACGME work duty hour requirements, many pediatric residency programs have initiated a Night Team (NT) rotation. There may be limited direct contact with faculty overnight. The provision of an educational experience and the ability to evaluate performance on the NT rotation are needed. Methods: The curriculum was originally developed at the University of Connecticut. Goals for the rotation were identified with resident input. These included improving clinical reasoning and communication, increasing faculty feedback, providing appropriate patient surveillance, and preserving the teaching role of the senior resident. Educational activities include 1) Periodic structured audit of resident admit notes by

- on-service faculty assessing documentation of clinical reasoning 2) Completion of reflection logs related to self-identified encounters 3) Formal feedback on resident initiated calls to faculty targeting handoffs 4) Structured clinical observations of interns' patient interactions by senior residents 5) Senior resident led teaching sessions based upon common clinical scenarios encountered overnight. Evaluations for the NT residents come from multiple sources. In addition to faculty correspondence, patients assess the interpersonal and communication skills and professionalism of the residents. Nurses evaluate the interpersonal and communication skills, professionalism, and systems based practice abilities of the resident. In addition, teaching skills are evaluated by peers. Results: The curriculum has been modified at the University of Connecticut and gradually implemented at the George Washington University. Evaluations of this curriculum by the residents at both programs have proven satisfactory. A study is underway to determine the reliability and validity of the chart audit tool. Conclusion: A night team curriculum has been established at two institutions in the setting of limited direct contact with faculty overnight. Different educational activities allow for a more comprehensive assessment of the residents and can be adapted to fit the traditions of the residency program.

• **Poster Number 21**

• **COMPETENCIES OF PEDIATRIC RESIDENTS IN THE CARE OF SURGICAL PATIENTS: A NEEDS ASSESSMENT**

• *Anna Marie Carr, MD, Matilde Irigoyen, MD, Albert Einstein Medical Center, Philadelphia, PA*

• Background: The role of pediatricians in the care of surgical patients continues to grow. The Pediatric RRC mandates experience in perioperative care, but specific residency competency domains have yet to be defined. Objectives: To assess pediatric resident perceptions of preparedness and need for further training in the care of surgical patients. Methods: Pediatric residents at an urban academic medical center were invited to participate in an anonymous on-line survey. Six clinical vignettes were presented highlighting ten perioperative domains: pain management, procedural sedation, respiratory care, fluid and electrolytes, nutrition, rehabilitation, discharge planning, psychosocial needs, patient safety, and multidisciplinary team work. Outcomes were self rating of preparedness and training needs (5-point Likert scale). Results: 21/30 residents (70%) completed the survey. In the pain management domain, the majority of residents felt very prepared (52-62%) to address uncomplicated postoperative pain, but only 24% to treat pain in a child with behavior problems. The majority felt very prepared to address perioperative respiratory care, fluid and electrolytes and to work in multidisciplinary teams. (52-62%). Nutritional management was variable (19% - 61%). The psychosocial domain was also variable: over half felt very prepared to contact Child Protective Services (62%) but only 38% to consult Psychiatry. Fewer residents felt very prepared to address the domains of rehabilitation (33%), discharge planning (14%) and procedural sedation (14%). Most residents agreed a formal curriculum in perioperative care would be helpful (80-95%). Conclusion: Pediatric residents felt prepared to manage surgical patients, particularly in perioperative domains overlapping with traditional medical care. However, residents expressed the need for more formal curriculum. Resident perceptions of their preparedness and learning needs may help identify specific competencies to be developed in perioperative care training.

• **Poster Number 22**

• **RESTRUCTURING THE MORBIDITY AND MORTALITY CONFERENCE TO TEACH CORE COMPETENCIES**

• *Vasudha L. Bhavaraju, MD, Paul Bakerman, MD, Phoenix Children's Hospital/Maricopa Medical Center, Phoenix, AZ*

• Purpose: The ACGME requires that residencies include Morbidity and Mortality Conference (M&M) as part of regular didactics and that curriculum be competency-based. Historically, at our program's M&M Conference, faculty has presented interesting cases, but not always those with adverse outcomes. Residents attended but did not actively participate. A survey showed that residents prefer M&M Conference be a forum to "learn from our mistakes". The purpose of this project was to reformat M&M Conference whereby residents present cases with adverse outcomes and focus on patient safety and competencies. Methods: Residents presented M&M Conference with faculty mentors and chose cases they were either involved with or related to their specialty interests. The goal was to present a variety of clinical issues and competencies. Evaluations were distributed to attendees. Results: From 2009-10, there were 15 resident-led M&M Conferences. Examples of cases were a medication error, delayed diagnosis of a procedural complication, ethics of prolonged drowning resuscitation, and miscommunication during transfer of care. The main competencies highlighted were "Medical Knowledge" and "Communication". "System-Based Practice" and "Professionalism" were less often the focus. Evaluations showed that residents "strongly agreed" that the discussion focused on enhancing patient safety rather than assigning blame (3.93 on Likert scale 1-4), that gaps in quality leading to adverse events were identified (3.73), and that strategies were outlined to prevent similar events (3.75). Resident responses to "Is there anything you will do differently as a result of this conference" included "use a multi-disciplinary approach with anorexia" and "cautiously use medications that alter exam findings." Overall satisfaction with M&M Conference increased from 3.85 to 4.14 (Likert scale 1-5). Conclusion: Analytical review of cases is vital to the professional growth of residents. Our revised M&M Conferences have had a positive impact. By tracking which competencies are addressed, we can select future cases accordingly and monitor the overall effect on patient safety.

• **Poster Number 23**

• **MAKING IT A HABIT: A PRACTICAL APPROACH TO TEACHING EVIDENCE-BASED MEDICINE TO PEDIATRIC RESIDENTS**

• *Rachel Boykan, MD, Stony Brook University Department of Pediatrics, Stony Brook, NY*

• Most residents learn evidence-based medicine (EBM) by participating in a journal club, a format that does not lend itself to practical application. The purpose of this curriculum is to teach pediatric residents basic EBM skills, and to encourage their

regular use in the care of patients. **Methods:** The overall curricular goals are to teach question building, searching strategies and critical appraisal skills, with independent guided practice. The objectives of a pilot unit were to teach residents how to build questions using the PICO format, and perform basic search strategies. Four pediatric interns attended two, two-hour, small group, instructional sessions and completed three independent literature searches, which were reviewed with a preceptor. **Pilot Program Evaluation:** Four expert reviewers provided feedback prior to the implementation of the pilot unit. Before and after the pilot test, interns completed surveys and four timed cases for which they generated PICO questions and completed searches. Results of the pre- and post- surveys were compared, as well as the times and completion of the four case scenarios. **Results:** All four participants completed the pre- and post- pilot surveys and case scenarios. Interns showed improved knowledge and efficiency in using EBM in the daily care of their patients, and indicated that they were more likely to continue to use evidence-based resources in the future. Based on the results of the pilot, this EBM curriculum was implemented with all incoming pediatric interns in July, 2010, as part one of a new three-year longitudinal EBM curriculum. **Conclusions:** Teaching EBM in a practical fashion may improve its use on a daily basis.

Poster Number 24

A CREATIVE COMBINATION OF TEACHING RESOURCES

Karen R. Judy, MD, Loyola University Medical Center, Maywood, IL, Allen Korenblit, MD, Rush University Medical Center, Chicago, IL

Introduction: After completing Pediatric Residency, all pediatric residents take the same certifying examination. Their success rate is a reflection of the program's success and competency in improving their residents' knowledge base. It is a measure of the success of the Residency Program. Exposure to the various subspecialties is the foundation of quality training. Some subspecialties are scarcely represented; each program may not have, at all times, a full panel of experts, with their specific clinical teaching cases. **Methods:** Chicago, a metropolis of more than 10 million inhabitants, has 10 pediatric training programs. To allow for a better-balanced exposure to some specialties, Loyola Medical School organized an intensive week-long Pediatric Board Review course for 5 years in a row from 2004-2009. Graduating, or third-year residents, from 3 other local programs were invited to attend free of charge. The course concentrated on the less-well-represented subspecialties; the combined teaching staff of the 4 residencies presented the material in a comprehensive theoretical, clinical, and problem-based manner. **Results:** Over the last 5 years, the Board Exam success rate reported by the 4 Program Directors increased from a combined 85 to 99%. This collaborative course was rated as a very effective way to prepare for the board exam by resident participants. **Conclusions:** Striving for quality education is a relentless endeavor, which can include sharing resources of expertise, time, and enthusiasm in teaching, even across the party lines of various residency programs. Over the last 5 years, the Board examination passing rate of the 4 participating pediatric programs has improved. Sharing resources in a collaborative educational event proved to be a successful forum for broadening pediatric residents' knowledge base in preparation for their certifying examination.

Poster Number 25

FUSION OF CHILD ADVOCACY AND QUALITY IMPROVEMENT: A COMBINED CURRICULUM

Jerry G. Larrabee, MD, University of Vermont Pediatric Residency Program, Burlington, VT

In redesigning the Advocacy component of our training program, it became clear that this would be an ideal home for a quality improvement initiative. The longitudinal component of our Advocacy training program hinges on the strategies put forth in Dr. Charles Oberg's publication, "Pediatric Advocacy: Yesterday, Today, and Tomorrow." Our program requires that every resident design and carry out an advocacy project over three years. Each project has a platform, political analysis, coalition strategy, research question and project, conclusion and direction for future work. In order for the projects to be robust, they need to be anchored in evidence-based data. This is where an initiative around quality improvement has become a necessary ingredient of the advocacy curriculum. The quality improvement component of the curriculum is comprised of core lectures on measures and outcomes, the PDSA cycle, IRB certification, and identification and application for grant support. While lectures provide the knowledge base, the informal teaching and guidance of the faculty mentor aligned with each resident project allows practical application. The residents therefore learn about quality improvement concepts in a setting about which they feel passionate. We are measuring success of our curriculum by tracking trends in percent of residents who are IRB certified, percent of residents with measures and outcomes tied to their project, and overall grant support for resident-driven advocacy and quality improvement projects. There has been a significant improvement in these measures with the implementation of the combined curriculum. Additionally, we are measuring trends in resident knowledge and comfort around advocacy and quality improvement with the use of a peer-validated questionnaire. Preliminary results show a clear trend toward improvement. We conclude that fusion of our child advocacy program with a quality improvement curriculum has resulted in a significant improvement in our residents' overall knowledge, comfort, and success with these initiatives.

Poster Number 26

RAINBOW JOURNAL WATCH: TEACHING RESIDENTS HOW TO "KEEP UP"

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

Critical to the maintenance of competence and the development of proficiency is the ability to keep up with new developments in medical information and patient care recommendations. As part of the Practice Based Learning and Improvement competency, the ACGME requires that residents develop lifelong learning skills so that over the course of their careers they are able to improve their knowledge, skills, and practice performance. We have developed a learning activity,

- Rainbow Journal Watch, that gives residents an opportunity to develop strategies to aid them with this important task. On a monthly basis, residents on subspecialty and ambulatory rotations are asked to summarize and comment on 1-2 recent contributions to the pediatric literature that they feel are relevant to general pediatricians. They are specifically instructed to scan the tables of contents of the major pediatric journals, those journals in the subspecialty in which they are rotating and the key medical journals for appropriate articles. These summaries are collated by the Chief Residents, further commentary is provided by one of the general pediatric faculty and the finished product is distributed by email to all the residents and faculty at our institution. In addition, it is posted to the hospital's website where it is accessed by practitioners in the community. By participating in the production of this publication, the residents develop an awareness of the content of pediatric subspecialty and key medical journals, learn to access and review tables of contents on-line, become familiar with on-line updating services provided by major journals while at the same time, applying their evidence appraisal skills. In addition, they learn the value of reading literature synopses as one approach to maintaining a current knowledge base. Finally, they provide an opportunity for the community practitioners to update their knowledge and practice. Feedback on the publication from the community pediatricians has been uniformly positive. Collection of resident feedback on the value of this activity is underway.

• **Poster Number 27**

• **ETHICS AND CULTURE IN GLOBAL HEALTH TRAINING**

• *Ryan J. Collier, MD, Lee T. Miller, MD, Kate Perkins, MD, PhD, University of California, Los Angeles, Los Angeles, CA, Robert McGregor, MD, St. Christopher's Hospital for Children, Philadelphia, PA*

• Interest in training experiences in resource-poor international settings continues to expand, with participants aiming to meet needs of partner institutions. Though the aim is to benefit the participant and host, poorly prepared experiences may have unintended and deleterious consequences in ethics and cultural competence domains. AAP consensus guidelines for international child health electives have been described, but there is notable lack of content describing ethics and cultural competence training for residents prior to embarking on global health experiences. Using an illustrative case and review of the literature, we define the problem and propose research and curriculum development plans. The UCLA Program in Global Health and Regional Hospital of Loreto in Iquitos, Peru have collaborated to create a resident rotation. In January, 2010, as part of a trip intended to train host-providers in medical education and competency constructs as well as mechanical ventilator use, the first pediatric ICU patient in hospital history was successfully intubated and ventilated after presenting severely dehydrated in status epilepticus. The child's condition deteriorated eventually to brain death. The visiting physicians, host-institution, and family made end-of-life decisions and withdrew care. None of the US-based physicians were adequately trained to facilitate this process in a culturally appropriate manner. It is unknown what positive or negative effect this process had on the host-institution or family. Literature review found little evidence to direct future participants in appropriate pre-trip preparation. The case demonstrates how international training experiences and capacity building with technology and its complications, introduces significant medical, ethical and cultural complexity. Global health electives should have curricula that include cultural competence and ethics, and are evidence-based. We propose goals and objectives for electives, and describe survey indicators to evaluate resident participant experience with pre-trip planning, post-trip debriefing, and knowledge, attitudes and skills related to these domains in international electives.

• **Poster Number 28**

• **A NOVEL MODEL FOR CONTINUITY CLINIC: PRELIMINARY RESULTS FROM AN ACGME EXPERIMENTATION AND INNOVATION PROJECT**

• *Heather McPhillips, MD, MPH, Marah Gotcsik, MD, Maneesh Batra, MD, MPH, Jeffrey Wright, MD, Daniel Mallon, MD, Ben Mackowiak, MD, Susan Marshall, MD, Richard Shugerman, MD, University of Washington, Seattle, WA*

• **PROJECT DESCRIPTION:** We were granted a waiver by the Pediatric RRC for the requirement of 36 clinic weeks per year to address the following goals: 1. Improve child health outcomes by minimizing fragmentation of care. 2. Improve resident education by allowing focused blocks of learning in both ambulatory and inpatient settings. 3. Prepare residency graduates for careers more closely resembling practice trends in our region. **METHODS:** We implemented alternating 4-week ambulatory and inpatient blocks for the R1 class of 2010. Residents attend a minimum of 2 half-day sessions of continuity clinic (CC) each week during ambulatory and elective blocks for a minimum of 42 sessions per year. Residents do not attend CC during inpatient rotations, allowing for a focus on inpatient medicine and increasing resident presence on the wards. **PRELIMINARY RESULTS:** Preliminary measures of continuity in clinics are stable. From 2006-2009 in our largest CC site, R1s saw their primary patients for health supervision visits 54% of the time. In the first quarter of academic year 2010, R1s saw their primary patients 57% of the time. Clinic preceptors report more rapid attainment of skills by R1s during this period. To assess the impact of the change on the quality of care in CC, immunization rates (% 1st year immunizations complete by 15 months) and the Continuity of Care Index (measure of dispersion of visits among providers) are being measured. By design, CC sessions for R1s will increase from 36 to 42 per year (17% increase). In the inpatient setting, handoffs between R1s decreased from an average of 4 per team per day (morning, post-call, clinic, evening) to 2 per day (morning, evening). Noon teaching conference attendance increased by 65% comparing August 2009 to 2010. **CONCLUSIONS:** Our initial experience with block ambulatory and inpatient rotations has been positive with no detriment to continuity of care. Inpatient handoffs are reduced and conference attendance has increased. We will present the first six months of data on quality markers for patient care in the CC setting.

Poster Number 29

HANDOFF INDEX (HI): THE HI AND LOW OF HANDOFFS WITH NEW DUTY HOUR RESTRICTIONS

Laura E. Norton, MD, Michael C. Weisgerber, MD, MS, James Nocton, MD, Medical College of Wisconsin, Milwaukee, WI

Background: Many residency programs must restructure resident schedules to comply with the new ACGME approved standards for duty hours. Although the ACGME recommends minimizing the number of transitions in patient care, we anticipate increased handoffs will result from new limitations in duty hours. This may lead to suboptimal patient care and increased medical errors. A system to accurately quantify handoffs may be useful for residency programs in the development of new resident schedules. Currently no tools exist to quantify and compare number of handoffs in various ward team schedules. Our objectives were to a) develop a tool (the Handoff Index [HI]) to project the number of handoffs occurring in various ward team schedules and b) validate the accuracy of the HI. Methods: We developed the HI to relate number of handoffs per day to patient census and facilitate comparisons. $HI = \text{total handoffs}/\text{daily census}$. We defined handoff as transition of care > 4 hours. The projected HI (HIp) for a given ward team schedule is a complex calculation based on expected handoffs that occur at the completion of calls and shifts, and time of departure to clinic. This calculation is easily adapted for variable numbers of interns and acting interns on a team. The HIp was calculated using a typical resident team of 4 interns with total patient census of 20 for a) every fourth night (q4) call schedule, b) day shift/night float (NF) schedule, and c) day shift/short call/night float (SC) schedule. The actual HI (HIa) will be calculated for a) current q4 schedule and b) piloted SC schedule. Data to calculate the HIa will be prospectively collected by tracking daily census and all handoffs. Results: The HIp is 1.6 for q4 schedule, 2.2 for NF schedule, and 2.8 for SC schedule. The HIa results for the q4 schedule and SC schedule will be available and presented. Conclusions: The HIp is a tool to compare expected number of handoffs in various resident schedules. It may be useful for programs planning changes in resident schedules. A comparison of the HIa and HIp will provide further data on its accuracy as a predictor of handoffs.

Poster Number 30

ACHIEVING RESIDENT POTENTIAL: DEVELOPING A COMMITTEE TO MAXIMIZE RESIDENT PERFORMANCE

Megan E. Aylor, MD, Beau Weill, MD, Dana Hargunani, MD, Cindy Ferrell, MD, Oregon Health & Science University, Portland, OR

Background: Identifying and remediating problem residents is a challenge that nearly every residency training program faces. Programs are challenged to recognize difficult learners, determine the underlying cause of their struggles, and manage deficiencies. In response to this need at our own institution, the Achieving Resident Potential Committee (ARPC) was founded in 2008. The committee was developed for longitudinal assessment of the clinical and professional competency of pediatric residents in training at OHSU. The ARPC reviews and monitors resident progress and provides guidance to the resident, her advisor and/or Program Director in situations where a resident may need help to maximize her potential. The primary goal of the ARPC is to ensure that residents have every opportunity to succeed during their training and that they have access to the tools necessary to accomplish this. The objectives of the committee are the: early identification of, and intervention for, residents demonstrating learning or professionalism needs, timely and clear communication with those identified residents, creation of, and support in completing a learning/remediation plan, and the identification of and collaboration with outside personnel (advisors, mentors, etc.). Residents are referred to the committee in various ways, including in training exam scores, rotation/peer evaluations or by personal request. Upon referral to the ARPC, the committee reviews the case, determines appropriate next steps, and, if necessary, develops a plan for intervention. The plan is reviewed on a regular basis and the resident's successful achievement of competencies is monitored. Outcomes: In its 2 year existence 11 of our 53 residents were reviewed by the ARPC. Competencies and issues reviewed included Medical Knowledge (4), Professionalism (5), Burnout/Mental Stress (3), and Efficiency (2). Interventions ranged from referral to the resident wellness center to creating senior resident prep experiences. Involved residents have demonstrated improvement in targeted areas and have successfully advanced through the program.

Poster Number 31

CREATING AN INNOVATIVE MODEL TO IMPROVE RESIDENT HANDOFFS: THE UNANTICIPATED PATIENT OCCURRENCE

Jennifer K. O'Toole, MD, MaryCarol Burkhardt, MD, Samuel Hanke, MD, Ryan Buchholz, MD, Cincinnati Children's Hospital Medical Center, Cincinnati, OH

INTRODUCTION: The frequency of handoffs in patient care among resident physicians is increasing due to duty hour restrictions. These transitions of care between physicians represent high-risk points for potential errors in patient care. A multi-disciplinary team in a large pediatric teaching hospital undertook a quality improvement initiative with a global AIM of improving the transitions of care between resident physicians. METHODS: A multi-disciplinary team was formed that included faculty, residents, nurses, and QI consultants. The team developed an instrument to measure unanticipated patient occurrences (UPOs) which would detect potential triggers for adverse events or precursor safety events. The following occurrences constitute UPOs: an unanticipated transfer of a patient to the ICU, code or medical response team (MRT) activation, incorrect orders, and failure to communicate abnormal vital signs/physical exam findings, critical study results, parent/nursing concerns, pertinent consultant information or key information leading to discharge delays. Once baseline UPO data collection was obtained, the team then instituted various interventions aimed at improving the communication and situation awareness, both written and verbal, that occurred between both physicians and nurses during the handoff process. Interventions included "group handoffs" between nurses and residents and standardization of the handoff document to

- highlight potential warnings. RESULTS: Following the institution of “group handoffs” on a pediatric inpatient team, the median number of days between UPOs improved from a baseline of 2 days to 7 days. The new baseline was maintained during the various other PDSA interventions. DISCUSSION: A resident-driven collaborative safety project focusing on handoffs of care was successful at developing a tool (UPOs) that detected potential triggers for adverse events on a pediatric inpatient service. The implementation of a group handoff and a standardized handoff tool, was associated with a decreased number of UPOs on one inpatient unit representing an initial step toward sustainable change.

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• **Poster Number 32**

• **DESIGNING AND IMPLEMENTING A NIGHT SHIFT CURRICULUM**

• *Daniel P. Mallon, MD, Marah E. Gotcsik, MD, Benjamin Mackowiak, MD, Sarah Hilgenberg, MD, Mary Ehlenbach, MD, Holly Romero, MD, Susan G. Marshall, MD, Maneesh Batra, MD, MPH, Heather McPhillips, MD, MPH, Richard Shugerman, MD, University of Washington/Seattle Children’s Hospital, Seattle, WA*

• Introduction: To comply with ACGME Duty Hour requirements, many programs have transitioned to a day and night shift care model for inpatient rotations. Day shift residents have the ability to attend teaching conferences and have access to attendings and fellows for additional teaching. Overnight residents in our program have not previously had structured educational sessions. Our goals were to 1) develop a structured educational experience for residents at night and 2) to evaluate the quality of this curriculum over time. Methods: Residents were surveyed for their opinions regarding the desired structure, content, personnel, and timing of proposed night shift teaching sessions as well as their baseline satisfaction with and time allotted for educational activities at night. Based on their input, a formal night shift curriculum was implemented October 2010. At the end of each rotation, residents complete a web-based survey to assess changes in their satisfaction, allotted time and perceived value of night-time teaching. Results: 32 of 64 eligible residents responded to the survey. 61% of surveyed residents were interested in structured night shift teaching and learning. Residents agreed they would prefer case-based discussions, and 93% endorsed focusing on management of acute inpatient problems. 70% wanted sessions to be led by hospitalists and/or 3rd-year residents. Cases were developed to facilitate discussion around key management decisions and are distributed by facilitators as 1-page handouts with relevant case history and data with sequential prompts for discussion. By March 1, 2011, comparative data will be available for at least 80 residents who have completed night shift rotations. Changes in resident interest, allotted time and perceived value of night-time teaching will be reported. Discussion: Residents at our institution are interested in structured night shift education about management of acute inpatient problems. The growing prevalence of night shift work during residency and the increasing presence of hospitalists in pediatrics present a new opportunity to formalize educational experiences overnight.

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• **Poster Number 33**

• **SELF-DIRECTED LEARNING LOGS: USING NIGHT TEAM TO BUILD LIFELONG LEARNING SKILLS**

• *Ginna Priola, MD, Martha S. Wright, MD, Robyn Strosaker, MD, Rainbow Babies and Children’s Hospital, Cleveland, OH*

• As residencies move to utilize Night Teams to provide overnight inpatient coverage, the challenge of providing didactic education to these residents during off-hours has become increasingly evident. Some programs have made daytime conferences available for viewing on the internet, others have implemented on-line learning opportunities. We describe a different approach to this issue, one which promotes self-directed learning, allows the residents to choose learning options that are most conducive to individual learning styles and encourages and rewards small group teaching by senior residents. In September 2010, we instituted overnight self-directed learning logs in which Night Team interns and residents document the teaching and learning that they do during night shifts. The interns and residents are instructed to catalog all of the learning activities they engage in, the key points learned and the strategies utilized. Multiple educational modalities are available to the overnight residents including morning conference Powerpoint presentations, on-line Grand Rounds, journal or textbook reading, PREP questions and small group teaching sessions led by the senior residents. Each learner can choose their educational opportunities and match them to their learning style preferences thus promoting effective self-directed learning. Residents who participate in and document overnight educational activities are eligible for conference attendance credit based on a point system that accounts for likely amount of time spent in any one activity. Senior residents who lead teaching sessions overnight receive double credit for these activities (to teach is to learn twice). Collection of formative feedback on the log format and utility as well as resident satisfaction with the process is underway. We anticipate that this activity will encourage further development of self-directed learning behaviors in our residents and motivate them to engage actively in their education.

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• **Poster Number 34**

• **EXPOSING RESIDENTS TO NOVEL CAREER CHOICES: A MULTI-PRONGED APPROACH TO CAREER DEVELOPMENT**

• *Rebecca Blankenburg, MD, MPH, Sahar Rooholamini, MD, MPH, Michael Tracy, MD, Lucy Lee, MD, Laura Bachrach, MD, Madelyn Kahana, MD, Lucile Packard Children’s Hospital at Stanford, Palo Alto, CA*

• In order to help residents explore possible career choices, identify the one they are most interested in, and prepare them for whatever additional training they might need in order to realize their career goals, the Pediatric Career Development curriculum was created at Stanford. This curriculum strives to go beyond just helping residents successfully apply for a job or fellowship. It addresses a number of areas including how to be successful in fellowship, how to apply for your first job post-residency/post-fellowship and be successful in your pediatric career, how to prepare CVs and cover letters, the interviewing

process, contract negotiation, credentialing, moonlighting, specific careers in general and subspecialty pediatrics, academic vs. non-academic careers, non-clinical career options, and work-life balance. A number of modalities are employed to reach residents: noon conferences, evening career development sessions (including didactic sessions, panels, question and answer sessions), one-on-one advising, mentored scholarly activity, CV review sessions, mock interviews, development of an alumni network, and web-based modalities. A continuous needs assessment is done, and the curriculum is continuously adapted to learners' needs. Resident reflections have noted that the most valued aspects of the curriculum have been hearing about attendings' career paths, networking, one-on-one advising sessions, and web-based resources. This innovative, web-based curriculum can be adapted to meet any program's needs (website: peds.stanford.edu/professional-development).

Poster Number 35

INNOVATIVE RESIDENT AS TEACHERS FORMAT: THE TEACHING SENIOR ROTATION AT STANFORD, MORE THAN A DECADE OF TEACHING RESIDENTS TO TEACH

Rebecca Blankenburg, MD, MPH, Gretchen Shawver, Julie Pantaleoni, MD, Melissa Dunagan, MD, Erin Augustine, MD, Elizabeth Stuart, MD, MEd, Lucile Packard Children's Hospital at Stanford, Palo Alto, CA

The Stanford Teaching Senior Rotation is a required one-month experience that allows PL-3 residents to build their skills in teaching and giving feedback, and helps fulfill the teaching aspect of the Practice-Based Learning competency. Learning objectives focus on large group teaching, small group teaching, bedside teaching, one-on-one precepting, and teaching in the busy context of patient care. Residents are mentored throughout the month by a dedicated faculty member. The rotation begins with an orientation, which includes goal-setting and an exploration of residents' learning styles and teaching perspectives using a series of on-line tools. To meet objectives for large and small group teaching, residents review key educational models before designing and implementing their own teaching sessions. They then receive immediate, structured feedback and set goals for future work. Residents are encouraged to be creative in their teaching roles and push themselves to try new techniques. There is an emphasis on the impact that learning climate and learning styles have on the teaching interaction. Learning sessions on giving feedback provide practice with setting expectations and using a variety of feedback models and tools. In the past year, there has been added emphasis on coaching struggling learners, through role plays and reflection on specific encounters. At the end of the month, residents engage in written and oral reflection on goals met and next steps for further development. Resident's reflections indicate that the following aspects of the rotation are most highly valued: giving morning report with structured feedback from the same faculty member after each report; developing teaching relationships with a small group of medical students and seeing their improvement over the month; and taking time to reflect on teaching/feedback techniques that are modeled in everyday work. The components of this innovative rotation can be adapted to meet any program's needs, as part of existing clinical rotations, longitudinal Residents-As-Teachers programs, or as an elective.

Poster Number 36

USE OF ELECTRONIC RESOURCES AMONG PEDIATRIC RESIDENTS

Laura Y. Haubner, MD, Valerie Panzarino, MD, Sally Coovert, PhD, Robert M. Nelson, MD, University of South Florida Health, Pediatrics Resid, Tampa, FL

Most pediatric residents are members of the "Millennial" generation, which refers to those born between 1970 and 2000 with increased use of communication, media, and digital technology. We set out to determine the degree of electronic resource use among pediatric residents. An anonymous survey was sent to 52 pediatric residents via Survey Monkey with 35 responses. The survey evaluated resident demographics, study patterns, medical reference use and use of electronic media. The respondents were 77% female and 80% were 25-30 years old. Social networking is used by 83% of our pediatric residents, most (89%) do to keep in touch with family and friends others use it for work or educational activities. When asked about time spent reading about medical topics relevant to pediatrics, 51% stated they spend more than three hours in the prior week. For 51%, reading is done during work hours in the clinical setting, rather than non-work hours. The number of literature searches done in the prior month varied greatly with 20% performing more than seven. Bedside information products were used most commonly to answer clinical questions. Google, PubMed, Medline/Ovid, and text books are used in decreasing frequency in that order. Only 3% of respondents use text books most commonly to answer clinical questions. When asked how often they use electronic resources to answer clinical questions, 67% responded they do so daily while 3% do so every two weeks. Overall, 63% of our pediatric residents utilize mobile electronic devices for clinical or educational reasons. Frequently used resources such as handbooks or papers are used by our residents in the following manner: 34% carry them on their person, and 63% access them from a website, and 3% access them for a server. In conclusion, the majority of the USF pediatric residents rely on digital resources as tools to enhance their pediatric knowledge and to improve their health care delivery. Further development and availability of these resources needs to be evaluated closely for impact on learning and patient care.

Poster Number 37

QUALITATIVE STUDY OF AMERICAN MEDICAL GRADUATES' CHALLENGES AND THEIR AWARENESS OF PEER INTERNATIONAL MEDICAL GRADUATES ACCULTURATION CHALLENGES

Aarati Rao, MD, Marilyn O'Brien, Christopher Freed, PhD, Franklin Trimm, MD, University of South Alabama, Mobile, AL

25% of residents and practicing physicians are International Medical Graduates (IMGs). IMGs face transitional challenges which are work-related (e.g. communication, interpersonal interactions, and navigating the health care system) and non-work-related (e.g. establishing residence and identity in the US) acculturation issues. The authors conducted focus groups with American Medical Graduates (AMGs) to assess: 1. AMG awareness and understanding of IMGs' acculturation challenges; and

- 2. challenges AMGs faced while working in a residency program with IMG peers. The authors explored: 1. AMG transition challenges at work; 2. experience with staff and patients; 3. non-work issues such as finding a place to live and adjusting to a new city; 4. the AMGs' assessment of challenges faced by IMG peers; and 5. how these challenges affect the work relationships between them. Qualitative data revealed that AMGs were aware of some of the non-work challenges that IMGs face and reported helping out suggesting solidarity among AMGs and IMGs. Focus group themes also revealed that AMGs easily adapted to the work-related challenges of a new hospital and personnel and to the non-work related challenges of settling into a new city. At work, AMGs recognized a communication hierarchy between staff, residents and faculty. Unlike their IMG counterparts, AMGs quickly recognized the "hidden agenda" that practicing medicine is governed as much by medical liability as by medical knowledge. The AMGs are challenged by decision making. The AMGs appreciated that most of the IMGs were experienced MDs coming into the residency and as such had the advantage of knowledge and experience over them. However, similar to IMGs, AMGs felt that patients and hospital staff often did not credit them for being medical professionals in the initial year of residency. AMGs expressed frustration in dealing with professional issues such as USMLE step 3, licensing and applying for the boards. In conclusion AMGs do not experience the same work and non-work transitional challenges that their IMG counterparts encounter.

• **Poster Number 38**

• **IT CAN BE DONE! ENGAGING PEDIATRIC RESIDENTS IN QUALITY AT THE "101" LEVEL**

• *Paul M. Shore, MD, MS, Robert Bonner, MD, Celeste Chamberlain, BSN, MS, CPHQ, David Cooperberg, MD, Mackenzie Frost, MD, Cheryl Gebeline-Myers, BS, Bryon Lauer, MD, Matthew McDonald, MD, Robert McGregor, MD, St. Christopher's Hospital for Children, Philadelphia, PA*

• Physicians must evaluate their roles in health care systems and improve quality of care delivery. Few curricula exist to educate pediatric residents in Quality Improvement (QI). We describe an approach to the challenge of educating pediatric residents and fulfilling ACGME requirements without a large in-house QI program. In a freestanding, 3^o-care children's hospital in urban Phila. with 78 Categorical Pediatric residents, a core group of 2 general and 2 subspecialty pediatricians with interest in QI (but no formal training) were chosen as faculty leaders to develop a curriculum. Four additional physicians assist with implementation. All meet regularly with 15 residents and the hospital's 2-member QI Dept. to plan and revise the curriculum and its implementation. After a literature review, the core group developed a general curricular framework, then assessed residents' perspectives on implementation in each continuity clinic. Residents clearly wanted a strong role in developing their projects and close guidance from faculty mentors. Our 1-yr curriculum consists of a series of interactive, monthly noon conferences where faculty-guided, sequential didactics parallel the development of the residents' projects. In the first conference, residents learned basic QI principles then self-selected into 6 groups based on domains of pediatric care: Ambulatory, Emergency, Inpatient, Outpatient/Subspecialty, Units, Other. Each subsequent conference has a distinct learning objective that parallels the days' assignment for their smaller group projects. For example, one conference introduces the Plan part of the PDSA cycle and teaches how to make an effective aim statement; residents then develop their projects' aim statement guided by faculty mentors recruited from the 6 domains. All conferences have both didactics and project work time. By year's end, residents will have received the entire curriculum and completed a measurable step in a full PDSA cycle. Learning progress will be measured by the QIKAT (Vinci 2010), which we modified for pediatrics and will publish. Residents are enthusiastic so far as culture is being transformed.

• **Poster Number 39**

• **THE PATIENT PROTECTION AND AFFORDABLE CARE ACT: TEACHING RESIDENTS WHAT THEY NEED TO KNOW ABOUT HEALTH CARE REFORM**

• *Ryan Collier, MD, Alma D. Guerrero, MD, MPH, Alice A. Kuo, MD, PhD, UCLA, Los Angeles, CA*

• Background: The passage of the Patient Protection and Affordable Care Act (ACA) was a landmark legislation in our recent history. This more than 2,000-page piece of legislation will dramatically affect the practice careers of the recent graduates and young physicians currently in residency training. Not understanding how the ACA will affect care of this nation's children will be a tremendous detriment to these young physicians as they enter a changing practice market. Activities: In our program, we have had a one-month, third-year legislative and media advocacy rotation for over seven years. For March 2011, we have 13 residents scheduled for the rotation. Each year, we work with the Executive Director of our District of the American Academy of Pediatrics (AAP) to prepare fact sheets on ongoing bills in the legislature, write letters to legislators on behalf of the AAP and make visits to both legislators and regulators in Sacramento. This year, we have engaged national AAP staff in State Government Affairs to develop the curriculum for our 2011 advocacy rotation, looking specifically at the impact of the ACA on California. Our residents will be preparing materials for California pediatricians to understand the impact of the ACA on children in California. In addition, they will each write an opinion piece for the Los Angeles Times newspaper, and pitch their piece to an editor. Finally, a subset of the residents will give a presentation at Grand Rounds on the impact of the ACA locally at UCLA. Conclusions: While health care reform has many positive things for insurance coverage for traditionally underserved children, there are many practice implications in the ACA (i.e., formation of Accountable Care Organizations, financing, exchanges) which will affect young physicians practicing in the 21st century. As residency programs, we have a responsibility to our trainees to educate them both on how the ACA will improve care for children and how the ACA will change the way they practice medicine in the near future.

Poster Number 40

SCHOOL FUNCTION PROGRAM: AN APPROACH TO TEACH RESIDENTS HOW TO ADDRESS MENTAL HEALTH PROBLEMS IN CONTINUITY CLINIC

Alice A. Kuo, MD, PhD, Bobby Verdugo, MSW, Alma D. Guerrero, MD, MPH, UCLA, Los Angeles, CA

Background: Pediatric residents often care for children with Medicaid insurance or no insurance. While these children are often physically “healthy”, they often suffer from mental health and family dysfunction issues which impact their academic performance in school. It has traditionally been difficult to incorporate mental health education and clinical practice into residency education. Activities: Each continuity clinic afternoon, at least two patient slots were designated as “School Function” slots for referrals from pediatric residents, staff pediatricians, family medicine physicians, teachers, or parents for school-aged children with school difficulties. These school problems could include poor grades (at least 2 C’s or worse), history of school failure, behavioral problems, inattention problems, or difficulty accomplishing homework tasks. A toolkit was developed which consisted of a PowerPoint presentation on common school function problems; clinical algorithms for common mental health issues contributing to poor school performance such as anxiety, depression, attention-deficit hyperactivity disorder (ADHD), and oppositional defiant disorder/disruptive behavior disorder; intake forms which guide the residents through an appropriate school function history; and resources that the residents could offer to the patient and family. We also use the AAP Vanderbilt ADHD toolkit to diagnose, manage and monitor children subsequently diagnosed with this disorder. In addition, during each continuity clinic session, either a social work intern or case manager (supervised by a social worker) was available to provide support to the residents seeing the school function patients. Conclusions: With this approach to addressing mental health problems in continuity clinic, we are able to give residents valuable skills in an area which has traditionally not be taught well during residency training. In addition, we are providing an important service to an underserved population which has not had access to educational advocacy.

Poster Number 41

QI OLYMPICS: “QUALITY” TIME OUTSIDE THE HOSPITAL

Elizabeth R. Hanson, MD, Lee Atkinson-McEvoy, MD, Katie E. McPeak, MD, Glenn Rosenbluth, MD, Univeristy of California San Francisco, San Francisco, CA

Background: QI principles and methodologies can be learned and applied in a variety of settings. UCSF pediatrics residents participate in a medically-based QI curriculum with lectures, a community rotation, and continuity clinic. Objective: Expand our QI curriculum to include non-medical QI activities at a residency retreat. Methods: We developed two 50-minute QI-based activities: Egg Drop, and Alphabet Soup. 36 residents participated (42%). In Egg Drop, teams of 4-5 designed and tested packages to protect an egg during an 8-foot drop. In the preliminary attempt they were asked to, “Make the best container you can”. Packages were scored (Weight+Length+Width+Cost). Teams then had to improve the package using PDSA methodology. Egg-breaking was a never- event. If the egg broke on the first attempt, the goal was to protect the egg. If the egg survived the drop intact, the goal was to improve the score. In Alphabet Soup, teams of 8-10 had to step on 26 letters sequentially with only one person on the field at a time. After a preliminary attempt, they were challenged to improve their time using PDSA methodology. For both activities teams completed QI worksheets after each cycle, documenting Aims, Measures, PDSA cycles, and decisions to Adapt, Adopt, or Abandon change. Post-workshop surveys were distributed. Results: In Egg Drop, 8 teams completed 27 drops and 19 PDSA worksheets. One team adopted their original design; 7 teams adapted/improved their original design (mean 38% improvement in score). In Alphabet Soup, 4 teams completed 19 cycles and 15 PDSA worksheets. All teams improved after multiple PDSA cycles (mean improvement was 15%). 31/32 (97%) residents who completed surveys marked Excellent or Very Good for both “Attainment of Goals & Objectives” and “Applicability to Residency & Practice of Medicine”. Conclusions: Non-medical QI activities can enhance QI curricula. In our activities, resident teams completed many PDSA cycles in a ramp fashion. Activities were well-liked and felt to be relevant to clinical work. This spring we plan to continue the QI curriculum in a medical setting (continuity clinic) with 100% of our residents.

Poster Number 42

RESIDENT PERCEPTION OF HALF-DAY EDUCATIONAL SESSION

Penny L. Adams-Kraus, C-TAGME, Kristin L. Koehn, MD, Joy C. Drass, MD, University of Missouri-Columbia, Columbia, MO

Introduction: Our program transitioned to a half-day didactic session in July after discussion with faculty and resident education leaders. They identified barriers to effective education in a noon format including a lack of protected time, insufficient time for simulation, procedure labs, quality improvement and advocacy projects, and a lack of flexibility in educational styles. The new system incorporates lectures, group sessions for QI, practice management, and advocacy, skill labs, and case simulation. We wanted to assess resident satisfaction with the new system. Methods: Current R2 and R3s who participated in both educational formats completed an anonymous survey examining their satisfaction in a noon or half-day session covering the following areas: procedural skills, core pediatric topics, management of common clinical scenarios, common outpatient parental questions, management of ICU clinical scenarios, practice management, QI, and an overall grade. Results: Survey participation examining the noon lecture format was 77% and the follow-up half-day format was 69%. Greater than 50% of residents reported a poor educational experience in procedures in the noon format and fair-poor experiences in management of ICU clinical scenarios, QI sessions, and practice management. Following implementation of the half-day sessions, resident satisfaction in the problem areas of procedural skills, ICU management, QI, and practice management all demonstrated improvements with >80% of residents ranking these areas fair-good. Overall grade was rated as good by 70% of residents in the half-day format versus 50% in the noon format. Conclusions: Early response to the new system has been positive with improvements noted in the areas

- traditionally difficult to cover in 60 minutes. We have room to improve our educational efforts and continue to adjust the content of didactics based on frequent resident feedback. The half-day format has been beneficial in addressing our gaps in simulation and procedure labs in addition to augmenting our curriculum in advocacy and QI.

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• **Poster Number 43**

• **QUALITY IMPROVEMENT CURRICULUM: LESSONS LEARNED & PLANS FOR THE FUTURE**

- *Amanda D. Osta, MD, Michelle M. Barnes, MD, UIC-Pediatrics, Rachel N. Caskey, MD, UIC-Med-Peds, Chicago, IL*
- The ACGME requires that residents gain competence in systems-based practice and practice-based learning. Historically, quality improvement education has not been a priority for pediatric GME, thus, many residents do not have adequate skills to participate in quality improvement (QI) efforts. To provide our pediatric residents with the framework for understanding and implementing QI in a medical practice, we implemented a QI curriculum in 2009. After this inaugural year, a PDSA cycle on our curriculum was performed. We identified components of our curriculum that were successful: 1) didactic lectures describing the process of QI; 2) QI resident work groups based in continuity clinic with PGY2s as group leaders; and 3) resident presentation of QI projects at Grand Rounds at the end of the academic year. We found several areas which need to be improved including expanding the QI projects to other settings to prevent overburdening one clinical arena. Many of the projects attempted to incorporate ancillary staff with varied success. The resident projects also needed to have more rapid PDSA cycles in order to truly improve quality of care. During the academic year 2010-11, resident QI projects will take place not only in continuity clinic but also on the inpatient unit. In continuity clinic, there is now a multidisciplinary structure of QI improvement that integrates all of the staff. There is a team leader from the clerks, MAs, nurses, faculty, and PGY2 residents who participate in monthly meetings regarding quality improvement. These monthly meetings are rapid improvement circles (RIC) which facilitate multidisciplinary involvement in QI projects with the goal of expediting implementation of the QI efforts. A sustainable QI curriculum in which residents are active participants is an opportunity for teaching core competencies to residents. In order for the QI curriculum to be successful it is best if it is incorporated into other QI initiatives that are occurring throughout the hospital. Ongoing evaluation of a QI curriculum is just as important as evaluation of QI initiatives.

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• **Poster Number 44**

• **INTERNATIONAL MEDICAL GRADUATES: AN ASSET TO YOUR PROGRAM LOCALLY AND GLOBALLY**

- *Charles J. Schubert, MD, Javier Gonzalez, MD, Cincinnati Children's Hospital Pediatric Residency, Cincinnati, OH*
- Global health experiences for US residents are valuable but often one sided. Therefore, to make global health more of a two-way street, our Global Health Program at Cincinnati Children's Pediatric Residency set an intentional goal of matching 3 IMG each year, in addition to encouraging residents to take rotations abroad. The concerns with international medical graduates (IMG), stated or not, revolve around the academic competency of these students and the potential of encouraging "brain drain" from other countries. However, if the best and brightest IMG could be trained here and encouraged to "give back" to their home countries, the U.S. program training them could benefit from increased diversity and future collaboration with other countries. Our program interviews top international residency candidates from approximately 400 applicants and makes selections based on training, interest, transcripts, USMLE and letter of recommendations. Nineteen IMG have been matched in the past 9 years. Nine residents are still in training, 10 have graduated with 9 of these entering fellowships. Five now have academic appointments in 4 different academic institutions. They are outstanding candidates and perform as well on the wards and in the clinics as our US trainees. When all 19 were asked their future plans, 18 responded and all but one stated plans to maintain a connection with their home country by research, teaching or service collaborations. Five plan to return to their home country to build training or research programs. Training the best and brightest international medical graduates brings diversity and a richness of experience to a training program. The involvement of these residents at a US residency program provides a better understanding of global health for other trainees and allows global health to become a two way street. Encouraging our IMG to give back can also lead to building health care capacity in the home countries as well as international collaborations with our institution.

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• **Poster Number 45**

• **IMPLEMENTATION OF A THREE YEAR RESIDENCY RESEARCH CURRICULUM**

- *Erika L. Abramson, MD, MS, Cori Green, MD, Mary J. Ward, PhD, Weill Cornell Medical College, New York City, NY*
- Background: While pediatric residency programs are mandated by the ACGME to develop a curriculum advancing resident knowledge of the basic principles of research, there is little published research on how best to deliver this curriculum.
- Objective: To describe the development of a comprehensive, 3 year curriculum designed to educate residents about the research process and enable them to develop and complete an IRB approved research project. Setting: Sixty person pediatric residency program at an academic-affiliated tertiary care medical center. Program Principles: The main tenants of our program include: 1) developing a structure to facilitate research; 2) formal mentoring of residents and faculty; 3) creating a culture in which research is an expected and valued part of the residency experience. Curriculum Overview: By the end of intern year, every resident is expected to have identified a research project and mentor to oversee their work. A Residency Research Oversight Committee (RROC) of dedicated faculty members actively engaged in clinical research meets monthly to oversee the progress of their assigned resident advisees. Progress is mapped to a series of required milestones developed by the RROC and distributed to residents during intern year. Junior residents present research updates to their peers and the RROC, while senior residents present their final project at a department-wide conference attended by peers, faculty, and senior departmental leadership. The RROC has also developed a series of lectures on research principles for residents, and faculty

members receive training during faculty development workshops on successful mentoring. Results: Since the program began in 2005, 100% of residents have successfully completed a research project. In the past 2 years alone, 40% of senior residents (n = 16) have presented their work at regional or national meetings and 2 residents published papers in peer-reviewed journals. Conclusions: A structured program over 3 years with multiple levels of oversight and mentorship can successfully promote pediatric resident involvement in scholarship activity.

Poster Number 46

ONLINE RESIDENT EDUCATION: A NEW MODEL

Leah Busse, MD, Aisha Davis, MD, April Troy, MD, Childrens National Medical Center, Washington, DC

Background: A web-based home for core academic resources was created for pediatric residents at Children's National Medical Center utilizing an online learning management platform. The website provides pediatric residents unrestricted access to core articles, technique-based videos, and educational links, but use is generally not mandated. Web-based curricula are a growing trend which allows adult learners to diagnose needs, formulate learning objectives, and fill knowledge gaps asynchronously. However, there is limited information regarding usage patterns and satisfaction to guide curriculum design in an era when duty hour restrictions are likely to make these tools necessary. This study aims to determine when residents naturally utilize its resources most in order to guide further design and implementation. Methods: Using the tracking mechanism embedded in the course management platform, a query of six months of utilization data was performed. Use data was cross-referenced with resident schedules to determine hits based upon rotation type and level of training. Utilization was specifically evaluated for supervisory and night float rotations although general trends were also evaluated. Results: Analysis reviewed usage patterns by post graduate year, time of day, and most frequently viewed aspects of the curriculum revealing a bimodal pattern of use, greater utilization during supervisory roles, and increased utilization during night float rotations. Conclusions: In the absence of established best practices, usage patterns of web-based resources is a major factor guiding their implementation. Given naturally increased use of these resources during night float and supervisory roles, opportunities for implementation in these settings should be considered. Multi-institutional evaluation should also be considered.

Poster Number 47

DEVELOPMENT OF A SUSTAINABLE AND ETHICAL RESIDENT TRAINING EXPERIENCE IN GLOBAL CHILD HEALTH

Maneesh Batra, MD, MPH, Suzinne Pak-Gorstein, MD, MPH, PhD, Judd L. Walson, MD, MPH, University of Washington, Jaqueline Naulikha, KRCHN, KEMRI-University of Washington, Heather A. McPhillips, MD, MPH, Brian D. Johnston, MD, MPH, Richard P. Shugerman, MD, University of Washington, Seattle, WA

An increasing number of US residency programs are developing global health training experiences. Given the time limitations during residency, many experiences are short-term and can become self-serving, ineffective, or unsustainable. Leveraging a long-standing collaborative relationship between the University of Washington (UW) and the University of Nairobi (UoN), we developed a global health "pathway" to equip both US and Kenyan pediatric residents with knowledge and experience to reduce health disparities among children. The curriculum focuses on community pediatrics and advocacy and is based on the principles of collaboration, teamwork, education, service, and sustainability. For US residents, the pathway begins with a 1 month experiential rotation in the PL2 year that focuses on public health, social justice, program evaluation, and ethics. In the PL3 year, UW residents are paired with a UoN resident and together participate in a 2-month block in a Kenyan rural provincial hospital. The focus of this rotation is to extend their experiences beyond clinical management of hospitalized patients. Each resident pair assesses community health needs, develops and implements proposed solutions, and monitors the results of prior interventions. They present their findings to the Provincial Hospital, the public health community and to faculty and trainees at the UW and UoN. To date, 5 pairs have successfully completed the rotation and have established a focus on community-based prevention and management of malnutrition as a longitudinal goal. Global health electives involving resident physicians can be conducted responsibly and ethically if undertaken with forethought and planning. Partnering with one community and one hospital ensures greater sustainability. Focusing on community health needs, rather than on individual patient management, highlights the importance of health promotion and disease prevention for sustainable improvements. Finally, by partnering with the UoN residency, the collaboration provides community-based training for Kenyan residents and integrates US residents into the local health structure.

Poster Number 48

FILLING A GAP: CREATING A DEPARTMENTAL FACULTY DEVELOPMENT PROGRAM FOR CLINICIAN-EDUCATORS

Wendy Hobson-Rohrer, MD, MSPH, James Bale, MD, John Carey, MD, University of Utah, Salt Lake City, UT

Background: Pediatric departments must ensure that their faculty members are well prepared to teach and to lead others. Strategies by which individual departments can create rigorous faculty development programs for clinician-educators are needed. Methods: At the University of Utah Department of Pediatrics, an Academy of Pediatric Education and Leadership (APEL) was created to fill this need for our faculty. Utilizing local and national expertise, including the Initiative for Innovation in Pediatric Education (IIPE), we developed the APEL curriculum to provide weekly seminars to teach education and leadership skills for faculty scholars. With faculty from our main and medical campuses, scholars are learning about adult learning theory, curriculum design, behavior change, research design, and negotiation. Scholars will also complete

education portfolios to assist with their career development. Results: In the first year of the program, we have enrolled four faculty scholars and three chief resident scholars. The scholars meet weekly for workshops centered on educational methodology, educational research, and leadership skills. All scholars have an educational research project, with a committee of mentors. The research topics include: simulation in education, teaching research associates, teaching residents to improve breastfeeding in teen mothers, revising a resident quality improvement curriculum and pediatric neurology curriculum for residents.

Poster Number 49

ASSESSMENT OF HOW INTERNATIONAL MEDICAL GRADUATES (IMGS) ADAPT TO THE US HEALTH CARE SYSTEM: A QUALITATIVE STUDY

Aarati Rao, MD, Marilyn O'Brien, Christopher Freed, PhD, Franklin Trimm, MD, University of South Alabama, Mobile, AL
International Medical Graduates (IMGs) encounter acculturation challenges that delay their 'learning'. In August 2009 and August 2010, focus groups were held with IMG interns to identify problems encountered in acculturation and to follow up and determine how they had adapted to these problems. In 2009, the IMGs voiced concern in: 1) understanding medical insurance and medico-legal liability; 2) language fluency and how accents lead to misinterpretation, particularly by nursing staff and patients; 3) varied cultural and gender roles that are misinterpreted by peers and faculty; and 4) how patients did not respect their medical skills. Non-work-related challenges included difficulty obtaining social security numbers, apartments, a driver's license and automobile insurance, and establishing an individual identity in the US. In a follow-up focus group session in 2010 the IMGs no longer considered their language a problem. They determined that it was the patient who had the problem with communication as patients misunderstood American doctors as often as they misunderstood IMGs. Over the course of the first year, the IMGs learned part of the 'hidden curriculum' which the American medical graduates already understood, that medical malpractice concerns drive medical care in the US. While IMGs enter residency confident in their skills, they learn to worry about missing information or diagnoses in the US. Acculturation was not realized with regard to professional status values. Even after one year, the IMGs had difficulty accepting the casual doctor-patient relationship. For the IMGs, professional status is part of being a doctor and they are reluctant to see that status diminished.

Research Posters

Poster Number 50

IMPACT OF A PARENT DIRECTED TEACHING PROGRAM IN FAMILY CENTERED CHRONIC CARE

Teri L. Turner, MD, MPH, MEd, Elaine J. Hime, Mark A. Ward, MD, Baylor College of Medicine, Houston, TX

Background: 9.4 million U.S. children have special health care needs. Project DOCC (Delivery of Chronic Care) is a national training program involving families of children with chronic illness/disabilities as faculty to transfer their knowledge and life experiences to pediatric residents. Objectives: To describe the impact of Project DOCC on pediatric intern's knowledge, attitudes, and beliefs regarding family centered delivery of chronic care. Methods: Project DOCC training consists of two components: a home visit to learn about activities of daily living and accommodations necessary for the child/family and a structured parent interview using a chronic illness history. Training occurs over 2 half days during a 2 week survey course for interns covering content associated with the core competencies. Assessment questionnaires were completed by each intern at the beginning and end of the rotation (1=not at all familiar to 9=extremely familiar). Results: Paired data was available for 174 interns from 2006-2010. 91% rated the parent educators "highly effective." There was a statistically significant increase in the resident's "ability to assist a parent 'burned out' by the care" (pre=3.7, post=5.9, p<0.001), "understanding of the long term impact upon the family" (pre=4.7, post=6.7, p<0.001), "familiarity with community resources" (pre=3.2, post=6.0, p<0.001) and in the belief that "parents should have an active and equal role with physicians in making decisions" (pre=7.8, post=8.0, p=0.016). 78% of all residents who participated in the program felt it made them more willing to work with children who have a chronic disorder. Conclusion: A community based program with parent educators advocating for family centered care is an effective intervention to change knowledge and attitudes regarding the delivery of chronic care to children. Future research should focus on replicating this model in other areas of health care delivery and/or physician populations.

Poster Number 51

OUTSOURCING LETTERS OF RECOMMENDATION REVIEW: CAN A NON-PHYSICIAN RATER RELIABLY SCORE LETTERS OF RECOMMENDATION?

Teri L. Turner, MD, MPH, MEd, Mark A. Ward, MD, Anne S. Gill, DrPH, MS, Baylor College of Medicine, Houston, TX

Background: Residency programs attempt to identify applicants that best "fit" their program. Selection of applicants for interview is usually based upon the written application, including medical school grades and performance, United States Medical Licensing Examination scores, Dean's letters, and letters of recommendation (LORs). The application review process is time consuming. If a portion of the review process could be done reliably by a non-physician, it would free physician time for other selection related tasks. Objective: The purpose of the study was to measure inter-rater reliability of a physician and non-physician rater scoring narrative residency applicant LORs using a validated scale. Method: Letters of recommendation for a randomly selected sample of applicants (n=124) to a large general pediatrics training program were reviewed. All letters (n=438) were scored by a physician reviewer and a nurse educator using a validated 7-point Likert-type scoring system

previously described by Girzadas, et al (1998). Mean LOR scores for each applicant were calculated. Inter-observer reliability was calculated using the kappa statistic. Comparison of the mean LOR scores was done using a 2-sample t-test. Results: The kappa value between physician and non-physician reviewer was 0.7. There was no statistically significant difference in the mean LOR score assigned to individual applicants by the 2 reviewers ($p=0.779$). Conclusion: A non-physician rater can reliably score LORs using an objective scoring system. Using non-physician raters may be an efficient means to expedite the application review process.

Poster Number 52

DEVELOPING AN EDUCATIONAL RESEARCH NETWORK: WHAT IS THE BASELINE FOR L.E.A.R.N. MEMBERS?

Hilary M. Haftel, MD, MHPE, University of Michigan, submitted for APPD LEARN, Ann Arbor, MI

Background: The demand for assessment of competency in Graduate Medical Education has led to a call for the development and utilization of reliable instruments with sufficient validity evidence to be useful. Although it is not known if such instruments exist, the responsibility for assessment falls to Program Directors (PDs). To establish a network of programs (APPD Longitudinal Education Assessment and Research Network) to develop and test such instruments, we sought to understand the baseline skills of PDs who may participate in such a project. Methods: An anonymous web-based survey of APPD-affiliated Pediatrics PDs was conducted which included questions about PD training in educational research and resources available to them at their home institutions. Responses were collected and analyzed using SPSS. Results: Survey response rate was 42% (100 programs). The majority of PDs (67%) stated that they would take primary responsibility for leading participation in an educational research network at their program. The majority of PDs had participated in research in the past, but only 2/3 had participated in educational research. Most (73%) had received no formal training in educational research and training for those that had consisted primarily of workshops and on-the-job experience. Most PDs have had experience submitting IRB protocols (85%), but 45% had never submitted an IRB for an educational research project. Most responding PDs had access to support personnel, including help for IRB submission and also had access to a simulation center. Most had use of an electronic data-collecting system, but the type varied widely. Conclusions: PDs will have primary responsibility for measuring outcomes of training, but a significant number have little to no experience with educational research design. In order to participate in the development and testing of new instruments, PDs will need education and development of education research skills.

Poster Number 53

REMIEDIATION IN PEDIATRIC RESIDENCY PROGRAMS: A SURVEY OF PEDIATRIC PROGRAM DIRECTORS

Meredith P. Riebschleger, MD, Hilary M. Haftel, MD, MHPE, University of Michigan, Ann Arbor, MI

Background: Studies in many specialties have shown that problem residents are relatively common in graduate medical education (GME). Problem residents often undergo remediation, with the ultimate goal of producing a competent attending physician. The expense of medical training and concern about a looming shortage of doctors highlight the importance of successful remediation. To date, no studies have investigated the characteristics of remediation in pediatric residency programs. Objective: To describe remediation practices in pediatric residency programs in the US. Design/Methods: Data were obtained via an anonymous online survey of 196 pediatric residency program directors (PDs). The survey was developed with input from experts in medical education and survey design. It was piloted within the GME community at the authors' institution prior to launch. PDs were asked to provide information about the identification of residents requiring remediation, techniques used for remediation, and outcomes of remediation at their institutions. Data were analyzed using simple frequencies. Results: 104 PDs (53%) responded to the survey. 103 respondents (99%) reported at least one resident requiring remediation over the past 5 years. The mean annual incidence of residents requiring remediation was 3%. All respondent programs used faculty evaluations to identify residents in need of remediation and most use several methods (mean number of methods 5.7). Most programs used multiple techniques during remediation (mean 5.4), with one-on-one mentoring being used most often. Overall, respondents reported that 22% of residents undergoing remediation had their training terminated. Conclusions: Remediation occurs in almost all pediatric residency programs. Most programs use multiple methods to identify residents who need remediation and multiple techniques to perform that remediation. The mean annual incidence of remediation is relatively low, but more than one of every five residents who enters remediation has their training terminated. It will be critical to learn more about those residents to determine what "successful remediation" means.

Poster Number 54

IS THERE A FAVORABLE RETURN ON A CHILDREN'S HOSPITAL'S INVESTMENT IN A COMMUNITY PEDIATRICS RESIDENCY TRACK?

Denice Cora-Bramble, MD, MBA, Mary Ottolini, MD, Dewesh Agrawal, MD, Cara Lichtenstein, MD, MPH, Children's National Medical Center, Washington, DC

BACKGROUND: Hospitals incur education expenses associated with their educational mission. The associated direct and indirect costs and the institution's financial and non-financial return on its investment (ROI) is rarely quantified, analyzed or published. METHODS: We quantified the total cost per year associated with training twelve residents (four PL-1, four PL-2 & four PL-3) as well as the financial and non-financial benefits to Children's National. RESULTS: The total direct cost was \$836,036 and the indirect cost was \$10,000. The patient revenue of preceptor-resident clinical sessions per year at a primary care health center ranges from \$705,120 to \$1,175,040 depending on the level of training. If we subtract the opportunity cost of preceptor-only session from the patient revenue generated by preceptor-resident, there is a positive margin ranging from \$59,040 to \$528,960. The total margin generated by residents, while not explicitly calculated by this study, is likely to be significantly

- higher because the net revenue generated by inpatient and subspecialty services is much more significant than the revenue associated with an ambulatory general pediatric service. The replacement cost of community health track (CHT) residents by physician extender yielded a cost savings, in that CHT residents' salary was approximately 60% of physician extenders' salary. The non-financial benefits included ACGME/RRC competencies addressed through CHT-specific curriculum, participation by residents from other tracks in CHT-specific educational sessions and improvement in overall rank sum of residents matched to CHT as compared to the overall residency program. CONCLUSIONS: There is a definite financial and non-financial return on Children's National's investment in the CHT. Data such as the CHT residents' contribution to the institution's IRS-mandated community benefits reporting as well as their post-residency practice location, while not assessed for this study, provide additional opportunities to more comprehensively quantify the ROI.

• **Poster Number 55**

• **FELLOWS' PERCEPTIONS OF EDUCATION IN HUMANISM AND PROFESSIONALISM**

• *Katharine C. Garvey, MD, Division of Endocrinology, Jennifer C. Kesselheim, MD, EdM, Pediatric Hematology-Oncology, Kara O'Brien, BS, Office of Graduate Medical Education, Alan Leichtner, MD, Pediatric Gastroenterology/Nutrition, Children's Hospital, Boston, MA*

• Background: Humanism and professionalism are integral to the practice of medicine and deterioration of these attributes during graduate medical training remains a concern. Objectives: We aimed to conduct a needs assessment about humanism and professionalism education for a national sample of pediatric gastroenterology fellows. Methods: We invited second-year pediatric gastroenterology fellows at the North American Society for Pediatric Gastroenterology, Hepatology, and Nutrition conference in Spring 2010 to participate in our needs assessment. Before completing the paper survey, respondents were asked to read the ACGME's definition of professionalism and the Arnold P. Gold Foundation's definition of humanism. The survey contained 33 multiple-choice items about fellowship training in humanism and professionalism in the following domains: (1) perceptions of training quality; (2) current sources of learning; (3) desire for formal education on specific topics (e.g.: Bereavement, Medical errors); and (4) demographics. Results: The instrument was completed by 56 participants (96%). Sixty-six percent of fellows were 31-35 years old and 52% were female. When asked if training in humanism and professionalism meets their needs, 87% of fellows chose "Strongly Agree" or "Agree," but 54% still wished for more opportunities to reflect on these aspects of their doctoring. The most commonly used strategies for learning humanism and professionalism were role modeling (66%) and informal discussion (63%) with attending physicians. However, a minority reported utilizing retreats (34%), small-group discussions (21%) or lectures (16%). When asked to rate the value of formal teaching on various topics, "Strongly Agree" or "Agree" responses ranged from 52-93%, with the highest proportions for Difficult patients (93%), Competing demands of clinical care and research (88%), and Depression and burnout (82%). Conclusions: Current fellowship education in humanism and professionalism is largely informal. The majority of respondents desire more education in humanism and professionalism and several areas for curricular development are identified.

• **Poster Number 56**

• **HIGH-FIDELITY CROSS COVER SIMULATION COURSE TO IMPROVE RESIDENT DOCUMENTATION**

• *Marjorie L. White, MD, MEd, MeKeisha R. Pickens, Julia M. Niebauer, MD, Kenny Murray, Cassi Smola, Nancy M. Tofil, MD, MEd, University of Alabama at Birmingham, Birmingham, AL*

• Introduction: Effective documentation is essential for high-quality, safe patient care. Despite this, limited formal training is provided in medical school or residency. Communication can be improved by increasing the presence and thoroughness of cross-cover notes. Our hypothesis is that a structured simulation exercise could improve documentation proficiency. Methods: 2.5 hr simulation course provided formal documentation training to new interns. Interns received a simulated checkout of patient lists from chief residents exemplifying proper and improper technique. Interns were called by a bedside confederate nurse to evaluate a simulated patient. The team cared for the patient and each intern composed a cross-cover note. The note was reviewed for 12 items. Feedback was provided and the 12 elements were taught. Interns then cared for a second patient and composed a second note. Feedback was again provided. Cross-cover notes of actual patients transferred to a higher level of care were reviewed for the 12 items before and after the intervention. Chi square and t tests were done utilizing SPSS 11.5. Results: 22 interns participated. Feedback was overwhelmingly positive. On chart review, 42/50 (84%) pre-course charts had a note vs. 23/47 (48%) post course ($p < .01$). The average items present were the same pre and post (9 ± 2 vs. 9 ± 3). Most commonly missed elements for both time periods included assessment (33/65 not present) and temperature and respiratory rate (31/65 not present). Most commonly present items included date (65/65) and time and signature (62/65). Assessment was present more significantly post- intervention ($p < .01$). Laboratory data was present more significantly pre-intervention ($p < .01$). Discussion: A simulation course did not improve the presence of cross cover notes on actual patients. It was however well received. Interestingly there was significant improvement in the presence of an assessment component. The study shows which items are most likely missing in a cross cover note. A different educational approach may be more helpful in improving the presence of this documentation.

• **Poster Number 57**

• **IMPACT OF AGES AND STAGES QUESTIONNAIRES ON PEDIATRIC RESIDENT KNOWLEDGE**

• *Ashweena Gonuguntla, MD, Michigan State University, East Lansing, MI*

• Background: In 2008, the AAP updated the guidelines which recommend developmental screening with a validated screening tool. Most of these tools, such as Ages and Stages Questionnaires (ASQ), are parent based questionnaires. Medical educators

have voiced concerns about the potential negative impact on knowledge of residents due to their reliance on these screening tools instead of direct assessment. Objective: The purpose of this study was to evaluate the impact of ASQ usage on resident knowledge of normal development. Methods: Over a two year period, pediatric residents completed knowledge tests of normal development and in-service training exams (ITE) before and after the implementation of the ASQ in their continuity clinic. Results: 14 subjects were tested before and one year after ASQ implementation. Their pre-ASQ scores were 39+/-14% on the development exam and 51+/-7% on the ITE, while the post-ASQ scores were 44+/-11% on the development exam and 62+/-7% on the ITE. A paired t test showed that the developmental test scores did not significantly differ before and after the use of the ASQ ($p=0.24$). However, the residents' ITE scores significantly improved despite having used the ASQ ($p=0.0003$). Six of the subjects were also tested two years after ASQ implementation. Their pre-ASQ scores were 44.5+/-14% on the development exam and 49.4+/-6% on the ITE, whereas their two year-ASQ scores were 47.2+/-10% on the development exam and 64.4+/-4% on the ITE. A paired t test again showed similar results with no significant difference before and after the use of the ASQ on the developmental test ($p=0.76$) but significant improvement on the ITE ($p=0.0009$). Conclusions: Over one to two years, resident knowledge of normal development remained low, which is consistent with previous studies. General knowledge on the ITE improved, as is expected of residents going through their training. While the results of this study suggest that residents' reliance on the ASQ does not degrade their knowledge over periods up to two years, further studies with control subjects are needed to draw definitive conclusions on the impact of knowledge for learners.

Poster Number 58

THE SAN FRANCISCO PROJECT ASSESSMENT TOOL: VALIDITY AND RELIABILITY

Lee R. Atkinson-McEvoy, MD, Glenn Rosenbluth, MD, Patricia O'Sullivan, EdD, Daniel West, MD, UCSF, San Francisco, CA

Background: In medical education completing a scholarly project is encouraged. In fact, this is required by the American Board of Pediatrics (ABP) for subspecialty fellowship training. Despite its growing importance, valid and reliable measures of the quality of scholarly projects are lacking. Objective: To provide preliminary evidence of the validity and reliability of a new tool, the San Francisco Project Assessment Tool (SFPAT), designed to assess the quality of scholarly projects. Methods: To establish content validity of the SFPAT, an expert panel ($N=8$) used a modified Delphi method to identify 3 domains: conceptualization, organization and sustainability, and 2 assessment items per domain (6 total items). The same panel developed a 5 point response scale with specific anchors for each assessment item. To pilot test the SFPAT, 2 faculty raters independently scored 20 projects submitted by subspecialty fellows to their scholarship oversight committee to complete the ABP scholarly project requirement. We applied classical test and generalizability theory (2 facet, rater x item design) to determine reliability. Results: The panel reviewed the content 6 times. The Intraclass Correlation Coefficients (ICC) were as follows: overall score 0.799 (95% CI: 0.492-0.92); conceptualization domain 0.776 (95% CI: 0.433-0.911); organization domain 0.615 (95% CI: 0.026-0.847); sustainability domain 0.400 (95% CI: -0.516-0.763). The variance in score due to differences between individual fellows was 0.101 (14%). Other large sources of variance included: rater (0.052 [7%]), item (0.99 [13%]), rater-item interaction (0.133 [18%]), fellow-item interaction (0.78 [11%]), three way interaction and residual variance (0.273 [37%]). The generalizability coefficient (G coef) was 0.73. To get a G coef > 0.8 on this 6 item assessment would require 4 raters. Conclusion: The SFPAT is a reliable tool with content validity; use of the current rubric would require 4 raters for high-stakes decision making. For fewer raters, enhanced rater training and/or increase in items in the organizational and sustainability domains would be required.

Poster Number 59

THE WESTERN PEDSCO: A DIRECT OBSERVATION TOOL TO MEASURE RESIDENT PERFORMANCE IN PEDIATRIC PATIENT ENCOUNTERS

Daniel C. West, MD, University of California, San Francisco, San Francisco, CA, Cynthia L. Ferrell, MD, Oregon Health Sciences University, Portland, OR, Christy Boscardin, PhD, Alexis Jannicelli, University of California, San Francisco, San Francisco, CA, Adam Rosenberg, MD, University of Colorado, The Children's Hospital, Aurora, CO

Background: Currently available direct observation tools lack content validity for encounters with children and psychometric properties for high stakes decision-making, and do not allow for rating performance on a continuous scale that can discriminate between residents. Objective: To establish the content validity of a pediatric-specific direct observation tool designed to measure the performance of residents on a continuous scale. Design/Methods: The four essential elements (data gathering, physical exam, medical decision making, and patient counseling) of pediatric patient encounters were identified by 20 associate and program directors in the Western Region of the APPD. A draft tool included items modified from other published (e.g. mini-CEX, check list SCOs, etc.) and unpublished tools used by residency programs. To establish content validity, a 16 member expert panel of program directors in the Western Region of APPD rated each item through an iterative review (modified Delphi) process. Content analysis of the expert ratings was performed and those items with a content validity index (CVI) > 0.8 were included in the final tool. CVI is the proportion of experts who agreed/strongly agreed that an item was valid and rated it important/very important. Results: Based upon expert review and the CVI, the categories (items) on the final tool which are rated on a 7-point scale ranging from novice to expert include: data gathering (8), physical exam (6), medical decision making (9), patient counseling (10). Sufficient data will be available in January 2011 to perform factor analysis (construct validity) and a generalizability-study (reliability). These data will be reported at the 2011 APPD meeting. Conclusions: We have established the content validity of a new 33-item pediatric-specific direct observation tool (Western PedSCO). A multi-institution study is currently underway to establish construct validity and reliability.

• **Poster Number 60**

• **DEVELOPMENT OF A TEST TO EVALUATE PEDIATRIC RESIDENTS' KNOWLEDGE OF ETHICS**

• *Jennifer C. Kesselheim, MD, MEd, Steven Joffe, MD, MPH, Pediatric Hematology-Oncology Fellowship, Graham McMahon, MD, Endocrinology Fellowship, Children's Hospital/Boston Medical Center, Boston, MA*

• Background: The Accreditation Council for Graduate Medical Education (ACGME) requires residents to demonstrate professionalism and "an adherence to ethical principles." Improving outcomes of resident education in this area is hindered by the absence of a standardized tool to measure ethics knowledge. Objectives: We aimed to formally develop a novel assessment instrument intended to measure knowledge in pediatric ethics. Methods: We created 23 true/false questions to test knowledge in several domains of pediatric ethics including: professionalism, adolescent medicine, genetic testing and diagnosis, neonatology, end-of-life decisions, and decision-making for minors. All questions and their correct answers were derived from published statements from the American Academy of Pediatrics (AAP) Committee on Bioethics. We then asked 1st year medical students, PGY-3 pediatric residents, and experts in pediatric ethics to complete the test either on paper or electronically. Item test characteristics and reliability of the instrument were evaluated. Score differences were evaluated with a Wilcoxon rank sum test. Results: The instrument was completed by 22 medical students, 26 PGY-3 pediatric residents, and 6 pediatric ethicists and demonstrated internal reliability (KR-20) of 0.73. Performance on the test appropriately improved with degree of expertise: median scores for medical students, PGY-3 residents, and ethicists were 15 (65%, range 11-19), 19 (83%, range 14-23), and 22 (96%, range 20-23). Ethicist scores were significantly greater than medical students ($P < 0.001$) and residents ($P = 0.007$). Items most frequently answered incorrectly pertained to pediatric assent, requests for genetic testing, and decision-making about life-sustaining treatments. Conclusions: We developed a standardized instrument to evaluate residents' knowledge in pediatric ethics that is easy to administer, reliably discriminates between learners, and has identified content areas in which knowledge may be deficient. The test can help focus future educational efforts and can serve as a useful means of measuring educational outcomes.

• **Poster Number 61**

• **IMPACT OF FACULTY DEVELOPMENT ON INCREASING RESIDENTS' ACTIVE LEARNING IN LECTURES**

• *Bonnie Desselle, MD, George Hescocock, MD, Robin English, MD, Andrea Hauser, MD, Melissa Roy, MD, LSUHSC, Tong Yang, MD, Sheila Chauvin, PhD, Office of Medical Education Research and Development, New Orleans, LA*

• PURPOSE: To evaluate the impact of a faculty development workshop on increasing faculty members' use of active learning strategies during resident conferences. METHODS Two trained observers assessed each lecture in the resident conference series (3 months pre-intervention and 3 months post-intervention) using two dichotomous (observed/non observed) scales: an 8-item scale for faculty use of active learning strategies and a 7-item scale for residents' engagement in active learning. One hour faculty development workshops (intervention) were conducted with small groups of faculty members approximately one-month prior to their lectures. Pre/post differences were examined using Chi Square statistic. RESULTS Twenty-one pre-intervention lectures (group 1) were compared to 30 post-intervention lectures (group 2). Of the 30 post-intervention lectures, 20 were conducted by faculty who participated in the workshop (group 2a). Reliability estimates were Kappa = 0.78 and Cronbach's alpha = 0.85. FACULTY BEHAVIORS: Percentage observed for all 8 items were higher for post-intervention lectures (group 2) than for pre-intervention (group 1). Five were statistically significant ($p < .02$): use of questioning, patient problem solving, small group activities, worksheets, and soliciting resident questions. Group 2 was also higher than group 1 for use of quizzes, audience response systems and role play, but not statistically significant. Lectures presented by faculty workshop participants (group 2a) were statistically higher than group 1 (pre) for the same 5 items ($p < .02$). RESIDENT BEHAVIORS: Percentage observed for 6 of 7 items were higher in group 2 lectures than group 1. Four were statistically significant ($p = .00$): developing a problem definition, interpreting data, reaching a diagnosis, applying basic science content. Five items were statistically higher ($p < .02$) for group 2a compared to group 1, including the above-mentioned items plus problem-solving. CONCLUSION Participation in a faculty development workshop can significantly enhance residents' active engagement in thinking and learning during lectures.

• **Poster Number 62**

• **HOME VISITATION: TEACHING PEDIATRIC RESIDENTS TO EXTEND THE MEDICAL HOME INTO THE COMMUNITY**

• *Megan M. Tschudy, MD, Rheanna Platt, MD, Janet R. Serwint, MD, Johns Hopkins Pediatric Residency Program, Baltimore, MD*

• Background: The scope of primary care has broadened with pediatricians addressing an increasing range of social and environmental issues. In vulnerable populations, home visits have improved many child health indicators. No previous studies have examined pediatric resident change in knowledge, attitudes or behaviors after a home visit with a patient whom they have a longitudinal relationship. Methods: A prospective cohort study was conducted between September 2009 and June 2010 in two outpatient clinics at an urban academic pediatric residency program in Baltimore, Maryland. The participants were residents who serve as primary care providers ($n = 32$). Infants who received care in these clinics were recruited for a newborn home visit intervention. Residents completed an educational module about home visits and the community prior to the visit. They also completed a pre and post visit survey assessing knowledge of community, attitudes, and practice behaviors. Comparison of pre and post intervention Likert scores was made using a nonparametric Wilcoxon sign rank test. Results: Post home visit intervention residents had improved knowledge of the community, positively changed attitudes towards their patients, and clinical behaviors tailored better toward the patients and families they serve. There was a significant positive change ($p < 0.05$) in: adequacy of medical knowledge, not being concerned about safety, understanding of home and

community, excitement about home visits, understanding that the home situation affects how one prescribes medicine and refers to subspecialists, and likelihood of making a future home visit. 39% percent reported a change in their views of how they should treat patients and 87% indicated home visits should be part of the permanent curriculum. Conclusions: Conducting home visits was associated with residents' improved understanding of the community and home situation of their patients. Residents felt home visits provided an important educational experience. Next steps will examine the impact of resident home visitation on family trust and healthcare utilization.

Resident QI Posters

Poster Number 63

IMPROVING DEVELOPMENTAL SCREENING IN A RESIDENT GROUP CONTINUITY CLINIC PRACTICE

Catherine Chang, MD, Jennifer DiPace, MD, Sue Hong, MD, New York Presbyterian Hosp - Weill Cornell, New York, NY

Both the Denver Developmental Screening Test (Denver) and the Modified Checklist for Autism in Toddlers (M-CHAT) are recommended to screen for developmental delay or abnormalities. In our Resident Group Practice in an urban academic center, there was inconsistency in the timing of screening and in the follow-up of abnormal screens. In an initial review of our practice, less than 50% of patients at the 9 or 24 month visit had a Denver performed and only 63% of patients had a M-CHAT at 18 months. The goal of our quality improvement (QI) project was to increase performance of screening tests and to improve timeliness of developmental interventions. Specifically, during one academic year, our aim was to screen 95% of children presenting for well-child care at the 9, 18, and 24 month visits. Also, 95% of patients with abnormal tests will have appropriate documentation in the chart and a plan for follow-up. Each PGY-2 resident participated in this team-oriented QI project during a 3 week primary care block. Our interventions centered around modification of the electronic medical record (EMR) and provision of education to the residents in the practice about appropriate developmental screening practices. After each intervention, approximately 5-10 charts from each target age group were reviewed with a focus on our aim measures. After resident education, administration and documentation of developmental screening tests increased but did not reach our goal. The next cycle consisted of implementation of changes to the EMR, including prompts to complete the exam at certain visits. Review of charts after this cycle revealed that 100% of patients had documentation of screening. However, among children with an abnormal screen, only 79% had an appropriate referral or plan for follow-up. In conclusion, increasing residents' awareness of developmental screening recommendations was not sufficient. Permanent modification of the EMR did achieve results that satisfied one of our aim measures. In the future, continued work needs to be done to ensure that patients with abnormal results are managed appropriately.

Poster Number 64

IMPLEMENTATION OF POSTPARTUM DEPRESSION SCREENING TOOL IN PEDIATRIC CLINIC: A RESIDENT QI PROJECT

Alicia Idler, MD, Kaylan R. Parashette, MBBS, Sindhuja Harsha Vardhan, MBBS, Amanda D. Osta, MD, UIC-Pediatrics, Chicago, IL

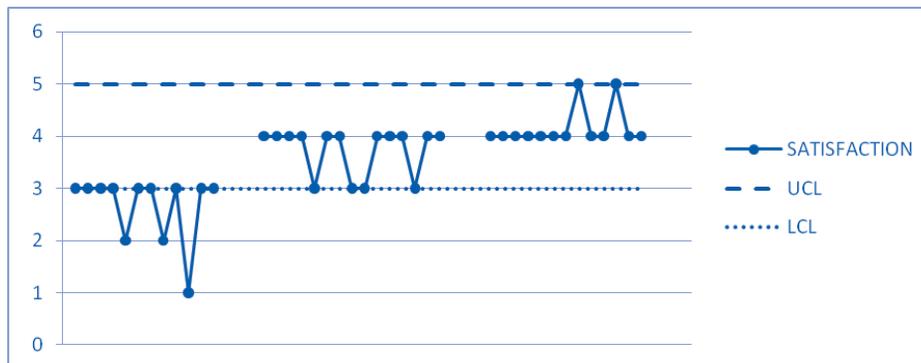
Background: Postpartum psychiatric disorders are very common with postpartum depression (PPD) affecting 12-13% of women. In our pediatric resident clinic, prior to the implementation of our QI project, only 0.5% of mothers were being screened for PPD using an objective screening measure. Aim Statement: Objective screening for PPD using the Edinburgh scale will increase to at least 25% of mothers who bring their infants in for well child care in the first two months of life. Methods: In the planning stage of our PDSA cycle, a questionnaire was given to all pediatric residents to assess pre-implementation knowledge. It revealed that there were significant knowledge gaps regarding PPD. We discussed screening for PPD with psychiatry, social work, and ob-gyn to determine the best scales to use for screening and the resources within our hospital. In the do stage of our PDSA cycle, an educational conference was given to all pediatric residents on how use the Edinburgh and where to refer the women if they scored high. We implemented universal PPD screening to all mothers in the first two months post-partum. The residents distributed the PPD scale to the mothers and scored it immediately. We created a PPD algorithm to guide the screening which was displayed prominently in the clinic. Resources were kept in an easily accessible location. In order to study our PDSA cycle, we did a retrospective analysis of the billing sheets for period of 7 week post implementation to determine how many mothers were screened. Results: After the implementation of our QI project, 85 of 420 of the target mothers (20%) were screened over a 7 week period, which was increased from 0.5% prior to the implementation of the QI project. Conclusion: By educating the medical team and providing accessible kits and guidelines on screening for PPD the screening increased dramatically. Although our screening efforts were greatly improved, we still have more mothers to screen, and we will act on these results by repeating several more PDSA cycles this year to continue to increase our screening for PPD.

• **Poster Number 65**

• **SELF DEVELOPED ELECTRONIC SIGN OUT FORMAT TO ENSURE SAFE TRANSFER OF PATIENT CARE**

• *Narayan P. Iyer, MD, Marina Lazbin, MD, David Kaelber, MD, Abdulla Ghori, MD, MetroHealth Medical Centre (Case Western), Cleveland, Ohio*

• Background: Transfer of care between teams (sign outs) are a leading cause of sentinel errors and the problem is likely to get worse with changes to the resident work hours. Aim: To create a standardized format for sign outs that ensures complete and accurate transfer of information and patient responsibility with better resident satisfaction. Design: Prospective quality improvement project using the PDSA cycle. A group of 13 residents were involved in the planning of the project. Process map and fish bone analysis were used to identify strengths and weaknesses in the prevailing sign out process. The information was used to create an ideal sign out format which was then introduced in the Electronic Health Record (EHR) system. Setting: 24 bedded pediatric inpatient floor with 7 residents rotating through every module. Intervention: Introduction of a standardized EHR based sign out system with training of residents about components of an ideal sign outs. We endeavored to make sign outs an educational experience. Measurement: 3 phases were identified- pre intervention (PI), post intervention 1 (PI1-Resident training on MS Word based sign out system) and post intervention 2 (PI2-Resident training and use of EHR based sign out). The completeness and accuracy of sign out sheet were measured by comparing individual sign out sheets against an 'ideal' sign out sheet. Resident satisfaction with the newly designed sign out format was measured by means of a survey with a Likert scale of 1-5. Control chart was used to analyze the change in resident satisfaction with the change in process. Project time scale was 6 months between October 2009 and April 2010. Results: Number of sign outs analyzed during the three phases were: PI- 35, PI1- 37 and PI2- 35 respectively. Improvements were noticed in all aspects in the PI1 and PI2 compared to PI. The maximum differences were seen in documentation of Code status and If/Then format of sign out. Compared to PI1, PI2 was better in terms of demographic details, allergies, past medical history, diet orders and If/Then format. Median Resident satisfaction for PI, PI1 and PI2 was 3, 4, and 4 respectively with the control chart showing better satisfaction with the PI2.



Conclusions: We created a new sign out system based on EHR that resulted in more complete and improved accuracy of the sign out data while also resulting in better resident satisfaction. The resident survey also suggested less time was spent with the new system. We believe that improved efficiency of the system allowed residents to focus on forming a problem based plan, thus, making the sign out an educational experience.

• **Poster Number 66**

• **USING QI METHODOLOGY TO ASSESS AND IMPROVE THE PEDIATRIC ADMISSION PROCESS**

• *Anca Dumitriu, MD, Sara Gonzalez, DO, Janet Weis Children's Hospital, Danville, PA*

• Background: Admission from the emergency department is perceived as inefficient, lengthy, and suboptimal for ideal patient care. 2009 Press Ganey data indicated that satisfaction scores for overall admission ranged from 21-44%. Satisfaction with speed of admission was even lower: 12-37. Aims: We aim to improve the process of admission from ED to Janet Weis Children's Hospital, thereby increasing patient satisfaction, improving efficiency, and enhancing patient safety. Specifically, we aim to decrease patient dwell time in the ED by 30 minutes. Participants: Pediatric residents. Methods: Background data from the EMR, showed that the median time from ED triage to arrival on the floor was 325 minutes. The longest time intervals were time of lab results to the time the admission order was placed and from that to the time of arrival in JWCH, 95 min and 83 min respectively. Reviewing process flows and analyzing causes and effects from this data identified resident delays in entering the admission order, as their standard admission process incorporated the order for admission as part of a order set. As part of a PDSA cycle, pediatric residents were asked to place the bed request order prior to and independent of other admission orders. Results: Residents placed the bed request order early in 51% of post-intervention admissions. In comparing pre and post-intervention data, there was an improvement of 44 minutes in the time to place admission order. When looking at the time from ED to floor arrival data there was only an improvement of 7 minutes within the intervention group. Conclusions: Though placement of the admission/bed request order was identified as an area for improvement in the admission process, the initial intervention did not significantly impact outcomes. Future interventions include targeting specific medical conditions and establishing evidence-based, admission criteria with hopes of increasing the efficiency of the ED triage process. This project has increased our knowledge, skills and attitudes regarding QI and has empowered our ability as residents to identify and effect change on a system level.

Poster Number 67

DEVELOPMENTAL SCREENING IN THE OUTPATIENT SETTING

Audrey Wehr, MD, Timothy Brady, MD, Elizabeth Kuonen, MD, and Alexander M. Djuricich, MD IUSOM, Indianapolis, IN

In 2006 the American Academy of Pediatrics issued a statement recommending developmental screening using formal tools at 9, 18, and 30 months of age. Pediatricians require a formal tool for screening because practitioners are noted to miss 39% of patients who would qualify from referral to early intervention services without one. The overall aim of this project was to increase the rate of developmental screening at the 18 month well child visit using the Ages and Stages Questionnaire (ASQ) in a community health center (CHC). The pre-intervention rate was 0%, and we decided upon a goal of 90% of eligible patients to be screened. Chart audits were performed every 2 months and feedback was given to the physicians immediately. We began by running several PDSA cycles and completing a formal process map using LEAN methodology. Next the proposed model was reviewed by the clinic physicians and staff. We addressed anticipated barriers such as identifying methods to recognize the appropriate patients and incorporation of the process into the rooming protocol. The 18 month ASQ applies to 17-19 month olds so calendars with appropriate birth months were made and distributed to registration clerks. The medical assistants (MAs) daily scanned the physicians' schedules, identified eligible patients, and provided the list to the registrar. The registrar provided the ASQ to the parent at check-in allowing time for completion. MAs then collected and scored the forms, thus providing the physician with the ability to counsel parents about the results. After 2 months of the new process being in place, 33.3% of 17-19 month olds were screened. This increased to 64.3 % at 4 months and 92.9% at 6 months, which has been sustained at above 92% for at least 6 more months with continued auditing every 2 months. In conclusion, we were able to implement a successful QI project in our clinic to improve the rate of developmental screening of 17-19 month old children using the ASQ. In the future, we plan to utilize a similar process towards developmental screening at different ages.

Poster Number 68

IMPROVING MED-PEDS RESIDENT COMPLIANCE WITH REACH OUT AND READ BOOK DISTRIBUTION

Maria C. Monge, MD, Jane V. Trinh, MD, Suzanne K. Woods, MD, Duke Internal Medicine-Pediatrics Residency Program, Durham, NC

Background: Reach Out and Read (ROAR), a national non-profit organization, is designed to incorporate early literacy awareness into well child visits (WCV) from age 6 months to 5 years. Research demonstrates importance of early literacy and parental reading to children as factors in long-term adult literacy. Utilization of ROAR resources has not been optimal in the Duke Med-Peds continuity clinic. Methods: A proposal to improve ROAR book distribution was constructed based on the Duke Med-Peds program standard template for quality improvement. Baseline data collection over 2 weeks compared the number of books distributed in this period to the number of eligible WCV in this same time by manual count. During the Plan, Do, Study, Act (PDSA) cycles that followed, we introduced several interventions to improve rates of ROAR book distribution. During the first cycle, nurses highlighted eligible patients for books on resident schedules and provided ROAR bookmarks to those patients at check-in. In the next PDSA cycle, book location was changed to the resident work area. Residents were informed of each intervention and data collection ensued for 2 week periods post-intervention using baseline data collection methods. Data analysis was performed after each intervention. Results: Baseline data revealed book distribution compliance was 52.2% with 23 books distributed to an eligible 44 patients. Initial PDSA cycles revealed several factors as impeding book distribution. One was that residents did not remember to distribute books during WCV despite nursing provided reminders (i.e. bookmarks). Second, lack of visibility of the books impeded their distribution. Moving books to a more accessible location resulted in an increase in book distribution, up to 90.9%. Conclusion: A simple change introduced in the Duke Med-Peds continuity clinic (i.e. book location) resulted in an increase from 52.2% to 90.9% in ROAR book distribution. Future PDSA cycles will involve posting signs in clinic to improve distribution to 100% of eligible WCV and to expand our interventions to the remainder of the pediatric clinic.

APPD ANNUAL REPORT

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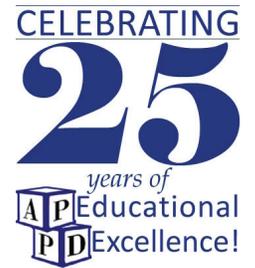
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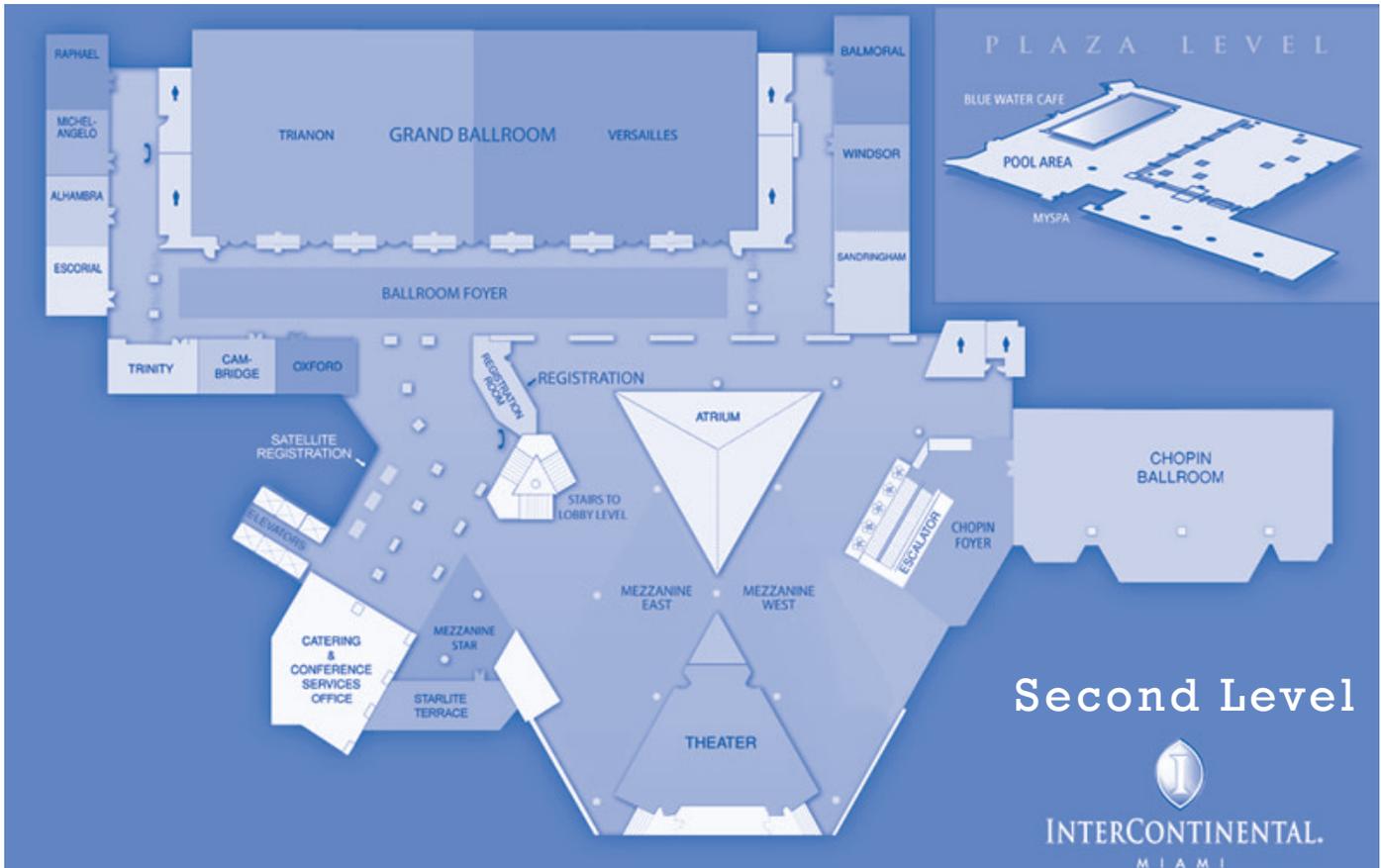
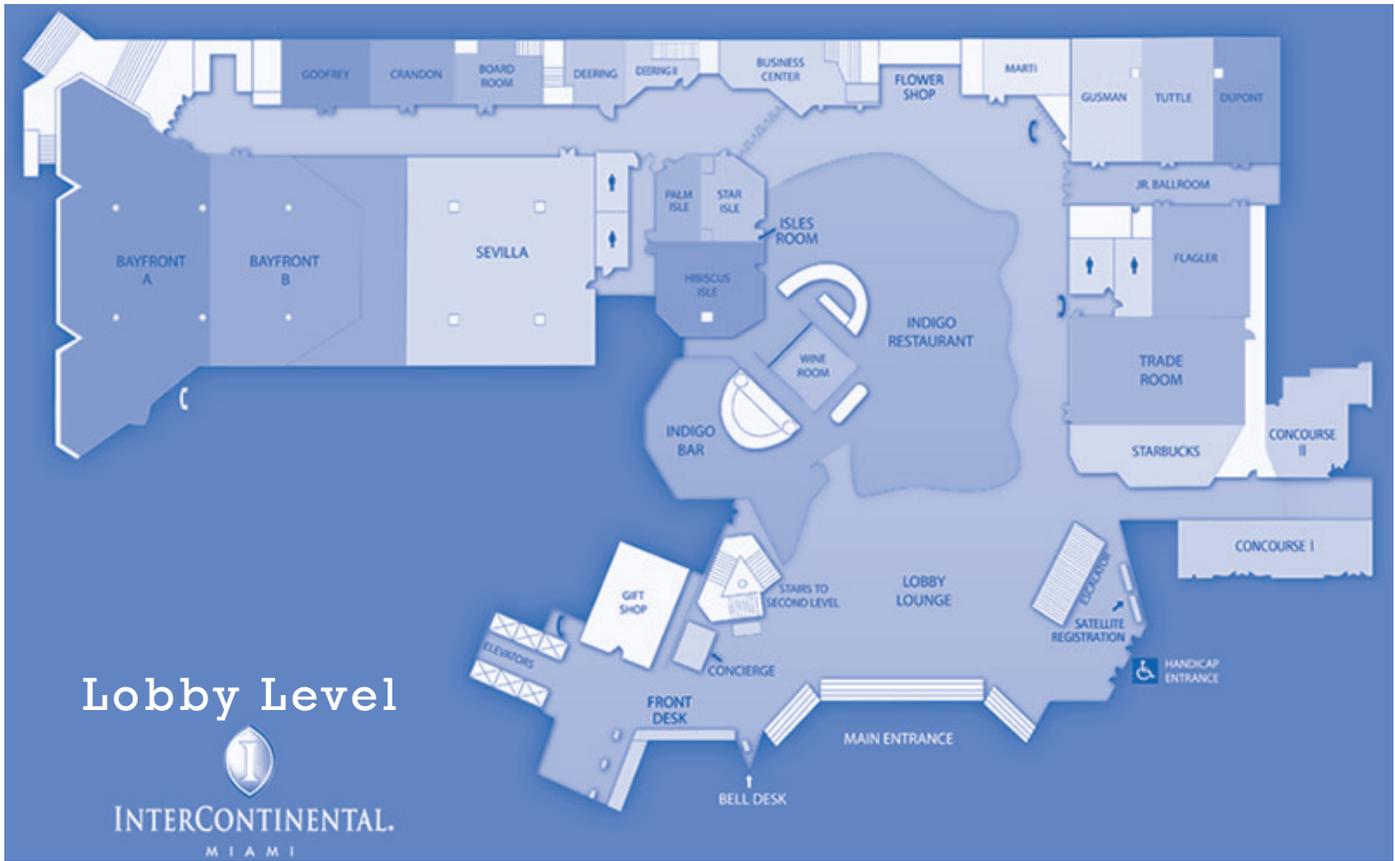
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