2014 Annual Meeting

Association of Pediatric Program Directors

Professional Formation for Learners: Education and Assessment

April 2 - 5, 2014
Chicago, IL

Hyatt Regency Chicago
Chicago, IL

*This activity has been approved for AMA PRA Category 1 Credit™
Welcome to the APPD 2014 Annual Spring Meeting in Chicago!

Spring is here, with Pediatric Education Groups (PEGs) sprouting and budding new ideas in innovative research, exciting workshops, and updates from Pediatric community partners. Networking, mentoring and other programming is in full bloom - all planned by the Executive Planning Committee and Program Committee members – altogether 30 talented individuals from throughout the organization’s Task Force groups, Executive Committees and dedicated at-large members!

We hope you take the opportunity to learn, share and celebrate with your friends and network of colleagues at APPD!

CME INFORMATION

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) and the Association of Pediatric Program Directors (APPD). 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 21.5 AMA PRA Category 1 Credits™. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

<table>
<thead>
<tr>
<th>Session Time</th>
<th>Session Title</th>
<th>Credit Hours</th>
</tr>
</thead>
<tbody>
<tr>
<td>Wednesday, April 2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>9:00am - 11:15am</td>
<td>Forum for Directors of Small Programs/Affiliate Chairs</td>
<td>2.25</td>
</tr>
<tr>
<td>11:30am - 2:45pm</td>
<td>Pre-Conference Workshop</td>
<td>3.25</td>
</tr>
<tr>
<td>3:00pm - 5:45pm</td>
<td>Grassroots Forums for Program Directors</td>
<td>2.75</td>
</tr>
<tr>
<td>3:00pm - 5:45pm</td>
<td>Grassroots Forums for Associate Directors</td>
<td>2.75</td>
</tr>
<tr>
<td>3:00pm - 5:45pm</td>
<td>Grassroots Forums for Fellowship directors</td>
<td>2.75</td>
</tr>
<tr>
<td>Thursday, April 3</td>
<td></td>
<td></td>
</tr>
<tr>
<td>11:45am - 1:00pm</td>
<td>Platform Presentations - Best of Research and QI Abstracts</td>
<td>1.25</td>
</tr>
<tr>
<td>1:15am - 1:45 pm</td>
<td>APPD President’s Message</td>
<td>.50</td>
</tr>
<tr>
<td>1:45pm - 3:30pm</td>
<td>Key Stakeholders Session</td>
<td>1.75</td>
</tr>
<tr>
<td>3:45pm - 6:00pm</td>
<td>Mentoring Session</td>
<td>2.25</td>
</tr>
<tr>
<td>Friday, April 4</td>
<td></td>
<td></td>
</tr>
<tr>
<td>8:00am - 10:00am</td>
<td>Workshop Session 1</td>
<td>2.00</td>
</tr>
<tr>
<td>10:15am - 12:15pm</td>
<td>Workshop Session 2</td>
<td>2.00</td>
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<tr>
<td>2:00pm - 4:00pm</td>
<td>Workshop Session 3</td>
<td>2.00</td>
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<tr>
<td>Saturday, April 5</td>
<td></td>
<td></td>
</tr>
<tr>
<td>9:15am - 10:45am</td>
<td>Workshop Session 4</td>
<td>1.50</td>
</tr>
<tr>
<td>TOTAL CREDIT HOURS</td>
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<td>21.5</td>
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## Wednesday, April 2, 2014

<table>
<thead>
<tr>
<th>Time</th>
<th>Event</th>
<th>Location</th>
</tr>
</thead>
<tbody>
<tr>
<td>7:00am</td>
<td>Registration Begins</td>
<td>Regency Ballroom Foyer, WT</td>
</tr>
<tr>
<td>7:30am-11:15am</td>
<td>APPD LEAD Meeting</td>
<td>Toronto Room, WT</td>
</tr>
<tr>
<td>8:00am – 5:00pm</td>
<td>APPD Forum for Chief Residents</td>
<td>Crystal B Ballroom, WT</td>
</tr>
<tr>
<td>9:00am-11:15pm</td>
<td>APPD Forum for Directors of Small Programs / Affiliate Chairs</td>
<td>Regency A Ballroom, WT</td>
</tr>
<tr>
<td>11:30am-2:45pm</td>
<td>Pre-Conference Workshops (additional fee required – includes box lunch)</td>
<td>See page 13-14</td>
</tr>
<tr>
<td>1:00pm-6:00pm</td>
<td>Coordinators' Workshops / Invited Speaker</td>
<td>Regency B Ballroom, WT</td>
</tr>
<tr>
<td>3:00pm-5:45pm</td>
<td>Grassroots Forum for PDs</td>
<td>Regency C Ballroom, WT</td>
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<tr>
<td></td>
<td>Grassroots Forum for APDs</td>
<td>Regency D Ballroom, WT</td>
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<tr>
<td></td>
<td>Grassroots Forum for FDs</td>
<td>Gold Coast Room, WT</td>
</tr>
<tr>
<td>6:00pm-7:00pm</td>
<td>Networking Reception</td>
<td>International Suites, WT</td>
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## Thursday, April 3, 2014

<table>
<thead>
<tr>
<th>Time</th>
<th>Event</th>
<th>Location</th>
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<tbody>
<tr>
<td>7:00am-8:00am</td>
<td>Continental Breakfast</td>
<td>Regency Ballroom Foyer, WT</td>
</tr>
<tr>
<td>8:00am-9:30am</td>
<td>APPD Members’ Meeting: Awards and Annual Reports</td>
<td>Regency Ballroom, WT</td>
</tr>
<tr>
<td>9:45am-11:30am</td>
<td>APPD Task Force Meetings (open to all)</td>
<td>See page 6</td>
</tr>
<tr>
<td>10:00am-1:00pm</td>
<td>Coordinators' Sessions with boxed lunch</td>
<td>Plaza Ballroom, ET</td>
</tr>
<tr>
<td>11:45am-1:00pm</td>
<td>Research Platform Presentations with boxed lunch</td>
<td>Regency Ballroom, WT</td>
</tr>
<tr>
<td>1:15pm-1:45pm</td>
<td>APPD President’s Message</td>
<td>Regency Ballroom, WT</td>
</tr>
<tr>
<td>1:45pm-3:30pm</td>
<td>Key Stakeholders Session</td>
<td>Regency Ballroom, WT</td>
</tr>
<tr>
<td>3:45pm-6:00pm</td>
<td>APPD Mentoring / “Meet the Professor” Session for Program Directors, Associate Program Directors and Fellowship Directors</td>
<td>Toronto Room, WT</td>
</tr>
<tr>
<td></td>
<td>Coordinators' Workshops</td>
<td>Plaza Ballroom, ET</td>
</tr>
<tr>
<td></td>
<td>Curriculum Task Force Poster Symposium</td>
<td>Crystal B Ballroom, WT</td>
</tr>
<tr>
<td></td>
<td>Pediatric Education Group (PEGs) Meetings</td>
<td>See page 7</td>
</tr>
</tbody>
</table>
## Friday, April 4, 2014

<table>
<thead>
<tr>
<th>Time</th>
<th>Event</th>
<th>Location</th>
</tr>
</thead>
<tbody>
<tr>
<td>7:00am-8:00am</td>
<td>Continental Breakfast</td>
<td>Regency Ballroom Foyer, WT</td>
</tr>
<tr>
<td>8:00am-10:00am</td>
<td>Workshops Session 1 (choice of 9)</td>
<td>See page 21-23</td>
</tr>
<tr>
<td>10:15am-12:15pm</td>
<td>Workshops Session 2 (choice of 9)</td>
<td>See page 23-26</td>
</tr>
<tr>
<td>12:30pm-1:45pm</td>
<td>Lunch on Your Own</td>
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<tr>
<td></td>
<td>Council of Regional Chairs Lunch Meeting</td>
<td>Atlanta Ballroom, WT</td>
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<tr>
<td>2:00pm-4:00pm</td>
<td>Workshops Session 3 (choice of 9)</td>
<td>See page 27-30</td>
</tr>
<tr>
<td>4:15pm-5:45pm</td>
<td>Poster Session (posters displayed 10:00am-5:45pm)</td>
<td>Regency A-C Ballroom, WT</td>
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## Saturday, April 5, 2014

<table>
<thead>
<tr>
<th>Time</th>
<th>Event</th>
<th>Location</th>
</tr>
</thead>
<tbody>
<tr>
<td>7:15am-8:45am</td>
<td>Regional Breakfast Meetings</td>
<td>See page 30</td>
</tr>
<tr>
<td>9:15am-10:45am</td>
<td>Workshops Session 4 (choice of 9)</td>
<td>See page 31-34</td>
</tr>
<tr>
<td>11:00am-12:30pm</td>
<td>Council of Task Force Chairs Lunch Meeting</td>
<td>New Orleans Room, WT</td>
</tr>
</tbody>
</table>

### APPD Mobile App

All you need to know about the Annual Spring Meeting is now available as a mobile app for Android, iPhone, and iPad devices. See page 62 for details on how to access the app or look for the poster near the registration desk.

### APPD Photo Release

By registering for the APPD Annual Meeting, attendees consent to be photographed during the course of the meeting, with the understanding that these images will be used in APPD documents and publications only. If anyone prefers to not have their photo used by APPD, please contact info@appd.org. We also request that you notify the photographer at the time a photo is being taken in which you may be included.

### Mother’s Room

In order to provide privacy and convenience to breastfeeding mothers, Skyway 281 (Blue Level/East Tower) has been reserved each day from 7am-7pm.

### Luggage Storage

As you check out of your hotel rooms on Saturday morning, you may store your luggage at the Hyatt Regency’s Bellstand, located in the hotel lobby (Blue Level/East Tower) near the front desk.
APPD Leadership

President
Patricia Hicks, MD, MHPE (2012-2014)
Children’s Hospital of Philadelphia

Secretary-Treasurer
Javier Gonzalez del Rey, MD, MEd (2013 - 2016)
Cincinnati Children’s Hospital Medical Center

Executive Director - Laura Degnon, CAE
Associate Director - Kathy Haynes Johnson

President-Elect
Dena Hofkosh, MD, MEd (2012 - 2014)
Children’s Hospital of Pittsburgh of UPMC

Past-President
Ann Burke, MD (2012-2014)
Wright State University

Board of Directors
Ann Guillot, MD (2011-2014)
University of Vermont
Christopher Kennedy, MD (2011-2014)
University of Missouri at Kansas City
Robert J. Vinci, MD (2012 - 2015)
Boston Medical Center

Nomination Committee
Ann Burke, MD, Chair
Wright State University
Debra Boyer, MD (2012-2014)
Children’s Hospital/Boston Medical Center
University of North Carolina at Chapel Hill

Associate Program Directors’ Executive Committee
Aditee Narayan, MD, MPH (2013 - 2016), Chair
Duke University Medical Center
Megan Aylor, MD (2013 - 2016)
Oregon Health Sciences University
Maneesh Batra, MD, MPH (2013 - 2016), Chair-Elect
University of Washington/Seattle Children’s
Hillary Franke, MD (2013 - 2016)
University of Arizona
Glenn Rosenbluth, MD (2013 - 2016)
University of California, San Francisco
Daniel Schumacher, MD, MEd (2013 - 2016)
Boston Medical Center

Coordinators’ Executive Committee
Jean Ashley, MSBC, C-TAGME (2011-2014) - Chair
University of Louisville
Ambrosya Amlong, BA, C-TAGME (2012-2014)
University of Michigan
Celeste M. Farley (2013-2014)
Teresa Flourney, MBA, C-TAGME (2013-2016)
Children’s Mercy Hospital
Patricia Jacobi (2013-2014) - Immediate Past Chair
St. Louis Children’s Hospital / Washington University
Kelley Pike, BA (2012-2015) - Chair-Elect
Albany Medical Center
Teresa Woods, C-TAGME (2013-2016)
St. Louis University

Fellowship Program Directors’ Executive Committee
Bruce Herman, MD (2013 - 2016), Chair
University of Utah
Michael Brook, MD (2013 - 2015)
University of California, San Francisco
Geoffrey Fleming, MD (2013 - 2016), Chair-Elect
Vanderbilt University School of Medicine
Kathleen McGann, MD (2013 - 2016)
Duke University Medical Center
Angela Myers, MD, MPH (2013 - 2016)
Children’s Mercy Hospital
Pnina Weiss, MD (2013 – 2016)
Yale University School of Medicine

2014 Meeting ● APRIL 2 - 5 ● CHICAGO, IL
2014 Annual Meeting Program Committee

Executive Planning Committee

Ann Burke, MD, Chair
Wright State University

Debra Boyer, MD, Co-Chair
Children’s Hospital/Boston Medical Center

Bruce Herman, MD
University of Utah

Dan Schumacher, MD, MEd
Children’s Hospital/Boston Medical Center

Teresa Flournoy, MBA, C-TAGME
Children’s Mercy Hospital

Program Committee Members

Jean Ashley, MSBC, C-TAGME
University of Louisville - Kosair Children's Hospital

Megan Aylor, MD
Oregon Health Sciences University

Katy Bartlett, MD
Duke University Medical Center

Maneesh Batra, MD, MPH
University of Washington/Seattle Children’s Hospital

Rebecca Blankenburg, MD, MPH
Stanford University/Lucille Packard Children’s Hospital

Robert Brooker, MD
St. Louis University/Cardinal Glennon Childrens Medical Center

Sharon Calaman, MD
St. Christopher’s Hospital for Children

Walter Dehority, MD
University of New Mexico

Hillary Franke, MD
University of Arizona

Helen Barrett Fromme, MD, MHPE
University of Chicago

Kimberly Gifford, MD
Dartmouth-Hitchcock Medical Center

Erin Giudice, MD
University of Maryland

Gregory Gorman, MD, MHS
National Capital Consortium Pediatrics Residency Program

Su-Ting Li, MD, MPH
University of California- Davis Medical Center

Tai Lockspeiser, MD
Children’s Hospital Colorado

John Mahan, MD
Nationwide Children’s Hospital/Ohio State University

Heather McPhillips, MD, MPH
University of Washington/Seattle Children’s Hospital

Maria Ramundo, MD
Children’s Hospital Medical Center of Akron

Jerry Rushton, MD, MPH
Indiana University/J.W. Riley Hospital for Children

Heidi Sallee, MD
St. Louis University/Cardinal Glennon Children’s Medical Center

Chuck Schubert, MD
Cincinnati Children's Hospital Medical Center

Julia Shelburne, MD
University of Texas Medical School at Houston

Erin Stucky Fisher, MD
University of California (San Diego)

Teri L. Turner, MD, MPH, MEd
Baylor College of Medicine

Linda Waggoner-Fountain, MD, MEd
University of Virginia
APPD Council of Regional Chairs

Chair
Program Director
Albert Einstein College of Medicine, Jacobi Medical Center
auxford.burks@einstein.yu.edu

Mid-America Region
Abdulla K. Ghori, MD (2009 - 2015)
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aghori@metrohealth.org

Christine Mayes, BA (2012 - 2015)
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Kelly Bradley-Dodds, MD (2011 - 2014)
Program Director, Pediatric Residency
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Jennifer C. Bishop, BA, MBA (2011 - 2014)
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jennifer.bishop@crozer.org

Meredith Carter, MD (2011 - 2014)
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meredith.carter@inova.org

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Thea Stranger-Najjar, BA (2013 - 2016)
Administrator, Medical Education Office
University of Chicago Medicine
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New England Region
Edwin L. Zalneraitis, MD (2011 - 2014)
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New York Region
J. Auxford Burks, MD (2011 - 2014)
Program Director
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auxford.burks@einstein.yu.edu

Elizabeth Sanchez-Rocca, C-TAGME (2011 - 2014)
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esanchez@brookdale.edu

Southeast Region
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Residency Prgrm Dir, Dept of Pediatrics
Vanderbilt Univ Medical Center
rebecca.swan@vanderbilt.edu

W. Michael Southgate, MD (2013 - 2016)
Program Director of Residency
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Southwest Region
Jon Courand, MD, FAAP (2011 - 2014)
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Beth Payne, MAEd, C-TAGME (2011 - 2014)
Asst Program Director, Director Academic Programs
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Teri L. Turner, MD, MPH, MEd (2011 - 2014)
Assoc Dir, PHSE & Gen Academic FD
Baylor College of Medicine
Teri.Turner@bcm.edu

Western Region
Sandra Barker (2012 - 2015)
Pediatric Residency Program Coordinator
Phoenix Children's Hospital
sbarker@phoenixchildrens.com

Lilia Parra-Roide, MD (2012 - 2015)
Associate Program Director
Phoenix Children's Hospital
lparraroide@phoenixchildrens.com
Join an APPD Task Force!

The APPD Task Forces are seeking new members. Please attend one of the task force meetings and plan to become an active part of these important groups. Task force meetings will be held on Thursday, April 3 from 9:45am-11:30am. See page 16 for room locations. All are welcomed!

**ASSESSMENT**
The APPD Assessment Task Force is charged with: a) understanding the needs of APPD membership in the domain of learner, faculty and program assessment and b) communicating to APPD leadership proposed areas of development of assessment instruments and procedures. As well, the Task Force will serve as a group of content experts (program directors and leaders) who assist pediatric residency programs in improving and implementing their assessment procedures. Such procedures may include assessment and feedback to individual trainees and faculty, as well as evaluating curricular or programmatic activities.

**CURRICULUM**
The APPD Curriculum Task Force is charged with: a) understanding the needs of the APPD membership in the domain of curriculum and b) communicating to APPD leadership ways in which APPD can take a lead role in promoting and developing training curricula that meet RRC requirements, prepare residents for certification and, most importantly, reflect the current needs of children in our society. As well, this Task Force will also serve as a group of content experts (program directors and leaders) who assist Pediatric programs in improving and implementing curriculum, including proposing to the APPD leadership an infrastructure for curriculum development.

**FACULTY AND PROFESSIONAL DEVELOPMENT**
The APPD Faculty and Professional Development Task Force is charged with: a) understanding the needs of the APPD membership in the domain of faculty development and b) communicating to the APPD leadership proposed areas of meeting programming, and curricular materials that address the APPD membership (Program directors and leaders) needs regarding professional development. These areas of professional development may include faculty teaching skills, for example.

**LEARNING TECHNOLOGY**
The APPD Learning Technology Task Force is charged with: a) understanding the needs of the APPD membership in the domain of technology; b) identifying and evaluating technology, including software, computers, personal digital assistants, telecommunication devices, and wireless technologies; and, c) communicating to the APPD leadership recommendations for technology solutions for APPD members (Program Directors and leaders). As content experts, members of the APPD Learning Technology Task Force will be called upon to work collaboratively across all APPD task force groups to advise and assure integration of technology.

**RESEARCH AND SCHOLARSHIP**
The APPD Research and Scholarship Task Force is charged with: a) understanding the needs of the APPD membership in the domains of research and scholarship; b) supporting the APPD’s organizational processes and procedures that promote and support APPD member research and scholarship; and, c) informing the APPD leadership regarding ways in which research and scholarship can be supported for all APPD members (Program Directors and leaders).

**APPD Task Force Leadership**
Javier Gonzalez del Rey, MD, Chair, Council of Task Force Chairs
Children’s Hospital Medical Center/University of Cincinnati College of Medicine

Assessment Task Force:
Kathleen Bartlett, MD, Chair
*Duke University*
Mark Vining, MD, Vice Chair
*University of Massachusetts*

Curriculum Task Force:
Rebecca Blankenburg, MD, Chair
*Stanford University*
Helen Barrett Fromme, MD, MHPE, Vice Chair
*University of Chicago*

Faculty and Professional Development Task Force:
Nancy Spector, MD, Chair
*St. Christopher’s Hospital for Children*
Marsha Anderson, MD, Vice Chair
*University of Colorado*

Learning Technology Task Force:
Mark Hormann, MD, Co-Chair
*University of Texas at Houston*
Emily Borman-Shoap, MD, Co-Chair
*University of Minnesota*

Research and Scholarship Task Force
Heather McPhillips, MD, Chair
*University of Washington*
Su-Ting T. Li MD, MPH, Vice Chair
*University of California (Davis) Health System*
JOIN an APPD Pediatric Education Group!

The APPD Pediatric Education Groups (PEGs) are seeking new members. Please attend one of the meetings and plan to become an active part of these important groups. Meetings will be held on Thursday, April 3 from 3:45pm-6:00pm. See page 20 for room locations. All are welcomed!

GLOBAL HEALTH PEG
The Global Health PEG has a goal of bringing together many or all of the pediatric faculty working in global health education in pediatric training programs with the purpose of working collaboratively to implement global health education for pediatric trainees to prepare them to better serve children in resource limited settings locally and globally. We will do this by developing and disseminating best practices in curriculum and in away rotations as well as providing mentorship within our PEG. We hope this will be a forum for both junior and senior faculty to work together to advance the science of global health education.

Participation in open to all members.

Chuck Schubert, MD, Co-Chair
Sabrina Butteris, MD, Co-Chair

LESBIAN-GAY-BISEXUAL-TRANSGENDER-QUEER/QUESTIONING-ALLY (LGBTQA) PEG
The LGBTQA (Lesbian-Gay-Bisexual-Transgender-Queer/Questioning-Ally) Pediatric Education Group is working on two aspects of LGBTQ well being. The first goal is addressing education of future pediatricians about LGBTQ health concerns. The second set of goals focuses on promoting a safe and inclusive work environment for LGBTQ residents and staff.

There is a workgroup focusing on each of these areas. The PEG is working in conjunction with groups with related goals in the American Academy of Pediatrics (AAP) and the Academic Pediatric Association (APA). The PEG has identified a number of inclusive strategies to incorporate when recruiting and interviewing residency applicants. Both workgroups are working on a needs assessment to identify current curriculum and training in LGBTQ health and the perceived safety and supportiveness of workplace environments. The results of this needs assessment will be used to develop and prioritize next steps for the PEG.

Participation in the LGBTQA PEG is open to all members. We invite you to join us and participate in addressing the group goals.

Dena Hofkosh, MD, Co-Chair
Franklin Trimm, MD, Co-Chair
Brian Lurie, MD, Curriculum Workgroup Leader

SIMULATION IN HEALTHCARE PEG
The Simulation in Healthcare Pediatric Education Group has an overall goal of exploring, disseminating and sharing simulation methods used in healthcare to teach and assess these skills in pediatric residents and fellows:

- Procedural Skills
- Resuscitation Skills
- Communication Skills
- Exam Skills
- Data gathering and emotion handling skills
- Teamwork and interprofessional skills

We will accomplish this by working collaboratively to develop simulation cases and curricular materials that can be shared, particularly around milestones, teamwork, and procedures. We will work with the Society for Simulation in Healthcare in the efforts to standardize simulation terminology, as well as collaborating with simulation research networks on projects.

Participation in the Simulation in Healthcare PEG is open to all members. We hope you will join us and participate in our efforts.

Sharon Calaman, MD, Co-Chair
Joe Lopreiato, MD, Co-Chair
APPD LEAD
APPD Leadership in Educational Academic Development (APPD LEAD)

APPD LEAD is a nationally recognized program that provides a unique opportunity for pediatric academic leaders in medical education to engage and learn from seasoned program directors, pediatric educators, and other national leaders in pediatrics.

The LEAD curriculum focuses on organizational leadership, competency-based curriculum development, faculty development, residency and fellowship program administration, scholarship and career development. The curriculum is paced over three educational conferences, with additional group activities, readings and project work expected between conferences.

A call for applicants for Cohort 3 is underway. The deadline for applications for this group is April 23, 2014. Visit www.appd.org/ed_res/LEAD.cfm for details.

For more information about LEAD, look for the APPD LEAD poster during the Networking Session at 6PM on Wednesday, near the registration area during Lunch On Your Own on Friday, and during the Poster Session on Friday. LEAD Council members will be available by the poster to answer your questions during those times. We look forward to talking with you!

Inaugural Council Members / Faculty
Franklin Trimm, MD, Chair
University of South Alabama

Susan Bostwick, MD, MBA
New York Presbyterian Hospital/Cornell Campus

Grace Caputo, MD, MPH
Phoenix Children’s Hospital/Maricopa Medical Center

John Frohna, MD, MPH
University of Wisconsin

Hilary Haftel, MD, MHPE
University of Michigan

Su-Ting Li, MD, MPH
University of California (Davis) Health System

Linda Waggoner-Fountain, MD, MEd
University of Virginia

The second APPD LEAD Cohort (see list below) was selected from among a highly qualified
A group of applicants. The second Cohort, an energetic and focused group of educational leaders, will graduate from the program during the APPD Members’ Meeting at the APPD 2014 Annual Spring Meeting.

John P. Breinholt, MD
Indiana University SOM/ J.W. Riley Hospital for Children

Heather Lee Burrows, MD, PhD
University of Michigan

Utpala (“Shonu”) Gopal Das, MD
Medical College of Wisconsin, Children’s Corporate Center

Diane Ferran, MD, MPH
Columbia University Medical Center at Harlem Hospital

Elizabeth (“Anne”) Greene, MD
Children’s National Medical Center

Sabeen Habib, MD
LSH Health Sciences Center at Shreveport

Joy Deanna Howell, MD
Weill Cornell Medical College

Jason C. Katz, MD
Miami Children’s Hospital

Elizabeth S. Kramer, MD
University of Illinois /Children’s Hospital of Illinois

Rhett Lieberman, MD, MPH
Children’s Hospital of Pittsburgh of UPMC

Ayesha Mirza, MD
University of Florida College of Medicine - Jacksonville

Sandra Elizabeth Moore, MD, MSc
Morehouse School of Medicine

Eyal Muscal, MD, MS
Baylor College of Medicine

Amanda D. Osta, MD
University of Illinois at Chicago

Neha Patel, MD
University of Wisconsin

David A. Turner, MD
Duke University Medical Center
APPD LEARN has been active on several fronts. Our pilot study of assessment of Pediatrics Milestones, conducted in collaboration with the National Board of Medical Examiners, has completed data collection. A total of 18 APPD LEARN programs participated in this study and engaged in observation of interns and subinterns using rating instruments. Currently, there are seven writing groups, each working on unique manuscripts using data from this study.

APPD LEARN received six proposals in its first submission round of the call for proposals from member sites to submit educational research projects that would benefit from using the APPD LEARN network, data repository, and project support. These proposals resulted in two studies that are currently ongoing. The first of these studies is led by Su-Ting Li (UC-Davis) and Kimberly Gifford (Dartmouth) and investigates the validity of resident self-assessment using the Pediatric Milestones. There are 53 APPD LEARN programs enrolled in this study, with each site collecting resident self-assessment and Clinical Competency Committee assessment data. The second study, led by Jennifer Kesselheim (Dana-Farber/Children’s Hospital Cancer Center), examines pediatric trainees’ perceptions and experiences with social networking sites. This study has enrolled 13 sites and data collection was wrapped-up at the end of February 2014. You’ll hear updates about all of the abovementioned studies, as well as future work for APPD LEARN and how you can become involved, at this meeting.

Alan Schwartz, PhD, APPD LEARN Director
Robin Young, APPD LEARN Program Manager

APPD LEARN has its own web site at http://learn.appd.org
Sessions for Coordinators

This year, there are many sessions and workshops for coordinators, including “Professional Empowerment and Advancement: What’s stopping you?”, “Understanding Generational Differences to Improve the Medical Teaching Environment” with special speaker Joe Gilhooly, MD, a Google Workshop, and “Is Your Iceberg Really Melting?” on Wednesday afternoon. New this year are the “Coordinators’ Table Talks”, an opportunity for coordinators to hear information on topics of interest based on recent survey feedback and to learn more about ways to become involved in a Task Force or Committee. Other “Coordinator-specific Sessions/ Workshops,” filled with important and useful information, will be held on both Thursday and Friday, with Coordinators’ workshops included in Workshop Sessions 1-3 on Friday. All Coordinator-specific sessions have been blocked and shaded in the program to assist in locating them.

Coordinators should note that they are encouraged to attend any and all non-Coordinator-specific sessions offered during the meeting. Feel free to tailor your workshop choices to your interests and needs.
2014 Annual Meeting
April 2 - 5 ~ Chicago, IL
Professional Formation for Learners: Education and Assessment

APPD Meeting Schedule

Wednesday, April 2

7:00am  Registration Begins
Regency Ballroom Foyer, Gold Level (West Tower)

7:00am - 7:00pm  Mother’s Room
Skyway 281, Blue Level (East Tower)
This room is reserved to provide privacy for breastfeeding mothers.

8:00am - 5:00pm  APPD Forum for Chief Residents (Breakfast and Lunch will be included)
Crystal B Ballroom, Green Level (West Tower)
Coordinated by Erin L. Giudice, MD, Pediatric Residency Program Director, University of Maryland, Blair Dickinson, MD, Associate Residency Program Director, St. Christopher’s Hospital for Children, Cynthia Ferrell, MD, MSEd, Pediatric Residency Program Director, Oregon Health Sciences University, Adam Pallant, MD, Pediatric Residency Program Director, Hasbro Children’s Hospital, Maria Ramundo, MD, Pediatric Residency Program Director, Akron Children’s Hospital, Glenn Rosenbluth, MD, Associate Director, Pediatric Residency Training Programs, University of California, San Francisco, Edwin L. Zalneraitis, MD, Pediatric Residency Program Director, University of Connecticut, Olga Charnaya, MD and Jennie Hart, MD, Chief Residents at the University of Maryland, Ryan Good, MD, Chief Resident at the University of Vermont, and Erica Meyer, MD, Chief Resident at Akron Children’s Hospital. Sponsored by the Faculty and Professional Development Task Force.
Rising Chief Residents and Graduating Chief Residents are invited to attend this forum! Chief Residents face a diverse set of challenges in academic medical centers related to the multiple roles that they assume as leaders, clinicians, educators, administrators, and mentors. 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 position. The APPD’s Forum for Chief Residents is a series of educational sessions designed to help residents learn key administrative, academic, and leadership skills in order to facilitate a successful year as a Chief Resident, and to be able to use the Chief Resident year for enhancing success in subsequent years. This one-day forum will include a variety of interactive workshops led by experienced program directors and current Chief Residents to address these administrative, academic, and leadership topics relevant to Chief Residents. There will be opportunities to network with current and rising Chief Residents. The afternoon session will have two separate tracks: a track for rising Chief Residents will focus on planning the Chief Resident’s academic year and a track for graduating Chiefs will focus on professional development beyond the chief resident year.

9:00am - 11:15am  APPD Forum for Directors of Small Programs / Affiliate Chairs
Regency A Ballroom, gold Level (West Tower)
Janara Huff, MD, Marielisa Rincon-Subtirelu, MD, University of Tennessee College of Medicine / T.C. Thompson Children’s Hospital, Abhay Dandekar, MD, University of California San Francisco School of Medicine, Keith Mather, MD, University of Oklahoma College of Medicine –Tulsa, Aneesh Tosh, MD, University of Missouri - Columbia
“Small programs” have been traditionally defined as having 10 or less residents per year. However, many programs consider themselves “small” as compared to other larger programs in their vicinity. This forum will highlight the experiences, successes, and challenges facing program directors to effectively educate and manage in these environments. The discussion will aim to stress best practices and cultivate collaboration and group solutions. No numeric cutoff is necessary and any program that feels they may benefit from participating is welcome to attend.
11:30am-2:45pm  APPD Pre-Conference Workshops
(Additional fee required ~ includes boxed lunch)

Pre-Conference Workshop 1
Acapulco Room, Gold Level (West Tower)
CREATING ENDURABLE CHANGE: HOW TO DEVELOP MEDICAL EDUCATION CURRICULA
Presented by the APPD Curriculum Task Force; Nicole Paradise Black, MD, MEd, University of Florida, Gainesville, FL; H. Barrett Fromme, MD, MHPE, University of Chicago, Chicago, IL; Rebecca Blankenburg, MD, MPH, Stanford University, Palo Alto, CA; Christine Skurkis, MD, University of Connecticut, Hartford, CT; Jessica Myers, MD, Stanford University, Palo Alto, CA; Cynthia Ferrell, MD, MSEd, Oregon Health and Science University, Portland, OR

Background: Curriculum development is one of the most common tasks required of medical educators. Accreditation bodies, such as the ACGME, require well-developed curricula that include objectives, educational methods, and evaluation. Unfortunately, not enough medical educators receive formal curricula development training and therefore are not familiar with the basic principles and process involved in this task.

Objectives:
1. Describe Kern’s six-step approach to the medical education curriculum
2. Provide examples of each step using the National Nighttime Curriculum development process
3. Coach each participant in the creation of preliminary work for his/her own curriculum

Description: In this workshop, we will introduce participants to Kern’s widely accepted six-step model for the development of medical education curriculum. In a large group, the presenters will introduce the steps using the National Pediatric Nighttime Curriculum development process as an example. The presenters will offer a question and answer period regarding their own experience. Participants will then be divided into small groups to work on individual curricular projects, with one presenter facilitating each group. The workshop will alternate between introduction of specific approaches to each step and small groups brainstorming and applying those steps to their own projects. Participants will work in pairs within their small groups to create goals and objectives for their curriculum and design implementation strategies (Steps 3, 4). Each participant will utilize an interactive handout to record their ideas, which they can take home for future use. We will wrap-up the workshop with a Gallery Walk where participants from all groups will view the “in progress” ideas from other participants and provide feedback. Finally, the participants will return to the larger group to discuss favorite ideas and plan next steps at their home institution.

Pre-Conference Workshop 2
Crystal A Ballroom, Green Level (West Tower)
SIMULATION USE FOR GLOBAL AWAY ROTATIONS (SUGAR) – USING A NOVEL, STANDARDIZED SIMULATION-BASED CURRICULUM TO PREPARE RESIDENTS FOR GLOBAL HEALTH EXPERIENCES
Sabrina Butteris, MD, Department of Pediatrics, Global Health Education Director, University of Wisconsin School of Medicine & Public Health; Michael Pitt, MD, Department of Pediatrics, Associate Program Director, Co-Director of Global Health Education, University of Minnesota; Amer Al-Nimr, MD, Department of Pediatrics, Global Child Health Program Director, Rainbow Babies & Children’s Hospital; Jacqueline Kuzminske, MD, Department of Pediatrics Global Health Program Associate Director, Medical College of Wisconsin; Anagha Loharikar, MD, MPH, Assistant Professor of Pediatrics, Ann & Robert H. Lurie Children’s Hospital of Chicago; Nicole St. Clair, MD, Department of Pediatrics Global Health Program Director, Medical College of Wisconsin; Chuck Schubert, MD, Associate Residency Program Director, Global Health, Cincinnati Children’s Hospital Medical Center; Sarah Webber, MD, Pediatric Resident and Rising Chief, University of Wisconsin School of Medicine and Public Health

Objectives:
1. Identify common emotional obstacles residents encounter during a global health rotations
2. Perform a program-specific self-assessment of current preparatory curriculum and identify areas where gaps exist
3. Become familiar with principles of simulation debriefing
4. Introduce a standardized simulation curriculum
5. Become comfortable facilitating & debriefing standardized global health simulation scenarios

Background & Description: As the number of residents participating in global health rotations continues to rise, residency program educators and staff strive to prepare their residents to embark on these rewarding but often challenging situations. Unlike their rotations in the U.S., residents rotating abroad will often be faced with limited available resources for providing care, high rates of childhood mortality, and unfamiliar diseases. These unique circumstances can be exceptionally challenging, particularly for the resident that is experiencing them for the first time alone and unprepared.

Preparation for global health rotations has generally involved self-study on the part of the resident (reading about the country,
culture & diseases to be encountered), discussion sessions with faculty and other residents, and didactic sessions covering health and travel safety as well as disease specific lectures. While these elements are important, they often fall short when it comes to emotionally preparing residents for the day-to-day emotional obstacles that they will encounter.

Given this preparatory gap, we have developed a standardized, simulation-based curriculum (SUGAR – Simulation Use for Global Away Rotations) aimed at evoking the difficult emotions experienced by residents participating in global health rotations. This curriculum allows residents to experience the most challenging scenarios and emotions before they embark on their rotation.

A structured debriefing allows them to process the emotions they experience and problem solve as a group about how they will approach these scenarios during their rotation. We have piloted this curriculum at 7 different sites and had overwhelmingly positive feedback about its content, structure and impact. The curriculum utilizes a novel, easy to use case format that has been successfully used by both novice and expert simulation educators following a brief facilitator training session. In this workshop, we will train residency program educators to facilitate these standardized simulation sessions though a combination of debriefing, case familiarization and interactive practice. In addition, participants will be offered the opportunity to be involved in a multi-center educational research project aimed at evaluating the curriculum on a national level.

No prior simulation experience is needed to attend the workshop and facilitate the sessions. As the cases can be run with a doll or inanimate object, participants do not need to have access to any simulation equipment at their home institutions.

Programs of all sizes and stages of global health infrastructure are strongly encouraged to attend.

Pre-Conference Workshop 3

Crystal C Ballroom, Green Level (West Tower)
(Limited to first 42 registrants)

YOU CAN BE A SUCCESSFUL EDUCATIONAL SCHOLAR: DEVELOPING YOUR SCHOLARSHIP ROADMAP

THROUGH USE OF EXPERT RESEARCH MENTORING

Presented by the APPD Research & Scholarship and Faculty & Professional Development Task Forces; Erika Abramson, MD, New York Presbyterian - Weill Cornell, New York, NY; Aditee Narayan, MD, MPH, Duke University Medical Center, Durham, NC; Heather McPhillips, MD, MPH, University of Washington - Seattle Children’s Hospital, Seattle, WA; Suting Li, MD, MPH, University of California, Davis Medical Center, Sacramento, CA; Janet Serwint, MD, Johns Hopkins University, Baltimore, MD; Nancy Spector, MD, St. Christopher’s Hospital for Children, Philadelphia, PA; Marsha Anderson, MD, University of Colorado, Aurora, CO

Background: Academic faculty must balance many competing priorities, including the need to participate in and produce scholarly work. Expert mentoring can greatly facilitate this process. This pre-conference workshop is designed to help educators transform their ideas into achievable projects through the use of facilitated small group and expert mentoring.

Objectives: Through participation in this workshop, attendees from APPD will:
1) Differentiate the key types of medical education scholarship
2) Identify the characteristics of a SMART research question and common study designs used in educational scholarship
3) Create a roadmap for carrying out their own scholarly project
4) Refine their scholarship approach through brief, focused mentoring sessions with peers and expert facilitators

Description: Prior to the conference, participants will receive brief biographies from all of the participating mentors. Participants will also be asked to complete a brief worksheet assessing their background in educational scholarship and area of research interest. At the conference, participants will be grouped together based upon these responses. Following introductions, presenters will begin with a brief interactive didactic introducing Glassick’s Criteria for Scholarship and illustrating three types of educational scholarship that relate to teaching (Discovery, Application, and Integration). Workshop participants will then be introduced to the concept of a SMART research question (specific, measurable, achievable, relevant, timely). Using a structured planning worksheet, attendees will be asked to develop their scholarship idea/question. In groups of 2 or 3, accompanied by an expert facilitator, attendees will have the opportunity to discuss and further refine their ideas.

The next section of the workshop will focus upon identifying outcomes and choosing appropriate study designs to answer an educational scholarship question. Following a brief interactive didactic using published examples highlighting different study types and outcomes, participants will have the opportunity to continue their individual project planning, focusing on outcomes and committing to a study design. Depending on the number of attendees, we will either do speed research mentoring or facilitated peer mentoring to allow participants to get feedback on and refine their project plans. Participants will leave the workshop with their completed project plan and timeline, mentor contact information, and annotated references on educational scholarship.
1:00pm - 6:00pm  

Coordinators' Workshops  

**Regency B Ballroom, Gold Level (West Tower)**

1:00-1:15  
Welcome and Introduction of APPD Coordinators' Executive Committee  
*Dena Hofkosh, MD, MEd, APPD President-Elect*

1:15-2:45  
**Workshop C1: PROFESSIONAL EMPOWERMENT AND ADVANCEMENT: WHAT'S STOPPING YOU?**  
*Michele Brooks, Stanford University/Lucile Packard Children's Hospital, Palo Alto, CA, Teresa Flournoy, MBA, C-TAGME, University of Kansas Medical Center, Kansas City, MO, Beth Payne, MAEd, C-TAGME, University of Texas HSC at San Antonio, San Antonio, TX, Charlene Larson Rotandi, Stanford University, School of Medicine, Palo Alto, CA*  
The role of Coordinator and Administrator in Graduate Medical Education (GME) is constantly evolving as standards, perspectives and needs increase for the role. Those working inside of GME continue to look for more opportunity to grow professionally and personally in hopes of catalyzing the field into a profession. However, many times the lack of progression is due to the absence of professional empowerment, the shortage in advancement opportunities or the deficiency in supportive working environments. This is the time to take our careers into our own hands and begin to empower ourselves and those around us to become leaders, lifelong learners and champions for advancement!

3:00-4:00  
**UNDERSTANDING GENERATIONAL DIFFERENCES TO IMPROVE THE MEDICAL TEACHING ENVIRONMENT**  
*Joseph Gilhooly, MD, Professor, Vice Chair of Education, Oregon Health and Science University*  
Objectives:  
- Describe generational differences and conflicting values  
- Understand the impact of generational differences on education  
- Create a generationally friendly hospital and educational environment  
- Optimize collaboration amongst faculty and learners

4:15-5:00  
**Workshop C2: HOW CAN GOOGLE MAKE YOUR LIFE EASIER?**  
*Amy Gaug, Assistant Residency Coordinator, University of Minnesota, Minneapolis, MN*  
The University of Minnesota Pediatric Residency Program prides itself in trying to make the most up to date technology work for us as well as make our lives easier and more efficient. This benefits not only the coordinators and program directors, but our residents, applicants and the faculty at large that we work with. Our continued use of Google calendars, forms and this year a Google site for recruitment continues to show that our program does not continue the same process year after year and is always trying to improve.

5:00-6:00  
**Workshop C3: IS YOUR ICEBERG REALLY MELTING?**  
*Melodie Allison, BS, C-TAGME, Cynthia Gaskill, Baylor College of Medicine, Houston, TX*  
Is 2014 the year of fear in graduate medical education? Fears associated with NAS, Milestones, ADS, CCC, EAP, etc, etc. The list of changes is quite extensive and overwhelming. In John Kotter’s book “Our Iceberg is Melting” the author describes how change affects people very differently. What may seem to be a small change for one is a mountain to another. What causes the anxieties and what do we do about it? Why are we afraid of change? Workshop leaders will use techniques from John Kotter’s book to teach participants the necessary skills to welcome and accept GME change. Interactive discussion will encourage workshop participants to voice their concerns, develop coping techniques and adjust their attitudes regarding change. Anxiety levels regarding change will be reduced or possibly even diminish altogether. By the end of the workshop participants will: 1. Understand why the upcoming GME changes affect their position. 2. Be less anxious regarding GME changes. 3. Acquire a toolbox to cope with change. 4. Be part of a large extended network for support.
3:00pm-5:45pm  APPD Grassroots Forum for Program Directors

Regency C Ballroom, Gold Level (West Tower)
The Grassroots Forum for Program Directors will focus on timely topics of interest to Program Directors. This year’s facilitators will be Drs. Heather Fagan (University of Chicago), Betty Staples (Duke University) and Kate Perkins (UCLA).

APPD Grassroots Forum for Associate Program Directors

Regency D Ballroom, Gold Level (West Tower)
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. As in previous years, the highlight of our session will be peer-reviewed presentations from Associate Program Directors around the country on innovative projects and programs they are working on. We hope to build upon seven years of successful meetings and invite you to bring your ideas and questions to this energetic group session. Leaders: Drs. Heather McPhillips (University of Washington), Lynn Gardner (Emory University), and Sue Poynter (University of Cincinnati).

APPD Grassroots Forum for Fellowship Directors

Gold Coast Room, Bronze Level (West Tower)
This moderated open forum is designed specifically for subspecialty fellowship directors and coordinators to discuss a variety of current trends in fellowship education. There will be open discussion of training challenges and sharing of solutions facilitated by the APPD Fellowship Directors Executive Committee.

We anticipate your active participation. There will also be representatives from the American Board of Pediatrics and the ACGME to engage in dialogue related to such potential topics as EPAs and Milestones, MOC, and new NAS requirements (CCC, PEC, reporting of Milestones). Registrants will be surveyed prior to meeting to identify other potential topics of interest.

6:00pm - 7:00pm  Networking Reception

International Suite, Gold Level (West Tower)

THURSDAY, APRIL 3

7:00am - 8:00am  Continental Breakfast

Regency Ballroom Foyer, Gold Level (West Tower)

7:00am - 7:00pm  Mother’s Room

Skyway 281, Blue Level (East Tower)
This room is reserved to provide privacy for breastfeeding mothers.

8:00am - 9:30am  APPD Members’ Meeting

Regency Ballroom, Gold Level (West Tower)
Awards (Holm/Tunnessen/Berkowitz), Election Results, Annual Reports, and APPD LEAD Graduation

9:45am - 11:30am  APPD Task Force Meetings (open to all - see page 6 for task force descriptions)

Assessment

Comiskey Room, Bronze Level (West Tower)
Curriculum

Crystal B Ballroom, Green Level (West Tower)
### Faculty and Professional Development

**Crystal A Ballroom, Green Level (West Tower)**

**Learning Technology**

**Crystal C Ballroom, Green Level (West Tower)**

**Research and Scholarship**

**Acapulco Room, Gold Level (West Tower)**

### Coordinators’ Session

**Plaza Ballroom, Green Level (East Tower)**

**10:00am - 1:00pm**

**10:00-11:30**

**Coordinators’ Table Talks**

This forum will be an opportunity for coordinators to hear information on topics of interest based on recent survey feedback. Participants will move from table to table in a “speed dating” format in this highly interactive presentation. Topics include: orientation; peer mentoring; how to survive as a coordinator; and much more!

**12:00-1:00**

**Mentoring/Networking Luncheon with boxed lunch**

In a continuation of last year’s movement to peer mentoring groups, this lunch meeting will be an opportunity for groups to reconnect and for new members (or unassigned coordinators) to make contact with a mentoring group. A brief presentation on peer mentoring will kickoff the luncheon then groups will convene to get to know one another and to discuss plans for the year. This will be an excellent opportunity for networking!

### Research Platform Presentations

**Regency Ballroom, Gold Level (West Tower)**

#### Platform Presentation 1

**CONCORDANCE AMONG CLINICAL COMPETENCY COMMITTEE MEMBERS ON EMOTIONAL INTELLIGENCE MILESTONE PLACEMENT OF PEDIATRIC RESIDENTS**

Matthew D. Eberly, MD, Theresa A. Kiefer, BA, Danika L. Alexander, MD, Theophil A. Stokes, MD, Jennifer H. Hepps, MD, Gregory H. Gorman, MD, National Capital Consortium; Walter Reed National Military Medical Center, Bethesda, MD

**BACKGROUND:** Clinical Competency Committees (CCC) will assess trainees using the new ACGME Milestones. Inter-rater reliability of CCC members for placement and progression of residents along the Milestones has not been established.

**METHODS:** The CCC of a single medium-sized pediatric program with 12 residents per year assessed the Interpersonal and Communication Skills-2 (ICS2) Milestone (‘Demonstrate the insight and understanding into emotion and human response to emotion that allows one to appropriately develop and manage human interactions’) of 10 PGY2 residents who were 4 months into the academic year. CCC members, trained in Milestone assessment, were read 360-degree evaluations from the previous 3 months of rotations, and participated in discussion of the resident’s progress. Each member then independently assessed the resident using the ICS2 Milestone. Weighted kappas of all faculty pairs were calculated. Stratified analysis by pairs of hospitalists, pairs of continuity clinic faculty, and pairs of GME leaders were performed. The Program Director participated in the CCC deliberations, but did not assess trainees using the Milestone. RESULTS: Twenty-two faculty members of the CCC participated for a total of 231 pairs of assessments. Weighted kappas ranged from 0.008 to 0.83 with a median of 0.37 [Interquartile range 0.24-0.56] and a mean of 0.39 +/- 0.20. Excellent (K>0.81) agreement was seen in only 1.3% of observer pairs and substantial (0.61-0.8) agreement in 17.8%. The majority of pairs (54.6%) had poor agreement. There were 105 continuity clinic faculty pairs, 35 hospitalist faculty pairs, and 6 GME leader pairs. Continuity clinic faculty had higher agreement than hospitalist faculty [0.46 +/- 0.19 vs 0.23 +/- 0.15; p<0.0001]. GME leaders had the highest agreement, with a mean kappa of 0.57 +/- 0.15. //CONCLUSIONS: Milestone assessment by members of key faculty using 360-degree observations and personal experience with trainees has poor inter-rater reliability. Faculty who interact with pediatric trainees in the primary care continuity clinic have better agreement on the ICS2 Milestone assessment with each other than do hospitalists. The level of agreement on Milestone placement of residents may be improved by smaller-sized CCC and by limiting membership to those most familiar with the Milestones project.

#### Platform Presentation 2

**RESIDENTS’ REPORTS ON THE IMPACT OF FATIGUE IN THE PAST DECADE: IMPACT OF DUTY HOUR CHANGES**

Daniel J. Schumacher, MD, MEd, Boston Combined Residency Program, Boston, MA, Mary Pat Frintner, MSPH, William Cull, PhD, American Academy of Pediatrics, Elk Grove Village, IL

**BACKGROUND:** Concern about resident fatigue and patient safety has led to changes in Accreditation Council on Graduate Medical Education (ACGME) requirements over the last decade, most notably in 2003 and 2011. **OBJECTIVE:** Examine 2002, 2004,
and 2013 graduating pediatric residents' experiences on fatigue from work to determine changes over the period spanning pre-
implementation of duty hour limits (2002) through two major limitations of hours in the past decade. METHODS: National, random
sample survey of 500 graduating pediatric residents in 2002, 500 in 2004, and 1,000 in 2013; n = 1250 (63% response rate). Residents
were asked about the impact of fatigue from work and moonlighting. Chi-square and multivariate analyses were conducted to
compare reported differences between 2002, 2004, and 2013 residents while controlling for resident characteristics. RESULTS: The
majority of residents report falling asleep during an educational conference, with the proportion decreasing over time (81% in 2002,
73% in 2004, 60% in 2013, adjusted p<.001). Residents' reports of falling asleep while driving from work also decreased over time
(32% in 2002, 21% in 2004, and 19% in 2013 (adjusted p<.001). Resident reports of moonlighting at least once in the last 12 months of
residency also decreased over time (41% in 2002, 38% in 2004 and 30% in 2013, adjusted p<.001). Following the 2003 requirements,
Fewer residents reported making an error in patient care due to fatigue from work (17% in 2002 vs 8% in 2004, adjusted p<.01). This
report however rose to 14% in 2013 (8% in 2004 vs 14% in 2013, adjusted p<.05). DISCUSSION: Surveys of graduating residents over
the past decade indicate reduced fatigue effects, shown by gradual improvement in falling asleep during educational conferences
and while driving home from work with implementation of duty hour limits. This is important for optimizing resident education
and safety. During this same time frame, reports about making patient care errors improved but then worsened.

Platform Presentation 3

MILESTONE-BASED ASSESSMENTS BETTER ILLUSTRATE RESIDENT PROGRESSION

Kathleen W. Bartlett, MD, Shari A. Whicker, EdD, MEd, Duke Pediatric Residency Training Program, Jack Bookman, MAT,
PhD, Duke Department of Mathematics, Aditee P Narayan, MD, MPH, Betty B. Staples, MD, Holly Hering, BS, Kathleen A.
McGann, MD, Duke Pediatric Residency Training Program, Durham, NC

The Pediatric Milestones use behavioral anchors to describe learner progression through ACGME competencies. Behavioral anchors
may prevent some types of rater bias (e.g. halo effect, central tendency and stereotyping errors) when compared to symmetric agree-
disagree (Likert-type) rating scales. Faculty development is critical to ensure accurate assessment using behavioral anchors. Methods:
We sought to compare assessment results after changing from Likert-type scales to Milestone-based behavioral anchors. In February
2013 the Duke Pediatric Residency program began revising end-of-rotation assessments. The Curriculum Committee mapped the 21
required competencies to resident rotations based on where each competency would be best assessed. Rating scales were changed
from Likert-type responses to Milestone-based behavioral anchors. Prior to implementing the new assessments, program leadership
provided faculty development workshops on Milestones to each division. We evaluated the new system by: 1) comparing average
PGY-1 scores on Likert-type vs. Milestone-based assessments for 3 representative competencies; and 2) comparing average scores on
the Milestone-based assessments across PGY levels. Results: The average score for PGY-1 was significantly higher on the Likert-type
scales used 7-9/2012 vs. the Milestones-based scales used 7-9/2013 for all 3 competencies (p<0.001). Stratification by PGY level was
not observed on the Likert-type scales (e.g. average score on ICS-1 for PGY-1: 3.91 vs. PGY-3: 3.40, p=0.505). In contrast, the Milestone-
based assessments demonstrated emerging stratification by PGY level (average score on ICS-1 for PGY-1: 2.86, PGY-2: 3.50, PGY-3:
3.81, p<0.001 for PGY-1 vs. PGY-3). Similar findings were noted across 21 competencies on the Milestone-based assessments (p<0.001
for PGY-1 vs. PGY-3). Conclusion: Initial results indicate that Milestone-based assessments better illustrate resident development
than Likert-based assessments. The average PGY-level scores may also provide benchmarks for determining which residents are not
progressing through the curriculum at the expected pace.

Platform Presentation 4

WHAT LEARNING GOALS DO RESIDENTS DEVELOP?
Su-Ting T. Li, MD, MPH, Debra A. Paterniti, PhD, Daniel J. Tancredi, PhD, University of California Davis, Sacramento,
CA, Ann E. Burke, MD, Wright State University Boonshoft School of Medicine, Dayton, OH, Ann Guillot, MD, University of
Vermont, Burlington, VT, R. Franklin Trimm, MD, University of South Alabama, Mobile, AL, Susan Guralnick, MD,
Winthrop University Hospital, Mineola, NY, John D. Mahan, MD, Nationwide Children's Hospital/Ohio State University,
Columbus, OH

Background: Self-directed learning is essential to lifelong learning and to becoming an effective physician. Residents are
comfortable self-assessing competency, but less comfortable developing learning goals. Purpose: To determine incidence of self-
reported learning goal by competency area, and assess whether goals fall into competency areas with lower self-assessment scores.
Methods: Cross-sectional analysis of the existing de-identified American Academy of Pediatrics' PediaLink Individualized Learning
Plan database for academic year 2009-2010. Residents self-assessed their competencies (1-100 scale) for each of the 6 Accreditation
Council for Graduate Medical Education competency areas and wrote learning goals. Textual responses for goals were mapped to:
Plan database for academic year 2009-2010. Residents self-assessed their competencies (1-100 scale) for each of the 6 Accreditation
Council for Graduate Medical Education competency areas and wrote learning goals. Textual responses for goals were mapped to:

- MK (18)
- SBP (improve MK, they were less likely to write learning goals to improve their self-assessed SBP skill gap.
- ICS (area was not associated with the learner s' relative self-assessment score for that competency area.

Conclusions: Residents rated themselves least competent in their MK and SBP skills. While residents recognized their MK skill gap and wrote learning goals to improve MK, they were less likely to write learning goals to improve their self-assessed SBP skill gap.
1:15pm-1:45pm  APPD President’s Message
*Regency Ballroom, Gold Level (West Tower)*
Patricia Hicks, MD, MHPE, APPD President

1:45pm-3:30pm  Key Stakeholders Session
*Regency Ballroom, Gold Level (West Tower)*
Significant Updates from the ABP, ACGME, APPD LEARN with Q&A

3:45pm-6:00pm  APPD Mentoring / “Meet the Professor” Session for Program Directors, Associate Program Directors and Fellowship Directors
*Toronto Room, Gold Level (West Tower)*
APPD Mentorship Committee of the Faculty and Professional Development Taskforce:
Aditee Narayan, MD, MPH, Duke University Medical Center, Durham, NC; Rhonda Acholonu, MD, New York University Medical Center, New York, NY; Nancy Spector, MD, St. Christopher's Hospital for Children, Philadelphia, PA; Marsha Anderson, MD, University of Colorado, Aurora, CO; Janet Serwint, MD, Johns Hopkins University, Baltimore, MD; Theodore Sectish, MD Children’s Hosp Boston, Boston Combined Residency, Boston, MA; Teri Turner, MD, MPH, MEd, Baylor College of Medicine, Houston, TX; Cliff Yu, MD, National Capital Consortium, Bethesda, MD; Joe Lopreiato, MD, MPH, National Capital Consortium, Bethesda, MD
Participants will work in small groups with faculty mentors to address specific mentoring needs. Topics include: skills development in leadership, education research, curriculum, evaluation, learning technology, quality improvement, program management, and others. Please register to reserve your spot and bring your questions, ideas and challenges!

3:45pm-6:00pm  Coordinators' Workshops
*Plaza Ballroom, Green Level (East Tower)*

3:45-5:15  CCC: CLARIFICATION FOR COORDINATOR CONFUSION - NAVIGATING OUR UNDEFINED RESPONSIBILITIES
Samantha Comarnitsky, MPA, Children’s Hospital of Pittsburgh, Pittsburgh, PA; Holly Hering, BS, Duke University Medical Center, Durham, NC; Maura Reilly, MHP, University of California, Davis, Sacramento, CA
The shift towards meaningful-competency based resident evaluations, and the introduction of the Clinical Competency Committee (CCC), has made it necessary for residency programs and coordinators to revise evaluation data collection and reporting processes. The structure of each CCC and the expectations of the Residency Coordinator will vary based on individual program needs. However, certain considerations remain universal: What are the expectations of a Coordinator when preparing for CCC meetings? What role does a Coordinator play during CCC meetings? What expectations are universally placed on the Coordinator post CCC meeting? This highly interactive workshop will help coordinators answer many of these questions through group discussion and resource sharing. Topics to be examined include: best practices for data gathering, data preparation techniques and usage of technology aids to optimize workflow. Length of workshop - 90 minutes

5:15-6:00  TO TAGME OR NOT: THAT IS THE QUESTION!
Melodie Allison, C-TAGME-Baylor College of Medicine, Houston, TX; Jaime Bruse, C-TAGME-University of Utah, Salt Lake City, UT; Rebecca Hasegawa, C-TAGME-Medical University of South Carolina, Charleston, SC; Susan Quintana, C-TAGME-University of New Mexico, Albuquerque, NM
What is Training Administrators of Graduate Medical Education (TAGME) all about? What does it mean to be certified and how do I start the application process? Session to include a panel of pediatric TAGME-certified coordinators, followed by Q & A.
3:45pm-6:00pm  
Curriculum Task Force Poster Symposia  
**Crystal B Ballroom, Green Level (West Tower)**

The APPD Curriculum Task Force will be hosting a poster symposium on “Individualized Curriculum Implementation.” Great ideas, tips, etc. to share with program directors, associate program directors, fellowship directors, coordinators, chief residents and others as they are thinking of perfecting their own programs’ individualized curricula.

3:45pm-6:00pm  
Pediatric Education Groups (PEGs) Meetings (see page 7 for PEG descriptions)  
**Global Health**  
**Crystal C Ballroom, Green Level (West Tower)**  
**LGBTQA**  
**Acapulco Room, Gold Level (West Tower)**  
**Simulation**  
**Crystal A Ballroom, Green Level (West Tower)**

**FRIDAY, APRIL 4**

7:00am - 7:00pm  
Continental Breakfast  
**Regency Ballroom Foyer, Gold Level (West Tower)**

7:00am - 7:00pm  
Mother’s Room  
**Skyway 281, Blue Level (East Tower)**

This room is reserved to provide privacy for breastfeeding mothers.

8:00am - 10:00am  
Workshop Session 1 (choice of 9)

**Workshop 1: WHERE WE TEACH AND WHERE THEY LEARN: LISTENING TO OUR RESIDENTS IN DEVELOPING A CLINICAL LEARNING ENVIRONMENT (CLE) CURRICULUM**  
**Comiskey Room, Bronze Level (West Tower)**  
Steve Paik, MD, EdM, Columbia University, New York, NY  
Jennifer I. DiPace, MD, NYPH-Weill Cornell, New York, NY  
Dorene Balmer, PhD, Mark Ward, MD, Baylor College of Medicine/Texas Children’s Hospital, Houston, TX

The ACGME defines the CLE by six focus areas: patient safety, quality improvement, supervision, care transition, fatigue management/mitigation and professionalism. The workshop facilitators conducted a qualitative study to explore how residents experience “real-life” learning in these six areas. We anticipated the important role of learning opportunities in the explicit/formal curriculum (e.g. noon conference). However, we under-recognized the impact of the learning opportunities in the implicit or informal curriculum (e.g. modeling attendings in clinic) and in the extracurriculum (e.g. reading Atul Gawande).

In this workshop, facilitators will share the results of this multi-institutional study, but more importantly will challenge the workshop participants to develop curricular activities that meet the learning needs of residents. In small group activity #1, the participants will identify patterns of learning that best match their own program and will discuss rationale for their choices, i.e. why certain focus areas of the clinical learning environment may be more suited for learning in their program’s implicit curriculum. This discussion will frame the second small group activity focused on curricular planning. In small group activity #2, the participants will deliberate over a sample question that a CLER reviewer might ask during an interview. Considering the discussion from activity #1, how might a program or activity director plan curricular activities to meet the residents’ learning needs and to meet the expectations of the CLER team member? To close the workshop, the facilitators will lead a large-group discussion/debrief and summarize small group responses.

**Workshop 2: DEVELOPING AND DELIVERING PRESENTATIONS: SKILLS FOR FACULTY AND TRAINEES**  
**Crystal A Ballroom, Green Level (West Tower)**  
Karen J. Miller, MD, Tufts Medical Center, Boston, MA  
Barbara A. Bernhard, MA, New York, NY

Powerful presentations change lives. Presentation skills can be learned. Teaching and communication skills are core competencies that programs need to address. Faculty development of teaching skills is a focus of the ACGME’s Next Accreditation System (NAS). This session addresses the skills needed to prepare and present engaging and effective presentations. Attendees practice using tools to teach and mentor new speakers. Attendees participate in a variety of teaching strategies that can be used across multiple settings applying adult learning theory and the techniques used by the entertainment industry to get their message across creatively and memorably. The shift away from “information dump” lectures to presentations that drive practice change and improve learning outcomes will be emphasized. Participants will try out brainstorming techniques and...
and then learn how to craft their presentation as a story by combining Facts and Emotions with Active and Visual learning tools for maximum impact. Once they know WHAT they want to say and WHY their audience should care about it, they get to practice HOW to say it. They will also learn what NOT to do when giving a talk. The business side of speaking engagements is rarely discussed. How to accept, negotiate details, conduct yourself before, during and after an engagement will be reviewed and a worksheet provided. Session faculty combines Dr. Karen Miller, a developmental-behavioral pediatrician who has been giving presentations for 20 years including talks on speaking skills and Barbara Bernhard, an Emmy award winning producer-writer for national TV programs. They recently presented this talk at the Society for Developmental-Behavioral Pediatrics.

Workshop 3: CULTIVATING RESILIENCE DURING PEDIATRIC RESIDENCY
Crystal Ballroom, Green Level (West Tower)
Susan Bostwick, MD, Weill Cornell Medical College, New York, NY; Ann E. Burke, MD, Wright State University Boonshoft SOM, Dayton, OH; Albina Gogo, MD, UC Davis, Sacramento, CA; Susan Hoffkos, MD, Children’s Hospital of Pittsburgh of UPMC, Pittsburgh, PA; Marta A. King, MD, MEd, St Louis University School of Medicine, St. Louis, MO; Jennifer Linebarger, MD, University of Missouri-Kansas City School of Medicine, Kansas City, MO; Megan E. McCabe, MD, Yale University, New Haven, CT; Margaret R. Moon, MD, MPH, Johns Hopkins School of Medicine, Baltimore, MD; Amanda D. Osta, MD, Children’s Hospital University of Illinois-Chicago, Chicago, IL; Deborah T. Rana, MD, UCSD Medical School, San Diego, CA; Keely Smith, MD, University of Texas Medical School at Houston, Houston, TX; Janet R. Serwint, MD, Johns Hopkins University School of Medicine, Baltimore, MD
Pediatric residency training is an incredibly rewarding time in one’s career. It also can be demanding. Inexperienced pediatric housestaff are faced with the challenges of addressing emotionally charged situations such as communication of life-altering diagnoses, end of life care, and disclosure of medical errors. Implementation of new work hours has increased workload intensity, emotional detachment, burnout, and perceptions of decreased professionalism. An engaged and vibrant pediatrician must develop skills and cultivate mechanisms to maintain wellness by being present to human interaction in dynamic and mindful ways. This interactive workshop will present components of a new curriculum promoting resident resilience developed collaboratively by members of the AAP, APPD and APA. This curriculum with ready-to-use materials, slides and facilitator instructions will be available to APPD members. The need for such educational tools was identified by the AAP Section of Medical Students, Residents and Fellowship Trainees and the AAP Section on Hospice and Palliative Medicine. This workshop will use a train the trainer model such that participants will be exposed to the tools through small group discussion and participation in activities utilized in the curriculum. Participants will practice by working through an emotionally charged case, practice sharing bad news, designing a debriefing using key components provided by the curriculum, gaining better understanding of necessary approaches to wellness and designing a well-being plan. There will be a brief didactic review of current literature that informed the development of various sections of the curriculum. However, most of the time will be spent in activities and discussion. Participants will leave the workshop with strategies to implement this resilience curriculum for their own residents.

Workshop 4: COMMUNICATION & CONFLICT RESOLUTION 101: PREVENTION AND TREATMENT!
Acapulco Room, Gold Level (West Tower)
Ndidi Unaka, MD, Javier Gonzalez del Rey, MD, MEd, Sue Poynter, MD, Melissa Klein, MD, MEd, Jennifer K. O’Toole, MD, MEd, Cincinnati Children’s Hospital Medical Center, Cincinnati, OH
As residency programs continue to evolve in the era of Milestones-based evaluations and transitions of care due to shift work, communication skills have become of paramount importance in patient care, feedback, and patient safety. In addition, suboptimal communication may lead to conflict situations that in most cases would be preventable. Conflict resolution is a challenging component of the daily interactions of residents, fellows, and faculty. Most faculty and trainees have no formal training in the negotiations of conflict management and therefore, feel uncomfortable when managing or coaching how to resolve these situations. Resolving workplace conflict requires active engagement of the parties involved and the use of tools to help identify and prevent the escalation of high risk situations. This interactive workshop, which is part of our current curriculum for resident and faculty development in professionalism and communication, will give participants the opportunity to learn and practice several key concepts of basic communication, and to apply different conflict prevention / resolution techniques. Using engaging modalities including case-based learning, videos, role play, self-reflection, and active audience participation, attendees will be introduced to communication techniques such as “PEACE” and “LEAPS”, as well as other strategies used in the management of situations in which there are polarities of opinions. The workshop is designed to provide a forum for open discussion to uncover common mishaps in dealing with conflict and to share models in how to incorporate these techniques in residency education and faculty development on conflict management and communication skills. The participants will leave with guidelines to facilitate adapting the knowledge and skills presented into an ACGME core competencies and Milestones-aligned curriculum for trainees and faculty at their own institution.

Workshop 5: NEW PARADIGMS FOR A NEW GENERATION: FACULTY DEVELOPMENT IN INNOVATIVE CURRICULAR METHODS FOR TODAY’S LEARNERS
Crystal Ballroom, Green Level (West Tower)
Teri L. Turner, MD, MPH, MEd, Baylor College of Medicine, Houston, TX; Nancy Spector, MD, St. Christopher’s Hospital...
Over the past few years, several changes have taken place in pediatric education. Our trainees are digital natives and prefer learning that is interactive, collaborative, experiential and engaging. There has been a shift in evaluation to work-based assessment and development of performance progression. RRC requirements stipulate the need for and required participation in, defined faculty development activities to enhance the effectiveness of educator skills. Due to competing demands on faculty time and limited work hours for trainees, it is essential that teachers facilitate effective and efficient learning using evidence-based educational principles. As leaders of the APPD Faculty and Professional Development Task Force, we propose re-imagining and re-designing faculty development to best meet the needs of our learners. This workshop will explore 4 transformative methods for faculty development including: 1) flipping conferences, 2) just-in-time training (MedEd Tweets and other push technologies), 3) teaching and learning in a YouTube world (videos/podcasts), and 4) use of standardized actors for teaching and assessing skills. During this workshop, participants will perform a hands-on exercise to gain a deeper understanding of differences in learning styles. Next, a brief didactic will outline each of the four innovative methods using curricular examples. Participants will then break into small groups; each group will focus on one of the 4 transformative methods. Within small groups, participants will work with facilitators to develop ways to incorporate the innovation into their own learning environments and create a lesson plan that utilizes the innovative curricular method to teach a topic of interest. Groups will then reconvene together to share the plans. At the conclusion of the session, the group will identify ways to create faculty learning communities and mentoring networks as well as develop a commitment to action for incorporating what has been learned. Participants will leave with tools, resources and references to take back to their home institution.

Workshop 6: PATIENT RESPONSIBILITY IN CONTEMPORARY MEDICAL EDUCATION: YOURS, MINE, OR OURS?
Gold Coast Room, Bronze Level (West Tower)
Debra M. Boyer, MD, Jennifer C. Kesselheim, MD, MEd, Boston Children's Hospital, Boston, MA, Jim Bale, MD, University of Utah-Primary Children's Medical Center, Salt Lake City, UT
Today's trainees learn care delivery in an environment which has evolved substantially in recent decades. These trends may reduce trainees' sense of responsibility over their patients and hinder trainees ability to demonstrate patient ownership. This workshop will utilize a novel and highly interactive format that will enable attendees to formulate a definition of patient ownership and describe the challenges in fostering a sense of patient responsibility among training physicians. Participants will identify educational experiences, assessment methods, and faculty development strategies that promote trainee ownership of their patients. By the end of the workshop, attendees will have a collective sense of what ownership means in contemporary medical education and will have identified concrete mechanisms to optimize patient responsibility among trainees.

Workshop 7: GOING THE EXTRA MILE IN YOUR QUALITY IMPROVEMENT CURRICULUM: INTEGRATING QUALITY IMPROVEMENT ASSESSMENT TOOLS AND THE PEDIATRIC MILESTONES
Toronto Room, Gold Level (West Tower)
Mackenzie S. Frost, MD, University of Texas Southwestern Medical Center, Dallas, TX, Mario Cruz, MD, Blair Dickinson, MD, St. Christopher's Hospital for Children, Philadelphia, PA, Javier Gonzalez-del-Rey, MD, Cincinnati Children's Hospital Medical Center, Cincinnati, OH, David Cooperberg, MD, St. Christopher's Hospital for Children, Philadelphia, PA
Although the ACGME and Resident Review Committee require quality improvement (QI) training, systematic reviews of published QI curricula demonstrate a consistent lack of methodological rigor. Many programs have established QI projects and curricula, but lack assessment tools to evaluate trainee knowledge, demonstration, and application of quality improvement methodologies in practice. At the same time, the pediatric milestones are being implemented nationally to assess our trainees. This workshop will focus on the development of robust assessment of trainee quality improvement skills by utilizing both published QI assessment tools and the pediatric milestones. Workshop facilitators will review the pediatric milestones related to quality improvement. Via large group discussion, workshop participants will share current practices in evaluating these milestones. Workshop facilitators will then introduce both published QI assessment tools (Mayo Evaluation of Reflection in Improvement Tool (MERIT), Quality Improvement Proposal Assessment Tool (QIPAT-T), and Quality Improvement Knowledge Application Tool (QIKAT)). In facilitated small groups, participants will practice using each assessment tool with provided QI data and sample projects. The large group will discuss the pros and cons of each assessment tool. In a facilitated large group discussion, participants will then apply QI principles to construct a key driver diagram focusing on ways to successfully integrate the QI assessment tools with a focus on the appropriate pediatric milestones into the current QI curricula at their institutions. Finally, small groups will identify and discuss potential areas for collaborative QI education research in curricular and assessment tool development.
One aspect often overlooked in the professional formation of fellows is assuring that they are equipped with leadership skills for future success in academic medicine. The goal of this workshop is to describe and further enhance a leadership curriculum for fellows which can be implemented in one’s department. After introductions and descriptions of leadership curricula currently in place at participating institutions, participants will be asked to complete a leadership questionnaire. This will be followed by a didactic overview of leadership, including the key components of leadership in medicine, leadership theory and leadership styles, and the skills of successful physician leaders (conflict resolution, emotional intelligence, building credibility, vision & change management, organizational altruism and communication). Small groups will then be asked to delineate the challenges to leadership development of fellows and to identify specific leadership competencies or skills to develop in fellows. The large group will reconvene and report on the key competencies/skills identified by the small groups. Based on the competencies/skills identified, the group will vote on those that will be the focus for curriculum development. Small groups will then design curriculum focused on one or more of these leadership competencies or skills; participants will choose their group of interest. Various educational modalities will be proposed. For example, case vignettes describing potential scenarios that require fellows to define leadership skills and answer directed questions will be presented as a potential curricular technique. Topics, such as communication, self-awareness, building relationships, initiation and change and ethos, can be incorporated into the small groups curricular innovations. The focus will be on designing leadership education using practical, interactive modalities to equip fellows in their future roles. The large group will reconvene and share resources developed by each group for the leadership curriculum. Resources will be compiled by the workshop presenters and sent to participants for use at their institutions.

Workshop 9: LEADING FROM THE MIDDLE

Regency D Ballroom, Gold Level (West Tower)
Susan B. Hathaway, PhD, Children’s Mercy Hospital, Kansas City, MO
Program Coordinators are in the unique position of understanding the needs of their trainees, the challenges of day-to-day program management and the requirements of their program directors, institutions and accrediting bodies. From this vantage point, Coordinators are ideally situated to innovate and create change if they can tap into the sources of power available to them. This workshop examines the commitments and practices of leadership as posited by James Kouzes and Barry Posner and reinterprets them from the perspective of the Program Coordinator. Interactive and reflective activities will point participants to their areas of weakness and strength with resources and strategies to improve both.

10:15am - 12:15pm Workshop Session 2 (choice of 9)

Workshop 10: DEVELOPING A RESIDENTS-AS-TEACHERS CURRICULUM: DESIGN, IMPLEMENTATION AND ASSESSMENT

Crystal A Ballroom, Green Level (West Tower)
Melissa D. Klein, MD, MEd, Cincinnati Children’s Hospital, Karen E. Jerardi, MD, MEd, Cincinnati Children’s Hospital Medical Center, Cincinnati, OH, Barry Solomon, MD, MPH, Johns Hopkins School of Medicine, Jeffrey J. Padrowski, MD, MHS, Johns Hopkins University SOM, Baltimore, MD, Ndidi Unaka, MD, Cincinnati Children’s Hospital Medical Center, Matthew W. Zackoff, MD, Cincinnati Children’s Hospital, Cincinnati, OH, Janet R. Serwint, MD, Johns Hopkins University, Baltimore, MD
The Pediatric Milestones Project stresses the importance of residents developing the necessary skills to become effective teachers. Most residents have minimal background in adult learning theory and begin their training with a limited teaching skill-set despite the expectation that they assume the educator role in many clinical settings. AAMC surveys suggest that pediatric residents are not interested in increasing their teaching effectiveness given their key role in the education of medical students. Similarly, we have a dual responsibility to 1) better equip residents with teaching strategies grounded in adult learning theory to maximize their success, and 2) provide high quality assessment of their teaching to facilitate their progression along the Milestones. During this highly interactive workshop leaders will highlight the key components for successful development and implementation of a Residents-as-Teachers curriculum. Following a brief overview of adult learning principles, participants will explore specific strategies aimed at improving resident competence as effective teachers in ambulatory and inpatient team-based settings. These teaching strategies will include concepts relevant to one-on-one precepting, small group discussions and leading rounds. Participants will develop new skills via the use of role play, small group activities, and review of videotaped teaching encounters. In addition, participants will practice assessing resident teaching competency using objective, measurable, skill based assessment tools developed to evaluate team-based inpatient and one-on-one teaching skills. Lastly, the workshop leaders will provide participants with a roadmap for implementing a Resident-as-Teachers curriculum with corresponding assessment tools for use at their home institution.
Workshop 11: ENHANCING PROFESSIONAL TEAM FUNCTION: HARNESSING THE POWER OF INTROVERTS AND EXTROVERTS

*Toronto Room, Gold Level (West Tower)*

Sharon Calaman, MD, St. Christopher's Hospital for Children/Drexel University College of Medicine, Mario Cruz, MD, St. Christopher's Hospital for Children/Drexel University College of Medicine, Philadelphia, PA, Jennifer O’Toole, MD, MEd, Cincinnati Children's Hospital Medical Center/University of Cincinnati College of Medicine, Cincinnati, OH, Theodore C. Sectish, MD, Children's Hospital Boston, Boston, MA, Nancy D. Spector, MD, St. Christopher's Hospital for Children/Drexel University College of Medicine, Philadelphia, PA, Daniel C. West, MD, UCSF Benioff Children's Hospital, University of California, San Francisco, Anda Kuo, MD, UCSF Benioff Children's Hospital, University of California, San Francisco, Gold Level (West Tower)

As many as one in four to a half of the United States population are introverts, and the world of academic medicine reflects this mix of introverts and extroverts. Both introverts and extrovert personality styles have positive features that enhance the function of teams. Leaders may miss the opportunity to capitalize on the strengths of diverse teams if they do not know how to effectively engage and harness the power of the introverts and extroverts on their team. For individuals failure to learn how to vary one's introverted or extroverted tendencies may lead to missed opportunities, sub-optimal communication, and misguided mentorship. For example, those with a preference for introversion may be better served when they extend themselves in networking situations. Those with a preference for extroversion may communicate more effectively when they process thoughts internally before speaking. Program directors need to be able to effectively mentor and guide faculty and trainees with different traits, and coach them to success. In this workshop, faculty will discuss definitions and what preferences for introversion and extroversion mean, as well as how one can recognize these characteristics in themselves and others. We will explore the biases, myths, and assumptions around introversion and extroversion. We will utilize interactive activities, including reflective exercises and trigger videos, to look at ways that different types may approach situations that are common in medicine, such as rounds, committee meetings, conferences, interviews, and project work. We will explore strategies for success, such as allowing introverts time for reflection and processing as well as how to effectively mentor individuals of different types in your program and on your faculty. In addition, we will explore how the relationship between introverts and extroverts may play out in the academic world including possible conflicts and misunderstandings that may be a barrier to effective teamwork. Participants will leave with tools, resources and references to take back to their home institution.

Workshop 12: THE X FACTOR: IDENTIFYING RESIDENCY CANDIDATES WITH THE BEST ATTITUDES FOR YOUR PROGRAM’S CULTURE

*Crystal B Ballroom, Green Level (West Tower)*

Teri L. Turner, MD, MPH, MEd, Mark A. Ward, MD, Baylor College of Medicine, Houston, TX, Michelle Barajaz, MD, Children's Hospital of San Antonio, San Antonio, TX, Melodie Allison, BS, C-TAGME, Samuel Rosenblatt, MD, Baylor College of Medicine, Houston, TX

Residency programs attempt to identify applicants that best fit their program. Selection is based upon a weighting of a combination of factors that are unique for each institution. Overwhelmingly, the characteristics that define low performers in residency training are attitudinal or related to professionalism. Additionally, each program has a unique culture in which certain critical attitudes (X factors) define success as a resident. The goal of this workshop is for participants to create an interview process that will select for residents who will fit with and excel in the participant's unique training culture. The workshop goes beyond behavioral based interviewing and describes how the improper phrasing of questions can lead the candidate to give the desired answer. Why focus on attitudes? Quite simply, knowledge and skills can be taught. Attitude is much more difficult to teach and even harder to remediate. Participants will reflect on residents who are the top performers in their own program and identify critical attitudes for success as a resident in their training culture. Individuals will then be divided into small groups, based on the characteristics they defined, to develop interview questions that require candidates to describe specific incidents in the past that called for the critical attitude. These small groups will also create a scoring rubric for at least one of these “X factors”. Then the small groups will re-shuffle and practice conducting and scoring a structured residency interview for their identified critical attitude with a different group. Participants will reconvene as a large group to reflect on these experiences and to discuss methods to monitor the process in real-time during the interview season. Lastly, participants will develop a personal implementation plan identifying the steps they will take to transform what they have learned into actionable items. Participants will leave the workshop with tools, resources and references to take back to their home institution to use for the upcoming recruitment season.

Workshop 13: MAKING THE MOST OF YOUR INDIVIDUALIZED CURRICULUM: USING SMART LEARNING GOALS TO PROMOTE SELF-DIRECTED LEARNING

*Acapulco Room, Gold Level (West Tower)*

Priya Garg, MD, Tufts Medical Center, Boston, MA, Tai M. Lockspeiser, MD, University of Colorado, Aurora, CO, Su-Ting T. Li, MD, MPH, University of Colorado, Aurora, CO, Julia Aquino, MD, Tufts Medical Center, Boston, MA, Adam A. Rosenberg, MD, University of Colorado, Aurora, CO, Ann E. Burke, MD, Wright State University Boonshoft SOM, Dayton, OH

A resident’s individualized curricula should provide experiences that help the resident be better prepared for the next step in their career after residency. Ideally, residents would play an active role in designing their own individualized curricula with the guidance of faculty mentors. However, few residents have a framework by which to approach incorporating their self-identified learning needs into their individualized curricula. Learning goals and self-directed learning provide one possible...
framework. Our workshop will start with an overview of the literature on self-directed learning and the use of learning goals in medical education. Using a learning goal worksheet, participants will work in pairs to practice writing specific learning goals with the ISMART mnemonic based on example residents with different career plans. Pairs will exchange and then critique each other’s learning goals using the Colorado Learning Goal Scoring Rubric. Participants will then be provided with examples of actual goal worksheets from resident individualized curricula months from several different residencies. They will then work together in small groups to develop an approach to help the resident refine their goal, plan, and outcome. Next, we will share faculty development approaches our programs have used to address common challenges with creating and refining goals. The workshop will conclude with a large group discussion of how different programs have structured their individualized curricula and how goals can be included.

Workshop 14: RESIDENTS GOING GLOBAL

Plaza B Ballroom, Green Level (East Tower)

Deidra Ansah, MD, Parminder S. Suchdev, MD, MPH, Emory University, Atlanta, GA, Michael B. Pitt, MD, University of Minnesota/Amplatz Children’s Hospital, Minneapolis, MN, Sabrina M. Butteris, MD, University of Wisconsin School of Medicine & Public Health, Madison, WI, Maneesh Batra, MD, MPH, University of Washington, Seattle, WA, Cindy R. Howard, MD, University of Minnesota, Minneapolis, MN, Nicole E. St Clair, MD, Medical College of Wisconsin Department of Pediatrics, Wauwatosa, WI, Sophie Gladling, PhD, University of Minnesota, Minneapolis, MN

The primary goal of this workshop is to equip program leaders with the tools to develop formal evaluation methods for GH tracks and GH track residents. The workshop will use a combination of both large and small group discussions to achieve its objectives. In order to achieve our discussion, participants should come prepared with an understanding of their own residency program’s current evaluation methods for both individual learners and the program as a whole. Using data recently collected from a national survey of global health program directors, the session will begin by summarizing the current methods pediatric global health programs are using to evaluate their track residents. Based on this data, a framework for evaluation will be presented. Participants will explore formal tools used in program evaluation and complete a program-specific logic model for global health program evaluation. Through the use of small group discussions, participants will develop individualized global health track resident and program evaluation schemes for their respective programs. After gaining an understanding of various evaluation methods, and those being used at other institutions, the workshop will switch focus to how these evaluation methods can be standardized across institutions in order to produce a national benchmark to measure the competencies of a pediatric resident graduating from a global health track. The workshop will conclude with a discussion of how the APPD Global Health Educators Group can best support the monitoring and evaluation of residency program global health curricula. The workshop, led by global health track directors and residents from five institutions, will provide participants with the opportunity to explore their personalized goals for their institution’s global health track, and how these goals can be translated into effective curriculum and evaluation.

Workshop 15: WHO BETTER THAN PEDIATRICIANS? CLINICAL COMPETENCY COMMITTEES - THE PERFECT VENUE FOR DEVELOPMENTAL SCREENING OF PEDIATRIC RESIDENTS

Crystal C Ballroom, Green Level (West Tower)

Susan Guralnick, MD, Winthrop University Hospital, Mineola, NY, Robyn J. Blair, MD, Stony Brook Medicine, Stony Brook, NY, Jill Leavens-Maurer, Winthrop University Hospital, Mineola, NY, Jean Segall, MA, Stony Brook Medicine, Stony Brook, NY, Clinical Competency Committee (CCC) Meeting. …for many programs those words induce a feeling of fear and dread. The goal of the CCC is laudable – to determine whether an individual resident is progressing as expected, and if not, to recommend a course of action. This should be natural for the pediatrician. It is akin to applying a developmental screening tool in your practice, identifying the children not meeting their milestones, and recommending early intervention. The challenge for programs is to implement this practice for an entire program in an efficient and effective manner. The programs at Winthrop University Hospital and Stony Brook Medicine have almost 2 years experience with active CCCs. Through a process that began with carefully designed selection of committee membership followed by a step-wise, focused and continuing faculty development/training program, the programs have developed distinct, highly effective and streamlined CCC processes. This workshop will begin with a brief overview of the design and implementation of CCCs at the two institutions. In addition to faculty members, the essential role of the program coordinator will be highlighted. A highly functioning CCC will be modeled for the large group, followed by a discussion of successes and barriers the participants have encountered. The participants will then work together in small groups acting as program CCCs. The groups will be tasked with a variety of CCC challenges commonly encountered, devising approaches for handling situations such as acting out CCC members, Inadequate data, inadequate resident performance, inappropriate faculty evaluation, faculty disagreement with PD, and remediation issues. The large group will reconvene to discuss key situational management points identified. Participants will leave with faculty training materials, as well as new ideas and solutions to enable efficient and effective CCC function.

Workshop 16: A TASTE OF BALINT: INTRODUCTORY EXPERIENCE WITH THE BALINT GROUP MODEL TO ENHANCE EMPATHY AND PROFESSIONAL DEVELOPMENT AMONG PEDIATRIC RESIDENTS

Gold Coast Room, Bronze Level (West Tower)

Evelyn C. Reis, MD, Children’s Hospital of Pittsburgh of UPMC, Phillip A. Phelps, LCSW, UPMC Shadyside Family
Pediatric residents may feel frustrated or unsettled following interactions with some patients or their families. One way to better understand and learn from these challenging situations is to participate in a Balint group. A Balint group is a small group of physicians who meet regularly and participate in a supportive facilitated case discussion. In contrast to traditional case discussions which focus on problem-solving, Balint groups focus on enhancing the physician’s ability to connect with and care for the patient and family. Following a case presentation, the group members explore different perceptions about the physician’s and patient’s thoughts and emotions, and consider what is needed for the physician to build an empathic, fulfilling and effective relationship with the patient. Balint groups offer a valuable opportunity to support residents’ achievement of ACGME Core Competencies, including Patient Care, Interpersonal and Communication Skills, and Professionalism, and can be used to promote self-assessment on specific Pediatric Milestones. Typically, Balint groups are held longitudinally over years. The challenge for pediatric programs is finding time in the curriculum to add another longitudinal experience. To address this logistical challenge, we implemented a weekly Balint experience for PL-2 residents during two of their 1 month-long block rotations. Residents have shared that they appreciate the Balint experience as it provides an opportunity to reflect on challenging cases and gain insights into their own and their patients’ perspectives. During this interactive workshop, we will provide participants with an introductory experience with the Balint method. We ask that participants have clinical contact with patients and be willing to present a case. In addition to participating in a Balint group, workshop attendees will discuss the ACGME Core Competencies and progress along Milestones that Balint supports, the practical aspects of starting and maintaining Balint Groups for trainees, and Balint leadership training opportunities.

Workshop 17: ADAPTING THE PEDIATRIC MILESTONES INTO YOUR FELLOWSHIP PROGRAM
Comiskey Room, Bronze Level (West Tower)
Pnina Weiss, MD, Yale University School of Medicine, New Haven, CT, Bruce Herman, MD, University of Utah School of Medicine, Salt Lake City, UT; Angela Myers, MD, Children’s Mercy Hospitals and Clinics, University of Missouri School of Medicine, Kansas City, MO
The milestones provide a developmental roadmap of the acquisition of skills, knowledge and attitudes in medical education. Fellowship programs will be required to report specific milestones to the ACGME in 2014. The aim of this workshop is to increase the understanding of fellowship directors about the milestones and to demonstrate how to incorporate them practically into evaluations and feedback to fellows. First, there will be a presentation on the history and background of the pediatric milestones and their relationship to EPAs. The pivotal role of the clinical competency committee will be explored. The specific competencies that have been selected for reporting of milestones to the ACGME in the pediatric subspecialties will be highlighted. Both the conceptual framework of these milestone-based competencies and the mechanics of reporting to the ACGME will be described. Next, the participants will be divided into small groups for a more in-depth discussion of clinical competency committees and the specific subspecialty-related milestones. They will participate in a mock clinical competency committee meeting using vignettes and then will have the opportunity to analyze challenges and opportunities for greater efficiency. A second small group exercise will include discussion of: 1) using milestones to give verbal feedback to fellows and to remediate problem learners, 2) methods of educating faculty and fellows about the milestones, 3) minimizing faculty fatigue in the evaluation process. After each small group discussion, best practices will be shared with the group. Novel milestone-based methods of evaluation and feedback will be explored.

Workshop 18: RECRUITING BEST PRACTICES
Regency D Ballroom, Gold Level (West Tower)
Recruitment/Panel Discussion Members: Jaime Bruse, C-TAGME, University of Utah, Avis Grainger, C-TAGME, Carolinas Medical Center/Levine Children’s Hospital, Salvatrice Hall, Baylor College of Medicine / Texas Children’s Hospital, Christine E. Mayes, Akron Children’s Hospital, Kathryn M. Miller, B.S., C-TAGME, Johns Hopkins University School of Medicine
The presenters for this workshop will talk about Strategies and Best Practices for Recruitment. They will share numerous tips as well as answer questions. During this interactive 2 hour session, the following topics will be discussed:
• Strategies on Best Practices for your 2015 Recruitment Season
• Review “nuts” and “bolts”
• Review Common Pitfalls, Lessons Learned and More

12:30pm - 2:00pm Lunch on your own

Council of Regional Chairs Lunch Meeting
Atlanta Room, Gold Level (West Tower)
Workshop 19: A PRACTICAL APPROACH TO THE NEXT ACCREDITATION SYSTEM: USING ENTRUSTABLE PROFESSIONAL ACTIVITIES

Crystal A Ballroom, Green Level (West Tower)

Lynelle M. Boamah, MD, MEd, Natalie J. Burman, DO, MEd, Jamie K. Overbey, DO, Christine L. Johnson, MD, Naval Medical Center San Diego, San Diego, CA, Gregory S. Blaisdell, MD, MPH, Oregon Health & Science University/Doernbecher Children’s Hospital, Portland, OR, Melissa D. Klein, MD, MEd, Cincinnati Children’s Hospital Medical Center, Cincinnati, OH, Cynthia L. Ferrell, MD, MEd, Oregon Health & Science University/Doernbecher Children’s Hospital, Portland, OR

The Accreditation Council of Graduate Medical Education is moving towards a continuous accreditation model with more comprehensive and frequent evaluation of residents. Implementation of competency-based curricula has been shown to be challenging and the content can be perceived as abstract for faculty. Entrustable Professional Activities (EPAs), developed by Olle ten Cate, enable faculty a concrete approach to aligning core competencies with essential, discipline specific activities. This workshop will address how EPAs can streamline the evaluation process. Participants will be asked to bring goals and objectives of a curriculum. At the workshop they will develop their own EPA. In small groups, participants will determine which pediatric milestones can be observed within the EPA, which can subsequently be used to create a corresponding curricular evaluation. Participants will be asked to consider how existing assessment tools, such as mini-clinical evaluation exercises and multi-source feedback, correspond to their newly created EPAs. Our interactive discussion will include lessons learned from a practical approach to implementation of EPAs into the curricula of three unique and variably sized programs. Participants will experience creating an EPA, mapping it to milestones, and incorporating assessment tools into evaluation. The workshop will provide participants along the educational continuum a foundation to implement new assessment tools into their own training programs.

Workshop 20: FORM A BETTER LEARNER: MILESTONES-BASED APPROACH TO SUCCESSFUL REMEDIATION

Crystal C Ballroom, Green Level (West Tower)

Aditee P. Narayan, MD, MPH, Betty Staples, MD, Kathleen Bartlett, MD, Shari A. Whicker, EdD, MEd, Kathleen A. McGann, MD, Holly Hering, BS, Robert Drucker, MD, Duke University Medical Center, Durham, NC

Rationale: Multiple challenges can hinder successful learner remediation including: program consistencies, accurate learner assessment, clear learner expectations, appeal-proof documentation, and faculty engagement. We present a milestone-based approach to individualized remediation that addresses these challenges. Workshop leaders have successfully remediated trainees using this approach. The aim of this workshop is to train program directors in this approach for adaptation within their institutions. Participants will leave with a toolkit including remediation policy and corrective action templates, milestones-based assessments for common remediation scenarios, and successful remediation strategies. Methods and Content: The workshop will begin with identification of common remediation challenges by the large group. This will be followed by didactics on remediation principles and review of policy and corrective action templates. Then, small groups will each be assigned a domain of competence and given a scenario. Facilitated small groups will determine which competencies need remediation in their scenario. They will then assess the resident’s current performance based on the competency-specific milestones. The large group will reconvene for report-back. Didactics will follow on competency-based tool utilization to create robust, multi-rater (self, peer, program, faculty) assessments. We will discuss methods to identify which milestones residents need to attain for successful remediation, using expert consensus or data from peer evaluations. Additionally, we will employ an audience response system to demonstrate how to agree upon these milestones. Facilitated small groups will then identify strategies to help residents attain the selected milestones. Large group report-back will conclude the workshop with discussion of quantitative assessment analysis and value of clear documentation. Participants will leave with a toolkit of suggested strategies for remediation across 4-6 domains of competence.

Workshop 21: CSI PEDIATRICS: COMMUNICATIONS SKILLS INSTRUCTION AND GUIDED SELF REFLECTION USING ROLE PLAY WITH SIMULATED PATIENTS AND SCENAROIS FOR VARIOUS LEVELS OF LEARNERS

Gold Coast Room, Bronze Level (West Tower)

Evelyn C. Reis, MD, Sylvia S. Choi, MD, Dena Hofkosh, MD, MEd, Children’s Hospital of Pittsburgh of UPMC, Pittsburgh, PA

Effective communication is vital for physicians; however, teaching communication skills and assessing competency is challenging. We have developed a course for pediatric residents consisting of 2 hour sessions focused on communication skills needed in provocative emotional situations, using realistic clinical scenarios and simulated parents. The process of learning is experiential and uses guided self reflection, discussion among peers, and feedback from the simulator and faculty. Trained faculty members facilitate learning using positive commentary from fellow learners to highlight skills, and gentle guidance about identifying and responding to emotion and building empathy. Scenarios present different challenges, building on the skill sets relevant for each trainee’s level. Interns experience delivering difficult news, second year residents practice leading Family Centered Rounds with a challenging medical student, and third year residents practice disclosing a medical error. The simulated parents are actors who are trained in portraying both content and emotion, and provide valuable feedback about specific aspects of the interaction. Residents are encouraged to reflect on their current skills and to develop a deeper awareness of internal obstacles to enhanced communication. In addition to resident self assessment, faculty facilitators can directly observe and assess Pediatric Milestone based competencies in Interpersonal and Communication Skills and Professionalism. During this workshop we will describe how to create similar courses at other institutions. The Primary Teaching Method of guided facilitation and self reflection will be explained and demonstrated. Training of faculty facilitators,
creating a safe learning environment for role play, and the specifics on essential resources will be reviewed. We will share the
specific scenarios for different levels of trainees. Participants will be given the opportunity to practice using role plays so they
can receive real-time feedback from the course directors.

Workshop 22: “AND THE SURVEY SAYS”: DESIGNING SURVEYS TO EFFECTIVELY MEASURE OUTCOMES IN
EDUCATIONAL PROGRAMS
Acapulco Room, Gold Level (West Tower)
Timothy W. Kelly, MD, Daniel C. West, MD, University of California, San Francisco, San Francisco, CA
Surveys are commonly used in educational projects for needs assessment, curricular quality improvement, faculty
development, recruitment, and research projects. Indeed, surveys are likely familiar to all of us (e.g. from the iconic Family
Feud game show) and often appear deceptively easy to construct. Yet optimal survey design can be very challenging because
there are numerous potential pitfalls that can result in surveys that yield data that do not answer the intended question.
Furthermore, training in survey design is often a gap in the skill set of individuals responsible for educational programs.
This workshop is designed to fill this gap by providing the basic skills needed to create valid surveys for a wide range of
educational projects. Prior to the conference, participants will complete a web-based survey that will illustrate both effective
survey design and common pitfalls. At the conference, the workshop session will begin with an interactive didactic session on
writing survey questions, choosing response formats and scales, survey quality control methods, and survey administration
principles. Using pair-share and large group formats, participants will practice applying these concepts by critiquing
questions from the pre-conference survey and mock survey questions. Using a survey development worksheet, participants
will work in small groups to practice developing different types of survey questions and choosing response formats. The
workshop will conclude with a large group session to critique survey questions developed in the small groups. Participants
will leave the workshop with a basic knowledge of optimal survey design, a list of resources for future reference, and a step-
by-step guide that can be used to write high quality survey questions and identify appropriate response formats and scales
for nearly any project. No prior knowledge of survey design is required. Participants with survey project ideas are welcome to
work on those ideas during the workshop.

Workshop 23: THE MENTEE-DRIVEN APPROACH TO MENTORING RELATIONSHIPS AND CAREER SUCCESS:
BENEFITS FOR MENTORS AND MENTEES
Toronto Room, Gold Level (West Tower)
Mario Cruz, MD, Sharon Calaman, MD, Blair Dickinson, MD, St. Christopher’s Hospital for Children, Philadelphia, PA,
Mackenzie Frost, MD, University of Texas Southwestern Medical Center, Dallas, TX, Grace Haymes, Nicholas Kuzma, MD,
Stephanie Skuby, MD, Emily Souder, MD, St. Christopher’s Hospital for Children, Philadelphia, PA, Barry Solomon, MD,
Johns Hopkins University School of Medicine, Baltimore, MD, Theodore Sectish, MD, Boston Children’s Medical Center,
Boston, MA, Janet Serwint, MD, Johns Hopkins University School of Medicine, Baltimore, MD, Nancy Spector, MD, St.
Christopher’s Hospital for Children, Philadelphia, PA
Mentorship is a bi-directional relationship between mentee and mentor and understanding these relationships will lead to
the most rewarding outcomes. Effective mentoring relationships are important contributors to career satisfaction, academic
productivity, perceived self-efficacy, and successful networking. They are especially critical during times of transition in
one’s career. Unfortunately, such relationships can be difficult to initiate and challenging to sustain. With the emergence
of individualized learning plans (ILP) at all levels of medical education, we use the ILP concept to examine and optimize
the mentee-driven mentorship. Workshop leaders will represent a wide continuum of clinical and leadership experiences,
and includes program directors, associate program directors, chief residents, and a residency program coordinator. After
dividing into mixed and level-specific subgroups, participants will reflect on their unique mentoring needs as they transition
into the next career stage. Participants will then apply the corporate concept of managing up to their current mentoring
relationships. Next, workshop leaders will introduce the optimal characteristics of mentors, as well as the concept of a
mentoring mosaic. Participants will then create their own mentoring mosaics that describe the depth and breadth of their
existing and potential mentoring networks. With guidance from the workshop facilitators, participants will expand upon their
mentoring mosaics by exploring possibilities for untapped mentoring resources (recognizing that mentors can come from the
junior, peer, and senior levels). In small groups, participants will discuss strategies to overcome several challenging mentoring
scenarios, including how to: recruit new mentors; maximize the limited time of a mentor; and recognize mentor abuse.
Participants will leave with a better understanding of their roles as mentees and mentors, along with materials, resources and
an instructor’s guide that participants can use to replicate this workshop at their home institutions.

Workshop 24: CREATING AN INTEGRATED LONGITUDINAL TRAINING EXPERIENCE: IMPLEMENTATION
STRATEGIES AND BARRIERS TO CONSIDER
Comiskey Room, Bronze Level (West Tower)
Catherine Distler, MD, Kenneth Michelson, MD, Ronald Samuels, MD, MPH, Daniel Schumacher, MD, MEd, Laura Johnson,
MD, MPH, Theodore Sectish, MD, Robert Vinci, MD, Boston Combined Residency Program in Pediatrics, Boston, MA
Traditional pediatric training is made up of focused, independent block rotations in single disciplines. Although the block
rotation model is deeply embedded in residency training, some question whether this model adequately trains residents
in areas of professional development, interdisciplinary teamwork, and quality improvement and if it provides adequate
longitudinal supervision for high-quality assessment and feedback. Longitudinal experiences have been shown to make learners feel more connected to patients, invest more deeply in their care, and pursue advocacy efforts. Taking this model a step farther, an integrated longitudinal training experience (ILTE) allows complementary disciplines to be integrated and experienced over a longer time period than a traditional block rotation. With longer exposure time, ILTEs create opportunities for longitudinal learning and patient care; encourage quality improvement efforts; promote interdisciplinary team building; and build a framework for more meaningful assessment and feedback that emphasizes longer-term relationships and working toward targeted goals over time. With integration of multiple disciplines, ILTEs allow trainees to learn in clinical settings that inform and build from one another, highlighting areas of overlap and clinical relatedness. Given these advantages, why are residency and rotation directors not adopting more ILTEs into their training programs? The reasons likely involve comfort in the current model plus logistical and curricular barriers to restructuring. During this workshop, we will confront the value of block rotations versus ILTEs. We will briefly present our program's three-month ILTE pilot as an example. Participants will then work in small groups to 1) explore which clinical experiences in their own programs might be improved by an integrated, longitudinal structure, 2) cluster clinical experiences that naturally group in content and structure, 3) address barriers to implementation, and 4) describe first steps for ILTE development at their home institution. Participants will leave with an action plan for taking the next steps.

Workshop 25: BE NOT AFRAID: JUMPING EYES OPEN INTO THE JOY OF MILESTONES ASSESSMENT
Plaza B Ballroom, Green Level (East Tower)

Susan Guralnick, MD, Winthrop University Hospital, Mineola, NY, Robyn J. Blair, MD, Stony Brook Medicine, Stony Brook, NY, Jill Leavens-Maurer, MD, Winthrop University Hospital, Mineola, NY, Jean Seagall, Pediatrics Residency Coordinator, Stony Brook Long Island Children’s Hospital, Stony Brook, NY

This is the year of NAS. This is the year of milestones assessment. Programs are struggling to understand and implement milestones assessment. Rather than swimming against the tide, the residency programs at Winthrop University Hospital and Stony Brook Medicine decided to jump into the milestones world early and with arms wide open. Beginning in July of 2012, the two programs implemented milestones assessment into their programs, along with an intensive educational initiative aimed at preparing residents and faculty for this change in mindset. The result has been wide acceptance and excitement among all stakeholders. Session leaders will share their successful approach to integrating milestones into the educational process, as well as their approach to resident and faculty development. Prior to the meeting, participants will be asked to complete a brief survey regarding the approaches their programs have taken and barriers programs have encountered thus far in milestones implementation. The workshop will begin with a large group discussion of the results of that survey. Participants will share their approaches to barriers encountered, both effective and ineffective. The session leaders will then present a brief overview of the process at the two institutions, from planning to implementation, including the continuous quality improvement approach training residents and faculty in milestones-focused assessment. The participants will then work in small groups utilizing a strategic planning approach to address the barriers discussed, developing formalized approaches to conquering them. Participants will leave with resources that can be adapted for use in their programs including faculty and resident development materials, milestone mapping plans, and the session’s developed strategic plans.

Workshop 26: THIS IS MORE THAN JUST JEOPARDY - DESIGNING AND USING EFFECTIVE MEDICAL EDUCATION GAMES
Crystal B Ballroom, Green Level (West Tower)

Michael B. Pitt, MD, Emily Borman-Shoap, MD, University of Minnesota/Amplatz Children’s Hospital, Minneapolis, MN, Walter Eppich, MD, MEd, Northwestern University/Ann & Robert H. Lurie Children's Hospital of Chicago, Chicago, IL

Innovative educational games have been shown to be effective alternatives (and reinforcers) to traditional didactics with participants reporting higher attitudes about learning. Well-designed game-based learning (GBL) sessions use non-threatening components intended to capitalize on heightened learner engagement, allowing for dynamic group discussion that is fun, memorable, and effective. This GBL workshop will give participants the tools to create their own games and to maximize their impact as an educational tool for both large and small group settings. As a part of the session, participants will be introduced to a framework of Twelve Tips for Effective Game-Based Learning which they will immediately be able to apply in small groups to create and present a novel educational game. In addition, participants will share examples of games they have seen used before, and obtain group feedback incorporating the 12 Tips on how that game might be improved for future use. Participants will also be provided with a flash-drive loaded with a variety of effective pediatric education games that are easily adaptable for multiple settings and learners. These games, which will be reviewed in the workshop, have a wide range of technology requirements, with most requiring no computer at all. Several are intended to be played in short bursts, and are ideal for use on rounds in between patients. Audience: As using effective game-based learning can help residents to develop their skills in Practice-Based Learning and Improvement, this workshop is ideal for pediatric educators of all levels who are looking to expand and improve their educational toolkit.
**Workshop C27: SPLIT SESSION**

*Regency D Ballroom, Gold Level (West Tower)*

2:00pm - 3:00pm: **PROGRAM COMMUNICATION DYNAMIC - THE COORDINATOR AND THE DIRECTOR**  
Kerrie J. Jordan, MS, C-TAGME, Senior Coordinator; Tiffany Chow, MS, Fellowship Coordinator, UMKC/Children’s Mercy Hospital, Kansas City, MO  
This workshop will include an overview of communication styles. Participants will learn how to best communicate with the Program Director and Faculty. Participants will have the opportunity to take a communication styles test, identify their style and what style encompasses their Program Director and best practices to bridge the gap between the Coordinator and the Program Director.

3:00pm - 4:00pm: Workshop: **YOU’VE BEEN A COORDINATOR FOR HOW LONG?**  
Cindy Colpitts, Residency Coordinator, Creighton Nebraska Pediatrics Residency Program; Ellen Marr, C-TAGME, Residency Program Coordinator, Southern Illinois University SOM; Kelley Pike, Residency Coordinator, Albany Medical Center; Brenda Roach, Fellowship Program Coordinator, Children’s National Medical Center; Tara Shirley, Pediatrics Residency Coordinator, University of Kansas School of Medicine-Wichita; Veronica Tomlinson, Sr. Fellowship Program Coordinator, Connecticut Children’s Medical Center  
Seasoned fellowship and residency coordinators will answer questions and provide tips/strategies for new coordinators.

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<td>4:15pm - 5:45pm</td>
<td>Poster Session (see pages 35-61 for poster/abstract details)</td>
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<td><strong>Regency A-C Ballroom, Gold Level (West Tower)</strong></td>
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<td>(posters displayed 10:00am-5:45pm)</td>
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<tr>
<td>4:00pm - 6:00 pm</td>
<td><strong>LEARN and Pediatrics Milestones Assessment Collaborative (PMAC)</strong></td>
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<td><strong>Toronto Room, Gold Level (West Tower)</strong></td>
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<td>Stop by to find out more about a new CCC study in LEARN and about the newly formed Pediatrics Milestones Assessment Collaborative!</td>
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**SATURDAY, APRIL 5**

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<td>7:00am - 1:00pm</td>
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<td><strong>Skyway 281, Blue Level (East Tower)</strong></td>
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<td>This room is reserved to provide privacy for breastfeeding mothers.</td>
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<td>7:00am - 1:00pm</td>
<td><strong>Luggage Storage</strong></td>
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<td><strong>Hyatt Regency's Bellstand</strong></td>
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<td>As you check out of your hotel rooms on Saturday morning, you may store your luggage at the Hyatt Regency's Bellstand, located in the hotel lobby (Blue Level /East Tower) near the front desk.</td>
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<td>7:15am - 8:45am</td>
<td><strong>APPD Regional Breakfast Meetings</strong></td>
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<td>Mid-Atlantic: Southern NJ, East PA, DE, MD, Washington DC</td>
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<td>New York: NY, Northern NJ</td>
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Workshop 29: AN INNOVATIVE RESIDENT CONFERENCE TO TEACH COST-EFFECTIVE, EVIDENCE-BASED DIAGNOSIS OF PEDIATRIC ILLNESSES

Regency A Ballroom, Gold Level (West Tower)

Wayne H. Liang, MD, Erin R. Powell, MD, Tyler E. Reimschisel, MD, Whitney Browning, MD, Rebecca Swan, MD, Monroe Carell Jr. Children’s Hospital at Vanderbilt, Nashville, TN

Many residents are unaware of the costs of diagnostic testing, as this has not traditionally been emphasized in residency education. However, practical understanding of healthcare economics is vitally important to the practice of medicine. The ACGME Common Program Requirements state that residents are expected to “incorporate considerations of cost awareness and risk-benefit analysis in patient and/or population-based care.” The need for a curriculum on cost-conscious evidence-based clinical practice will be presented. We will then demonstrate the process our institution used to implement “The Chairman’s Cup,” a novel conference designed to address this knowledge gap. Participants will be immersed in this process during a full conference simulation. An unknown case will be presented, including the chief complaint, HPI, past medical history and physical exam. Workshop participants divided into teams will then use the Vanderbilt Electronic Pediatric Resident Organizer (VEPRO), a Moodle-based Course Management System, to generate a differential diagnosis to guide their workup, order diagnostic tests, and answer questions about their evaluation. Throughout the process, associated charges (based on actual billing data) for each diagnostic test will be viewed and tallied as they are ordered. At the end of the case, each team’s work-up, thought process and total charges will be compared and contrasted in the large group setting. The “ideal workup”, as pre-determined by a panel of content-area specialists and a review of evidenced-based guidelines, will be presented with targeted teaching based on observations of the groups’ management. Finally, the winning team will be selected based on the quality of the critical thinking demonstrated, diagnostic workup performed and total charges incurred. At various points in the workshop, we will pause to identify roadblocks experienced in the planning and implementation processes. We will conclude with a discussion and reflection on how participants could implement a similar curriculum at their institutions.
Workshop 30: INTERACTIVE WEB-BASED GLOBAL HEALTH EDUCATION FOR PEDIATRIC RESIDENTS: THE GLOBAL CHILD HEALTH EDUCATIONAL MODULES PROJECT

Crystal C Ballroom, Green Level (West Tower)

Ty T. Dickerson, MD, MPH, University of Utah School of Medicine, Salt Lake City, UT; Nicole E. St Clair, MD, Medical College of Wisconsin/Children’s Hospital of Wisconsin, Wauwatosa, WI; Suzanne Pak-Gorstein, MD, MPH, PhD, University of Washington, Seattle, WA; Chuck Schubert, MD, Cincinnati Children’s Hospital Medical Center, Cincinnati, OH; Michael B. Pitt, MD, University of Minnesota, Minneapolis, MN; Sabrina M. Butteris, MD, University of Wisconsin School of Medicine & Public Health, Madison, WI; Christiana Russ, MD, Children’s Hospital Boston, Boston, MA

The 21st century health care professional is called upon to understand factors affecting the health and survival of children worldwide in order to optimize care for immigrant children and children in international settings. GCHEMP provides a series of interactive, case-based, web modules for pediatric residents. These peer-reviewed modules focus on public health and pediatric clinical topics in global settings. This workshop will equip participants with tools to develop and augment residency global health (GH) curricula through use of the GCHEMP modules, thus complementing their local activities, resources and objectives. The facilitators, all with extensive GH experience, are developers of the GCHEMP modules. Topics include: Preparing For GH Electives, Cultural Aspects of GH, Child Malnutrition in Developing Countries, Approach to Respiratory Illnesses, Trauma, Injury Prevention and Diarrheal Diseases. (Explore an example: http://depts.washington.edu/gchemp/Malnutrition/player.html). Small facilitated groups of participants will engage hands-on with the GCHEMP modules and review strategies for integrating the modules into residency training. These groups will summarize and share their findings with the larger group. Facilitators will present a framework to incorporate the modules into residency curriculum. Participants will break into groups again to discuss the application of the framework and the tools needed to develop a plan to implement and evaluate GH training at their institutions. Participants will present key concepts to the larger group about these strategies. Participants are encouraged to bring their own laptop to view the modules and thumb drive to load materials; extra laptops will also be provided at the workshop. Participants will be provided with a take-home digital library of practical teaching tools, including: a GH curriculum planning template; learner performance metrics; teaching instruments (e.g., focus questions for discussion, reading lists, web resources, etc.), and; links to on-line modules.

Workshop 31: APPLYING SELF-DETERMINATION THEORY TO DIAGNOSE AND TREAT RESIDENTS AS LEARNERS

Crystal A Ballroom, Green Level (West Tower)

MacKenzi N. Hillard, MD, William S. Varade, MD, University of Rochester Medical Center, Lynn C. Garfunkel, MD, University of Rochester and Rochester General Hospital, Constance D. Baldwin, PhD, Caren Gellin, MD, University of Rochester Medical Center, Rochester, NY

Studies of self-determination theory (SDT) have demonstrated that individuals who are intrinsically motivated achieve more personal satisfaction and ultimately become higher achievers than those who are motivated by extrinsic rewards and punishments. This interactive workshop will apply SDT concepts to pediatric medical education. In the first half of the session, we will explore ways in which we can use strategies borrowed from SDT to improve our teaching and our assessments of the struggling learner. To begin, participants as a group will reflect on and discuss motivating factors in their own lives. This discussion will generate a dynamic list of motivators that we will add to throughout the session. Next, we will present a short didactic introduction to SDT and its components, with examples from resident education. With the assistance of audience volunteers, we will dramatize two short role-plays that depict challenging teacher-resident interactions. In small groups, participants will discuss the observed scenarios and use the language of SDT to diagnose the educational problem to be addressed. A large group debriefing will follow. The second half of the workshop will focus on strategies to help residents and faculty apply SDT to treat challenging teacher-learner interactions. In small groups, participants will be given a list of sample interactions, and asked to identify both (1) how the teacher can support the basic needs of the learner (autonomy, competence, relatedness), and (2) how residents can bolster their satisfaction of their own basic needs. As a large group, we will discuss lessons learned from both small group activities. A comprehensive list of generated strategies will be distributed to the group after the workshop. We will also share faculty and resident teaching techniques drawn from SDT that have been used at our own institution.

Workshop 32: PRACTICAL CONVERSATIONS AND STRATEGIES FOR THE 2014 REPORTING OF THE PEDIATRICS MILESTONES: WHAT’S A PROGRAM TO DO?

Crystal B Ballroom, Green Level (West Tower)

Ann E. Burke, MD, Wright State University Boonshoft SOM, Dayton, OH; Lynelle M. Boamah, MD, MEd, Naval Medical Center San Diego, San Diego, CA; Sara M. Multerer, MD, University of Louisville, Louisville, KY; Lynn C. Smitherman, MD, Wayne State University/Childrens Hospital of Michigan, Detroit, MI; Beth Payne, MAEd, C-TAGME, The University of Texas HSC at San Antonio, San Antonio, TX

Programs must report on their assessment ratings of the 21 Milestones as formulated by the required Clinical Competency Committee on each of their residents in May 2014 under the auspices of the Next Accreditation System. Programs have been working through the details and logistics of the changes needed to make informed decisions about these ratings. Programmatic changes are complex and take significant time and effort to implement, as do assessment systems that rates multiple domains of clinical competence. The Pediatric community is excited and actively participating in the development of pilot tested Milestone assessment tools via APPD Longitudinal Educational Assessment Research Network (LEARN). While those tools, which will be supported by significant validity evidence, are being studied and developed, program leadership must be creative, practical and
innovative with how to proceed! Some programs may be modifying their whole assessment system, while others are mapping existing items to the 21 required Milestones. Sharing of ideas and details of implementing assessment systems is needed!

This interactive workshop will begin with a brief literature review and update regarding Milestone reporting and assessment considerations. Large group discussion will then elicit challenges APPD members are having with the transition to Milestone reporting. Subsequently, three programs will share their strategies on modifying how they manage learner assessment allowing for informed inferences to be made with ratings. Each program will present their experiences, emphasizing the time, effort and faculty buy-in needed to make effective changes. Small group in-depth discussions about the ideas presented and participants’ own strategies will occur. The large group will reconvene and each group will report their perceived “best practices” and any additional ideas. We foresee the collaboration and conversation to be quite valuable to participants who are looking for detailed ways to accomplish the daunting task of Milestone reporting!

Workshop 33: ASSESSMENT IN A WORLD OF MILESTONES AND EPAS: A STEP-BY-STEP APPROACH TO UNDERSTANDING AND DEVELOPING VALIDITY EVIDENCE

Regency C Ballroom, Gold Level (West Tower)
Daniel C. West, MD, University of California, San Francisco, CA, Tai M. Lockspeiser, MD, Colorado Children's Hospital, Aurora, CO, Su-Ting T. Li, MD, MPH, University of California, Davis, Sacramento, CA

Determining that trainees have achieved Milestone levels or are able to perform Entrustable Professional Activities unsupervised are high-stakes decisions that will require development and adoption of many new assessment tools. To be able to choose the best assessment tools to use, program directors will need to understand and interpret validity evidence. This workshop is designed for educators who want to learn more about validity and how to judge the strength of validity evidence. It will also be valuable for educators who want to generate validity evidence for a new assessment tool they are developing. The workshop will review the basic concepts of validity based on the most current Standards for Educational and Psychological Testing including: content validity, response process, internal consistency, relationship to other variables, and the consequences of the proposed interpretation of the data generated by the tool. A significant portion of the workshop will focus on reliability and ways to recognize and adjust for measurement error (e.g. rater variability, context variability, etc.).

Participants will practice application of these concepts by critiquing the validity evidence of published assessment tools and by discussing how to interpret different types of validity and reliability evidence. At the end of the workshop, participants will be able to identify the key elements of validity, recognize common sources of measurement error, and identify the types of validity evidence required depending on the intended use of an assessment tool. All participants will leave with a step-by-step guide that will help them interpret validity evidence for any assessment tool and determine the evidence required for high-stakes decision making. Participants who are working on their own assessment tool will leave with a framework for generating validity evidence for their project that is sufficient to publish their work.

Workshop 34: UNMASKING THE HIDDEN CURRICULUM: STRATEGIES TO ADDRESS THE DEVELOPMENT OF PROFESSIONAL IDENTITY IN RESIDENCY TRAINING

Toronto Room, Gold Level (West Tower)
Julia Aquino, MD, Priya Garg, MD, Tufts Medical Center, Boston, MA

The ACGME Milestone Project has made explicit the importance of addressing professional identity formation in pediatric trainees. This can present challenges to educators since professional formation happens less often through formal curricula but rather through more informal processes such as clinical experience, peer relationships and role modeling: the hidden curriculum. This workshop is designed to help educators identify the hidden curriculum and develop strategies to address it. The workshop will begin with a review of the literature around professional identity formation. We will use vignettes and videos to exemplify the hidden curriculum and in small groups discuss its impact on professional formation during residency. The second half of the workshop will focus on role modeling as an educational strategy to address the hidden curriculum. Participants will explore the importance of role modeling, drawing from multiple sources and their own personal experiences. We will then describe our collaborative mentoring program: a novel structure that has replaced a dyadic advising system to engage both resident peers and faculty as role models and address topics important to professional development such as leadership skills, conflict resolution and mindfulness. Workshop attendees will participate in simulated faculty development exercises used in our program to promote faculty as role models. Participants will then critically evaluate and discuss the mentorship/advising structure at their own institutions and identify ways that role modeling and education around professional formation can be incorporated. Workshop participants should leave with strategies to explicitly address the hidden curriculum and a toolkit to engage resident learners and faculty in role modeling for professional identity formation.

Workshop 35: SOCIAL MEDIA AND MEDICAL EDUCATION PROGRAMS: POLICY, PROFESSIONALISM, AND OPPORTUNITY IN THE AGE OF FACEBOOK

Regency D Ballroom, Gold Level (West Tower)
Lahia Yemane, MD, Michael J. Holland, MD, Brian F. Flaherty, MD, Rebecca Blankenburg, MD, Stanford University Program in Pediatrics, Palo Alto, CA, Michael P. McKenna, MD, Indiana University Department of Pediatrics, Indianapolis, IN, David K. Hong, MD, Stanford University Program in Pediatrics, Palo Alto, CA

Since the advent of Facebook, social media platforms have proliferated rapidly, and have now become ever-present in training centers due to use of mobile devices. A 2010 study exploring use of a single social media platform (Facebook) at a single
academic center showed approximately 40% of residents, and 70% of medical students had active accounts. This represented more than triple the resident participation of a similar study two years prior, and participation is thought to be even greater now. Despite this massive increase in use, there appears to be wide variation in the amount and type of guidance given to residents and other learners regarding use of social media. This new technology presents new opportunities for teaching, but also a new avenue for a wide array of intentional and unintentional unprofessional behavior. The workshop will open with small group and large group discussion of positive and negative experiences with social media in medical education programs, followed by a brief introduction to social media platforms, a review of the literature surrounding their use by physicians-in-training, and preliminary results from the presenters’ national study on e-professionalism in pediatric residency programs. During the next portion of the workshop, participants will discuss scenarios of potential learner misuse of social media as a large group. These include creating/maintaining appropriate boundaries, HIPAA compliance, posting potentially unprofessional content, and managing relationships and conflicts with colleagues. After each scenario is presented, break out groups will discuss the issues raised, and attempt to reach a consensus. These consensus positions will then be shared between groups, and critically evaluated. Participants will identify proposed best practices for each area of potential concern, and apply them to the scenario in the form of a policy statement. In the final section, participants will break into groups and discuss potential positive roles for social media within medical education programs. After this brainstorming session, each group will identify an area of need, and construct a planned intervention using a social media platform to address the need. Finally, the whole group will reconvene to discuss the proposed interventions, and plan next steps for use of social media in home institutions.

Workshop 36: FELLOWSHIP READINESS: ARE PEDATRIC RESIDENTS PROPERLY PREPARED FOR FELLOWSHIP?
Regency B Ballroom, Gold Level (West Tower)
Debra M. Boyer, MD, Boston Children's Hospital, Boston, MA, Mel Heyman, MD, University of California, San Francisco, San Francisco, CA, Bruce Herman, MD, University of Utah, Salt Lake City, UT, Adam Rosenberg, MD, University of Colorado, Children's Hospital Colorado, Aurora, CO, Christine Barron, MD, Brown Medical School/Hasbro Children's Hospital, Providence, RI, Michael Brook, MD, University of California (San Francisco), San Francisco, CA, Suzanne Lavoie, MD, Virginia Commonwealth University Health System, Richmond, VA, Jim Bale, MD, University of Utah-Primary Children's Medical Center, Salt Lake City, UT
The preparedness of pediatric residency trainees entering pediatric subspecialty training programs has been questioned in light of recent changes in graduate medical education. These modifications have included reduced duty hours and a significantly increased level of supervision for residents. Sequelae from these new requirements have affected all pediatric residents, not merely those bound for fellowship training. However, specific changes to the ACGME requirements that have been developed allow resident curricula to be tailored to the career plans of trainees. These six individualized months must be determined by the learning needs and career plans of the resident. It has been proposed that these six individualized months could be effectively used to address many of these new gaps in residency training. This workshop will enlist the participants to discuss these gaps and work collectively to determine creative solutions for residency program directors.

11:00am - 12:30pm Council of Task Force Chairs Luncheon Meeting
New Orleans Room, Gold Level (West Tower)
Present educational opportunities were mapped against the core advocacy competencies as the Child Health Advocacy Institute and Government Affairs offices, and representatives from the American Academy of Pediatrics. We convened a workgroup consisting of residency program leaders (including residents), representatives from the hospital at our institution and create a 6 month individualized advocacy curriculum that would meet ACGME requirements.

**METHODS:**
- **Future Career:** Of these, 67% felt the present curriculum should be expanded.
- **Objective:** To transform advocacy education at our institution in 2010 showed 82% of respondents were interested in advocacy and 55% anticipate having advocacy as part of their future career. All pediatric residents have a minimum of 6 educational units of an individualized curriculum. A survey of residents at our institution showed that 82% of respondents were interested in advocacy and 55% anticipate having advocacy as part of their future career. All pediatric residents have a minimum of 6 educational units of an individualized curriculum.

**Background:**
- **The ACGME now requires that:**
- **Learning Objectives:**
- **Residency programs:**

**Objectives:**
- **To develop and implement a comprehensive advocacy curriculum:**
- **To prepare residents for future careers:**

**Methods:** During academic year 2013-14, 13 2nd year residents will participate in a longitudinal class project. In May 2013, all rising 2nd years participated in 2 basic QI sessions. Topics included: SMART Aim statements, PDSA cycles, team development and data collection. In a July 2013 conference, an aim statement of decreasing inpatient heme/onc admission time by 50% was developed along with a QI charter. A year-long curriculum was created by the program and given to the class which included monthly QI goals, linked IHI modules, and the final product development process maps, formed a team, and established their first PDSA cycle with data collection. To date, all residents have completed the IHI modules assigned, and presented to the group using QI terminology and tools. Conclusions: This novel curriculum allows residents to participate in multiple steps of a QI project and observe the evolution of the project as data is collected. Through this process, residents will be able to take a scholarly approach to QI and better understand the methodology.

**Impact:**
- **Residents will:**
- **Faculty mentors:**

**Results:**
- **To date:**

**Conclusions:**
- **This novel curriculum allows residents to participate in multiple steps of a QI project and observe the evolution of the project as data is collected. Through this process, residents will be able to take a scholarly approach to QI and better understand the methodology. We believe this will impact their ability to participate in MOC in a more meaningful way when they graduate.

**2) MAKING QUALITY IMPROVEMENT MEANINGFUL THROUGH A LONGITUDINAL CLASS QUALITY IMPROVEMENT PROJECT**

**Megan Z. Cardoso, MD, Priya Garg, MD, Floating Hospital for Children at Tufts Medical Center, Boston, MA**

**Background:** Many residency programs have incorporated QI, but struggle with demonstrating resident proficiency in QI at graduation. Previously, our residents were asked to complete individual QI projects often leading to: lack of interdisciplinary teams, lack of data and limited interventions. We hypothesize that if residents participated in a longitudinal class project, they will demonstrate QI proficiency and be able to test multiple QI interventions. **Methods:** During academic year 2013-14, 13 2nd year residents will participate in a longitudinal class QI project. In May 2013, all rising 2nd years participated in 2 basic QI sessions. Topics included: SMART Aim statements, PDSA cycles, team development and data collection. In a July 2013 conference, an aim statement of decreasing inpatient heme/onc admission time by 50% was developed along with a QI charter. A year-long curriculum was created by the program and given to the class which included monthly QI goals, linked IHI modules, and the final monthly deliverable product for each resident. An assigned individualized curriculum month was utilized for the QI experience. Each month, the resident hands off the project to a peer, facilitated by the faculty mentor. Quarterly, 2 hour sessions are incorporated into the noon conference curriculum for presentation of QI work to the group and the next PDSA cycle intervention is determined. **Results:** To date, the class has developed SMART aim statements, conducted a literature review, fishbone and process maps, formed a team, and established their first PDSA cycle with data collection. To date, all residents have completed the IHI modules assigned, and presented to the group using QI terminology and tools. Conclusions: This novel curriculum allows residents to participate in multiple steps of a QI project and observe the evolution of the project as data is collected. Through this process, residents will be able to take a scholarly approach to QI and better understand the methodology. We believe this will impact their ability to participate in MOC in a more meaningful way when they graduate.

**3) DEVELOPMENT OF A CHILD HEALTH ADVOCACY AND PUBLIC POLICY PATHWAY**

**Cara Lichtenstein, MD, MPH, Lee Savio Beers, MD, Heidi Schumacher, MD, Jerome Paulson, MD, Children’s National Medical Center, Washington, DC**

**Title:** Development of a Child Health Advocacy and Public Policy Pathway **Background:** The ACGME now requires that all pediatric residents have a minimum of 6 educational units of an individualized curriculum. A survey of residents at our institution in 2010 showed 82% of respondents were interested in advocacy and 55% anticipate having advocacy as part of their future career. Of these, 67% felt the present curriculum should be expanded. **Objective:** To transform advocacy education at our institution and create a 6 month individualized advocacy curriculum that would meet ACGME requirements. **Methods:** We convened a workgroup consisting of residency program leaders (including residents), representatives from the hospital’s Child Health Advocacy Institute and Government Affairs offices, and representatives from the American Academy of Pediatrics Department of Federal Affairs. Present educational opportunities were mapped against the core advocacy competencies as

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**APPD Posters**

**Descriptive Posters**

1) **THE CSW PROGRAM: AN INTERDISCIPLINARY APPROACH TO SUPPORTING RESIDENT WELL-BEING**

**Arthur Taub, LCSW, Shari A. Whicker, EdD, MEd, Betty B. Staples, MD, Duke University Medical Center, Durham, NC**

In this era of limited duty hours and ever-increasing educational requirements and responsibilities, the issue of resident fatigue and its impact on patient care, patient safety, and resident well-being continues to be a major source of stress and unhappiness. Stress and unhappiness in the lives of residents is well-documented throughout the literature. In our attempt to address these concerns, our program integrated a dedicated Clinical Social Worker into the program as a unique source of resident support. Through our CSW program, one Pediatric CSW (.2 FTE) was designated to work directly with the residents on an ongoing basis. This work includes regularly scheduled psychosocial discussion and communication skills group sessions and one-on-one or family sessions as requested. A designated CSW offers several unique and valuable attributes including: a background in dealing with stress and psychopathology; a history of working and coping with the same patient/family population as the residents; a non-physician with no administrative authority over the residents; easy accessibility to residents at all times; a resource with whom residents are familiar on a collegial level. Several program policies help to make this program a success: 1) Residents are never required to see the CSW; 2) The CSW is available for totally confidential self-referral or by Program Director or Advisor referral; 3) The CSW is not limited to performing psychotherapy, but also is available for any/all significant resident concerns; 4) The CSW takes a systems theory approach and is also available to significant others or family members; 5) The CSW is paid by the program and, therefore, is a free resource to residents. All pediatric residents work with the CSW in group sessions throughout their training, having the opportunity to develop a comfortable rapport with the CSW which may encourage self-referrals or increased comfort with program referrals. Approximately 6-8 residents per year utilize these services (includes both self and program referrals). This service has been viewed as a valuable resource for residents in need and has also improved residents perception of the program as caring and supportive.

2) **MAKING QUALITY IMPROVEMENT MEANINGFUL THROUGH A LONGITUDINAL CLASS QUALITY IMPROVEMENT PROJECT**

**Megan Z. Cardoso, MD, Priya Garg, MD, Floating Hospital for Children at Tufts Medical Center, Boston, MA**

**Background:** Many residency programs have incorporated QI, but struggle with demonstrating resident proficiency in QI at graduation. Previously, our residents were asked to complete individual QI projects often leading to: lack of interdisciplinary teams, lack of data and limited interventions. We hypothesize that if residents participated in a longitudinal class project, they will demonstrate QI proficiency and be able to test multiple QI interventions. **Methods:** During academic year 2013-14, 13 2nd year residents will participate in a longitudinal class QI project. In May 2013, all rising 2nd years participated in 2 basic QI sessions. Topics included: SMART Aim statements, PDSA cycles, team development and data collection. In a July 2013 conference, an aim statement of decreasing inpatient heme/onc admission time by 50% was developed along with a QI charter. A year-long curriculum was created by the program and given to the class which included monthly QI goals, linked IHI modules, and the final product development process maps, formed a team, and established their first PDSA cycle with data collection. To date, all residents have completed the IHI modules assigned, and presented to the group using QI terminology and tools. Conclusions: This novel curriculum allows residents to participate in multiple steps of a QI project and observe the evolution of the project as data is collected. Through this process, residents will be able to take a scholarly approach to QI and better understand the methodology. We believe this will impact their ability to participate in MOC in a more meaningful way when they graduate.

3) **DEVELOPMENT OF A CHILD HEALTH ADVOCACY AND PUBLIC POLICY PATHWAY**

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defined by Dr. Wright et al in Toward the Development of Advocacy Training Curriculum. This includes knowledge and skill
competencies at the patient level, community level, and legislative level. The workgroup assessed whether each competency
should have been 1) Not introduced, 2) Introduced, 3) Achieved proficiently or 4) Mastered at the end of each learning
experience. The group then developed educational experiences to fill in gaps related to these core competencies. A pathway
map was created to allow the resident to plan their individualized curriculum. RESULTS: This work culminated in the creation
of a 6 block individualized curriculum that consists of a pick list of advocacy electives, opportunities to integrate advocacy into
existing rotations, and research opportunities with individualized mentorship. CONCLUSIONS: A detailed review and gap analysis
of advocacy education opportunities can guide formation of individualized curricula for residents. By creating robust and unique
advocacy training experiences, our program is not only fulfilling ACGME requirements, but also meeting the needs of our
residents.

4) DEFINING THE NEXT CHAPTER: A GUIDE THROUGH PEDIATRIC FELLOWSHIP APPLICATIONS
Erica Silva, MD, Jonathan Meyer, MD, Beth Payne, MAEd, C-TAGME, The University of Texas HSC at San Antonio, San
Antonio, TX

Background: Currently in the UTHSCSA Pediatric Residency Program, residents proceed through the fellowship application
process independently. A concise resource detailing locations of applications, the components of an interview, and methods to
present oneself as the best candidate would be a valuable reference. Objectives: To improve comfort levels in the fellowship
application process by 25%, determined by pre- and post-surveys. To determine if our newly developed format effectively
presented the information seen by residents feeling more confident applying for fellowship. Methods: Before proceeding,
IRB approval was sought and obtained. Current pediatric residents completed a pre-survey to assess familiarity with the
fellowship application process and to provide an opportunity for specific questions to be asked of UTHSCSA fellowship
directors. Faculty, Fellowship Program Directors and Fellows representing various subspecialties were asked to provide
answers to seven of the most FAQ's as well as to develop a list of top qualifications sought in an applicant. A meeting was
held among residents and UTHSCSA pediatric fellowship directors to introduce applicants to a more effective method of
applying to fellowship. Material covering ERAS, NRMP, interviews, and CV preparation was presented with additional handouts
provided to attendees. Residents able to attend completed both a post-survey to reassess fellowship application familiarity
and a reaction survey to ascertain usefulness of the workshop. Results: Thirty-six residents from all training levels completed
the pre-workshop survey, 89% of which stated they planned to apply for fellowship. Thirty-seven to 81% of these residents
felt either somewhat comfortable or somewhat uncomfortable with the application process. All twelve meeting participants
agreed the information presented was beneficial, and 100% of those surveyed felt somewhat comfortable or very comfortable
with the application process after the workshop. Conclusions: Creating a central location detailing the fellowship application
process is an effective means of providing residents with support and guidance as demonstrated by an increase in resident
knowledge and familiarity with the application process. Though the percentage of residents intending to apply for fellowship
decreased, this was likely due to the smaller number of responses received from the post-workshop survey. Due to the
overwhelmingly positive response to the workshop, we plan to make this an annual event with sustained resident feedback for
future improvements.

5) COLLABORATIVE LEARNING MODEL: THE “BUDDY” SYSTEM FOR PEDIATRIC RESIDENTS & CHILD
PSYCHIATRY FELLOWS
Christopher D. Motyl, DO, Brian P. Youth, MD, Maine Medical Center, Portland, ME

Formal mental health curriculum to train pediatric residents is often limited in residency programs. This results in pediatricians
feeling ill-equipped to assess and treat children with mental health concerns. Similarly, child psychiatry fellows often have
minimal pediatric training, which can limit their understanding of common pediatric illnesses and well-child development.
Aim: To increase resident comfort in screening, assessing, and treating child mental health disorders, while giving them
experience in collaborative consultations. Method: We paired senior pediatric residents with child psychiatry fellows (buddy).
The pediatric residents shadowed their “buddies” at the child psychiatry clinic during adolescent and community rotations.
They also arranged to see patients with mental health concerns jointly with their “buddies” at the on-site pediatric clinic.
Both parties were available for phone or e-mail consultation. Residents were given baseline and post-implementation surveys
about comfort with pediatric mental health concerns and were asked to evaluate the buddy collaborative. Results: Baseline
survey data was completed by 77% of the residents. At baseline, 60% of residents felt comfortable managing ADHD, while
only 4% felt comfortable managing PTSD, bipolar disorder, and disruptive behavior disorders. The post-implementation
survey was completed by 48% of residents. Of those who consulted their “buddy”, 67% reported helpful experiences. After
implementation, all paired residents reported having the skills necessary to have a collaborative relationship with mental
health providers and 80% felt they had adequate knowledge to care for children and adolescents with psychiatric disorders.
Conclusions: Pairing pediatric residents with child psychiatry fellows during training allowed for timely and effective
management of children with mental health illnesses and modeled the importance of collaborative relationships between
these disciplines post-training.

6) LONGITUDINAL BOARD REVIEW: A RECIPE FOR BOARD SUCCESS
Emily Souder, MD, Nicholas Kuzma, MD, Stephanie Skuby, MD, Sharon Calaman, MD, Blair Dickinson, MD, Nancy Spector,
MD, Mario Cruz, MD, St. Christopher’s Hospital for Children, Philadelphia, PA
INTRODUCTION: Passing the ABP exam is an important step in the professional development process for pediatricians. In residency, board content is often taught in didactic sessions, a passive experience that may not engage all learners or emphasize study habits and test-taking skills. Several residency programs have designed curricula to address these issues, demonstrating improved ITE scores, but none in pediatrics using residents as teachers. Building on this work, a resident-facilitated, interactive, longitudinal board review (LBR) curriculum was developed to improve resident preparedness for the ABP exam. METHODS: Beginning in August 2013, topic-specific PREP questions were selected for monthly sessions. Residents were divided into 4 groups, each led by a 3rd year resident who prepared discussion points with specialists. During each 1 hour session, learners individually answered 5 PREP questions and participated in group discussion of question content, answers and exam strategies. Short-term outcomes measured via surveys assessed resident satisfaction, attendance and perceived board readiness. Long-term measures include ITE scores, ABP exam pass rates and study habits. RESULTS: Surveys were completed by 58 housestaff (73%). Regarding study habits, 54% completed PREP questions at least monthly and 69% read at least weekly. One-half believed they were poor test-takers, 13% were satisfied with their ITE scores and 25% felt they will be unprepared to pass the ABP exam. There was no significant difference between attendance at LBR and traditional conferences (38% vs 44%, p = 0.12). Resident satisfaction of LBR sessions was 100% compared to 85% for chief rounds and 47% for noon conference as board preparation. CONCLUSION: LBR is a unique opportunity to increase resident accountability as life-long learners and teachers, and addresses two important resident concerns: 1) Dissatisfaction with content and 2) Lack of confidence in test-taking skills. Given the strong resident satisfaction and encouraging results of curricula that have targeted similar issues, LBR has the potential to improve ITE scores and ABP exam pass rates at our institution.

7) DEVELOPMENT OF A NOVEL NURSE/RESIDENT COMMUNICATION EDUCATIONAL CURRICULUM IN A PEDIATRIC ACUTE CARE SETTING

Michael V. Ortiz, MD, Heidi Schumacher, MD, Kristen Reese, MD, Nina N. Duke, MD, Mary Ottolini, MD, Dewesh Agrawal, MD, Children’s National Medical Center, Washington, DC

INTRODUCTION: Interprofessional communication between members of the patient care team is vital to providing optimal care. Good collaboration and communication duty hours are coincident with declines in satisfaction among nurses. Nurses and physicians have been shown to have positive effects on patient outcomes and satisfaction. Recent changes in duty hours are coincident with declines in satisfaction among nurses. Nurses reported dissatisfaction in their communication with residents in our institution’s most recent hospital-wide nurse satisfaction survey. METHODS: We conducted an interprofessional web-based survey of 45 (of 117) residents plus 59 (of 100) nurses on a 50 bed acute care unit. This survey instrument utilized a 1-5 likert scale (1 = almost never, 2 = rarely, 3 = sometimes, 4 = usually, 5 = almost always) to evaluate teamwork, respect, knowledge of responsibilities and optimal routes of communication. We defined negative scores as a 1 or 2 on the likert scale. RESULTS: 39% and 92%, respectively, of nurses responded negatively to “There is teamwork between nurses and residents on the unit” and “Orders are updated in a timely manner”. 65% of residents responded negatively to “Nurses respect the work flow and patient load of the residents” and “Nurses respect the times of day when the residents are in lecture or rounds”. Based upon this needs assessment we developed a unique educational curriculum to attempt to improve interprofessional communication at our hospital. Our intervention involves a series of interprofessional simulations, team building exercises, and videos led by the chief residents and nursing leadership. The simulations include: a role reversal mock code in which the resident and nurse change roles in the middle of a simulation, a case in which the resident discovers a decompensating patient and must work alongside only the bedside nurse to provide care, and a case where the resident triages multiple nurse phone calls and must address those calls based upon priority. The videos each focus on their discipline’s respective schedules, responsibilities, and optimal routes of communication. The team building exercise utilizes team resumés to highlight both unique and common skills and experiences. CONCLUSIONS: The outcomes of this educational curriculum will be assessed by comparing the pre- and post- intervention scores on our survey instrument, which was adapted from three validated instruments, the ICU Nurse-Physician Questionnaire, Jefferson Scale of Attitudes towards Physician Nurse Collaboration, and Practice Environment Scale of the Nursing Work Index.

8) RESIDENTS AS PEER-EDUCATORS: A UNIQUE APPROACH TO SHIFTING THE CULTURE OF RESIDENTS WITH REGARDS TO COMMUNITY VIOLENCE-RELATED ANTICIPATORY GUIDANCE

Joshua Grahe, DO, Kheyandra Lewis, MD, Nova Ashanti, MD, Maria-Elana Garay, MD, Diamond Harris, MD, Mario Cruz, MD, St. Christopher’s Hospital for Children, Philadelphia, PA

Background: Homicide is the major cause of death for African-American adolescent males. Pediatricians hesitate to discuss these issues due to a lack of training and comfort. We previously developed a 90-minute case-based module for pediatric interns which improved knowledge of community violence, but without improving attitudes or behaviors. To promote a culture change, we recruited 5 resident champions who would serve as peer educators. Their aim was to improve resident preparedness and behaviors with regards to community violence-related anticipatory guidance in an adolescent clinic. METHODS: In May of 2013, the 5 identified resident champions participated in 20 hrs of multi-modal, self-directed training in community violence prevention. During the pilot phase, July’13-Oct.’13, resident champions provided a 30 minute didactic to 2-3 resident peers at the beginning of each adolescent medicine rotation. These sessions focused on the prevalence, risk factors, resiliency factors, and screening questions for community violence. Residents on the rotation were then provided with scripts and reminders to facilitate community violence-related anticipatory guidance for the duration of their rotation. Surveys assessing behaviors, attitudes, and knowledge were distributed at the beginning and end of each four week block. Results from the post-rotation survey were used to facilitate a resident champion led, half-hour debriefing session about resident experiences in providing community violence anticipatory guidance. Results: During the pilot phase, post-rotation surveys
• from participating residents (n=5) demonstrated increases (42% pre vs. 77% post) in the following domains: discussion about adolescent fighting, screening for weapons carriage, attitudes about the acceptability of community violence-related anticipatory guidance, and knowledge about community resources. Conclusion: The use of resident champions as peer educators has the potential, over time, to shift resident behaviors and improve community violence-related anticipatory guidance with adolescents.

9) MANAGING AND FOSTERING UP: IMPROVING SATISFACTION AND EFFECTIVENESS WITHIN MENTOR/MENTEE RELATIONSHIPS BY PROMOTING MENTEE-DRIVEN INTERACTIONS
Corrie Fletcher, DO, Advocate Children’s Hospital, Oak Lawn, Patricia M. Notario, MD, Advocate Children’s Hospital, Oak Lawn, Oak Lawn, IL
Aim: Mentoring is an essential part of medical education and plays an important role in physician development; however, the practical application of mentoring can often present with difficulties. In the context of physician education, most residents have only experienced school-based mentor relationships where an educator provides career guidance with little or no emphasis on developing into a mentor themselves. Thus, our aim is to equip residents and faculty with the skills to initiate and maintain mentor relationships both when they are the mentee and when they are the mentor such that they can accomplish their professional goals. Methods: We conducted an educational workshop for residents and junior faculty to educate them on the mentoring concept of managing up, through which they could identify their professional goals, develop strategies for recruiting mentors to address these goals, establish an assortment of mentoring options, and manage the relationships in order to meet their needs. We also presented the idea of fostering up, defined as the application of managing up to the education and modeling provided by the mentor for the mentee, as a crucial companion in mentoring education and development. Analysis/Results: We administered a pre-survey to workshop participants to assess their existing mentoring skills (n=31), 73% of participants did not identify themselves as mentors including 50% of the faculty and 22% of our PGY-3s, and 50% of our faculty indicated that they themselves had no mentor. Additionally, regardless of level of training, most participants disagreed that their current mentor/mentee relationships were helping to achieve their professional goals. We will administer a survey six months post-workshop to evaluate application of mentoring skills as provided through the workshop and effect upon mentor/mentee relationships. Effectiveness will be assessed as follows: a) the mentee identified varied mentors for specific goals and the mentor recognized which of their mentee’s goals they are suited to address, b) specific and accomplishable goals were defined within the relationship, c) structured meetings were held to address these, and d) goal or project completion as a result of these meetings. Conclusion: We hypothesize that teaching specific mentee-promoted strategies will improve physician satisfaction and effectiveness within both mentor and mentee relationships as their ability to manage these relationships improves.

10) HIGH FIDELITY SIMULATION: A 3 YEAR LONGITUDINAL CURRICULUM
Sydney P. Primis, MD, Michelle Chiu, MD, Carolinas Medical Center, Charlotte, NC
Background: Simulation training provides a forum to teach and reinforce behaviors and skills critical to not only high risk, low frequency events, but also to enhance critical thinking and practice teamwork skills and communication. Methods: With the support of our Education Committee, we developed a 3 year longitudinal simulation curriculum for pediatrics residents. Participation is mandatory and scheduled time in the simulation lab is protected. The curriculum consists of 12 2-hour sessions over 3 years, each with a theme of 1-2 cases, facilitator-led debriefing and teaching, and relevant skills practice using high and low fidelity task trainers. All sessions utilize a confederate nurse, and some scenarios incorporate standardized patients acting as a parent. There are 1-2 facilitators per session with 4 PL1-PL3 residents. Goals and objectives are provided for each scenario and procedural skills workshop. Articles relevant to the topics are available on a shared computer server for review before or after lab. Following the session, residents complete a questionnaire regarding their experience and the degree to which the session met the stated educational objectives. The culmination of the curriculum is a mega code during which each PL3 is individually observed in the team leader role and receives immediate performance feedback. In addition, the structured simulation lab curriculum is enhanced by in situ simulation in the hospital with mock codes run by a multidisciplinary resuscitation team. Results: Residents have consistently rated their experience in the simulation lab highest compared to 10 other educational offerings when asked to rate the usefulness to overall pediatric education. This has been reproduced in the last 3 annual end-of-year anonymous program reviews. Post-session feedback surveys since 2010 have been overwhelmingly positive, with 100% of responses (n=337) either agreeing or strongly agreeing with the statements I found today’s session helpful and informative, I will use the lessons learned today to change my practice, and I see simulation as a valuable learning method and would recommend to others. Conclusions: The addition of a structured simulation curriculum is fulfilling for residents in both cognitive and procedural skills as well as self-confidence. Residents find time in the lab to be meaningful and positive, and most have asked for even more time there. Our experience thus far is that simulation training offers an excellent adjunct to medical education and teamwork training.

11) A MILESTONE-BASED EVALUATIVE TOOL TO MEASURE INTERPERSONAL AND COMMUNICATION SKILLS
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Background: Successful mastery of interpersonal and communications skills (ICS) are critical to the development of pediatricians. As part of the ACGME’s Next Accreditation System (NAS), residency programs are in need of objective tools to measure the ICS-specific pediatric milestones, especially those relevant to patient encounters. To date, no assessment tool has been developed to directly observe and measure the ICS-specific pediatric milestones. Without performance review data derived from standardized observation tools, measuring, reporting and trending these important milestones will be
challenging and subjective. Purpose: To develop an observation-based assessment tool that measures the patient-related pediatric ICS milestones (ICS1 and ICS2). Description: Following extensive literature review of patient-based ICS measurement tools and related measurement tools from a variety of disciplines (e.g., medicine, psychology), skills salient to milestones ICS1 and ICS2 were identified. Together, an interdisciplinary team with expertise in the proposed pediatrics milestones and ICS (i.e., psychologists, pediatricians, and program directors) generated a continuum of observable ICS behaviors ranging from novice to aspirational. Through field testing of observed patient-resident encounters, the Patient-Related ICS Milestone Measurement Tool underwent several revisions to arrive at its current state. Summary: The Patient-Related ICS Milestone Measurement Tool serves as a customizable template for pediatric residency programs to measure the critical and reportable ICS skills. In the future, creators of the tool plan to continue its refinement and to establish inter-rater reliability.

12) “I NEVER GOT ANY FEEDBACK”: A TRUTH FOR MANY RESIDENTS ROTATING ON NIGHTS
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Background: Many residency programs have a resident night float rotation. Feedback to residents working night rotations may be poor and is especially challenging in programs without in-house night time faculty. Methods: We retrospectively analyzed data (2009-2013) regarding nighttime feedback from an annual resident survey about the hospitalist program (without in-house night time faculty) at Children’s Hospital Colorado. Residents were asked, “rate the feedback you received from hospitalists during your night shifts” using a 5-point Likert scale (1=poor/never, 5=excellent). For interns, we implemented: 1) a weekly chart stimulated recall meeting with faculty (2010) and 2) weekly staffing of a new patient by phone (2012). For seniors, we instituted a nightly “check-in” phone call from the hospitalist to the senior resident in 2010. No guidance was provided regarding phone call content. We compared pre- with post-intervention feedback ratings using an independent samples t-test. Results: Over the study period, intern nighttime feedback ratings were poor (mean: 2.16). Many nighttime interns reported receiving no feedback and/or had minimal interaction with attendings. Intern feedback ratings did not improve following implementation of chart-stimulated recall (P=0.24) or weekly staffing of a new patient (P=0.80). After implementing the nightly phone call, senior residents’ ratings of nighttime feedback significantly improved comparing 2009 to 2012 and 2009 to 2013 (P=0.0011 and P=0.0225). There was no baseline (2009) difference in the nighttime feedback ratings between interns and seniors (intern mean 2.48/senior mean 2.56, P=0.74), however, there was a significant difference between their ratings for the two years after a nightly senior resident phone call was in place (2012: intern mean 1.53/senior mean 3.42, P<0.0001, and 2013: intern mean 1.93/senior mean 3.00, P=0.0004). Discussion: Chart-stimulated recall and staffing new patients by phone did not improve intern nighttime feedback ratings, but a simple nightly check-in phone call improved senior residents’ ratings. We propose instituting a similar nightly phone call with interns.

13) OPTIMIZING CCC WORK: TAKING ADVANTAGE OF OVERLAP ACROSS MILESTONES BY COUNTING ASSESSMENT INFORMATION MULTIPLE TIMES
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INTRODUCTION: In June 2014, pediatrics residencies will be required to begin reporting milestones for their residents in 21 competency areas. Clinical Competency Committees (CCC) will determine milestone level assignments every 6 months. The practicality and workload of CCC review of assessment data can be optimized through collecting information that informs milestone level assignments for multiple competencies and teaching CCC members to perform this activity. METHODS: The milestones of all 21 reporting competencies were reviewed to determine areas of overlap. Competencies with overlap were then grouped by theme. RESULTS: Three themes for overlap across all domains of competence were identified: 1) information processing and management plans, 2) communications with families, and 3) help seeking/improvement. The first theme represents overlap between the patient care (PC) competencies for history gathering (PC1), clinical reasoning (PC4), and management plan development (PC5) as well as the professionalism competency of trustworthiness (Prof5). The second theme represents overlap between management plan development (PC5); response to uncertainty (Prof6); care coordination (systems-based practice 1, or SBP1); and both interpersonal and communication skills competencies (ICS1 and 2), which focus on tailoring communication approach to individual patients and families as well as emotional intelligence. The third theme represents overlap across help seeking (Prof4); trustworthiness (Prof5); and all four practice-based learning and improvement competencies (PBLI1-4), which focus on identifying strengths and gaps, identifying and performing learning activities, analyzing and improving practice, and incorporating formative feedback. CONCLUSION: The content of the milestones for 13 of 21 competencies for initial reporting have overlap in three thematic areas. Focus on collecting assessment data in these areas and training CCC members to use this information to inform multiple milestone level placements will optimize CCC efficiency through providing more data points to inform the process.

14) FACULTY DEVELOPMENT IN NARRATIVE MEDICINE: USING STORIES TO TEACH, LEARN, AND THRIVE
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Purpose: Each day, pediatric residents witness incredible events, make powerful decisions, and are touched in both uplifting and discouraging ways; yet these moments often disappear within demanding tasks, duty hours, and fatigue. We designed a Faculty Learning Community (FLC) for physicians interested in utilizing literary readings and reflective writing to guide residents to recognize these moments and to gain deeper understanding of their patients, the connection with their colleagues, and their journeys through medicine. Our goal for this innovative curriculum was to give faculty tools to inspire residents in exploring
15) IMPROVING PEDIATRIC RESIDENT KNOWLEDGE OF BREAST FEEDING

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Introduction: Research has shown that pediatricians are not adequately prepared to promote and help manage breastfeeding. To address this gap, a two-week Lactation Rotation for all first-year pediatric residents was developed. Methods: Twelve participating residents were provided a breastfeeding curriculum. Each resident spent a minimum of 50 hours with an American Board Certified Lactation Consultant (IBCLC). Training included inpatient rounding, hands-on management, observation in the neonatal intensive care unit, answering helpline calls, and viewing of breastfeeding videos. In addition, each resident delivered a presentation for staff. To measure breastfeeding knowledge and clinical confidence levels, each resident completed the AAP's Breastfeeding Residency Curriculum Pre-test four times: the first and last day of the rotation, and at 6 and 12 months post rotation. Results: Pre-test and confidence scores were evaluated. Statistically significant differences were found between test 1 and 2 (M=74.67, SD=8.41 vs. M=87.33, SD=7.78, p=.001), test 1 and 3 (M=74.67, SD=8.41 vs. M=89.33, SD=5.48, p<.001), and test 1 and 4 (M=74.67, SD=8.41 vs. M=89.0, SD=7.65, p=.001). No significant differences were found between Tests 2, 3, and 4 (p values>.05) demonstrating retention of knowledge gained. With regards to clinical confidence, the ability to adequately address parent's questions about breastfeeding, differences between Test 1 and 2, 1 and 3, and 1 and 4 were significant with confidence increasing in Tests 2, 3, and 4 (p values being .003, .020, and .009 respectively) and the ability to completely manage common breastfeeding problems, differences between Test 1 and 2, 1 and 3, and 1 and 4 were significant with confidence increasing in Tests 2, 3, and 4 (p values being <.001, .010, and <.001 respectively). Conclusion: As a result of an innovative, comprehensive educational lactation program, the pediatric residents' knowledge and clinical confidence related to breastfeeding significantly increased.

16) EFFECTIVENESS OF A LONGITUDINAL PROGRAM FOSTERING SCHOLARLY RESEARCH BY RESIDENTS

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ACGME common program requirements highlight the importance of pursuing scholarly activities during training. Through the REACH (Research, Education, and Advocacy in Child Healthcare) program, pediatric residents at Children's National Medical Center (CNMC) apply for one-half day per week protected time in their 2nd and 3rd years to pursue scholarly research projects in the areas of research, education, and advocacy. Our objective was to evaluate the effectiveness of the REACH program in promoting scholarship during residency from 2009-12. Annual reports of resident scholarly activity and annual ACGME Resident Survey reports from the last 4 years were reviewed. Additionally, web-based surveys assessing REACH utility and scholarly work products were sent out to all REACH faculty mentors and CNMC pediatric residents with start dates 2009-12. From 2009-12, 83% of CNMC residents participated in REACH. Residents obtained 37 grants and awards totaling $46,550. REACH projects resulted in 53 presentations at 20 worldwide conferences and a total of 45 publications in over 30 major medical journals. On the annual ACGME Resident Survey question, “How satisfied are you with the opportunities your program provides for you to participate in research or scholarly activities?”, CNMC averaged 4.6 (out of 5), whereas the national mean for pediatric programs was 3.9. 116 of a possible 142 CNMC residents responded to the web-based survey. 85% of respondents stated that the REACH program positively influenced their decision to rank CNMC highly when interviewing for residency. Finally, 100% of residents who interviewed for fellowship stated that their REACH project was discussed during fellowship interviews. A program with longitudinal protected time for research is an effective means for pediatric residency programs to enhance their residents' scholarly pursuits while satisfying ACGME requirements. Not only is the REACH program essential to the recruitment of top applicants at CNMC, but participation in REACH has also provided our residents a leg up in competitive fellowship matches.

17) CLINICAL LEARNING ENVIRONMENT: A SPONSORING INSTITUTION'S EXPERIENCE IN MEETING THE CLER FOCUS AREAS BY “LEARNING TO S.O.A.R.”

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Background: The IOM advocated for systems that promote safety & decrease errors. The ACGME NAS CLER Program’s 6 focus areas all relate to safety & error prevention. The SOAR curriculum (adapted from LifeWings & aviation industry) uses checklists,
standard procedures, & focuses on handoff & fatigue mitigation to reduce error. The institution adopted it in 2009 in surgical areas, followed by institution-wide implementation. Methods: The GME dept fully adopted the program in 2010-2011. It applies aviation concepts to modules addressing human errors, systems, and team skills. Interactive sessions cover team building, communication, cross-checking, and checklists to enhance red flag recognition. It provides tools to mitigate causes of human errors such as those due to sleep and fatigue. Pre and post surveys were completed by trainees at the time of training, & a follow-up survey focusing on the application of the curriculum and barriers was conducted. Results: Perceived below average knowledge (< 80 on 0-100 scale) as rated by 330 respondents decreased from 42% pre to 0% post training. Post training, there was an increase in self-perceived knowledge (48 pre vs 93 post) and rating of communication skills as excellent/very good (60% pre vs 89% post). 98% of respondents reported feeling impact on patient safety, 71% are likely to use the learned skills always/often, and 91% felt that SOAR training helped make their clinical practice safer. 100% felt comfortable speaking up to peers and hospital staff. We also assessed barriers faced before and after the training. Shift Handoff and Daily Huddles lead the list in both pre and post surveys as the single measure chosen to ensure open communication. Conclusions: Institutional GME departments can use national safety curricula to address related ACGME competencies and meet the CLER Program focus areas. This experience serves as an example of a process implementation of an institution wide curriculum with the goal to effectively augment residents’ competency with emphasis on patient safety and interdisciplinary communication.

18) INTERNS AS TEACHERS: AN INTERVENTION PROMOTING EARLY EFFECTIVE TEACHING
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BACKGROUND: In the academic setting, residents are expected to teach, but most formal guidance about teaching skills comes long after residents’ first teaching opportunities. OBJECTIVE: Our study aims to establish whether early instruction in pedagogy increases the amount and quality of education provided by interns. DESIGN/METHODS: We designed a one-hour session for the interns in our residency program as part of a prospective, mixed-method study. The intervention was part of a mandatory 10-week orientation for 24 participating interns at Lucile Packard Children’s Hospital, Stanford. During the session, interns learned and practiced applying the 5-Step Lesson Plan (5-SLP), an instructional tool used by professional educators. Interns were surveyed pre- and post-intervention to assess their attitudes and confidence regarding teaching.

Two-tailed, paired t-tests were used to compare the pre- and post-groups. Efficacy was also evaluated by medical student ratings of the amount and quality of intern-led instruction on the wards pre- and post-intervention (Sept-Nov 2012 and Sept-Nov 2013). Students noted each teaching encounter initiated by interns and listed any of the five components of the 5-SLP utilized. Two-tailed, unpaired t-tests were used to compare the pre- and post-intervention groups. RESULTS: Pre-intervention, interns were observed teaching 19 times, and per lesson, an average of 3.2/5 components of the 5-SLP were included. Post-intervention, interns taught 17 times with an average of 3.7/5 components of the 5-SLP (p=0.28). Surveys from intern subjects showed significant improvement in the desire to teach medical students (mean 4.2/5 pre, 4.5/5 post; p<0.05) as well as improved feelings of instructional preparedness (mean 2.5/5 pre, 3.3/5 post, p<0.05) following participation in our session. CONCLUSION: Following the intervention, interns were more eager and comfortable teaching in the clinical setting, though there was not a statistically significant increase in the quantity of teaching and the use of the 5-SLP as rated by medical students. Future directions include additional sessions throughout the first year of residency targeted toward intern teaching.

19) A “FOCUS” ON IMG COMMUNICATION: FOCUS GROUPS WITH INTERNATIONAL MEDICAL GRADUATES
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Background: International Medical Graduates (IMGs) comprise 30% of U.S pediatricians, the largest concentration in NYC. IMGs face unique challenges in doctor-patient communication, an essential component of becoming a successful physician, and an ACGME core competency. Since there are no reports of successful curricula designed to improve IMGs communication with patients, we set out to design one. Objectives: 1) Find challenges our IMG residents face in communicating with their African American (AA) and Hispanic patients 2) Gather suggestions from residents to build a doctor-patient communication skills and cultural competency curriculum. Design/methods: We conducted a needs assessment for curriculum planning as 3 separate 1 hour focus groups (FGs) in July, August and September, 2012. Each FG consisted of a representative resident sample: 7-8 students. Future directions include additional sessions throughout the first year of residency targeted toward intern teaching.
20) VALUING ACADEMIC PHYSICIAN TEACHING EFFORTS
Rachel L. Jamison, MD, Lauren L. Gore, MD, UT Southwestern Medical Center, Dallas, TX

INTRODUCTION: Relative Value Units (RVUs) approximate the level of physician time and skill required to provide a clinical service. There is no equivalent valuation system for teaching responsibilities. At Advocate Children’s Hospital-Park Ridge (ACH-PR) expectations for faculty teaching were noted to be inconsistent, therefore a novel system was implemented to establish a culture of accountability for teaching. METHODS: In 2008, ACH-PR led a process to establish quantifiable expectations for physician teaching positions, monitor teaching compliance and tie reimbursement to the level of participation. All members of the pediatric faculty were invited to participate in this process. Various categories of teaching and scholarly activity were identified and operational definitions were created. These categories were ranked ordered and assigned Teaching RVU (TRVU) values. A set of minimal expectations to maintain faculty privileges was created and assigned a base salary amount. RESULTS: A TRVU system was created along with a database to track faculty compliance. Each faculty member receives a base salary in accordance with his or her full time equivalent status. In addition to the base salary, physicians are paid $100/TRVU. Every educational activity is assigned a TRVU point value (e.g., Morning Report = 2.0 TRVUs). Approximately 2/3 of the allotted medical education budget is used to fund the base salary. The remaining 1/3 funds the TRVU system. ACH-PR is currently completing the fourth year utilizing this method of monetary compensation. Over this period, 100% of faculty participated in the TRVU system, and a majority completed or exceeded their teaching commitment. In contrast to prior years, every core educational activity since 2010 has been attended by at least one faculty member.

CONCLUSIONS: ACH-PR implemented a system of transparency, clearly delineated duties, and TRVUs to create accountability for teaching responsibilities. Most of the faculty have fulfilled or exceeded their commitments. As a result of measuring and rewarding teaching responsibilities, physician engagement in residency education has increased.

21) INTER-ITEM RELIABILITY OF THE ICS-2 MILESTONES USING AN OBJECTIVE STRUCTURED CLINICAL EXAMINATION
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Institutions: Walter Reed National Military Medical Center, Bethesda, MD; Children’s National Medical Center, Washington, DC Programs: National Capital Consortium Pediatrics Residency; Children’s National Medical Center Pediatric Residency Program Background: Valid and reliable tools for assessing milestones have not been formally developed, yet the ACGME is expecting program directors to report the attainment of milestones by pediatric residents on a semiannual basis. An existing evaluation tool, the Objective Structured Clinical Exam (OSCE), was adapted to assess the milestone attainment of end-of-year pediatric interns from 2 pediatric residency programs. We aimed to determine the internal reliability of milestones associated with a single subcompetency assessed across multiple OSCE stations. Methods: Faculty from the 2 programs assessed PGY1 residents at the end of the academic year. The interpersonal communications skills-2 subcompetency (ICS-2: Demonstrate the insight and understanding into emotion and human response to emotion that allows one to appropriately develop and manage human interactions) was assessed with a 5-point scale that included half-point increments between milestone levels through 4 cases: a child with a cough, a HEAddS interview of a teen, a well-baby exam, and a child with abdominal pain. Raters were trained in use of the milestones associated with this subcompetency. Cronbach’s alpha measured inter-item correlation of the four cases in the assessment of the ICS-2 milestones. Results: Forty-five PGY1 residents from the 2 programs were evaluated by twenty-six faculty members over 5 days. Forty residents (89%) had 4 assessments of the ICS-2 milestones and were included. Range of scores was from 1 to 4, with median 2.5 and interquartile range 2-3. Cronbach’s alpha for the ICS-2 milestones measured across all four cases was 0.20, which is considered poor. Assessment of the ICS-2 subcompetency using the child with abdominal pain case had the highest item-test correlation at 0.44. Conclusions: Internal reliability of assessments of the milestones associated with the ICS-2 subcompetency in our individual simulated patient encounters was less than optimal. Case design and the logistical need for multiple faculty raters may impact the internal reliability of milestone assessments in OSCEs. More reliable tools to assess milestones should be developed.

22) APPRENTICESHIP FOR THIRD YEAR RESIDENTS
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Background: Our residents are encouraged to select electives to meet individual learning needs determined by career interests. Until this year residents autonomy has been limited to that offered to a senior resident. We created this elective to fill the training gap between senior resident and first year fellow or community practitioner. Objective: To create an educational experience that prepares residents for either fellowship or pediatric practice by allowing more autonomy and opportunity to assume more responsibility within their field of choice. Methods: We piloted a new program, Apprenticeship, designed to provide a deeper experience in a given field of pediatrics. During this month long elective, residents are given increased autonomy and responsibility within their chosen field commensurate with their anticipated position upon completion of residency. To date, two residents have completed their apprenticeship rotations in gastroenterology and general pediatrics.

Three more apprenticeships are scheduled this academic year. We meet individually with each resident to develop learning goals and objectives. The LGOs are tailored to address residents specific interest. For example, the Gastroenterology
Apprenticeship included functioning as a co-fellow on consult service and wards, and a week in the GI lab. Three additional residents in the fields of rheumatology, neonatology, and cardiology will complete an Apprenticeship this year; we plan to expand to the entire residency class of 34 in 2 years. Results: Resident feedback to date cited the rotation as being very different from being a senior and great opportunity to see what fellowship would be like. Comments included I truly acted as a fellow and gained experience in procedures I would not have had prior to fellowship. The weaknesses of the rotation included not taking call; experiences depend on the attending and fellow. Overall, the rotation was highly recommended. Conclusions: The apprenticeship rotation is an excellent way to provide third year residents the opportunity to transition to the field of their choice, and is the capstone for the individualized curriculum.

23) DEVELOPING RESIDENT SKILLS IN COMMUNITY PEDIATRICS: A LONGITUDINAL APPROACH THROUGH SCHOOL-BASED HEALTH CENTERS
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Professional formation of pediatricians in our future workforce must encompass exposing trainees to a variety of community based experiences and developing the tools to care for populations. At our institution, resident community experiences were variable in quantity and quality, void of a developmental progression of acquired experiences, and mostly limited to focused block rotations. Residents and faculty recognized this to be an area needing improvement. We describe now a longitudinal curriculum that allows residents to understand the needs of communities, empowers learners to use tools of self-reflection and project development, and integrates activities and evaluations into milestone-based assessments across several competency domains. The Kaiser REACH (Resident Education in Advocacy and Community Health) curriculum, assigns individual residents to a neighborhood with monthly experiences that are tethered to a school-based health center throughout the thread of residency training. Using existing curricular tools, each trainee was scheduled for periodic experiences that introduced concepts of resource assessment, fostered relationships with community and school partners, cultivated legacy projects, and offered a pathway toward progressive competency attainment. Self-reflective portfolio-based writing and the AAP’s Community Pediatrics Self-Assessment tool aid in formative and summative assessments using milestone-based descriptors for residents and supervisors. Preliminary data from self-evaluation show residents with improved knowledge of community resources, increased satisfaction of community-based experiences, and possibly accelerated and more comprehensive development of knowledge, skills, and attitudes. Resident teams assigned to each site meet periodically and their qualitative and quantitative feedback, along with multi-source evaluations aid in the continual improvement process for individual learners, assigned sites, curriculum, and programs. We will also share reflective themes from these team meetings regarding pitfalls and strengths of longitudinal curriculum that have aided in the improvement process and ongoing implementation and evaluation strategies.

24) A COACHING PROGRAM FOR PEDIATRIC RESIDENTS: PROGRAM DESCRIPTION AND EARLY OUTCOMES
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Background: The ACGME beginning in 2014 requires that all pediatric residency programs develop semi-annual report cards for each pediatric residency on the 21 subcompetencies/milestones. Leaders in medical education suggest that the best way to assess learners’ competencies is through direct observation. Program Description: The Stanford Pediatric Residency Coaching Program began in April 2013 as a pilot for the intern class (n=27) and then expanded in July 2013 to all three residency classes (n=83). The program consists of eight faculty coaches and one coaching director, each of whom has 0.1 FTE dedicated to coaching residents. Coach training occurs at monthly Coaching Faculty Development Sessions. Each coach is assigned 10-11 residents from all PGY levels and performs direct observations, provides verbal feedback, encourages reflection and goal-setting, and completes documentation using feedback forms for history-taking, physical examination, patient presentations, and I-PASS handoffs. Coaches are instructed to observe PGY1s 10-12 times annually, PGY2s 7-9 times, and PGY3s 5-6 times. Observations and feedback are standardized through coach training, and one observation may generate one or more feedback forms. Results: During the first 6 months of the program, including 3 months of pilot data and 3 months of full-program data, the coaches completed a total of 326 direct observation forms, an average of 40.75 observation forms/coach. PGY1s received an average of 5.5 observation forms, PGY2s averaged 5.25 observation forms, and PGY3s averaged 2.5 observation forms. Early feedback from residents and coaches shows that the Coaching Program is helpful and well-received by residents and coaches. Conclusions: A Coaching Program for pediatric residents provides improved opportunities for evaluation of competence through faculty training and a structured program in direct observations and feedback. Early data suggests this program is feasible and well-received by residents and coaches.

25) DESIGNING RESPONSIVE FACULTY DEVELOPMENT
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Background There is a paucity of empirical studies that describe the critical features of high-quality faculty development in graduate medical education. Additionally, there is an acute need for research on faculty development in independent academic and community settings where physicians are increasingly asked to incorporate teaching into their clinical activities. Drawing from the robust teacher education literature, we are exploring a faculty development model that utilizes the following design features: (1) addressing teaching issues proximal to application (in contrast to disconnected, periodic workshops); (2) anchoring around problems of practice (in contrast to abstract theoretical discussions or generic teaching examples);
and (3) coupling discussions of teaching with assessment strategies. Objectives In our Pediatrics Residency Program, we
are engaged in: (1) a qualitative study of evolving faculty development needs; and (2) a faculty development initiative that
attempts to respond to those identified needs mid-stream. We are investigating this iterative process (gather data -> re-
design faculty development -> gather new data) using design-based research methods from the learning sciences. Methods
Our IRB-approved study incorporates: (1) semi-structured faculty interviews; (2) opt-in observations of clinical and didactic
teaching; (3) periodic surveys of preferences for faculty development content. Data is analyzed using grounded-theory
techniques to reveal themes and trends in our faculty population. Findings will highlight those faculty development design
features that prove more and less useful in our context. Results and Discussion Our study-to-date has revealed meaningful
tensions. For example, faculty have expressed interest in further developing didactic skills at a time where, programmatically,
we are prioritizing assessment theory as we engage with the Next Accreditation System. These tensions clarify which design
principles from teacher education are applicable in our context - and which are not. We will present a snapshot of this evolving
design model in our poster.

26) TALKING WITH PARENTS: TEACHING PROFESSIONALISM IN A RESIDENT-PARENT GROUP
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MD, Ali Nadroo, MD, Eric Keller, DO, Revathy Sundaram, MD, Jolanta Kulpa, MD, New York Methodist Hospital, Brooklyn, NY
Background: Professionalism can be taught in a variety of venues. Teaching in a non-clinical setting allows a focus on
reflection. This abstract describes a program designed to engage residents and families in a dialogue about professionalism.
Objective: To assess the knowledge and attitudes of the residents who participated in the program. Materials and methods:
The residents are divided into groups of 6-8, united by a common post-residency career orientation, which meet weekly as
part of a longitudinal small group learning experience. Each group has two faculty facilitators. As part of this experience, two
times each year, the faculty invites a family to the group meeting to discuss their experiences with the health care system. The
families reflect the diversity of the community. Participants have included young families with newborns, grandparents raising
grandchildren, single parent families, same sex couples, and families completed through adoption. They represent a range of
socio-economic, racial and ethnic groups. School aged children and adolescents often participate with their parents. Some of
the children are healthy and typically developing, while others have chronic diseases (including sickle cell anemia, ADHD, and
autism). Prior to the session, the families are oriented by the faculty and provided with questions to consider. They are asked
to describe the qualities they look for in a pediatrician and to discuss the characteristics and behaviors of the best and worst
physicians they have encountered. The session begins with an introduction of the family by the facilitator. The families then
speak about their experiences. A general discussion and questions and answers follow. The session lasts 90 minutes. Breakfast
is provided. Following the session, the family is debriefed by the facilitator. The residents complete a written reflection within
a week. The program is also evaluated by the residents annually in writing and via a focus group. Results: The average rating
was 4 (out of a maximum of 5). All of the residents were able to describe clinician and practice characteristics that were
important to parents. 50% learned things about parental preferences that surprised them. 92% articulated concrete changes
they intended to make in their interaction with families as a result of this experience. 89% deemed it a valuable contribution
to their education. 98% wished to meet with additional families. The families uniformly enjoyed the session. They relished the
opportunity to share their experiences, to teach young pediatricians, and to show their appreciation of a clinician who had
been helpful to them. None felt that the experience was too intrusive or inappropriate. Several spontaneously volunteered to
return. Conclusion: The program provides an opportunity for an intimate and personal discussion of professionalism outside
the intensity of the care-giving environment that is well accepted and deemed valuable by the participants. Residents intend to
use insights gained from this experience to modify their professional behavior with families.

27) LAY BOOK CLUB: READING WHAT OUR PARENTS READ
Laura Koenigs, MD, Barbara Stechenberg, Baysate Children’s Hospital, Springfield, MA, Cheryl Tierney, MD, Penn State
Hershey, Hershey, PA, Patrick Brown, MD, Baysate Children’s Hospital, Springfield, MA
Lay Book Club: Reading What Our Parents Read Parents read a wide variety of books on parenting topics. As pediatricians, we
are supposed to be experts and resources for parenting advice for the families of our patients. In a residency program, there
seldom is a curriculum that discusses different approaches to parenting issues. We developed a book club that has met about
three times a year for the last 10 years for which residents and faculty read one or two books on parenting available in the lay
press, then gather in a faculty home to discuss the book(s). The books describe parenting approaches throughout the years from
newborn (“Happiest Baby on the Block” by Harvey Karp) through adolescence (“Get Out of My Life, but First Can You Drive Me
and Cheryl to the Mall?” by Anthony Wolfe). We decide on the books through discussion with a developmentalist and a popular
vote. We debate the approaches recommended by the books and reflect on how what we read might change our advice or our
own approach to the children in our families. Some of the discussions have been facilitated by the authors or an outside expert.
The discussions center on whether the advice is consistent with what we understand about child development, is reasonable to
teach to the families of the children we see, is practical to be imparted in a busy practice, and whether we can recommend the
book to parents. When graduates of our program were surveyed on our curriculum within 11 years of graduating, the majority of
those working in general pediatrics or hospital medicine or those currently in fellowship found the book club to be a “beneficial
to extremely beneficial” component of our curriculum. Several pediatricians in private practice keep their “book club books”
in their offices as a lending library for parents. We describe an innovative, fun approach to teaching parenting philosophies and
approaches to resident physicians through a lay book club that our residents have found beneficial.
28) RESIDENT-MEDICAL STUDENT PARTNERSHIP TO PROMOTE ADOLESCENT HEALTH EDUCATION
Leah M. Philippi, MD, Medical College of Wisconsin/Children's Hospital of Wisconsin Pediatric Residency, Wauwatosa, WI, Archna Eniasivam, MD, Medical College of Wisconsin/Children's Hospital of Wisconsin Pediatric Residency, Wauwatosa, WI, Gitanjli Arora, MD, DTMH, UCLA, Los Angeles, CA, Sabrina M. Butteris, MD, University of Wisconsin School of Medicine & Public Health, Madison, WI, Nicole E. St Clair, MD, Medical College of Wisconsin Department of Pediatrics, Milwaukee, WI, Stephen D. Warrick, MD, Cincinnati Children's Hospital Medical Center, Cincinnati, OH, Jacquelyn C. Kuzminski, MD, Medical College of Wisconsin Department of Pediatrics, Milwaukee, WI, Ann M. Campagna, MD, University of Minnesota, Minneapolis, MN, Tina Slusher, MD, University of Minnesota, Minneapolis, MN, Amer Al-Nimir, MD, Rainbow Babies & Children's Hospital, Cleveland, OH, Scott A. Hagen, MD, Univ. of Wisconsin School of Medicine and Public Health, Madison, WI

Background: Many medical trainees have a desire to engage in community outreach; however, the transient nature of training can challenge sustainability. Based on an identified need by leadership at Journey House (JH), a neighborhood organization in Milwaukee, Wisconsin, a partnership to provide health education to the teenage population was formed between JH and a team of Medical College of Wisconsin (MCW) pediatric residents and medical students. Objectives: The primary objective was to provide health education and mentorship to JH adolescents. A secondary goal was to create mentored teaching experiences for medical students. Methods: JH identified a need for health education in their community and initiated a partnership with the MCW Department of Pediatrics. Pediatric residents were connected with JH and recruited medical students interested in community health. A core team of 2 residents and 5 medical students was established. Topics for monthly educational sessions were identified through a needs assessment with JH teenagers. Residents served as advisors as medical students prepared sessions. After each session, the team met with JH leadership to identify areas for improvement. Results: In the first year of the partnership, 8 sessions were held. Teen engagement was enhanced by interactive activities, friendly competition and allowing anonymous questions. A curriculum template was developed emphasizing interactive elements. One struggle was maintaining attendance of males. An unintended benefit was the mentoring relationships that formed between residents and medical students, allowing students to grow in leadership as junior students joined the team. Conclusion: A resident-medical student partnership can be a model that promotes sustainability when created to respond to a community organization's request for education. Next steps include expanding the program by holding sessions within JH's high school program and recruiting more student and resident educators. We are vetting core educational topics and intend to promote scalability through publication and outreach to other Milwaukee neighborhood programs.

29) SIMULATING THE EMOTIONAL CHALLENGES OF A GLOBAL HEALTH ELECTIVE: A MULTI-INSTITUTIONAL STUDY OF A NOVEL CURRICULUM
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BACKGROUND: Increasing numbers of residents are participating in global health electives (GHE) in resource-limited settings. Pre-departure preparation is acknowledged as critical to residents’ success abroad. Yet most preparation is relatively passive relying on didactic presentations, discussion and independent readings. Little active preparatory curriculum exists to allow residents to experience and debrief the challenges they may face abroad. OBJECTIVE: Design and evaluate a global health pre-departure simulation curriculum to prepare residents for common challenges they may encounter abroad. METHODS: Pediatric global health educators from a consortium of 7 institutions agreed on common challenges residents encounter on GHEs including frustration at working with limited resources, floundering when encountering a disease they haven’t seen before, perceived futility, and dealing with failure. We developed cases addressing these themes and created 2-page simulation guides including a debriefing script. Facilitators from each site were trained to lead and debrief the cases. After each case, participants and facilitators completed an evaluation. We used descriptive statistics to analyze perceptions of usefulness of the simulation and conducted a thematic analysis of written comments of the most difficult and valuable parts of each case. RESULTS: We obtained surveys from 160 resident learning encounters, and 52 facilitator surveys. Respondents generally found the simulations useful with a mean resident score of 4.49/5 (SD 0.82) and facilitator score of 4.85/5 (SD 0.36) on a 1-5 scale (1 = not at all useful to 5 = very useful). The two most common themes for the most difficult part of the case were: working with limited resources and lack of medical knowledge. For the most valuable part of the case, the two most frequent themes were: expansion of medical knowledge and learning to work with limited resources. Strong emotions such as frustration, nervousness, fear, and sadness were elicited in 98% of participants. CONCLUSIONS: Active pre-departure preparation for GHEs using standardized, simulated cases appears to be an effective way to prepare residents for the challenges they will face abroad when encountering unfamiliar diseases and working with limited resources. Residents reported experiencing strong emotions in the simulated environment, which may be useful in mitigating the challenges they can present when encountered while abroad.

30) INDIVIDUALIZING BEYOND SIX EDUCATIONAL UNITS: INCORPORATING GLOBAL HEALTH INTO ALL RESIDENCY ROTATIONS
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BACKGROUND: Increasing numbers of residents are participating in global health electives (GHE) in resource-limited settings. Pre-departure preparation is acknowledged as critical to residents’ success abroad. Yet most preparation is relatively passive relying on didactic presentations, discussion and independent readings. Little active preparatory curriculum exists to allow residents to experience and debrief the challenges they may face abroad. OBJECTIVE: Design and evaluate a global health pre-departure simulation curriculum to prepare residents for common challenges they may encounter abroad. METHODS: Pediatric global health educators from a consortium of 7 institutions agreed on common challenges residents encounter on GHEs including frustration at working with limited resources, floundering when encountering a disease they haven’t seen before, perceived futility, and dealing with failure. We developed cases addressing these themes and created 2-page simulation guides including a debriefing script. Facilitators from each site were trained to lead and debrief the cases. After each case, participants and facilitators completed an evaluation. We used descriptive statistics to analyze perceptions of usefulness of the simulation and conducted a thematic analysis of written comments of the most difficult and valuable parts of each case. RESULTS: We obtained surveys from 160 resident learning encounters, and 52 facilitator surveys. Respondents generally found the simulations useful with a mean resident score of 4.49/5 (SD 0.82) and facilitator score of 4.85/5 (SD 0.36) on a 1-5 scale (1 = not at all useful to 5 = very useful). The two most common themes for the most difficult part of the case were: working with limited resources and lack of medical knowledge. For the most valuable part of the case, the two most frequent themes were: expansion of medical knowledge and learning to work with limited resources. Strong emotions such as frustration, nervousness, fear, and sadness were elicited in 98% of participants. CONCLUSIONS: Active pre-departure preparation for GHEs using standardized, simulated cases appears to be an effective way to prepare residents for the challenges they will face abroad when encountering unfamiliar diseases and working with limited resources. Residents reported experiencing strong emotions in the simulated environment, which may be useful in mitigating the challenges they can present when encountered while abroad.
We developed a simulation-based resuscitation curriculum to train PICU and PEM fellows to lead a pediatric resuscitation of a child and fellows should be able to integrate communication skills with clinical skills during resuscitation. Curriculum: leading resuscitations well into their training. Literature indicates family members wish to be present during the resuscitation skill for pediatric critical care (PICU) and pediatric emergency medicine (PEM) physicians, yet fellows report discomfort clinical and procedural skills of their specialties, and in communication and professionalism. Pediatric resuscitation is a core background: Due to a new ACGME mandate, pediatric residents are now required to develop an Individualized Curriculum, composed of six educational units that cater to their career interests. In 2013, an APPD workshop was provided to assist educators with developing individualized frameworks for residents with global health interests. At that workshop, a global health educational tool was proposed that could be offered longitudinally throughout residency. This tool, consisting of global health-specific objectives for each pediatric core and specialty rotation, is intended to serve as an optional resource for self-motivated residents during their rotations. Due to significant interest in the idea, further efforts have been made to develop the tool. Objective: To describe an ongoing national effort to develop a global health educational tool that can be applied during all residency rotations. Methods: Interested faculty were recruited from the APPD global health educators network to serve as authors for global health-specific objectives for a core or specialty rotation. Authors were asked to develop objectives that are pertinent to the provision of care in low-resource settings; are vetted by sub-specialists; and are accompanied by resources that would allow the resident to achieve the objectives independently in 3 hours or less. Results: Objectives have been developed for 10 rotations, with an anticipated completion of objectives for 25 additional rotations by winter, 2013. Distribution of these objectives to interested residents will occur in spring, 2014, and will include obtaining pilot feedback from a cohort of senior residents nationally to optimize the tool. Conclusion: The development of global health-specific learning objectives for pediatric core and specialty rotations is a unique way to nourish a resident’s individual interests while completing standard residency training. This is an easily scalable tool for residents with other foci of interests, and should be considered as residency programs promote individualized training experiences.

31) COORDINATORS’ PEER MENTORING PROGRAM
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Background: The Coordinators Section of the APPD was established in 1997. An early task of this section was the creation of a mentoring program which was the traditional mentor-mentee dyad. This program met with some limited success. However, it has proven to be difficult in bringing everyone onboard and often the mentor and mentee do not connect. Over the past few years, we have experienced negative feedback because new coordinators don’t seem to have a reliable source from which to gain a strong foundation as they embark on a new career in Graduate Medical Education. Introduction: Data shows that most medical schools/teaching hospitals have established peer mentoring programs for their faculty, fellows, residents and medical students. These groups report that success and long term relationships have resulted. With that in mind, at the 2012 Fall APPD Meeting a new program for coordinators “Peer Mentoring” was introduced and was fully launched in spring 2013. Twenty groups were formed with two to three new coordinators in each group. Experienced coordinators comprised the remaining members of each group; two to three with five to ten years of experience and then a couple with 11 or more years of experience. Methods: This new program is an iterative process with opportunities to share ideas and best practices among new and more experienced coordinators. The program will be evaluated based on resulting processes and outcomes that groups achieve. The coordinators’ Peer Mentoring Program will provide resources for conference calls; solicit feedback from participants about the process; garner other resources if possible; and request a quarterly report from the groups regarding plans, progress, and outcomes. Groups are free to operate as their membership dictates. Summary: The idea behind peer mentoring is that the groups obtain and share knowledge from coordinators at different stages of their career. The next steps are to reassess some of the groups to more of a regional base and to place more fellowship coordinators together. Further information and revamping will come from our impending survey. Conclusion: The Peer Mentoring Program will help all of us to become more involved and to become better acquainted with other coordinators. It will also help us to learn more about the mentoring process while we are sharing information and ideas to make ourselves fully prepared for the Next Accreditation System. The ultimate goal is to assure that “No coordinator is left behind.”

32) COMMUNICATION DURING PEDIATRIC RESUSCITATION: A PILOT SIMULATION CURRICULUM FOR PEDIATRIC CRITICAL CARE AND EMERGENCY MEDICINE FELLOWS
Alisa A. McQueen, MD, Alisa A. McQueen, MD, Diana L. Mitchell, MD, The University of Chicago Comer Children’s Hospital Pediatric Residency Program, Angela D. Blood, MBA, MPH, The University of Chicago Medicine Center for Simulation, Chicago, IL
Background: The Accreditation Council for Graduate Medical Education requires that programs provide training in the clinical and procedural skills of their specialties, and in communication and professionalism. Pediatric resuscitation is a core skill for pediatric critical care (PICU) and pediatric emergency medicine (PEM) physicians, yet fellows report discomfort leading resuscitations well into their training. Literature indicates family members wish to be present during the resuscitation of a child and fellows should be able to integrate communication skills with clinical skills during resuscitation. Curriculum: We developed a simulation-based resuscitation curriculum to train PICU and PEM fellows to lead a pediatric resuscitation
33) MAPPING THE MILESTONES: LINKING COMMUNITY PEDIATRICS AND ADVOCACY TRAINING OBJECTIVES TO ACGME MILESTONE-BASED COMPETENCIES

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Background: Starting in spring 2014, pediatric residency programs will be required to use milestone-based assessment of trainees' performance. Since many programs' curricula were developed before the era of milestones, they will be faced with the daunting task of assessing residents using data gathered from their performance on curricular objectives designed without milestones language. Objectives: To develop a map for programs to translate their advocacy and community pediatrics curricula into milestones language. Methods: In 2007, the AAP’s Community Pediatrics Training Initiative (CPTI) developed a set of training objectives as a guideline for residency programs in developing their community pediatrics and advocacy training. In 2013, we convened an expert panel of 10 pediatric program and associate directors who direct community pediatrics and advocacy training at their institutions. Individually, they mapped the ACGME competencies proposed in the Pediatric Milestones Project to the CPTI objectives. In pairs, they resolved discrepancies by consensus, and a map was developed relating the CPTI objectives to specific competencies. To validate the proposed map, we used the Delphi Method among a larger group of experts with experience in curricular design, residency education, and community pediatrics and advocacy training to determine their level of agreement in assigning competencies that reflect a particular CPTI objective. Competency-objective pairs that achieved a 3.5/5 level of agreement remained on the map, and reevaluation occurred until consensus was achieved. Results: Creation of a detailed map linking CPTI objectives to specific competencies and their milestones. Conclusions: Programs can use their existing community pediatrics and advocacy training to inform their assessment of residents along several of the milestone-based competencies. Through a collaborative process, programs can work together to develop processes, such as the CPTI-based map, to translate existing curricular objectives into a meaningful tool to assess resident performance in the milestones era.

34) ATTRACTING MILLENNIALS TO YOUR PROGRAM USING A RECRUITMENT APP

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Today’s millennial applicants rely on their smartphones for personal organization and ease of access to ready information. In an effort to appeal to our millennial applicants we created a mobile application (app) using the web-based platform Conduit Mobile (mobilecp.conduit.com). This platform offers varying templates that use existing webpages and contact information to create a mobile application. Our app provided applicants with resources and information that is typically provided in hardcopy in a mobile format. Some of the information provided included: residency program & department details, institutional information, benefits, policies & procedures, and a sample contract. The template used also allowed us to incorporate: the program’s facebook page, contact information, GPS mapped location and directions to our location. During the 2012-13 recruitment season we interviewed 140 applicants; the app was downloaded 25 times. Twenty-three were from an Iphone (19) or Ipad (4). The app was used 48 times. Forty-three were for an Iphone (39) or Ipad (4). The most commonly viewed page was our facebook page and it had 89 views followed by our web-linked pages with 31 views. The 3rd most commonly viewed page was our contact page with 10 views. In total there were 135 pages viewed using the mobile app. Applicants had the opportunity to download our app during their interview day or form our program’s webpage using a Scan QR. Conduit Mobile offers support for marketing your app beyond this for additional fees. The mobile app took eight hours to set up. The app requires web addresses for the pages to be used. Using established webpages decreases the set-up time. Under the basic (free) version of Conduit Mobile there are limitations on the number of downloads and views allowed. Overall, the app should be easy to create for anyone with rudimentary webpage design experience (wikis and blogs). With this level of experience it should not require significant resources and can be a unique marketing tool to attract the new generation of applicants to your program.

35) AN INNOVATIVE RESIDENT CONFERENCE TO TEACH COST-EFFECTIVE, EVIDENCE-BASED DIAGNOSIS OF PEDIATRIC ILLNESSES

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Many residents are unaware of the costs of diagnostic testing, as this has not traditionally been emphasized in residency
education. However, practical understanding of healthcare economics is vitally important to the practice of medicine. The ACGME Common Program Requirements state residents are expected to “incorporate considerations of cost awareness and risk-benefit analysis in patient and/or population-based care.” To address this need in our residency curriculum, our institution developed “The Chairman’s Cup,” a novel conference designed to address cost-conscious evidence-based clinical practice. An unknown case that represents a diagnostic dilemma is presented, including the chief complaint, HPI, past medical history and physical exam. Teams based on level of training use the Vanderbilt Electronic Pediatric Resident Organizer (VEPRO), a Moodle-based Course Management System, to generate a differential diagnosis to guide their workup, order diagnostic tests, and answer questions about their evaluation. Throughout the process, associated charges (based on actual billing data) for each diagnostic test are viewed and tallied as they are ordered. At the end of the case, each team’s work-up, thought-process and total charges is compared and contrasted in the large group setting. The ideal workup, as pre-determined by a panel of content-area specialists and review of evidenced-based guidelines, is then presented with targeted teaching based on observations of the groups management. Finally, the winning team is selected based on the quality of the critical thinking demonstrated, diagnostic workup performed and total charges incurred. This conference has been an overwhelming success from the resident to faculty level and represents a unique modality to teach cost-conscious evidence-based clinical practice.

36) BOOT CAMP FOR PEDIATRIC RESIDENTS BASED ON MILESTONES: A MOVE TOWARD SUCCESS
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Background: Resident evaluations based on the Pediatric Milestones can be an effective tool in identifying gaps in the knowledge and their performance on the In-Training exams (ITE). This project stemmed from APPD LEAD assignment.

Objective: Identify and implement a Milestones-based education and evaluation program to help trainees improve medical knowledge and Board scores.

Methods: All residents were evaluated on five sub-competencies from Patient Care and Medical Knowledge Milestones. Intervention was implemented in the form of intense reading and learning plans, oral presentations and monthly quizzes. The evaluation tool based on Milestones provided hyperlinks to activities for their learning, excelling and achieving the next Milestone. Outcome measurements of their performance in clinical areas, knowledge base as well as communication, was collected at routine intervals. Comparison was made with previous year’s residents from year 2004-2010 using the Wilcoxon Two Sample Test. The study was reviewed by IRB and was exempted. Results: ITE scores in the year 2011 to 2012 increased 60% to 76% (16 percentage point) from PGY1 to PGY2. Average percentage point change in historical controls (2004-2010) has been 52% to 59% (9 percentage point) from PGY1 to PGY2. The baseline ITE scores (PGY1) were not significantly different between the historical controls and the 2011-2012 group, but the PGY 2 scores were significantly higher in the 2011-12 group (p<0.002). Scoring of the Milestones sub-competencies has shown steady progression during the years 2012 and 2013. The total of monthly quiz scores correlated well with ITE scores and clinical performance. The ITE scores for 2013 are not available for comparison yet. Implication: Well-organized learning programs in accordance with Pediatric Milestones are valuable in increasing residents knowledge base and can improve performance in the ITE score (p<.002). This is a small study and needs further substantiation with overall board pass rate and scores in a larger sample.

37) USE OF AN AUDIENCE RESPONSE SYSTEM IN CLINICAL COMPETENCY COMMITTEE
Ross Newman, DO, Denise Bratcher, MD, Celeste Tarantino, MD, Jane Knapp, MD, Children’s Mercy Hospital, Kansas City, MO

Background: The integration of milestones into Clinical Competency Committees (CCC) began in 7/2013. ACGME pilot study data found initial assessments required >1 hr/resident. Audience Response Systems (ARS) are used to promote active learning resulting in increased knowledge and improved attendance. There is less experience with other applications. Objective: Describe the process of CCC restructuring for resident milestone assessment with incorporation of ARS technology for consensus decision-making. Methods: In 7/2013 the CCC structure was changed from a single committee to 3 pediatric level-based committees. Each CCC meets quarterly. The CCC chair is responsible for summarizing milestone assessments from evaluations prior to the meeting. Committee membership is linked to resident curriculum for level of training. The agenda includes individual resident slide presentations that include career goals, previous CCC discussion, board preparation, peer comparison and milestone assessment. Using the ARS, each member votes on each resident from a list of 9 recommendations ranging from progression without intervention to probation. It is possible to vote for >1 recommendation. Members have been informally surveyed for satisfaction. Results: Following 1 cycle of CCC meetings resulting in discussion of all residents in the program (n=78), the average meeting time was 1 hr. 101 ARS recommendations were made, 77% of recommendations were for progression without intervention (96% PL1, 8% PL2 and 5% PL3) and resulted in minimal discussion for residents with expected advancement. Progression with intervention by the physician wellness program was the 2nd most common recommendation (12% [4% PL1, 7% PL2 and 20% PL3]). Intervention for board preparation was identified in 7% (0% PL1, 0% PL2 and 18% PL3). CCC members report high satisfaction with the process. Conclusion: Use of ARS technology increases efficiency, standardizes group consensus recommendations and eliminates undue influence of vocal participants. Class-based CCC improves focus per resident, decreases faculty fatigue and improves faculty representation.

38) THERE S AN APP FOR THAT! INTEGRATING LIVE POINT-OF-CARE SEARCHES INTO AN EVIDENCE-BASED MEDICINE CURRICULUM
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Background: Integrating evidence-based medicine into daily practice is an essential skill residents must attain. Our existing evidence-based medicine (EBM) curriculum included monthly, resident-led, large group sessions with didactics on key EBM topics and application via PICO question analysis. Review of our Annual Program Review and conference evaluations revealed a gap between the intended outcome of the EBM curriculum and residents' perceived abilities to integrate this knowledge into meaningful literature searches. The Curriculum Committee, a resident-driven QI task force, addressed this issue by revising the format of our EBM conferences to include small group, technology-driven, point-of-care clinical searches framed by the existing curriculum. Methods: Residents were surveyed regarding the barriers they face to answering real-time clinical questions, and to identify the web-based resources they most commonly use. Results: Residents identified lack of time during patient care and accessibility to online resources through wireless devices as the most prominent barriers to point-of-care EBM searches. Up To Date and Google Scholar were the most commonly used on-line resources. Discussion: Our task-force used information from the survey to restructure our EBM conferences. A technology session was offered to residents where medical librarians helped download and activate diverse web-based apps for wireless devices that could be used for point-of-care searches. EBM Conferences were reformatted to include: 1. Resident-led didactic session on a key EBM concept and introduction of a PICO question. 2. Small-group real-time searches on the PICO question using wireless devices. 3. Discussion of the live search results with librarian analysis of the apps used, and 4. Review of the quality and clinical relevance of a selected article. Resident feedback following these changes has been very positive. Conclusion: The revision of our EBM curriculum is a successful step towards residents using technology to facilitate EBM methodology in daily clinical practice.

40) MILESTONE ATTAINMENT OF END-OF-YEAR PEDIATRIC INTERNS
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Background: The Next Accreditation System of the ACGME requires semiannual documentation of each resident’s attainment of the pediatric milestones. There are a number of barriers to accumulating enough direct observation data to reliably assess each resident’s developmental progress. An objective structured clinical examination (OSCE) can be used to gather additional observations using select milestone sets as performance assessment tools. No normative data is available to which milestone each resident’s developmental progress. An objective structured clinical examination (OSCE) can be used to gather additional observations using select milestone sets as performance assessment tools. No normative data is available to which milestone each resident’s developmental progress.

Discussion: This theory provides a description of what an ideal approach to learning goals might look like in a pediatric residency. When pursuing this ideal, all five areas are necessary for the meaningful use of goals in a pediatric residency. Discussion: This theory provides a description of what an ideal approach to learning goals might look like in a pediatric residency. When pursuing this ideal, programs could focus on one main area at a time. Needs assessment and toolkits will be developed based on the results to guide programs in moving forward.
Faculty observers were trained in the use of the pediatric milestones prior to observing encounters. Interns were rated using the milestones, with the following scale which included half-point increments between levels: 1=novice, 2=advanced beginner, 3=competent, 4=proficient, 5=mastery. Verbal feedback was provided immediately following each encounter. Results: Five standardized patient cases were used to assess 11 pediatric subcompetencies from 4 domains of competency. 45 pediatric interns were assessed producing 1326 data points. Median milestones ratings for residents ranged from 2.0 to 3.0. Conclusions: An OSCE measuring pediatric interns end-of-year milestone achievements indicated milestone ratings primarily ranging between advanced beginner and competent.

41) THE STUFF THAT STAYS WITH YOU: PREDOMINANCE OF LEARNING ABOUT THE ACGME’S CLER FOCUS AREAS IN THE IMPLICIT CURRICULUM

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Introduction: Because residents perceive that meaningful learning related to CLER most frequently occurs in the implicit curriculum, efforts to enhance the clinical learning environment should focus less on explicit teaching and more on identifying strategies to make learning opportunities in the implicit curriculum more deliberate (i.e. giving residents opportunity to reflect on taken-for-granted learning).

42) REPRODUCIBILITY OF A DISCHARGE EDUCATION CURRICULUM FOR PEDIATRIC INTERNS ROTATING ON AN INPATIENT WARD

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Background: Pediatric residents receive minimal formal training about counseling families at the time of hospital discharge. A discharge education curriculum was created, implemented, and resulted in improved comfort and skills in providing discharge education(Noffsinger, PAS Abstract 2012). Key features combined to create the mnemonic DISCHARGE (Diagnosis, Instructions, Communication, Counseling, History, Discharge education). Methods: A 20-minute curriculum of videos, small group discussion, and brief didactic covering the mnemonic was taught mid-way through a 4-week inpatient rotation. Interns completed pre and post curriculum surveys about discharge education comfort and behaviors utilizing a 4-point Likert scale (1=strongly disagree, 4=strongly agree). Discharge counseling skills were evaluated by attendings or nurses using a 12-item yes/no observation checklist. In the first study, observations were done by attendings. Survey data was analyzed with a Two sample t-test and checklist data with a Wilcoxon Two-Sample Test reported as median (IQR). Results: Thirty interns enrolled and rated the curriculum favorably (median 3.6 (IQR 3.3-4.0)). Post-curriculum interns reported increased comfort providing discharge education (t=2.23, p<.002), giving more discharge education (t=2.16, p<.002), and intending to provide more future discharge education (t=3.21, p<.002). Performance on the checklist improved Pre: 10 (9,12) versus Post: 9 (7,9), p<0.032. Specfically, more interns asked families to summarize plans. Discussion: A brief educational intervention resulted in improved discharge counseling skills, was reproducible between institutions, and utilized interdisciplinary resources with nurses performing structured observations. Results will be analyzed for differences between nurse and physician ratings. Direct observation of residents performing discharge education with checklists could provide concrete examples of strengths and areas for improvement in ACGME competencies and/or could be mapped to Pediatric Milestones.

43) PEDIATRIC HOSPITALIST ATTITUDES REGARDING RESIDENT IMPACT ON COSTS AND QUALITY OF CARE: A SPRINGBOARD FOR CURRICULUM DEVELOPMENT?

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Background: Residency training is essential to the development of young physicians, and in many institutions hospitalists are important to this training. Some have suggested cost effective care be a 7th ACGME core competency. Curriculum development in this area has yielded mixed results, as have studies examining the impact of residents on quality and cost effectiveness. Faculty perceptions of these issues are unknown. Methods: We developed a 15-item survey to address faculty
perceptions of resident effects on costs and quality of care, as well as faculty experience and the perceived need for educating residents in these areas. The anonymous survey was pilot tested to ensure validity prior to electronic distribution to 180 pediatric hospitalists from 113 institutions who are members of a collaborative database. Results: 127 of the 180 members surveyed responded with complete data (71%). 55% always work with residents, 33% work with residents sometimes, and 12% never work with residents. Overall, 60% reported residents increase quality of care; 72% felt that residents increase hospital costs. Respondents who worked with residents all of the time more often felt residents increased quality (71%) compared to those who worked with residents some of the time (43%) or never (53%). The most stated reasons for increasing quality were more time at the bedside and improved continuity. Nearly all who felt residents increased costs identified more testing as the cause. 91% of respondents felt they know how to provide cost-effective care, and 81% agreed they were qualified to teach it. However, only 22% reported receiving formal training in this area; nearly all (91%) agreed that cost-effectiveness curricula were needed in current programs. Conclusions/Future Directions: Most pediatric hospitalists surveyed feel that residents increase the quality of care, but at increased cost. We next plan to evaluate the degree to which these attitudes reflect actual care delivery, further informing strategies for incorporating cost effectiveness training into graduate medical education.

44) EFFECT OF THE MEDICAL STUDENT PERFORMANCE EVALUATION (MSPE) “BOTTOM LINE” ON REVIEWER ASSESSMENT OF APPLICANT DESIRABILITY
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BACKGROUND: The Association of American Medical Colleges’ guideline for preparation of the MSPE recommends inclusion of a narrative describing performance during clinical rotations as well as an assessment of the student’s overall performance relative to his/her peers (bottom line). OBJECTIVE: To determine the relative impact of the narrative description versus the bottom line on reviewer assessments of applicant desirability. METHODS: Faculty members (n=29) from the Department of Pediatrics at Baylor College of Medicine with experience reviewing MSPE letters as a part of intern selection reviewed two pairs of sham MSPE letters. In each pair, the narrative in one letter was clearly superior to that in the other. Two bottom line descriptors describing relative class rank were created. Each subject was first presented with a pair of letters with mismatched bottom lines (study) (i.e. the letter with the better narrative was presented with the weaker bottom line and vice versa). He or she was then presented with the other pair of letters without bottom lines (control). Letter pairs were randomized as to study or control. Subjects ranked the relative desirability of the two applicants in each set. Responses were considered correct when the subject’s ranking coincided with the strength of the narrative comments. Associations between categorical variables were evaluated using Chi square tests (Fisher Exact Test if any cell value was less than 5). RESULTS: Subjects correctly ranked the letters 10/29 times under study conditions versus 24/29 times under control conditions (p=0.0004). There were no differences in the proportion of correct responses by subject age, gender, academic rank, or interview experience. CONCLUSION: The MSPE bottom line descriptor had greater impact than the narrative description on the determination of applicant desirability.

45) TABLETS...ARE THEY THE FUTURE OF CLINICAL EDUCATION?
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Background: The increasing conflict between productivity and clinical education, both for patients and providers in training, requires a new paradigm which technology may help address. The purpose of this pilot study was to evaluate the effectiveness and satisfaction of using iPads for patient/family education in pediatric residency clinics. Methods: A series of videos were created or downloaded onto iPads in the resident clinics. Ten general pediatric diagnoses (asthma, otitis media, sinusitis, allergies, anaphylaxis, colds, pharyngitis, pneumonia, UTI, Influenza) were selected, based on those most commonly seen in the acute clinic and availability of electronic teaching tools. Parents and patients 12-17 years of age were offered video teaching and, if they verbally consented to the study, they completed a brief, multiple-choice, online survey at the end of the visit. Pediatric Residents were asked to use the iPad as a teaching tool during their rotations in our acute clinic and were then asked to complete an online, multiple-choice survey. Results: We found that residents spent less face-to-face time educating their patients/families when using the iPad. Use of iPads for teaching increased (47% of residents never used prior vs 80% using it at least sometimes after). All residents were willing to use the iPad for future teaching, at least sometimes. None of the residents felt that their patients/families were dissatisfied with electronic teaching. Over half of the patients/families preferred to talk to their doctor and watch a video compared to 18% wanting to just talk to their provider without video education. 84% of patients/families felt they had a better understanding of the diagnosis after video education compared to previous, similar visits without the iPad. 63% felt the time spent teaching was about the same. More than half of the patients were willing to receive health information via the iPad in the future with 88% of them using technology at home. Conclusions: Given its overall effectiveness and satisfaction with residents and families, we plan to greatly expand use of video education for acute and well care patients in the pediatric clinics.

46) THE USE OF SOCIAL NETWORKING AND OPINIONS OF SOCIAL NETWORKING POLICIES IN PEDIATRIC RESIDENCY
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Introduction: Social networking is commonly used by both the lay public and medical professionals as a valuable communication tool; however, it is also a potential outlet for unprofessional behavior. Despite minimal data describing the use of social media by pediatrics residents, residency programs are increasingly implementing social networking policies. We present data from
a national study of pediatrics residents characterizing their pattern of social networking use and their degree of agreement or disagreement with common components of social networking policies. Methods: Anonymous, IRB-exempt, on-line survey of 21 pediatric residency programs. Results: Of the 1332 eligible residents, 241 completed the survey. The most common social networking sites used are Facebook (92%), Instagram (29%), and Twitter (15%). Sixty percent of residents feel that programs should have a social networking policy. A large majority of residents agree with the following: residents should be allowed to display their affiliations training sites on their social networking pages (95%), the professionalism should apply to social networking (93%), program leadership can request posts that violate patient privacy laws be removed (91%), social networking is a potential outlet for unprofessional behavior (76%), social networking poses a risk to patient confidentiality (72%), residents should not be allowed to interact with patients via social networking (71%), residency programs should have a curriculum that teaches residents to safely use social networking (70%). A smaller majority of residents agree with the following: program leadership can request the removal of posts they feel are unprofessional (57%), residents can use any language they choose on social networking (56%), residents can be disciplined for their social networking posts (56%). A majority of residents disagree with the statement that residency program leadership should screen residents’ social networking pages (83%). Conclusion: The use of social networking is extremely common amongst residents. A large majority of residents would agree with the development of social networking policies and curricula based on the tenants of professionalism and protection of patient privacy. Fewer residents would support measures that limit their speech on social networking.

47) WHAT DID THEY LEARN - A QUALITATIVE ANALYSIS OF PEDIATRIC RESIDENT CRITICAL INCIDENT ESSAYS.
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BACKGROUND: Reflective practice is recognized as an essential component of medical education and professional development. Critical incident (CI) essays are a reflective narrative in which learners are asked to describe a specific event that has greatly influenced their practice. As critical incidents often inspire novel insights and learning goals, these essays provide unique insight into the experiences and metacognitive processes of trainees. OBJECTIVES: (1) To describe the types of experiences depicted in pediatric resident CI essays. (2) To describe the insights and learning goals that emerge from personal reflection on critical incidents. METHODS: We performed a qualitative, thematic analysis of 90 de-identified CI essays written by pediatric residents at a single institution between 2002 and 2012. Essays were separated by year of training and were randomly sampled until thematic saturation was achieved. Four reviewers coded all essays by an iterative process. Atlas.ti 7 software was used to assist with analysis. RESULTS: Experiences reported generally described one or more of the following scenarios: a near miss, a medical error, a patient decompensation, the death of a patient, a communication breakdown, or a difficult social situation. Novel insights and learning goals fit into 5 major themes: (1) development of self-trust and sense of personal responsibility; (2) maturation of clinical skills, including critical thinking and comfort with uncertainty; (3) appreciation of humanism in patient care and commitment to social advocacy; (4) recognition of the importance of good communication and teamwork; and (5) professional identity development, including a commitment to lifelong learning.

DISCUSSION: Pediatric resident CI essays emerge from a diverse set of experiences and stimulate reflection and goal setting in many areas, including personal and professional development, communication, humanism and patient care. Many of these identified learning goals overlap with pediatric ACGME core competencies and the pediatric milestones. These findings help to illuminate the complex challenges faced by residents while providing patient care, and can inform our design of curriculum and support services.

48) EARLY CAREER EXPERIENCES OF PEDIATRICIANS PURSUING OR NOT PURSUING SUBSPECIALTY FELLOWSHIPS
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BACKGROUND: Choosing career paths can be difficult decisions for residents who contemplate whether or not to pursue fellowship training. There is not a significant body of literature for residency and fellowship directors to draw from in counseling residents in this area. OBJECTIVE: Compare the experiences of early career pediatricians who did and did not pursue fellowships. METHODS: We analyzed nationally-representative, weighted data from the AAP PLACES study of pediatricians 1-3 yrs (recent grad cohort) and 8-10 yrs (early career cohort) post-residency (n=1725). Work environment, work-life balance, financial compensation, and career satisfaction were compared for pediatricians in or who had completed fellowship training (FT) and those that did not pursue fellowship training (NFT). Multivariable logistic regression examined the independent effects of fellowship training while controlling for demographic differences (gender, IMG, race, and children) in each cohort. RESULTS: 44% of the recent grad cohort (384/880) and 39% of the early career cohort (331/845) were FT. FT were more likely than NFT to report learning opportunities in their work environment in both the recent grad (38 vs 18%, p<.001) and early career (25 vs 12%, p<.001) cohorts. FT in the early career cohort were more likely to report an income of $125,000 or higher (84 vs 67%, p<.001). NFT in both cohorts were more likely than FT to work less than 50 hours per week (recent grad: 76 vs 27%, p<.001 and early career: 77 vs 39%, p<.001), have flexibility with their schedules (66 vs 51%, p<.001 and 64 vs 54%, p<.01), and be satisfied with time spent with their children (59 vs 37%, p<.001 and 59 vs 47%, p<.01). Both FT and NFT were generally satisfied with their life on whole and found their work to be rewarding. (Table 1). CONCLUSION: Directors can reassure pediatric residents that although important life and career differences need to be considered when contemplating fellowship training, either choice usually results in overall life and career satisfaction.
averaged 65% on the topic they taught, and 51% on the topic they were taught. 6 weeks later the difference persisted, with
differentiation of topics, participants averaged 36% correct on the topic they taught, and 39% on the topic they were taught. After teaching, they
prepare to be tested on the other topic. At each teaching session, they took a quiz on both topics before and after teaching
They received a standardized article on each topic and were told to prepare a 5-10 minute session on their primary topic, and
another person. METHODS: Two topics were selected for their relevance and ability to discriminate, and each participant was
is to evaluate if there are greater benefits for learning when actively teaching a topic compared to being passively taught by
focus has been placed primarily on the success of those in the “pupil” rather than “teacher” roles. The objective of this study
decades, including within medical education. The advantages of these methods have been described in many studies, though
BACKGROUND: The adoption of peer-assisted learning (PAL) has increased in many educational settings in the past few
data has developed tools for the assessment of competency to perform the infant lumbar puncture (ILP) procedure. We previously
reported evidence to support the validity and reliability of these instruments when used by expert raters in a simulated
setting. The objective of this study was to evaluate the validity and reliability of these tools when used by resident raters
to assess simulated ILP performances. METHODS: Video recordings of 60 subjects performing an unsupervised LP on an
infant bench top simulator were collected prospectively; 20 performed by subjects in each of three categories (beginner, intermediate
experience, and expert). Six blinded resident raters independently scored each subject's video recording [3 via a global rating scale (GRS), 3 via a checklist instrument]. RESULTS: For the resident raters, across all subject groups, higher
GRS scores were found with advancing level of experience (P < 0.01). Total checklist scores were similar between the expert
(80.0%) and intermediate experienced (76.6%) groups (P = 0.68). Both groups scored higher than the beginner group (50.4%)
on the checklist instrument (P < 0.01). Cronbach's alpha coefficient for the checklist was 0.77. The intraclass correlation coefficients among raters for the GRS and total checklist scores were 0.49 and 0.47 respectively. CONCLUSIONS: Similar to that found for expert raters; 1) acceptable internal consistency was found for the checklist instrument, and 2) The GRS instrument outperformed the checklist in its discriminant ability. Only moderate agreement among raters was found for each of the
scoring tools. Compared to expert raters, we found the level of agreement among resident raters to be poorer for both of the

50) EFFECT OF RESIDENT COMMUNICATION TO CLINIC SCHEDULERS ON CONTINUITY IN PEDIATRIC CONTINUITY CLINIC
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Purpose/Objective: The ACGME requires pediatric residency programs provide a continuity clinic experience. There are a
number of barriers to maintaining continuity during residency training including resident service obligations and duty hour
restrictions. Lack of continuity creates dissatisfaction among residents both within our program and nationwide. The purpose
of this study is to determine if resident communication with clinic schedulers increases the level of continuity for residents
during their continuity clinic experience. Design/Methods: A retrospective chart review was conducted to determine the rate
at which patients seen by residents in continuity clinic were seen again by the resident at the next scheduled follow-up. In the
second phase of the study, 21 pediatric residents will be assigned into two separate groups based on the rate at which the
resident communicated to clinic schedulers their desire to see the patient again in follow-up. Residents who communicated >
50% of the time will be grouped as “communicators” and residents who communicated < 50% will be “non-communicators”. A resident self-assessment of their own status as “communicator” or “non-communicator” will also be conducted and
compared to the objective assessment. The level of continuity based on the UFC (usual provider continuity) index will be
assessed for the patients on each resident’s continuity panel. The average UPC index for the “communicators” group and the
“non-communicators” group will be compared. Results: Initial chart review was conducted of 110 patient encounters in
which residents requested follow-up for a patient seen in continuity clinic. The resident communicated the desired provider for
follow-up 32.7% (38/110) of the time. When residents specifically communicated the desired provider for follow-up, the
resident saw the patient at the next follow-up visit 72.2% (28/38) of the time. If the resident did not specifically communicate
the desired provider for follow-up with clinic schedulers, the next follow-up visit was with the resident only 33.8%
(25/74) of the time. Conclusions/Discussion: Based on the preliminary findings, we expect that the residents classified as
“communicators” will have a higher UPC index for their continuity panel than “non-communicators”. If our hypothesis proves
correct, improvement in communication with schedulers may represent a simple approach to improve continuity in pediatric
resident continuity clinic.

51) BENEFITS OF TEACHING IN MEDICAL EDUCATION
Elizabeth A. Sokol, MD, Victoria Rodriguez, MD, University of Chicago Pediatric Residency Program, Chicago, IL
BACKGROUND: The adoption of peer-assisted learning (PAL) has increased in many educational settings in the past few
decades, including within medical education. The advantages of these methods have been described in many studies, though
focus has been placed primarily on the success of those in the “pupil” rather than “teacher” roles. The objective of this study is
to evaluate if there are greater benefits for learning when actively teaching a topic compared to being passively taught by
another person. METHODS: Two topics were selected for their relevance and ability to discriminate, and each participant was
pretested on both topics. Each was assigned one topic to teach, and one topic that they would be learning from their partner.
They received a standardized article on each topic and were told to prepare a 5-10 minute session on their primary topic, and
prepare to be tested on the other topic. At each teaching session, they took a quiz on both topics before and after teaching
their partner. Six weeks later, they completed a follow-up post-test. RESULTS: 14 subjects participated, and before the teaching,
participants averaged 36% correct on the topic they taught, and 39% on the topic they were taught. After teaching, they
averaged 65% on the topic they taught, and 51% on the topic they were taught. 6 weeks later the difference persisted, with
an average of 47% on the topic they taught and 34% on the topic they were taught. Statistical analysis included paired t-tests, which showed a non-significant change in score before and after preparation, with no difference between groups. Before and after teaching sessions, both teachers and learners showed improvement, with non-significant difference in improvement between groups. Immediate post-tests and 6 week follow up post tests were statistically significant for a decline in scores as time passed (p=0.007 and p=0.01 for teachers and learners respectively), with no statistically significant difference in decline between groups. CONCLUSION: After preparing for the session, participants scored similarly on both topics. However, after actually teaching a non-statistically significant superior improvement for teachers was present, and persisted 6 weeks later despite similar rates of decline in scores. This suggests that the act of teaching has independent benefits for the learning of the teacher, above and beyond simply studying, via improved total knowledge learned despite similar rates of attrition of learning. This study’s conclusions on the importance of teaching should encourage peer assisted learning as a part of residency training, with lasting benefits in the areas of both knowledge acquisition and teaching skills.

52) BALANCING EDUCATION AND SERVICE
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Introduction: In contemporary GME, program directors (PDs) work to preserve both the centrality of service and the educational value of the training experience. These efforts are hindered by inadequate understanding of how PDs and trainees define service and education and lack of clarity about how the two should be balanced. Methods: We conducted focus groups of residents and PDs to explore participants’ definitions of both service and education and their perceptions of how each contribute to learning. Participants were asked for examples of how service and education are (or are not) well balanced in their programs. Following transcription of audio taped focus groups, data were qualitatively analyzed using a two stage coding process: level 1 structural coding and level 2 thematic coding. Results: Eighteen residents (median age 29 years, 72% female) participated, representing 16 residency programs and 3 PGY classes. Fourteen PDs (median age 51.5 years, 79% female) participated, with an average of 11.5 years of service as a PD. While both groups defined service as patient care activities, many trainees (but no PDs) also defined service as altruism, advocacy, and community action. Many PDs described service as activities falling outside of a physician’s scope, citing residents’ perceptions of administrative duties and scut. Nearly all residents believed service adds educational value to training. Some PDs agreed but a proportion believed service could be problematic in excess or if resident angst and ACGME citation ensue. Residents felt that balance was achieved when formal teaching time was protected and when every patient care experience had educational objectives. Residents also noted that balance increased as training progresses. When asked the same, PDs often deferred to residents, stating that a program balances service and education well when their residents say so. Conclusions: Many pediatric residents hold positive definitions of service and generally feel that service adds value to their education. While residents give suggestions for how to balance education and service, PDs often defer to residents to set these standards.

53) DEVELOPING A PEDIATRIC CURRICULUM ON THE REFERRAL AND CONSULTATION PROCESS.
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Background: The referral/consultation process is considered an Entrustable Professional Activity (EPA), however the skills required for competence in this EPA are not defined and a curriculum does not exist. Objective: To assess pediatric residents perspectives on their preparation for the referral/ consultation process as part of a curricular needs assessment. Design: Second and 3rd year residents from two large pediatric programs completed an online survey based on the literature and focus group data from parents and physicians. Results: Response rates were 70% and 81% (n=51, n=81). Not all residents felt prepared to: communicate with families who resist or press for referral; communicate about insurance/cost factors or appointment access; prepare the family by explaining the logistics of a referral, how to make an appointment. Most residents felt inadequately trained to ensure communication with the specialist (63%, 82%) and to provide them with all necessary pre-referral data. Use of critical thinking skills when making a referral was not universal. Not all residents had a standard way to follow up on patients; many (25%, 21%) never learned what happened at the visit. Even when they learned what happened, not all residents were clear about the next steps for management. Residents from both programs desired education about the referral process (96%, 72%), including; communication; logistics and process of a referral; knowledge related to decision to refer and ongoing management. To improve their education, they suggested that; they would like feedback from specialists about the appropriateness and ongoing management of their referrals; primary care and specialist preceptors should be trained to teach about referral/consultation; and the system should be standardized. Discussion: Experienced residents note that they are not fully prepared to make appropriate referrals and provide pre and post referral care. These resident responses combined with data from parents and physicians at both programs will provide a broad perspective for development of a comprehensive curriculum that will ensure that residents achieve competence in referral/consultation.

54) SELF-REPORTED MILESTONES OF RESIDENTS AND CORE FACULTY: THE FIRST TWO YEARS
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Background: As programs incorporate Milestones-based assessment, there is need to establish expectations for progression through training and competency level at completion of training. Methods: In a single categorical program, residents were required to complete Milestones self-assessments on New Innovations at the end of two academic years (2012 and 2013). Core
addition, this improvement was sustained over time, suggesting retention of skills learned. 

significantly after a selected educational intervention, demonstrating this critical and complex skill as a teachable one.

CONCLUSIONS We concluded that breaking bad news performance in first-year pediatric residents improved no change in two subscales (preparation and wrap-up), and a small but significant improvement in one subscale (bad news delivery). 

ING Death Notification Protocol, a 2-hour educational experience with didactics, small group discussion, and role-play, which includes SP scenarios, training instructions, and assessment tool. The assessment tool was further divided by investigators into subscales of preparation, news delivery, and wrap-up. 

RESULTS The Intraclass Correlation Coefficient demonstrated significant improvement from baseline to immediate post-intervention performance (average preparation score: pre-test 38.3%, post-test 67.7%, P = <0.001). In addition, performance measured at 3 months post-intervention showed no change in two subscales (preparation and wrap-up), and a small but significant improvement in one subscale (bad news delivery). 

CONCLUSIONS We concluded that breaking bad news performance in first-year pediatric residents improved significantly after a selected educational intervention, demonstrating this critical and complex skill as a teachable one. In addition, this improvement was sustained over time, suggesting retention of skills learned.
57) ELECTRONIC PORTFOLIO USE IN PEDIATRIC RESIDENCY PROGRAMS

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The intent of electronic portfolio (efolio) use in residency programs is to organize data as well as to teach and assess lifelong learning skills, yet their use is not universal. Objectives: The purpose of this study is to examine current efolio use, interest in future use, and barriers to use across pediatric residency programs. The existing research on eflos in medical education consists primarily of individual institutions describing implementation. Our aim is to identify common features valued by efolio users and potential future users. Methods: An online survey was sent to 199 pediatric residency program directors. Summary statistics were tabulated and qualitative responses summarized. A subgroup was defined of programs who thought their eflos were effective for teaching lifelong learning skills and efolio usage patterns among the subgroup were examined. Results: Of the 82 programs who responded (41% response rate), 55% (45/82) currently use efolio systems. Of the remaining programs who do not currently use an efolio, 65% (24/37) would like to. Common challenges reported by efolio users include limited functionality, usability, organization, and collecting, importing, and exporting data, yet these same features were ranked of highest priority by programs who have not adopted eflos. The 20% (9/45) of users who believe their eflos are effective at teaching lifelong learning skills reported greater usage of some efolio features than the rest of the programs, including use of reflections (50% vs. 21%), self-assessments (88% vs. 52%) and goal tracking (75% vs. 41%). Conclusions: There is a discrepancy between how eflos are actually being used by most users, and the way in which they would need to be used in order to achieve desired learning outcomes such as promotion of reflection and life-long learning skills. Some users believe that they have been able to achieve these outcomes and take advantage of features such as reflections, self-assessments, and goal tracking. The greatest barriers reported for more effective use of eflos are technical and must be addressed for eflos to meet their potential as valuable learning tools.

58) TRENDS IN RESIDENT EDUCATION IN YOUTH VIOLENCE

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Objectives: To evaluate Chicago pediatric and emergency medicine (EM) residents’ previous training in youth violence, to examine residents’ self-perceived level of competence in youth violence prevention and to assess the types of youth violence seen in clinical practice. Background: Youth violence is a serious threat to young people in the U.S. Through routine screening physicians have an opportunity to attempt to reduce youth violence. Methods: Emails were sent to all pediatric and EM residency directors in the Chicago area inviting them to participate in the study. Participating programs received written surveys, which were distributed and collected during the first 10 minutes of an educational conference. An electronic version of the survey was then sent to residents, targeting those who were not in attendance to complete the written form. Surveys were collected from April 2013 - October 2013. Results: A total of 8 pediatric and 6 EM programs were invited to participate. Seven pediatric and 2 EM programs completed surveys. Of the 355 surveys distributed, 197 (55%) were returned. Of residents surveyed, 56% reported receiving formal youth violence education in medical school and 60% in residency. Lectures were the most common modality used in both settings. Sixty three percent of residents viewed their training thus far as less than adequate; 11% reported no preparation at all. Eighty one percent of residents, regardless of previous training felt that they could not adequately counsel patients about youth violence prevention. In clinical practice, pediatric residents reported a higher incidence of bullying (one person vs one person) in the pre–escalation/contemplation stage of violence. EM residents reported more gang violence, after the violence has occurred. Conclusions: Youth violence is an important topic in medical education that residents encounter but feel inadequately trained to counsel families about. The differences in type and stage of violence encountered in pediatrics versus EM settings suggest that it may be prudent to tailor the educational curriculum at the residency level based on the type of violence most prevalent.

59) EVALUATION OF AN EBM CURRICULUM USING EDUCATIONAL PRESCRIPTIONS

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Background: Evidence based medicine (EBM) is an important part of lifelong learning. The formulation of clinical questions arising during the care of patients is an important first step in the EBM process. Objective: To teach the skill of generating an answerable question in order to improve the overall performance of residents on an EBM exercise. Methods: Prior to this study, the EBM curriculum in our program included an annual overview of the EBM process, a monthly journal club during which EBM cases were discussed, and completion of 2 EBM exercises. The EBM exercise is an educational prescription completed by each resident independently and these are collected annually as part of a resident portfolio. During the 2011-12 academic year we collaborated to design and conduct a workshop that focused on generating questions from clinical scenarios. Four follow-up sessions were conducted in small groups. Residents brought clinical questions to the session and had access to laptops to practice searching skills. Residents completed a self-assessment before and after the workshops, rating their perceived comfort with the different steps of EBM, their comfort with teaching these skills to peers and the frequency they performed each of the steps of EBM. All ratings were on a 5 point Likert scale. Residents completed 2 educational prescriptions and an EBM assessment tool before and after the workshops. The EBM assessments were scored using the published answer key and the EBM exercises were scored anonymously using a scoring rubric. The data were analyzed using paired t-tests with p<0.05 for statistical significance. Results: All 26 residents attended at least one of the workshops and 23 residents attended both workshops. All of the residents completed the pre and post intervention EBM assessment that included...
60) EVALUATION OF A MULTI-DISCIPLINARY GLOBAL HEALTH INTENSIVE COURSE FOR RESIDENTS AND FELLOWS

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Background: Few global health courses offered today incorporate non-medical disciplines, such as economics, health policy, water-sanitation, or public health, which are important to a comprehensive understanding of GH. Objectives: We developed and implemented a two-week intensive course on global health for residents and fellows at Stanford University School of Medicine in the fall of 2012 and 2013 entitled “Global Health: Beyond Diseases and International Organizations.” Methods: Our 10-day course included multiple modes of instruction, including didactic lectures, case-based learning, hands-on laboratory sessions, and group projects. Students from multiple sub-specialties including Pediatrics, Internal Medicine, Emergency Medicine, Surgery, Anesthesiology, Pathology, and Neurology enrolled in the course. Learners completed a pre and post-course survey that included a content knowledge section and an anchored confidence scale section. Analysis: 35 learners (76%) completed both a pre- and post/test. We measured knowledge gained using paired t-tests of pre/post-test knowledge (Table 1) and the effect size by calculating Cohen's d and the effect-size correlation. The mean score on the pre-test was 58% (SD=2.3) and 73% (SD=2.1) on the post-test, p-value 0.000. Cohen's d was -1.08544 and effect size r was -0.77000. Mean test scores increased from pre to post-test in both 2012 and 2013. This increase was both statistically significant and demonstrated a relatively large effect (Cohen's d>.8 and r >.3). We measured confidence gained using the nonparametric Wilcoxon Signed-Rank test on the anchored confidence scale questions. Learners confidence improved significantly in all but one of eight aspects of GH. Feedback from the 2012 students was used to modify the 2013 course. Learners assessed 25 of 39 (64%) of sessions in 2012 and 39 of 49 (80%) of sessions in 2013 as “very good” or “excellent” on a five-point scale. Conclusions: The course was successful in increasing both knowledge and skills related to global health practice as demonstrated in the gains in test scores.

61) THE IMPACT ON ACGME RESIDENT WORK HOUR RULES ON PICU RESIDENT VIGILANCE

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Background: In 2011 resident work hours were further reduced resulting in interns no longer than 16 hours resulting in no traditional overnight call. As a result, second year residents (PGY2) began to work extended shifts for the first time. Using Psychomotor Vigilance Test (PVT), a validated alertness tool, post-call alertness in PGY2 who had experienced the new hour restrictions in their intern year were compared to those who had not. Our hypothesis was that residents who took overnight intern call would have adapted strategies to better help them maintain alertness and thus would be more vigilant post-call. Participants: UAB pediatric PGY2 residents rotating in the PICU. The study included both residents who were interns prior to the new work hour rules (Intern Call Group) and residents who were interns after the restrictions (Intern No Call Group). PVT testing occurred post call just prior to leaving. Methods: Participants completed a demographic form and 3 minute alertness test designed to measure changes in psychomotor speed, lapses in attention, and impulsivity induced by fatigue. A laptop was used to administer the PVT. The participant would click a box on the screen to begin the test and would then click each time they saw a flash or box appear on the screen. PVT testing of these different groups spanned 2 years. Reaction times were analyzed by T-test using SPSS Statistics. Results: 46 residents participated. Residents in the Intern Call Group had an average PVT reaction time of 300 ± 81 ms vs. Intern No Call Group of 298 ± 22 ms (p=0.87). There was no difference in the number of false starts between the groups with on average 1.0±1.2 times per test. There was no significant difference in the number of hours of sleep and number of hours lying down without sleeping between groups 2.0±2.5, 1.5±3.2 respectively. The intern call group spent significantly more months with 28 hour calls than the non-intern call group. Discussion: Contrary to our hypothesis, there was no significant difference noted in average PVT reaction time between the two groups. It is important to note that there was no baseline PVT reaction time with which we could compare the post-call test.

62) DOES THE ASSESSMENT OF MILESTONES WITH OBJECTIVE STRUCTURED CLINICAL EXAMINATIONS (OSCES) CORRELATE WITH THE SUMMATIVE ASSESSMENTS MADE BY A CLINICAL COMPETENCY COMMITTEE?

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Background: The optimal approach for evaluating the clinical competencies of pediatric residents using the new ACGME milestones has not been determined. We aimed to determine whether the assessment of an individual milestone sub-
competency (Interpersonal and Communication Skills sub-competency-2; ICS-2) during a simulated OSCE encounter correlated with the assessment of the clinical competency committee (CCC). Methods: Residents in the final month of their PGY-1 year participated in an OSCE. The ICS-2 sub-competency was assessed during 4 separate OSCE encounters conducted over the course of one afternoon. Observing faculty members graded each encounter using the ACGME 9-point scale from 1 to 5. Five months later, members of the 24 member CCC reviewed and discussed 360-degree evaluations of the same residents from the first four months of the PGY-2 year. Median scores from the OSCE and the CCC meeting were calculated for each resident, and un-weighted and weighted kappa scores were calculated to assess for agreement. Results: Nine residents participated in the OSCE at the end of the PGY-1 year. The median ICS-2 score for the OSCE encounters was 2.5 (range 2-3), and the median ICS-2 score from the CCC 5 months later was 3.5 (range 2.5-4.5). The median delta was +1 (range 0-2). Agreement between the OSCE and CCC evaluations was poor, with unweighted and weighted kappa scores of 0.027 +/-0.24, and 0.098 +/-0.27 respectively. Conclusions: There was a poor agreement between the OSCE and CCC assessments of the ICS-2 sub-competency. Median CCC scores were overall higher than the OSCE scores obtained just 5 months previously. These results suggest that either the CCC or an OSCE, or both, incorrectly assess trainees. Another possible explanation for such a discrepancy is that there is a significant amount of developmental growth that occurs in this milestone during the transition from PGY-1 to PGY-2. Further studies aimed at using varied approaches to assess this milestone concurrently are warranted.

63) LET’S GIVE THEM SOMETHING TO TALK ABOUT: ASSESSMENT OF COMMUNICATION SKILLS IN PEDIATRIC RESIDENTS

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Objective: To assess whether utilization of a validated communication tool corresponds with faculty assessment and resident self-assessment on the pediatric communication milestone continuum. Methods: Pediatric residents were recruited to participate in the communication skills assessment. Continuity clinic faculty completed an assessment of each resident’s communication skills utilizing the 6 pediatric milestones that address interpersonal and communication skills. Each participating resident completed a self-assessment of their own communication skills utilizing the same milestones. After being placed on the milestones, the residents participated in a standardized patient interview that was recorded and subsequently evaluated by a faculty observer utilizing the Common Ground Instrument. Results: 16/16 of pediatric residents participated in the study. The milestones and common ground instrument were scored on a scale from 1 to 5 with 5 representing an expert rating. For PGY-1 residents, the average faculty score on the milestones was 3.17, self-assessed average score was 2.92 and common ground average score was 3.67. For PGY-2 residents, the average faculty score on the milestones was 4.40, self-assessed score average was 4.10 and common ground average score was 3.20. For PGY-3 residents, the average faculty score on the milestones was 4.70, self-assessed score average was 4.10 and common ground average score was 3.60. PGY-1s had significantly lower self and faculty assessments than PGY-2s or 3s. There were no significant differences among PGYs on the Common Ground Interview score. Faculty rated residents significantly higher than they rated themselves. Previous clinical skills training, standardized patient training, and English as a first language had no significant effect on the self-assessment, faculty assessment or Common Ground Instrument score. Conclusion: Faculty and residents observe an improvement in communication skills as residents progress through training; however, scores on a validated communication tool do not reflect this improvement.

64) INTER-RATER RELIABILITY OF PEDIATRIC MILESTONES ASSESSED IN SIMULATED ENCOUNTERS

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Background: Pediatric residents will be evaluated using milestones. Inter-rater reliability of these scales has not been determined. Objective: We aimed to determine the inter-rater reliability of three milestones assessed in a video-taped Objective Structured Clinical Encounter. Methods: PGY3 pediatric residents halfway through the year at a single institution were video-taped during three simulated patient encounters during a standardized clinical exercise. Two people familiar with the milestones reviewed each encounter and assessed each one using a single milestone. The A1 ‘Develop and Carry Out Management Plans’ was used to assess an encounter with a referring physician with a patient with diabetic ketoacidosis. The D1 ‘Communicate effectively with patients’ milestone was used to assess an adolescent HEADDS encounter. The A1 milestone ‘Gather essential and accurate information about the patient’ was used to assess an encounter with a coughing pre-teen. Kappas and weighted kappas were calculated. Weights were 0.75, 0.5, 0.25, and 0 for each successive level of discordancy. Results: Nine residents were assessed in three cases each. The kappa for the A7 milestone was 0.02 [95%CI -0.26 - 0.29]; the A1 milestone 0.1 [95%CI -0.57 - 0.36], and for D1 it was 0 [95%CI -0.29-0.18]. The weighted kappa for A7 was -0.16 [95%CI -0.46 - 0.14]; D1 was -0.1 [95%CI -0.57-0.36], and for A1 it was 0.07 [95%CI -0.38 - 0.52]. Conclusions: Assessment of three selected pediatric milestones from a single simulated patient encounter has poor inter-rater reliability. Multiple observations and other sources of assessment are recommended.
Background: Residents report that they receive inadequate feedback, and that verbal feedback and written evaluations do not match. Methods: In this cross-sectional study at a single institution, an anonymous, IRB exempt survey was distributed to 81 pediatric residents in March 2013 to assess their experiences with feedback and perceptions of coaching as a means to improve feedback, and an analogous survey was sent to 200 faculty. Results: 50 residents (61.7%) and 77 faculty (38.3%) completed the survey. 41.7% of residents and 37.8% of faculty felt residents receive inadequate verbal feedback in general. A few feedback areas were highlighted as ones to improve: (1) Physical Exams: 81.3% of residents and 72.4% of faculty felt residents receive inadequate feedback on physical exam skills; (2) Communication: only 82.4% of faculty felt very/fairly confident in providing feedback on communication skills; and (3) Professionalism: 31.2% of residents and 52.8% of faculty felt residents receive inadequate feedback on professionalism, and only 60.8% of faculty felt very/fairly confident in providing feedback on professionalism. 85.4% of residents agreed/strongly agreed that feedback from faculty is useful, but only 48% agreed/strongly agreed that faculty are well-trained in providing feedback and only 64.5% agreed/strongly agreed that written evaluations match verbal feedback. 87.2% of residents and 94.5% of faculty agreed/strongly agreed that a coach could provide real-time, useful feedback to residents. Conclusions: Both residents and faculty recognize that residents lack adequate feedback, and both feel optimistic that coaches can fill this void. Coaches need advanced training to become experts in giving feedback, including feedback on physical exam skills, communication skills and professionalism.

66) THE SISYPHUS EFFECT? NO CHANGE IN IMPLICIT BIAS AGAINST DISABILITY AMONG PEDIATRIC RESIDENTS OVER TIME
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Background: Disparities in health care are a well documented problem and recent investigation suggests that medical practitioners unconscious (implicit) biases may contribute to such disparities. Implicit bias against disability is present amongst most incoming residents, but the impact of medical training, particularly the hidden curriculum, on these biases is not known. Objectives: To determine the baseline levels of implicit bias amongst residents, and measure whether residency experiences have any impact (positive or negative) on these biases. Methods: Pediatric interns in 2010-2011 completed the Implicit Association Test (IAT) for disabled-abled. The same residents then completed the disabled-abled IAT during their PGY-3 year (2012-2013). Results: In both their PGY-1 and PGY-3 years, the majority (75% and 84%) of residents demonstrated a bias against disability. 64% of PGY-1s and 68% of PGY-3s showed a moderate or severe bias (see Table). These levels of bias did not change significantly between the intern and third year of residency (p=0.784). Conclusion: The majority of interns demonstrated an unconscious bias against the disabled social group. In spite of curricular experiences aimed at improving cultural competency and residents understanding of disability, levels of bias did not change over the course of residency training. Future Research: Further research is needed to determine the effect of disability bias on pediatric patient care and if impacted what curricular interventions mitigate the impacts of this bias.

67) RESIDENT FEEDBACK: THE PERSPECTIVES OF ATTENDINGS AND RESIDENTS
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Background: Two major stakeholders in resident feedback are the attendings delivering feedback and the residents receiving feedback. Therefore, it is critical to assess the perspectives of both groups regarding the strengths and challenges of current resident feedback systems. The purpose of this study was to ascertain those perspectives. Methods: An online survey was designed to investigate the perceptions of the Boston Combined Residency Program residents and attendings regarding the current state of resident feedback. The survey consisted of questions about the quality of different types of feedback; the differences between in-person and written feedback; and the largest limiting factors in providing quality resident feedback. Results: Only 57% of all attendings have had any formal training in giving feedback, and only 64.5% agreed/strongly agreed that faculty are well-trained in providing feedback and only 64.5% agreed/strongly agreed that written evaluations match verbal feedback. 87.2% of residents and 94.5% of faculty agreed/strongly agreed that a coach could provide real-time, useful feedback to residents. Conclusions: Both residents and faculty recognize that residents lack adequate feedback, and both feel optimistic that coaches can fill this void. Coaches need advanced training to become experts in giving feedback, including feedback on physical exam skills, communication skills and professionalism.

68) RESIDENT DRIVEN IMPROVEMENT OF PCP COMMUNICATION AT DISCHARGE
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Background: At Lucile Packard Children’s Hospital, there was concern that primary care physicians (PCPs) were dissatisfied...
with communication from hospital providers based on a Press Ganey Survey performed in 2012. In mid-2013, only 52% of PCPs had been contacted by the time of discharge, which inhibited continuity of patient care and provider relationships. Aim: To create a standard process for communicating with PCPs at discharge improving notification to 80% by December 2013. Methods: A multidisciplinary team led by pediatric residents was established in July 2013. Utilizing Lean methodology, specifically the A3 Quality Improvement tool, the team identified barriers to PCP communication and established recommendations and action items. We ran 2 PDSA cycles based on our initial analysis of the problem. In the first cycle, August 2013, resident education was targeted through morning report, blog posting, emails, and a hospital wide screen saver. In the second cycle, September 2013, we made changes to the electronic medical record (EMR) including notification at the time of discharge if communication with the PCP had not been documented. Ongoing action items include updating the PCP phone database to facilitate ease of communication from inpatient providers, obtaining real time feedback from PCPs on recently discharged patients, and utilizing care coordinators to fax admission notifications. Throughout the implementation of these measures, the data regarding PCP communication was tracked from the EMR. Results: After implementation of two PDSA cycles, PCP notification at discharge improved by 60% relative to prior months. Documentation of discharge communication with PCPs reached the goal of 80% on medical resident teams. Conclusion: Resident participation was key to the early success of this PCP communication improvement project. Results will continue to be followed and new PDSA cycles utilized as necessary for sustainment. Residents are uniquely positioned to lead hospital driven initiatives given their expertise with systems of care and direct involvement in the daily work surrounding hospitalized patients.

69) IMPLEMENTATION OF ASTHMA CONTROL TEST SCREENING TOOL IN PEDIATRIC RESIDENT CLINIC

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Background: Asthma is one of the most common chronic pediatric conditions. Asthma Control Test (ACT: for ages >12 years) or Childhood Asthma Control Test (C-ACT: for ages 4-11 years) is an easy assessment tool for asthma control. The C-ACT is a 7-question, 2-part questionnaire, with one part to be completed by the child age 4-11 with caregiver assistance and the other part to be completed by the caregiver. The ACT is a self-administered 5-item survey completed by the children age 12 and above. Uncontrolled asthma is defined as ACT < 19. Aim Statement: To increase the use of the ACT and C-ACT as a screening tool in a pediatric resident clinic to improve asthma management for patients with a history of asthma by 20%. Methods: We performed two PDSA cycles to increase use of the ACT and C-ACT screening tool. We included any patient with asthma age >4 years who presented for well child care and acute care visits. In the planning phase of each cycle we used the experiences gained from the previous PDSA cycles to introduce new strategies and implement changes. In the first PDSA cycle, we informed the providers about ACT screening through emails, educated faculty and residents at faculty meetings and noon conference, respectively, increased resident awareness by speaking to each continuity clinic group, and posted screen shots in resident work room. For the second PDSA cycle, we additionally posted flyers in the patient waiting area, resident lounge, and in examination rooms to increase awareness of ACT screening tool. Results: The pre-implementation chart review showed 2.53% of patients age >4 with history of asthma had ACT completed. The post-implementation first PDSA cycle demonstrated 23.2% of the patients age >4 with history of asthma had it completed. We are in process of collecting data from our second PDSA cycle to show sustainability of our interventions. Conclusion: Educating and increasing awareness of the ACT increased the screening of asthmatic patients dramatically. Although our screening efforts were greatly improved, not all patients with history of asthma are having an ACT performed. We will continue to add additional interventions to improve the use of the ACT test.

70) SCREENING OF DEPRESSION IN OVERWEIGHT AND OBESE CHILDREN AND ADOLESCENTS PRESENTING FOR WELL CHILD CARE VISITS TO THE CHILDREN’S HOSPITAL UNIVERSITY OF ILLINOIS

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Background: Studies have shown an association between the development and persistence of obesity and depression in children. Prior to our QI project, there was no screening process for depression in overweight and obese patients presenting for well child care visits (WCC). Aim Statement: Screening rates for depression among obese and overweight children and adolescents seen in the resident continuity clinic for WCC will increase to at least 50% over six months. Methods: Before beginning the project, we worked with our social worker (SW) to create an algorithm for screening and referral. In phase 1, we used the Children’s Depression Inventory 2 (CDI2) to screen patients who are obese or overweight presenting for WCC on one of five clinic days. We used lessons learned in the first phase to expand screening to the other clinic days, but to narrow our focus to children 12 y/o or older. In phase 2, because of cost, we moved to the Modified PHQ9 (MPHQ9) as our screening tool. We oriented all residents about the screening and referral process. We included the MHPQ9 in the patient education packets provided to age-appropriate patients during WCC. High-risk patients were referred to the SW. Results: 71% of eligible patients were screened using the CDI2, and 67% were 12 y/o or older. Total of 33 eligible patients were screened. Six patients (18%) scored positive for moderate risk of depression. Five of these patients agreed to referral to SW, and all of them were referred to Psychiatry. Patients who were moderately depressed had lower BMIs (p=0.33), compared with non-depressed patients. Conclusions: Educating all medical staff about the importance of depression screening in overweight and obese patients and having the algorithm accessible resulted in a dramatic increase in screening. Limitations and recommendations: A bigger sample size and longer study duration are needed to increase the statistical power of the study as well as to evaluate the long term effects of our clinical intervention. A dedicated SW and Psychiatrist are needed to facilitate a referral system.
Continued use of reminders and reinforcement will be necessary to sustain screening rates for depression among obese and overweight children in a busy resident’s clinic.

71) IMPLEMENTATION OF PEDIATRIC EBM CURRICULUM
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Background: The concepts of evidence-based medicine (EBM) are essential tools for residents to learn to appropriately appraise, analyze and interpret research in pediatrics. This skill will allow residents to provide the highest quality of care.

Objective: To establish an EBM curriculum that will increase the residents’ knowledge by 10% in 3 months and 50% in 9 months upon curriculum implementation.

Design: In the “plan” phase of the PDSA cycle, a committee was formed to create an EBM curriculum, focusing on 3 areas: research evidence, research methodology, and statistical analysis. In the “do” phase, we revised PICO (patient/intervention/comparison/outcome) sessions, restarted morbidity and mortality conference and monthly journal club with direct faculty mentorship, and fostered collaboration with a medical librarian. In the “study” phase, a validated EBM questionnaire developed by Chernick et al. (2010) was used for baseline assessment. Deficiencies identified from this assessment were incorporated into EBM curriculum. Analysis was done at 3 months to assess improvement.

Results: All 27 pediatric residents (7 PGY3, 10 PGY2 and 10 PGY1) demonstrated difficulty critiquing medical literature. Nearly 4 out of every 5 residents were found to have minimal experience with EBM. After implementation, mean resident EBM scores significantly improved by 12% (from 38% to 50%). Utilizing a paired t-test, the mean total score difference per residents was significant (p=0.0001). In our 3 focus areas, the mean difference in the scores in researching evidence and understanding research methodology were statistically significant (p=0.0002 and p=0.0015, respectively). However, the mean difference in the scores in understanding statistical analysis was not significant (p=0.119).

Conclusions: Since initiation of the EBM curriculum, residents have shown significant improvement on the assessment tool and appear to be more comfortable and confident when reviewing and utilizing medical literature. We anticipate that results will be even greater at the 9-month assessment and hope this will serve as a foundational pillar in educating residents as lifelong learners. Chernick, L., Pusic, M., Liu, H., Vazquez, H., & Kwok, M. (2010). A pediatrics-based instrument for assessing resident education in evidence-based practice. Academic Pediatrics, 10(4), 260-265. doi:10.1016/j.acap.2010.03.009; 10.1016/j.acap.2010.03.009
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