2020 Annual Meeting

APPD 2020
Annual Spring Meeting

March 30-April 2, 2020

Building Bridges

Sheraton San Diego Hotel & Marina
San Diego, California

*This activity has been approved for AMA PRA Category 1 Credit™*
Welcome to the 2020 APPD Annual Spring Meeting!

On behalf of the Board of Directors and Spring Meeting Planning Committee, we are delighted to welcome you to our community’s annual spring gathering, this year on the sunny shores of San Diego. We welcome back our experienced members, and particularly welcome those first time attendees who are getting to know all that APPD can offer.

Careful and thoughtful preparation has gone into this year’s meeting planning. We have continued to highlight meeting activities that are most effective when they occur in person. Inspired by San Diego’s Coronado Bridge just south of our venue this year, the meeting theme is “Building Bridges”. It reminds us of the importance of networking and collaboration to make the Pediatric GME community one that is driven by shared best practices, mentoring, and relationships. Based on meeting evaluations and feedback from participants last year, we continue to adjust the content you have found valuable to be shared as effectively as possible.

In furtherance of our meeting theme, you will notice that we continue to offer ample time for networking with your colleagues and content experts in all aspects of Pediatric medical education. The Grassroots Forum sessions again will allow sharing of innovation and inspiration among Program Directors, Associate Program Directors, Fellowship leaders, Coordinators, and Chief Residents. Based on excellent feedback for the past two years, we will again be offering the Table to Able session, facilitating the exciting work that happens when people come together around shared interests. This activity will feature informal discussions led by content experts on a variety of topics related to best practices. In addition, APPD’s popular Facilitated Mentoring Session, scheduled during the Facilitated Networking Lunch period on Wednesday, will provide opportunities to connect with mentors around the topics of Professional Development, Leadership Development and Personal Wellbeing. Also based on last year’s meeting feedback, we are offering two opportunities for Learning Communities to meet, once on Tuesday afternoon and again at the end of the meeting on Thursday morning. Again this year, in collaboration with Key Stakeholder organizations, we incorporated specific topics and processes of importance to our programs, our trainees, and our patients and families.

Very excitingly, this year had a record number of proposals for Enhanced Learning Sessions. The Program Committee evaluated every one of these high quality proposals to determine the strongest offerings that would meet the most diverse educational needs of the APPD community, with additional focus this year on encouraging Fellowship and Coordinator focused opportunities. There will be four sessions during the meeting in which to enjoy our Enhanced Learning Sessions. These offerings will continue to allow variable formats, again with the goal of having actionable items to take home to your individual programs. We look forward to continuing to hear your thoughts as we diligently strive to improve our program every year. Finally, and again in response to meeting feedback, we have increased the time available for viewing posters at the Wednesday Poster Session. We have nearly 120 posters showcasing the strongest Education Scholarship and Quality Improvement efforts of our members, and you are encouraged to take time to browse them!

In our vital work to train future pediatricians to promote the health of all children, our community is a critical source of knowledge, expertise, friendship, support and inspiration. Our annual spring gathering is essential to our mission, and we hope and expect you to experience these qualities over the next few exciting days here in San Diego.
# Schedule-At-A-Glance

**APPD 2020 Annual Spring Meeting**  
**March 30-April 2, 2020**  
**San Diego, California**

## Monday, March 30, 2020

<table>
<thead>
<tr>
<th>Time</th>
<th>Event</th>
<th>Pages</th>
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</thead>
<tbody>
<tr>
<td>7:30am-12:15pm</td>
<td>APPD LEAD Meeting <em>(LEAD Cohort Only)</em></td>
<td>Pages 14-15</td>
</tr>
<tr>
<td>8:00am-12:30pm</td>
<td>APPD Board of Directors Meeting</td>
<td>Page 5</td>
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<tr>
<td>9:00am-5:00pm</td>
<td>Coordinators’ Session</td>
<td>Pages 18-19</td>
</tr>
<tr>
<td>9:30am-5:00pm</td>
<td>Forum for Chief Residents</td>
<td>Page 19-24</td>
</tr>
<tr>
<td>12:30pm-3:00pm</td>
<td>APPD LEAD Council Meeting</td>
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<tr>
<td>1:00pm-5:30pm</td>
<td>Pre-Conference Workshops <em>(choice of 3 - additional fee)</em></td>
<td>Page 24-25</td>
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<tr>
<td>1:00pm-7:00pm</td>
<td>APPD AIMS <em>(Advancing Inclusiveness in Medical Education Scholars)</em></td>
<td>Page 17</td>
</tr>
<tr>
<td>5:30pm-7:30pm</td>
<td>APPD Leadership Orientation and Reception <em>(invitation only)</em></td>
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## Tuesday, March 31, 2020

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<thead>
<tr>
<th>Time</th>
<th>Event</th>
<th>Pages</th>
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<tbody>
<tr>
<td>7:00am-8:00am</td>
<td>Wellness Activity</td>
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<tr>
<td></td>
<td>Continental Breakfast</td>
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<td></td>
<td>“Welcome” Session for First-Time Attendees</td>
<td>Page 25</td>
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<tr>
<td>8:00am-9:00am</td>
<td>Plenary Session <em>(including APPD Updates, Holm Award &amp; Presidential Address)</em></td>
<td>Page 25</td>
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<tr>
<td>9:00am-10:00am</td>
<td>Platform Presentations in Educational Scholarship <em>(including Research Awards)</em></td>
<td>Pages 26-28</td>
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<tr>
<td>10:15am-12:15pm</td>
<td>Grassroots Forum for Associate Program Directors</td>
<td>Page 28</td>
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<tr>
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<td>Grassroots Forum for Chief Residents</td>
<td>Pages 28-29</td>
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<td>Grassroots Forum for Coordinators</td>
<td>Page 29</td>
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<tr>
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<td>Grassroots Forum for Fellowship Program Directors</td>
<td>Page 29</td>
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<tr>
<td>10:15am-12:15pm</td>
<td>Grassroots Forum for Program Directors</td>
<td>Page 29</td>
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<tr>
<td>12:30pm-1:45pm</td>
<td>Facilitated Networking Lunch Sessions *(listed below):</td>
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<tr>
<td></td>
<td>All About You: Facilitated Mentoring</td>
<td>Page 29</td>
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<td>Forum for Directors of Small Programs and Affiliate Chairs</td>
<td>Page 30</td>
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<tr>
<td></td>
<td>Coordinators’ Networking Lunch</td>
<td>Page 30</td>
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### Schedule-At-A-Glance (continued)

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<thead>
<tr>
<th>Time</th>
<th>Event</th>
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<tbody>
<tr>
<td>2:00pm-3:30pm</td>
<td>Enhanced Learning Sessions I <em>(choice of 11)</em></td>
<td>Pages 30-34</td>
</tr>
<tr>
<td>3:45pm-5:15pm</td>
<td>Learning Community Meetings <em>(choice of 11)</em></td>
<td>Pages 34-35</td>
</tr>
<tr>
<td>5:30pm-6:30pm</td>
<td>Networking Reception</td>
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**Wednesday, April 1, 2020**

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<th>Time</th>
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<tr>
<td>7:00am-8:00am</td>
<td>Wellness Activity</td>
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<tr>
<td></td>
<td>OLT Demonstration by the ABP</td>
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<tr>
<td></td>
<td>Continental Breakfast</td>
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<tr>
<td>8:00am-9:00am</td>
<td>Plenary Session <em>(including Berkowitz Award, LEAD Graduation &amp; ACGME Updates)</em></td>
<td>Page 36</td>
</tr>
<tr>
<td>9:00am-9:30am</td>
<td>Platform Presentations in Quality Improvement (QI) <em>(including QI Project Award)</em></td>
<td>Pages 36-37</td>
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<tr>
<td>9:45am-11:15am</td>
<td>Table to Able Session</td>
<td>Page 37</td>
</tr>
<tr>
<td>11:30am-12:45pm</td>
<td>Regional Lunch Meetings</td>
<td>Page 38</td>
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<tr>
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<td>APPD LEARN “10 Year Anniversary Event” <em>(with lunch)</em></td>
<td>Page 16</td>
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<tr>
<td></td>
<td>Council of Learning Community Chairs Lunch Meeting</td>
<td>Page 12</td>
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<tr>
<td>1:00pm-2:30pm</td>
<td>Enhanced Learning Sessions II <em>(choice of 11)</em></td>
<td>Pages 38-42</td>
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<tr>
<td>2:45pm-4:15pm</td>
<td>Enhanced Learning Sessions III <em>(choice of 11)</em></td>
<td>Pages 42-45</td>
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<tr>
<td>4:30pm-6:00pm</td>
<td>Poster Session - Educational Scholarship and QI Projects <em>(See page 45 for Poster numbers separated by topic area)</em></td>
<td>Pages 51-107</td>
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<tr>
<td>6:00pm-7:00pm</td>
<td>APPD LEAD Reunion <em>(LEAD Graduates only)</em></td>
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**Thursday, April 2, 2020**

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<tr>
<td>7:00am-7:30am</td>
<td>Continental Breakfast</td>
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</tr>
<tr>
<td>7:30am-8:30am</td>
<td>Plenary Session <em>(including Tunnessen Award, ABP Update &amp; LEARN Update)</em></td>
<td>Pages 45-46</td>
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<tr>
<td><em>(note earlier start time)</em></td>
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<tr>
<td>8:45am-10:15am</td>
<td>Enhanced Learning Sessions IV <em>(choice of 10)</em></td>
<td>Pages 46-49</td>
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<tr>
<td>10:30am-12:00pm</td>
<td>Learning Community Meetings <em>(continued and as needed – see page 29)</em></td>
<td>Pages 49-50</td>
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SUNY Upstate Medical University

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Ariel Winn, MD
Children’s Hospital/Boston Medical Center

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University of Texas Health Science Center/School of Medicine at San Antonio
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In addition to the national organization, pediatric programs in APPD are divided into regions. These regional groups have leadership opportunities, meetings, and activities which are a vital part of the APPD. All attendees are welcome to attend Regional Lunch Meetings on Wednesday, April 1 from 11:30am-12:45pm. www.appd.org/activities/regions.cfm

APPD Council of Regional Chairs

**Chair, Council of Regional Chairs**
Jason Homme, MD (2017-2021)
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Sylvia Yeh, MD (2019-2021)
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Join an APPD Learning Community!

Learning Community meetings will be held on Tuesday, March 31 from 3:45pm-5:15pm and on Thursday, April 2 from 10:30am-12:00pm. Come and see what the learning communities are all about. All are welcome!

www.appd.org/activities/learningCommunities.cfm

ASSESSMENT
The Assessment Learning Community is a group of program directors, associate program directors, coordinators, chief residents and other educational leaders seeking to improve assessment practices for trainees, faculty and programs. Areas of focus include improving or standardizing current assessment methods and developing novel assessment methods that meet the goals of outcomes-based evaluation. We welcome newcomers and returning members. Our Learning Community session at APPD Spring 2020 will be divided into two parts. For the first half of the session, we will explore the “hot topics” in assessment from the past year through an interactive review of the med ed literature. For the second half of the session, we will break into our four working groups to outline the status of our current projects and plan future directions. The four working groups include: Assessment of Learners focusing on Learner Communication, Multi-source Assessment, Assessment of Faculty, and Program Evaluation. These groups have been working throughout the year to meet our Learning Community’s three main goals for 2019-20: 1) To engage and develop members through project-based working groups. 2) To promote research and scholarship through the study of processes and procedures in the project-based working groups. 3) To foster leadership and collaboration through partnerships with other Learning Communities.

BEHAVIORAL AND MENTAL HEALTH
The Behavioral and Mental Health Learning Community is excited to welcome anyone interested in improving pediatric training experiences in the areas of mental/behavioral health to join us at the 2020 APPD Annual Spring Meeting in San Diego. This year, we are building upon the work of previous meetings and multiple collaborative initiatives that are advancing the training needs of residents and fellows. This session will include updates from groups representing the American Board of Pediatrics and the American Academy of Pediatrics. In addition, this session will review the recently published collaboration evaluating the longitudinal assessment of residents using Entrustable Professional Activities (EPAs), specifically EPA 9 – Assess and Manage Patients with Common Behavior/Mental Health Problems. Attendees will work in facilitated small groups focused on identifying the needs of Behavioral and Mental Health training and plans for implementation to share with the larger group. This learning community is also identifying those interested in leadership positions within the Community related to Curriculum, Scholarship, Advocacy and Faculty Development. Finally, our learning community has been asked by the APPD leadership to begin building an educational curriculum in this area that would be available to all APPD members. We need your input to make this happen, so please come join us!

COMMUNITY HEALTH AND ADVOCACY TRAINING
The Community Health & Advocacy Learning Community is open to program directors, associate program directors, chief residents, coordinators and other educational leaders seeking to share ideas and resources with the goal of strengthening community health and advocacy education in their programs. Through this LC, we aim to foster collaboration among leaders in community health and advocacy education within pediatric residency and fellowship programs. The session will include presentations by leaders in community pediatrics education from around the country who will discuss curricular strategies and innovations that they have implemented in their own programs. LC leaders will solicit input from participants to better understand how the LC can support their needs and goals for their programs. Participants will leave with new resources and ideas to enhance their community pediatrics curricula, and they will make connections with other leaders around the country to facilitate collaboration in the educational work that we do. We hope you can join us to help us plan for the upcoming year!

CURRICULUM
The Curriculum Learning Community is a group of program directors, associate program directors, residents and other educational leaders that seek to improve the development, sharing and collaboration of curriculum development across programs. We encourage all those with an interest in curricula (i.e., development, research, revision, innovation, collaboration), regardless of level of experience, to join us. During our session at the APPD annual meeting, we will briefly review our past accomplishments and then set to work on our future directions. We will be hosting small break out session and table talks to provide advisement and collaboration on our current projects. We encourage members to submit curricula in progress or projects that have opportunities for collaboration.
EDUCATIONAL TECHNOLOGY
The APPD Educational Technology Learning Community will host an interactive session, describing best practices and showcasing the latest technology used by program leadership. We hope to provide an opportunity for APPD members to share best practices and to create new applications for technology to enhance trainee learning, while responding to the needs, challenges and opportunities of the digital age.

FACULTY AND PROFESSIONAL DEVELOPMENT
The Faculty and Professional Development Learning Community provides opportunities for collaboration among APPD members interested in faculty development. To meet these goals, our learning community has four subsections, each with a focal project.

- The Educator Development subgroup manages the production and publication of “Nuts and Bolts” publications—short tip sheets on common education topics to be used as a resource for faculty development at the home programs of APPD members.
- The Chief Resident Forum subgroup plans and runs the APPD Forum for Chief Residents at the APPD annual spring meeting, designed to support and develop the Chief Resident roles at member programs.
- The Mentoring subgroup organizes mentoring activities for APPD members.
- The Professional Development subgroup plans the longitudinal pre-conference workshop series Professional Development 101 for APPD members.

Our leadership structure, with chairs of each subgroup, creates many opportunities for leadership roles within APPD. We encourage participation by any new APPD members in the subgroups to bring innovative ideas toward the aim of meeting the professional development needs of APPD and our home programs.

HEALTHCARE SIMULATION IN PEDIATRICS
The overarching goal of this Learning Community is to serve as a resource in simulation for residency and fellowship programs. We seek to help advance members’ work in simulation, regardless of level of expertise. Objectives are 1) Development of a Learning Community structure and members by offering opportunities for leadership, mentorship and collaboration and maintaining engagement between APPD meetings, 2) Promote research and scholarship in simulation, and 3) Increase awareness of currently available simulation resources and collaboration with other simulation organizations. We welcome all interested members to join the Healthcare Simulation in Pediatrics Learning Community.

LGBTQA+ LEARNING COMMUNITY
The LGBTQA+ Learning Community will hold its annual spring meeting in San Diego, and we are excited to meet those of you who are new and to reconnect with old friends! We plan to discuss relevant topics in medical education during our first meeting and then report out on the realignment of our three subgroups: curriculum, recruitment, and advocacy during our second session. In addition, as a large group, we will discuss the progression and next steps for our combined goals with the Underrepresented Minorities LC as we begin to work in tandem with the APPD Vision 2020 plans to better serve our members and the APPD. Please join us if you are a member of the LGBTQA+ community or have a passion for serving marginalized communities - we hope to see you there!

PEDIATRIC GLOBAL HEALTH EDUCATORS
The APPD Global Health Learning Community’s mission is to work collaboratively with pediatric faculty in the US and abroad to advance the science and implementation of global health education for pediatric trainees, to prepare them to better serve children in resource-limited settings locally and globally. Come join us for both sessions during which we will welcome our global health education scholarship recipients (this year joining us from Guatemala and Botswana), share abstract presentations about global health education, and discuss ways to get involved in the group’s efforts.

<table>
<thead>
<tr>
<th>MISSION</th>
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<td>The Association of Pediatric Program Directors (APPD) serves pediatric programs by leading the advancement of education to ensure the health and well-being of children.</td>
<td>Exemplary pediatric education.</td>
<td>The leadership is governed by these principles:</td>
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<tr>
<td></td>
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<td>✓ Leadership ✓ Scholarship</td>
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RESEARCH AND SCHOLARSHIP

Come get involved with the APPD Research and Scholarship Learning Community! The goals of the APPD RSLC are to: a) understand the needs of APPD membership in the domains of research and scholarship; and b) support the APPD’s organizational processes and procedures that promote research and scholarship by APPD members. To meet these goals, the RSLC engages in a variety of activities, including, developing and leading workshops focused on medical education research topics at the APPD Spring meeting, connecting learning community members with common scholarly interests, reviewing Spring meeting abstract and workshop proposal submissions, reviewing research surveys intended for APPD membership, and choosing research prize winners. We welcome all APPD members, regardless of experience with medical education research. This community is a great way to be connected with other APPD members with a particular interest in educational research and scholarship and take advantage of opportunities to improve your own research, appraisal, and mentoring skills.

This year, we will be holding two sessions at the spring meeting. During the first meeting, we will review our accomplishments over the past year, then brainstorm as a large group how we can continue to best support scholarship for all APPD members. The majority of our session will be spent in small working groups that mix experienced and new learning community members based on individual areas of interest. We will continue that work by holding a second session where individuals may continue to connect and advance their work and goals for the upcoming year.

UNDERREPRESENTED MINORITIES IN PEDIATRIC GRADUATE MEDICAL EDUCATION

The Underrepresented Minorities in Pediatric GME Learning Community was created in response to a lack of representation of URM trainees and medical education leadership in academic pediatrics. The goal of the learning community is to improve diversity, inclusion, and equity practices within pediatric GME. The overarching goals of the learning community are addressed through four sub-committees: recruitment, retention and support, curriculum, and mentorship. During our session at the APPD Spring Meeting, we will review our learning community structure, updates on our goals and objectives, and breakout in our sub-committees to continue current projects and brainstorm further ideas for the upcoming year. Additionally, to share and learn from each other, we will have selected peer-reviewed oral presentations by members of our learning community related to innovative work they are doing within diversity and inclusion. We welcome anyone with a passion for this topic to join us!
APPD Council of Learning Community Chairs
Patricia Poitevien MD, MSc, Chair CoLCC (2019-2021)
Brown University/Hasbro Children’s Hospital

Assessment Learning Community
Jennifer DiPace, MD
Chair (2019-2021)
New York Presbyterian - Weill Cornell

Mackenzie Frost, MD
Vice Chair (2019-2021)
University of Texas Southwestern Medical School

Healthcare Simulation in Pediatrics Learning Community
Amanda Rogers, MD
Chair (2019-2021)
Medical College of Wisconsin

Behavioral and Mental Health Learning Community
Kenya McNeal-Trice, MD
Chair (2018-2020)
University of North Carolina Hospitals

Sue Poynter Wong, MD, MEd
Vice Chair (2018-2020)
Cincinnati Children’s Hospital Medical Center/
University of Cincinnati College of Medicine

Lesbian-Gay-Bisexual-Transgender-Queer/Questioning-Ally (LGBTQA+) Learning Community
Elizabeth (Beth) Payne Wueste, MAEd, C-TAGME
Chair (2019-2021)
University of Texas Health Science Center School of Medicine at San Antonio

Community Health & Advocacy Training Learning Community
Michelle Barnes, MD
Co-Chair (2017-2019)
University of Illinois College of Medicine at Chicago

Sarah Garwood, MD
Co-Chair (2017-2019)
Washington University/B-JH/SLCH Consortium

Pediatric Global Health Educators Learning Community
Heather Crouse, MD
Chair (2019-2021)
Baylor College of Medicine

Curriculum Learning Community
Steve Paik, MD, EdM
Chair (2018-2020)
NYP Morgan Stanley Children’s Hospital/Columbia
University Medical Center

Christine Skurkus, MD
Vice Chair (2018-2020)
Connecticut Children’s Medical Center

Research and Scholarship Learning Community
Erika Abramson, MD
Chair (2018-2020)
New York Presbyterian - Weill Cornell

Educational Technology Learning Community
Michelle Miner, MD
Chair (2019-2021)
Southern Illinois University SOM

Amy Gaug, C-TAGME
Vice Chair (2019-2021)
University of Minnesota

Underrepresented Minorities in Pediatric Graduate Medical Education Learning Community
Lahia Yemane, MD
Chair (2018-2020)
Stanford Children’s/Stanford Pediatrics

Faculty and Professional Development Learning Community
Kimberly Gifford, MD
Chair (2019-2021)
Dartmouth-Hitchcock Medical Center

Emma Omoruyi, MD, MPH
Vice-Chair (2018-2020)
McGovern Medical School
The APPD Share Warehouse is a unique opportunity for members to collectively share and use content that supports the mission of pediatric residency education. The APPD Share Warehouse is a web-based collaborative project that provides a place for APPD members to browse, search, use, and share resources, including policies, curricula and evaluation tools. It’s a perfect place to submit workshop materials, poster presentations, and resources for APPD Learning Communities. Learners, leaders, and all team members will benefit from a rich repository of information and practical applications for our diverse needs.

The APPD Share Warehouse is emblematic of our community of members: innovative, collaborative, and scholarly. Learning together from our shared work cultivates great new solutions and ignites innovation. Members may share their work and report its use as part of their portfolio of scholarship. Explore the APPD Share Warehouse and submit materials to the site. And let us know how we can adapt the site to meet your needs. When we share and innovate together, all members benefit.

**Share Warehouse Design and Editorial Team**

Robert Lee, DO, MS  
Share Warehouse Team Leader  
*Winthrop University Hospital*

Hannah Kinoshita, MD  
*University of Hawaii*

Tara McKinley, MA  
*University of Louisville*

Michelle Miner, MD  
*Southern Illinois University*

Maren Olson, MD  
*University of Minnesota*

Sydney Primis, MD  
*Carolinas Medical Center - Levine Childrens’ Hospital*

Alan Chin, MD  
*University of California-Los Angeles*

Emily Borman-Shoap, MD  
*University of Minnesota*

Cindy Colpitts  
*Creighton Nebraska Pediatric Residency Program*

Alice Del Rosario, BS  
*University of California-Los Angeles*

**Visit the APPD SHAREWAREHOUSE at**  
www.appd.org/sharewarehouse
APPD LEAD
APPD Leadership in Educational Academic Development

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 9 is underway. The deadline for applications for this group is April 17, 2020. Visit www.appd.org/leadapp/begin.cfm for details.

LEAD Council Members / Faculty
Rebecca Swan, MD, Chair
Vanderbilt University School of Medicine

Marsha Anderson, MD
University of Colorado

Bruce Herman MD
University of Utah

Richard Mink, MD, MACM
Harbor-UCLA Medical Center

Richard Shugerman, MD
Seattle Children’s Hospital / University of Washington

Robert Vinci, MD
Boston Medical Center

Ingrid Walker-Descartes MD, MPH, MBA
Maimonides Infant’s and Child’s Hospital of Brooklyn
APPD LEAD, continued

The eighth APPD LEAD Cohort (see list below) was selected from among a highly qualified group of applicants. This eighth Cohort, an energetic and focused group of educational leaders, will graduate from the program during the Plenary Session on Thursday morning.

Hadi Anwar, MD
Children’s Hospital of Richmond at VCU
“How Do Two-Week Rotations Affect Resident Education? Resident and Faculty Perspectives”

Aline Baghdassarian, MD
Children’s Hospital of Richmond at VCU
“Preparing Pediatric Residents to Practice in the Urgent Care Setting Upon Graduation of Residency: An Educational Intervention”

Nalinda Charansangavej, MD
University of Texas at Austin Dell Medical School
“Developing Faculty Skills for Working with Residents with Disabilities”

Michael Green, MD
University of Texas Southwestern Medical Center
“Leadership Competencies Among Pediatric Subspecialty Fellows”

Elizabeth Hanson, MD
UT Health San Antonio, Long School of Medicine
“Building a Better CCC: Improving the Quality of Resident Feedback through Appreciative Inquiry”

Joni Hemond, MD
University of Utah
“Pediatricians’ Perceptions of Subspecialty Core Content in Pediatric Residency Training: A Descriptive Analysis”

Heather Howell, MD
New York University Grossman School of Medicine
“A Family Centered Communications Curriculum for Pediatric Residents”

Christine Hrach, MD
Washington University School of Medicine
“Enhancing Resident Quality Improvement Curriculum”

Rupa Kapoor, MD
Eastern Virginia Medical School
“Measuring the Impact of a Longitudinal, Integrated Professional Development Curriculum on Resilience and Burnout in Pediatric Residents”

Jacqueline Kitchen, MD, MS
Children’s Mercy Hospital- University of Missouri Kansas City
“Leadership Roles and Experiences in Recent Internal Medicine-Pediatric Program Graduates”

Lauren Nassetta, MD
University of Alabama at Birmingham
“Large-Scale Group Trauma Negatively Impacts Residents’ Stress and Resilience”

Rebecca Sanders, MD, PhD
Emory University School of Medicine
Mental and Behavioral Health Training in Pediatric Fellowships: A Needs Assessment

Catherine D. Shubkin, MD
Children’s Hospital at Dartmouth-Hitchcock
“If We Build It, Will They Come? A Needs Assessment of Bioethics Education”

Aliza B. Solomon, DO
Weill Cornell Medicine
“How does simulation and dedicated practice affect pediatric GI fellow skill performance and competency over time?”

Jennifer Yu, MD
University of California San Diego
“Improving Feedback in Pediatric Fellows Through an Observed Structured Feedback Exam (OSFE) and Feedback Training Workshop”

Eric Zwemer, MD
University of North Carolina
“Better evals in a minute?: The effect of the one-minute preceptor technique on evaluation quantity and quality”

From Cohort 7
Nicola Orlov, MD, MPH
University of Chicago
“Using Improvisational Theatre to Improve Communication Skills”
APPD LEAPES
APPD Leadership in Empowerment for Advancing Educational Specialists

APPD is very excited to announce the new LEAPES (Leadership in Empowerment for Advancing Educational Specialists) Course call for applications! Application information, instructions and online forms may be found on APPLY2LEAPES.

The Association of Pediatric Program Directors serves pediatric programs by leading the advancement of education to ensure the health and well-being of children. Pediatric Graduate Medical Education Specialists (coordinators, managers, and other program administrators) are an integral part of the pediatric program leadership team. LEAPES is designed to enhance the knowledge, skills, and networking for Pediatric Graduate Medical Education Specialists who wish to gain expertise needed to successfully guide the success of graduate medical education programs and advance their GME careers.

This 9-month advanced, longitudinal and hybrid, course provides outstanding training for administrators aspiring to develop the knowledge and skills needed to become leaders in medical education. APPD LEAPES FAQ

The program features:

- 3 educational conferences with over 32 hours of educational content
- A curriculum focusing on leadership, educational scholarship, career development, program management, and program development
- A nationally recognized council and subject matter experts with significant teaching and professional experience in program leadership and medical education
- Peer group activities and support
- A mentored workshop abstract, presentation, and educational project for the home institution
- Certificate given at the completion of all program-required elements

Prerequisites for Application

- Minimum of 3 years graduate medical education experience. Must not be within first year managing a new program.
- Member of the APPD
- Commitment of Department for funding for travel to three meetings and cost of tuition ($5,500).

Application timetable

- February 3, 2020 Application system opens
- April 17, 2020 Application deadline
- May 8, 2020 Applicants notified of status

For further information, send an email to LEAPES@appd.org

APPD LEARN
APPD Longitudinal Educational Assessment Research Network

APPD LEARN is APPD’s research network, open to all member programs, with 149 currently participating. During the past year, APPD LEARN has begun or continued several active collaborative studies, including the Pediatrics Milestones Assessment Collaborative (with the American Board of Pediatrics and National Board of Medical Examiners) and assessment of the relationships between entrustable professional activities and milestones in the Pediatric subspecialties (with the Council of Pediatric Subspecialties, the American Board of Pediatrics, and the Subspecialty Pediatrics Investigator Network) and in general Pediatrics (with the American Board of Pediatrics). Please visit with us during the meeting to learn more about your educational research network and how you can become involved! In addition, please look for more information on the APPD LEARN web site at http://learn.appd.org

Alan Schwartz, PhD
APPD LEARN Director

Beth King
APPD LEARN Program Manager
The Underrepresented Minorities in Pediatric GME learning community, in collaboration with the APPD Board, are proud to announce the first cohort of residents selected to participate in the APPD AIM (Advancing Inclusiveness in Medical Education) Scholars Program. The objective of this program is to expose underrepresented in medicine residents to the APPD community, and careers in pediatric medical education, earlier in their training with the goal of increasing diversity in pediatric medical education leadership. AIM scholars will be provided with mentorship and professional development on careers in medical education. Huge thanks to APPD members that are serving as mentors in this program!

Lahia Yemane, MD, Chair (2018-2020)
Underrepresented Minorities in Pediatric GME Learning Community
Stanford Children’s/Stanford Pediatrics

Emma Omoruyi, MD, MPH, Vice-Chair (2018-2020)
Underrepresented Minorities in Pediatric GME Learning Community
McGovern Medical School

APPD AIM Scholars:

Soore Akande, DO
Medical College of Wisconsin

Marcus C. Germany, MD
MetroHealth Medical Center
Case Western Reserve School of Medicine

Victoria Mitre, MD
Baylor College of Medicine

Elena Brandford, MD
Stanford University

Onell Grant, DO
Eastern Virginia Medical School

Tatiana Ndjatou, MD
New York Presbyterian Hospital Weill Cornell Medical Center

Stefan Breitling, MD
New York University School of Medicine

Jennifer Gutierrez-Wu, MD
University of North Carolina

Melissa Rodriguez, MD
Brown University

Morgan N. Cronin, MD
University of California, San Francisco

April Nicole Hobbs, MD
Prisma Health - Midlands Peds Residency
University of South Carolina

Rebka Tekeste, MD
University of Maryland
APPD Meeting Schedule

Sunday, March 29

8:00am-5:00pm  APPD LEAD Meeting *(LEAD Cohort Only)*

9:00am-6:00pm  APPD Board Meeting

Monday, March 30

7:30am-12:15pm  APPD LEAD Meeting *(LEAD Cohort Only)*

8:00am-12:30pm  APPD Board Meeting

9:00am - 5:00pm  Coordinators’ Session *(lunch included)*

9:00-9:30am  Welcome, the APPD Coordinators’ Executive Committee, and APPD Overview  
Amy Gaug, C-TAGME, Coordinators’ Executive Committee Chair

9:30-11:00am  MINDCRAFT: FINDING MEANING IN YOUR WORK THROUGH JOB CRAFTING  
Ashley N. Boyington, University of Utah, SLC, UT, AJ Fletcher, BA, Stanford University, Stanford, CA, Pamela Carpenter, MEd, C-TAGME, University of Utah, SLC, UT, Michelle Brooks, C-TAGME, Stanford University, Stanford, CA
The Roman philosopher, Marcus Aurelius, once said “Work itself is but what you deem of it.” In the constant grind of administrative work, program coordinators often forget the impact of their efforts. They might struggle to find the meaning in what they do daily and its importance to the trainees, program, institution, and faculty. This leads to increased burnout, stress, and, ultimately, high job turnover. Many people erroneously believe meaning is found. Contrarily, purpose and meaning are built. Increasing a sense of meaningfulness at work is one of the most powerful ways to increase productivity, engagement, and performance. Employees who derive meaning from their work are more than three times as likely to stay with their organizations, have 1.7 times higher job satisfaction, and are 1.4 times more engaged at work. (Peppercorn) In this interactive workshop, participants will explore the psychology behind meaningfulness and learn the differences between it and happiness. In addition, they will discuss common statistics surrounding building purpose in the workplace. Group activities will teach participants about job crafting techniques that can make their jobs more fulfilling, worthwhile, engaging, and meaningful. Participants will learn how to redefine, reimagine, and enhance meaning where they spend the majority of their time: the workplace. Martin Seligman, one of the founders of positive psychology, defined meaningfulness as “using your signature strengths and virtues

...
in the service of something much larger than you are” (Seligman, 2004: 284) Program administrators as professionals have curated resources and strengths beyond measure. This workshop will dedicate time to mine those efforts, creating personal virtues and sense of belonging in the program.

11:15am-12:15pm
**NAVIGATING NARNIA: THE (NOT SO) SECRET PATH TO BUILDING A PROGRAM COORDINATOR COUNCIL**

**Emily C. Mitchell, MA, Michele R. Bialkowski, University of Colorado, Aurora, CO, Teresa D. Hudson, C-TAGME, St. Louis University School of Medicine, St. Louis, MO**

Navigating Narnia: The (Not So) Secret Path to Building a Program Coordinator Council As ACGME continues to update accreditation requirements, the role of the program coordinator also continues to expand. Coordinators are eager to pursue professional development but there is no clear path identifying opportunities for growth. A successful Program Coordinator Council (PCC) helps provide coordinator training and support while raising the value of the coordinator role. Coordinators will be encouraged to “think big!” about their dreams for their career and professional development. Workshop facilitators will outline the steps for drafting a council, as well as provide training in people management and developing the council’s initial goals and objectives. Coordinators will leave this workshop with a PCC structure including timeline, bylaws, team members, and activities. An electronic binder of resources and templates will be given to attendees to carry this new adventure forward at their home institution.

12:15-1:30pm  
Break for Lunch (provided by APPD)

1:30-3:00pm  
Content to be planned and provided by Coordinators’ Executive Committee

3:30-5:00pm  
Workshop - Global Health Educators and Program Coordinators working together advancing the field of global health.

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9:30am-5:00pm
**Forum for Chief Residents (lunch included)**

*Coordinated by: Blair Dickinson, MD, MS, Associate Program Director, St. Christopher’s Hospital for Children, Co-Chair, Jay Homme, MD, Associate Fellowship Program Director, Mayo Clinic, Co-Chair, Edwin Zalneraitis, MD, Program Director, University of Connecticut, Senior Mentor, and the Chief Resident Forum Planning Committee (below)*

*Faculty: Andria Tatem, MD, Assistant Program Director, Baylor College of Medicine, Cheryl Taurassi, MD, Associate Program Director, Cohen Children’s Medical Center, Sarah Gustafson, MD, Resident Advisor, Harbor-UCLA Medical Center, Dave Mills, MD, Program Director, Medical University of South Carolina, Sumeet Banker, MD MPH, Associate Program Director, New York Presbyterian-Columbia University, Ross Myers, MD, Associate Program Director, Rainbow Babies and Children’s Hospital, Sybil Pentsil, MD, MPH, Program Director, Sinai Hospital of Baltimore, Kheyandra Lewis, MD, Associate Program Director, St. Christopher’s Hospital for Children, Alisa Acosta, MD, Associate Program Director, Texas Children’s Hospital, Bahareh Gordon, MD, Associate Program Director, University of California Los Angeles, Glenn Rosenbluth, MD, Associate Program Director, University of California San Francisco, Benioff Children’s Hospital, Erin Giudice, MD, Program Director, University of Maryland Children’s Hospital, Eric Zwemer, MD, Associate Program Director, University of North Carolina, Sophia Goslings, MD, Associate Program Director, University of South Alabama*

*Chief Residents: Nicole Shovlin, DO, Akron Children’s Hospital, Daniel Chilcote, MD, Baylor College of Medicine/Texas Children’s Hospital, Taylor Koerner, MD and Veronica Alix, MD, Baystate Children’s Hospital, Phillip Thomas, MD, Children’s Hospital of the King’s Daughters, Paige Stevens, MD, Children’s Hospital Los Angeles, Ashley Daniel, MD, Danielle Gonzales, MD, and Evan Weber, MD, Children’s Mercy Hospital Kansas City, Joshua Beiler, MD, Lance Feld, MD, and Rashi Kabra, MD, Cohen Children’s Medical Center, Amy Blodgett, MD, Abraham Khorasani, MD, MA, and Sarah Kollar, DO, Connecticut Children’s, Margarita Corredor, MD and Anna Kellund, MD, Mayo Clinic, Sarah Thompson, MD, National Capital Consortium, Amara Heard, MD and Joe Lammert, MD, Saint Louis University, Leslie Doucette, MD, Sinai Hospital of Baltimore, Sam Cross-Knorr MD, Jill Schaffer, MD, and Carlyn Todorow, MD, St. Christopher’s Hospital for Children, Mickinzie Morgan, MD, Texas Tech Health Sciences Center, Erin Crawford, MD and Rebecca Epstein, MD UH Rainbow Babies & Children’s Hospital, Nisha Divakaruni, MD and Vandana Racherla, MD, University of Maryland Children’s Hospital, Christian Lawrence, MD, Melissa Moore, MD, and Alana Painter, MD, University of North Carolina*

*Chief Residents:*

9:30 – 9:45  
Welcome and Introductions  
Blair Dickinson, MD, MS, Jay Homme, MD  
Welcome from Chief Residents of San Diego  
Meaghan Wido, MD, Naval Medical Center San Diego, Tara Fleming, MD, Patrick Passarelli, MD, and Pavika Varma, MD, University of California, San Diego
9:45 – 10:15  Planning the Chief Handoff and Chief Year  
Veronica Alix, MD, Leslie Doucette, MD, Nicole Shovlin, DO, Paige Stevens, MD, Jay Homme, MD, Ed Zalneraitis, MD

10:15 – 10:30  Move to breakout tracks

10:30 – 12:30  Breakout Tracks

Rising Chief Track
10:30 – 11:45  Not Your Average Morning Report  
Josh Belfer, MD, Sam Cross-Knorr, MD, Margarita Corredor, MD, Lance Feld, MD, Rashi Kabra, MD, Anna Kellund, MD, Jill Schaffer, MD, Carlyn Todorow, MD, Blair Dickinson, MD, MS, Kheyandra Lewis, MD

11:45 – 12:30  Diagnosing and Treating the Struggling Learner  
Daniel Chilcote, MD, Amara Heard, MD, Joe Lammert, MD, Mickinzie Morgan, MD, Philip Thomas, MD, Sarah Thompson, MD, Bahareh Gordon, MD, Sybil Pentsil, MD, Andria Tatem, MD, Ed Zalneraitis, MD

Graduating Chief Track
10:30 – 11:30  Professional Development Planning & Mentoring  
Erin Giudice, MD, Jay Homme, MD, Ross Myers, MD, Glenn Rosenbluth, MD, Cheryl Taurassi, MD

11:30 – 12:30  Debriefing the Chief Year  
Jay Homme, MD, Ross Myers, MD, Glenn Rosenbluth, MD

12:30 – 1:30  Lunch and Poster Viewing
Authors will stand by posters from 12:45 – 1:30pm
*Please see listing of posters below agenda

1:30 – 2:00  Meet the Professor Stations, Poster Viewing, Networking
“Meet the Professor” stations will be hosted by Chiefs and Faculty from the Planning Committee on a variety of topics, including “Implementing Change at Your Program,” “Contract Negotiation,” “Chief Wellness,” “Opportunities in Medical Education,” and more! You may use this time to visit the tables, to continue viewing posters, or to network with each other. This time may also be used to work with your co-Chiefs to begin plans for transitioning home after the conference.

2:00 – 4:00  Speed Chiefing  
Amy Blodgett, MD, Erin Crawford, MD, Nisha Divakaruni, MD, Rebecca Epstein, MD, Abraham Khorasani, MD, MA, Sarah Kollar, DO, Christian Lawrence, MD, Melissa Moore, MD, Ross Myers, MD, Alana Painter, MD, Vandana Racherla, MD, Eric Zwemer, MD

4:00 – 4:15  Top 10 Things About Chief Year  
Ross Myers, MD

4:15 – 4:30  Wrap-Up and Evaluations  
Blair Dickinson, MD, MS, Jay Homme, MD

4:30 – 5:00  Meet the Professor Stations, Poster Viewing, Networking (See description above)

Posters

CURRICULUM
Creation and Implementation of an Overnight In-House Support Rotation: The Senior In Charge Rotation  
Destiny Tolliver MD, Emily Cross MD, Avital Ludomirsky MD MPP, Daria Murosko MD MPH, Yuan He MD MPH, Christine Cheston MD, Theodore Sectish MD, Catherine Michelson MD MMSc, Boston Combined Residency Program, Boston, MA

Dissecting Clinical Pathways – A Curriculum Development Project  
Morgan Congdon, MD MPH, Bryn Carroll, MD, Anna Costello, MD, Tatiana Londoño Gentile, MD, Jeanine Ronan, MD MS MSEd, Rebecca Tenney-Soeiro, MD MSEd, Children's Hospital of Philadelphia, Philadelphia, PA

EPA-Based Assessment of Pediatric Residency Simulation Curriculum  
Paige Stevens, MD, Michelle Thompson, MD, Children's Hospital Los Angeles, Los Angeles, CA

Evaluating the Role of Clinical Pathways in the Residency Experience  
Vandana R. Racherla, MD, Nisha B. Divakaruni, MD, Matthew J. Grant, MD, Susan Feigelman, MD, Ronald San Juan, MD, Erin L. Giudice, MD, Leah S. Millstein, MD, University of Maryland, Baltimore, MD

Getting to the Root Cause: Resident Engagement in a Morbidity, Mortality, & Improvement Curriculum within a Large Pediatric Training Program  
Lance Feld, MD, Stephen Barone, MD, Cohen Children’s Medical Center, New Hyde Park, NY

Implementation of a Resident High Value Care Curriculum  
Leonid Bederman, MD, Andrew McReynolds, MD, Jonathan Ebelhar, MD, Susie Buchter, MD, Rebecca Sanders, MD, PhD, Emory University General Pediatric Residency Program, Atlanta, GA
Implementing a New Resident Interprofessional Curriculum
Tania Eid, MD, Nalinda Charansangavej, MD, The University of Texas at Austin Dell Medical School Pediatric Residency in Austin, TX

Institution of an Implicit Bias Training for Pediatric Residents and the Impact on Recruitment of a Diverse Residency Class
Sheilah M. Jiménez, BS, John D Watson, MD (co-chief), Amy Sass, MD, Tai Lockspeiser, MD, MHPE, Brandi K Freeman, MD, Adam Rosenberg, MD, University of Colorado School of Medicine and Children’s Hospital Colorado, Aurora, CO

Institution of a Longitudinal Palliative Care Curriculum in Resident Education
Jonathan Ebelhar, MD, Andrew McReynolds, MD, Katharine Brock, MD, Emiliee Flynn, MD, Susie Buchter, MD, Rebecca Sanders, MD, PhD, Emory University General Pediatric Residency Program, Atlanta, GA

Partnering Assessment and Curriculum in Simulation: creation of a comprehensive EPA informed pediatric mock code curriculum, and Performance under pressure: the use of EPAs to standardize pediatric mock code feedback
Vishal Naik, MD, Emily Borman Shoap, MD, University of Minnesota, Minneapolis, MN

Procedural Simulation Increases Knowledge and Comfort in Pediatric Residents
Josephine Stout MD, Drew Johnson MD, Hillary Franke MD MS, University of Arizona Pediatric Residency, Tucson AZ

Qualitative assessment of a novel equity, diversity and inclusion (EDI) curriculum for pediatric residents

Resident Comfort with Core Procedural Requirements
Elizabeth Landzberg, MD, Alison Mols, MD, Erin Cummings, MD, James Bohnhoff MD, Andrew Nowalk, MD, PhD, UPMC Children’s Hospital of Pittsburgh, Pittsburgh, PA

Residents as Speakers: Use of a Formalized Case Presentation Curriculum to Enhance Residents
Joshua Belfer, MD, Lance Feld, MD, Rashi Kabra, MD, Stephen Barone MD, Cohen Children’s Medical Center, New Hyde Park, NY

Simulation Based Remediation
Laura Becker, MD, Perri Hopkins, MD, Candace Percival, MD, Susan Whiteway, MD, Jessika Weber, DO, Adharsh Ponnappakam, MD, San Antonio Uniformed Services Health Education Consortium, Fort Sam Houston, TX

TEACH: An Experiential Learning Elective for Pediatric Residents
Sheridan Jost, MD, Adam Rosenberg, MD, University of Colorado School of Medicine and Children’s Hospital Colorado, Aurora, CO

What’s The Evidence? Evaluating the Impact of a Resident Evidence-Based Medicine Curriculum
Minnie Dasgupta, MD, Danielle Kirkey, MD, Jake Weatherly, MD, Kevin Kuo, MD, MHPE, Carrie Rassbach, MD, MAEd., Stanford Pediatrics Residency Program, Palo Alto, CA

EDUCATION
“Curated Content for Curious Crania,” a Novel Approach to Resident Conference Preparation
Lauren Naile, MD, Adam Frischknecht, MD, Vasu Bhavaraju, MD, Phoenix Children’s Hospital/Maricopa Medical Center Pediatric Residency Program, Phoenix AZ

Does Providing Consistent Feedback Improve the Perceived Quality of Morning Report?
Christian Lawrence, MD, Alana Painter, MD, Melissa Moore, MD, Kenya McNeal-Trice, MD, UNC Chapel Hill, NC

Incorporating a longitudinal procedural and code simulation curriculum into an established resident educational framework

Low Fidelity, In-situ Simulation: It Works!
Joshua Belfer, MD, Lance Feld, MD, Rashi Kabra, MD, Stephen Barone, MD, Cohen Children’s Medical Center, New Hyde Park, NY
Optimizing Educational Conferences: How Can We Engage Adult Learners?
Samuel Cross-Knorr, MD, Jillian Schaffer, MD, Carlyn Todorow MD, Blair Dickinson, MD, St. Christopher's Hospital for Children, Philadelphia, PA

Rapid Cycle Deliberate Practice Simulation for Resident Education at a Community Hospital Site
Leslie M. Harris, MD, Brielle Stanton, MD, Theiju Sebastian, MD, Meghan Wilson, MD, Isabel Gross, MD, PhD, MPH, Rachel R. Osborn, MD, Maha Dias, MD, Yale-New Haven Medical Center, New Haven, CT

Revamping the Resident Neonatal Resuscitation Mock Code Curriculum
Jina Park, MD, J. Vi-Anh Ngo, MD, MHA, Nami Jhaveri, MD, Rebecca Chasnovitz, MD, Kaiser Permanente Northern California Pediatric Residency Program; Oakland, CA

Use of a Modified Intern Check-In Tool to Improve Direct Peer Feedback on Inpatient Wards
Shauna Schord MD, Hannah Elkus MD, Taylor Jersak MD, Megan Yanny MD, Becky Zhao MD, Rebecca Wallihan, MD, Nationwide Children's Hospital, Columbus, OH

Utilizing a Resident Focus Group to Improve Conference Quality and Attendance
McKenzie Vater, MD, Ryan Byrne, MD, Rebecca Swan, MD, Vanderbilt Pediatrics, Nashville, TN

MISCELLANEOUS
Community, Collaboration, and Competition: Strategies for Improving Engagement in a Large Residency Program
Bryn Carroll, MD, Anna Costello, MD, Brooks Lanham, MD, MBA, Jeanine Ronan, MD, MS, MSEd, The Children's Hospital of Philadelphia, Philadelphia, PA

Increasing Gender Awareness and Inclusivity in the Hospital Through the Use of Pronoun Identification Badges
Misun Jung, MD, Miki (Josephine) Nishitani, MD, Robert Sanchez, MD, Alisa McQueen, MD, University of Chicago Comer Children's Hospital, Chicago, IL

“Peds Pulse”: A Tool for Soliciting Program Feedback from Residents
Tatiana Gellein MD, Lisa Gantz MD, Kristina Shemwell MD, Virginia Kee MD, Cambria Garell MD, James Lee MD, Megan Fuller, Alan Chin, MD, Mattel Children’s UCLA Pediatrics Residency, Los Angeles, CA

Using Social Media to Enhance Residency Applicant Engagement
Abraham Khorasani, MD, MA, Patricia Garcia, MD, MPH, Ed Zalneraitis, MD, University of Connecticut Pediatric Residency Program, Hartford, CT

QUALITY IMPROVEMENT AND SAFETY
Bringing Feedback to Fruition: A Focused Intervention to Create an Effective Resident Feedback Culture
Rashi Kabra MD, Lance Feld MD, Joshua Belfer MD, Stephen Barone MD, Cheryl Taurassi MD, Cohen Children’s Medical Center, New Hyde Park, NY

Faculty and Resident Engagement at Morning Report
Megan McBurnie, MD, John Ryan, MD, Mark Vining, MD, University of Massachusetts Pediatric Residency Program, Worcester, MA

Anna Miller, DO, Jennifer Kaczmarek, MD, MSc, Thomas A. Black, MD, PhD, Anna Hays, MD, University at Buffalo, Buffalo, NY

Getting Attendings in Line: A Quality Improvement Approach to Improving Completion of Attending Written Feedback for Resident Morning Report
Alana Painter, MD, Melissa Moore, MD, Christian Lawrence, MD, Eric Zwemer, MD, Kenya McNeal-Trice, MD, UNC Chapel Hill, Chapel Hill, NC

One Patient, One Team - Improved Communication for Better Patient Care
Ashley Daniel MD, Danielle Gonzales MD, Evan Weber MD, Ross Newman DO, Angie Etzenhouser MD, Children’s Mercy Kansas City, Kansas City, Missouri

Practice makes perfect, (or improved): Teaching Residents to find their own practice habits by assigning quarterly practice
Alana Painter, MD, Melissa Moore, MD, Christian Lawrence, MD, Martha Perry, MD, Kenya McNeal-Trice, MD, UNC Chapel Hill, Chapel Hill, NC
Provider-reported inequity in care delivered during Rapid Response Team (RRT) activations among patients of color (POC) and low-English proficient (LEP) patients
Jessica E. McDade, Aleksandra E. Olszewski, Ellie McMahon, Elizabeth Masse, Julia Martinez, Jessica Ramos, Shaquita Bell, Missy Lein, Joan Roberts, University of Washington Pediatric Residency Program at Seattle Children’s Hospital, Seattle, WA

Rapid Response Teamwork Makes the Dream Work: Implementing a novel standardized RRT communication tool
Aleksandra E. Olszewski, Jessica E. McDade, Ellie McMahon, Elizabeth Masse, Julia Martinez, Missy Lein, Maneesh Batra, Joan Roberts, University of Washington Pediatric Residency Program at Seattle Children’s Hospital, Seattle, WA

Resident Readiness Huddle Board Makes Positive Impact on Patient Care
Evan Weber MD, Ashley Daniel MD, Danielle Gonzales MD, Ross Newman DO, Children’s Mercy Kansas City, Kansas City, Missouri

Rounding Revamp: The Impact of Family-Centered Rounds (FCR)
Jennifer Kaczmarek, MD, MSc, Anna Miller, DO, Anna Hays, MD, Thomas A. Black, MD, PhD, University at Buffalo, Buffalo, NY

Utility of a Quality Dashboard Established by a Resident Quality Council
Lance Feld, MD, Stephen Barone, MD, Cohen Children’s Medical Center, New Hyde Park, NY

SCHEDULING
An Innovative Approach to Scaling the Steep Learning Curve of Resident Scheduling
Rachel Neville, DO, Adam Frischknecht, MD, Lauren Naile, MD, Romy Shane, MD, Patricia Macias, Vasu Bhavaraju, MD, Phoenix Children’s Hospital/Maricopa Medical Center Pediatric Residency Program

An Odd Scheduling Approach May Be Even Better for Residents
Ellen Soufleris, MD, LaKeshia Hyndman, MD, Evan Harvey, MD, Bindiya Bagga, MD, University of Tennessee Health Science Center, Memphis, TN

Getting to Yes: X+Y Scheduling with 27 Continuity Clinics!
Tonia Branche, MD, MPH, Kaleena Patel, MD, Rija Siddiqui, MD, Mary Villani, MD, Jeffrey McKinney, MD PhD, UT Southwestern Pediatric Residency Program, Dallas, TX

Promoting Resident Wellness: A Novel Clinic Scheduling Model During Pediatric Intensive Care Unit Rotations
Andrea Aguilera, MD, Jillian Halper, MD, MPH, Laura Petras, MD, Nathan Swinger, MD, James Slaven, MS, Lori Price, MD, Indiana University Riley Hospital for Children, Indianapolis, IN

The migrating continuity clinic: resident community and support in the face of variable clinic times
James Bohnhoff, MD, Samantha Faulds, MS, RHIA, Erin Cummings, MD, Elizabeth Landzberg, MD, Alison Mols, MD, Katherine Watson, DO, UPMC Children’s Hospital of Pittsburgh, Pittsburgh, PA

X+Y scheduling allows for flexible longitudinal educational experiences and an enhanced ambulatory experience
Chelsey Burke MD, Evan Facer DO, Andrew Wang DO, Annie Wolfe MD, Tania Eid MD, Erin Crawford M.D, Rebecca Epstein M.D, Victoria Giordani MD, Guillerm Pi, MD, Lauren Vrablik MD, Joanna Lewis MD, Nalinda Charansangavej MD, Lynn Thoreson DO, Keith Ponitz, MD, Ross Myers, MD, Jessica Goldstein, MD, Heather Howell, MD, Advocate Children’s Hospital--Park Ridge, Park Ridge, IL, University of Texas at Austin Dell Medical School, Austin, TX, Rainbow Babies and Children’s Hospital, Cleveland, OH, Hassenfeld Children’s Hospital at NYU Langone, New York, NY

TECHNOLOGY
App-based Longitudinal Infectious Disease Curriculum
Andrew Nguyen, MD, Keith Mather, MD, University of Oklahoma, Tulsa School of Community Medicine, Tulsa, OK

Do it for the “Gram”: Using Instagram to Educate the Millennial Learner
Joshua Belfer, MD, Lance Feld, MD, Rashi Kabra, MD, Stephen Barone, MD, Cohen Children’s Medical Center, New Hyde Park, NY

Implementation of an App-Based Curriculum to Strengthen Residents’ Knowledge of Evidence-Based Practices: A Feasibility Study
Rebecca Epstein, MD, Ross Myers, MD, Jessica Goldstein, MD, Rainbow Babies and Children’s Hospital, Cleveland OH
Leveraging Publicly-Accessible Technologies to Build Better Residency Leadership Teams
Abimbola Dairo MD, Shamita Punjabi MD, Liat Bird MD, Anne Lyon MD, Ellen Laves MD, Duncan Henry MD, Glenn Rosenbluth MD, Jyothi Marbin MD, Emily Roth MD, Beth Links Torwekar MD, Peter Cooch MD, Gayatri Madduri MD, Margaret Emmott Gilbreth MD, Margaret McNamara MD, University of California at San Francisco, San Francisco, CA

ProNoto: Helping Residents Acquire Knowledge Strategically Through Peer Network-Curated Content
Bryn Carroll, MD, Anna Costello, MD, Brooks Lanham, MD, MBA, Jeanine Ronan, MD, MS, MSEd, Brian Jenessen, MD, MSHP, The Children’s Hospital of Philadelphia, Philadelphia, PA

12:30pm-3:00pm APPD LEAD Council Meeting

1:00pm-5:30pm Pre-Conference Longitudinal Workshop Sessions (choice of 3 - additional fee)

PC1 - Calling All Global: Anything and Everything you need to know about Global Health Education
Jennifer Watts, MD, MPH, Children’s Mercy Kansas City; Heather Crouse, MD, Baylor College of Medicine; Heather Haq MD, MHS, Baylor College of Medicine; Tania Condurache MD, MSc, University of Louisville; Christiana Russ MD, DTMH, Boston Children’s Hospital; Joanne Mendoza MD, University of Virginia; Adelaide Barnes MD, Children’s Hospital Philadelphia; Elizabeth Keating, MD, University of Utah; Amy Rule, MD, Cincinnati Children’s Medical Center; Lee Morris, MD, MSPH, DTMH, Carolinas Medical Center; Kathy Ferrer Children’s National Medical Center.
Inviting all program directors, program coordinators, chief residents, global health educators, and anyone else who wants to join!! The global health preconference session from 1:30-5 will be packed with updates on resources in global health curriculum, highlights of global health publications, and much more! Opportunities to brainstorm and network in small groups with members of the global health learning community steering committee will be provided to help you navigate global health education, whether you are seeking ideas on how to improve your global health program or looking to start a new program in either residency or fellowship. Program coordinators and global health educators will come together in the last half of the session providing an interactive workshop on advancing the field of global health by working together. We look forward to seeing you there!

PC2 – Professional Development 101: Leading Your Teams
Jerri Rose, MD, Rainbow Babies and Children’s Hospital; Linda Waggoner-Fountain, MD, University of Virginia; Alisa Acosta, MD, Baylor College of Medicine; Elizabeth Chawla, MD, Georgetown University; Mary Beth Wroblewski, MD, University of Toledo; Adam Wolfe, MD, Baylor College of Medicine San Antonio; Erika Freihling MD, University of Pittsburgh; Teri Turner, MD, Baylor College of Medicine; Meredith Bone, MD, Northwestern University, Elizabeth Bonachea, MD, Nationwide Children’s Hospital
Developing excellent leadership skills is essential for medical educators to optimize the teams they lead and grow both professionally and personally. This session is for all medical educators including those who recently assumed a new educational role or are simply interested in enhancing their leadership skills. The focus of this interactive, half-day session will be on leading others in your team and organization. Registered participants will have opportunity to complete a leadership inventory prior to the session. Inventory results will be applied in the opening session, which will focus on understanding and effectively applying your own leadership style. During the second section of the workshop, we will concentrate on developing proven strategies for effectively leading groups, including strategically selecting team members, skillfully leading meetings, and preparing for leadership succession. The final portion of this session will delve into skills related to change management applicable for shaping culture and achieving goals for individual, programs and organizations. This pre-conference session is the third of a 3-part annual professional development series. Sessions within this series do not need to be completed in order. Participation in a previous APPD Professional Development 101 workshop is not necessary or required. All are welcome—this is a wonderful opportunity to network and have fun with your APPD colleagues while enhancing your leadership skills!

Session Objectives: Participants will
• Examine their personal leadership styles and understand how to leverage these strengths in communicating with leaders, team members, and trainees
• Collect strategies and tools for building effective teams and skillfully leading groups in meetings
• Prepare to lead new initiatives by utilizing frameworks for organizational change management

Topics:
Leadership styles
• Personal leadership style
• Characteristics of effective leaders
• Leading from the middle
Leading groups
• Leverage strengths in choosing and supporting team members
• Leadership succession planning
• Strategies to lead effective meetings
Creating and leading culture
• Change management
• Psychological safety in teams
PC3 - How to Conduct Your Own Qualitative Medical Education Research ~ from Soup to Nuts!

Presented by the following members of the APPD Research and Scholarship Learning Community: Catherine Michelson, MD, Erika Abramson, MD, Su-Ting Li, MD, Audrea Burns, MD, Ori Kas-Osoka, MD, Hayley Altman Gans, MD, and Bonnie Halpern-Felsher, MD

Medical educators are increasingly looking to qualitative research methods to understand complex educational challenges and address questions not easily studied through traditional quantitative measures. With interest in qualitative research at a tipping point, there is a critical need to build qualitative research skills and elucidate the principles of rigorous study design and analysis. In this highly interactive workshop, participants will participate in brief didactics, expert-facilitated small group work and large group discussion in order to learn about the steps of conducting qualitative research from the beginning to the end. The workshop will cover everything from formulation of a research question to the choice of qualitative framework, data collection strategies, writing interview questions, conducting interviews, and analyzing and presenting qualitative findings. By the end of the workshop, participants will have a foundational knowledge of qualitative research principles that can be applied to their own research.

**Learning Objectives:** At the conclusion of this workshop, participants will be able to:

1. Design a rigorous qualitative study, including selection of a qualitative research question, supportive qualitative framework (ethnography, phenomenology, grounded theory), data collection strategy, and sampling strategy
2. Create a facilitator guide and conduct an interview or focus group
3. Analyze qualitative data using one of the three common analytic approaches (content analysis, thematic analysis, or grounded theory)
4. Present qualitative data for dissemination

**1:00pm-7:00pm**

AIMS (Advancing Inclusiveness in Medical Education Scholars) Program (**AIMS Scholars only**)

**5:30pm - 7:30pm**

APPD Leadership Orientation and Reception (**invitation only**)

**Tuesday, March 31**

**7:00am-8:00am**

Wellness Activity

“Welcome” Session for First-Time Attendees (**including breakfast**)

The Mentoring Subcommittee for the APPD Faculty and Development Learning Community is pleased to sponsor a new session aimed at welcoming first-time attendees to the APPD Spring Meeting. The goal of this session is to help new attendees connect, meet APPD leaders, and learn how to make the most of the meeting. The session will consist of a brief meet and greet activity, a panel discussion in which key APPD leaders will share insights on how to get the most out of the Spring Meeting and become involved in the organization, and an opportunity for attendees to ask questions. Panelists will include Becky Blankenburg, APPD President-elect, Alan Schwartz, head of APPD LEARN, Pat Poitevien, Chair of the Council of Learning Communities, Ross Myers, Amy Gaug and Kathy Mason (heads of the Associate Program Directors’, Coordinators’, and Fellowship Directors’ Executive Committees, respectively) and Laura Degnon, APPD Executive Director. We hope to see you there!

Continental Breakfast

**8:00am-9:00am**

Plenary Session

8:00-8:10 Welcome ~ Javier Gonzalez del Rey, MD, MEd, APPD President
8:10-8:15 Introduction and APPD Updates
8:15-8:20 Presentation of Robert S. Holm, MD Leadership Award ~ Franklin Trimm, MD, APPD Immediate Past President
8:20-8:25 Intro to Presidential Address ~ Rebecca Blankenburg, MD, APPD President-Elect
8:20-8:50 Presidential Address ~ Javier Gonzalez del Rey, MD, MEd
8:50-8:55 Orientation to the day ~ Adam Wolfe, MD, PhD, APPD Program Chair
9:00am-10:00am Platform Presentations from Top Educational Scholarship Abstracts and presentation of Research Awards

9:00-9:05 Presentation of Research Awards ~ Adam Wolfe, MD, PhD, APPD Program Chair

APPD 2020 Research Award: Erika L. Abramson, MD, MS, New York Presbyterian Hospital (Cornell Campus), New York, NY – Platform Presentation #1 (details below)

APPD 2020 Trainee Research Award: Joshua Belfer, MD, Zucker School of Medicine at Hofstra/Northwell at Cohen Children’s Medical Center, New Hyde Park, NY – Platform Presentation #3 (details below)

9:05-10:15 Platform Presentations from Top Educational Scholarship/QI Abstracts

*Winner ~ APPD Research Award*

1. SCHOLARLY ACTIVITY TRAINING DURING FELLOWSHIP: A NATIONAL ASSESSMENT

Erika L. Abramson MD, MS, New York Presbyterian Hospital (Cornell Campus), New York, NY, Pnina Weiss MD, Yale-New Haven Medical Center, New Haven, CT, Elizabeth L. Mauer MS, New York Presbyterian Hospital (Cornell Campus), New York, NY, Monique Naifeh MD, MPH, Oklahoma State University Center for Health Sciences Program, Oklahoma City, OK, Michelle Stevenson MD, MS, University of Louisville, Louisville, KY, Jennifer Rama MD, Baylor College of Medicine (Houston), Houston, TX, Jennifer Duncan MD, Washington University/B-JH/SLCH Consortium, St Louis, MO, Linda L. Gerber PhD, New York Presbyterian Hospital (Cornell Campus), New York, NY, Su-Ting Li MD, MPH, University of California (Davis) Health System, Davis, CA

**Background:** ACGME and ABP requirements for fellows include at least 12 months of scholarly activity (SA) and generation of a work product. Yet there lacks detailed guidance on how programs can best integrate SA training into fellowship. **Objectives:**

Our objectives were: a) understand resources and perceived barriers to fellow SA training; b) identify factors associated with high productivity (>75% of fellows publish a manuscript); and c) identify factors associated with fellowship program director (FPD) satisfaction with overall SA training. **Methods:** Cross-sectional survey approved by SPIN, administered to pediatric FPD nationally in 2019. Data analysis included descriptive statistics, Chi-squared/Fisher exact tests, and multivariable modeling. **Results:** 517 of 810 FPD responded (64%).

35% (181/517) of programs were highly productive. 69% of FPDs were extremely/very satisfied with overall SA training. 28% felt resources were somewhat or not at all adequate. The most frequent major barriers were lack of funding to conduct SA (21%) and lack of sufficient divisional faculty mentorship (16%). 41% believed training should be shortened to two years for fellows pursuing non-academic careers. Programs with high productivity were twice as likely to have a T32, an FPD with >5 publications in the past 3 years, and not experience SOC expertise as a barrier (OR=2.1, 2.0, 1.9, respectively) (Table 1a). Not viewing an adequate research curriculum as a barrier was also significant (OR=1.6). Satisfaction was associated with high productivity, having a division specific research curriculum, FPD having >5 publications in past 3 years, and FPD belief that overall SA resources are adequate, SOC expertise is not a barrier, and training should not be shortened for fellows pursuing non-academic careers (all OR >2, Table 1b). **Conclusions:**

FPD research productivity, provision of an adequate research curriculum, and fostering expert SOC guidance appear critical to promoting fellow productivity and FPD satisfaction. Fellowship duration may need to be reconsidered given FPD beliefs and the dissatisfaction some have with their program SA training.

2. IMPACT OF X+Y SCHEDULING ON FACULTY PERCEPTIONS OF RESIDENT EDUCATION - RESULTS FROM THE PEDIATRIC X+Y SCHEDULING COLLABORATIVE

Ross Myers MD, Case Western Reserve University/University Hospitals Cleveland Medical Center/Rainbow Babies and Children's Hospital, Cleveland, OH, Lynn Thoreson DO, University of Texas at Austin Dell Medical School Pediatric Program, Austin, TX, Heather Howell MD, New York University School of Medicine, New York, NY, Kathryn Weeden MD, Advocate Health Care (Advocate Children’s Hospital/Park Ridge), Park Ridge, IL, Joyce Bevington MD, PhD, University of Toledo, Toledo, OH, Patricia Poitevien MD, Brown University, Providence, RI, Mary Beth Wroblewski MD, University of...
with high levels of competence at the program level.

Composite measures for B/MH assessment and treatment were calculated as mean scores for each domain.

MH skills. Competence was rated on a 5-point scale, and high levels of assessment and treatment competence were defined in the following areas: diagnosing ADHD, anxiety, or depression; assessing suicide; interventions; dosing and monitoring medications; co-management. Two questions explored who should be competent in B/MH assessment and treatment: (a) General pediatrics, hospital medicine, or other subspecialties. Questions were then tailored to the area of clinical focus to determine the impact of continuity clinic schedules on general pediatrics, hospitalist, and subspecialty rotation experiences using a 5-point Likert scale. Data were analyzed using z-tests for proportion differences for those answering Agree or Strongly Agree between baseline and post-implementation respondents.

Results: 384 faculty members were sent the survey with 51% response pre-implementation and 32% response at 12 months. Each general pediatrics faculty outcome was improved in the X+Y model compared to traditional clinic schedules (p<0.05) including ability to have continuity with patients (64% pre to 93% post) and having adequate time for teaching (39% to 93%). Hospitalists noted decreased impacts on inpatient workflow with X+Y (78% to 28%). There was no statistical difference noted in teaching time by hospitalist or other subspecialty faculty.

Conclusions: General pediatric and hospitalist faculty perceive improved patient continuity and enhanced educational opportunities in X+Y scheduling compared to traditional half-day per week continuity clinics. Hospitalist and other subspecialty faculty note no significant impact on educational time after X+Y scheduling implementation.

4. ARE FUTURE PEDIATRICIANS COMPETENT TO CARE FOR CHILDREN WITH BEHAVIORAL/MENTAL HEALTH CONDITIONS?

Cori Green MD, MS, New York Presbyterian Hospital (Cornell Campus), New York, NY, JoAnna Leyenaar MD, PhD, MPH, Dartmouth–Hitchcock/Mary Hitchcock Memorial Hospital, Hanover, NH, Brenda Nuncio MS, Adam Turner MPH, PMP, Laurel Leslie MD, MPH, American Board of Pediatrics, Chapel Hill, NC

Background/Objectives: With 20% of children and adolescents suffering from a behavioral and mental health (B/MH) condition, the urgency to prepare pediatricians to meet this need is paramount. This national study evaluates the perceived competence of pediatric residents and recent graduates in the assessment and treatment of B/MH conditions, characterizes variation across residency programs, and identifies program characteristics associated with high competence.

Methods: Cross-sectional survey of applicants for the initial certifying exam in pediatrics. Questions focused on B/MH training and perceived competence in 7 B/MH assessment skills (e.g. eliciting concerns with history or screening tools/rating scales; diagnosing ADHD, anxiety, or depression; assessing suicide) and 9 treatment skills (e.g. behavioral counseling; psychosocial interventions; dosing and monitoring medications; co-management). Two questions explored who should be competent in B/MH skills. Competence was rated on a 5-point scale, and high levels of assessment and treatment competence were defined as scores of >4. Composite measures for B/MH assessment and treatment were calculated as mean scores for each domain.

We examined variation in self-reported competence across programs and used linear regression to identify factors associated with high levels of competence at the program level. Results: 62.3% (n=2,086) responded. 32.8% (n=595) reported high competence in assessment skills and 18.9% (n=337) in treatment skills. The majority of respondents agree that residents...
entering primary care as well as subspecialties should be competent in B/MH assessment and treatment. There were large variations in reported competence across programs. Respondents from smaller programs (<30 trainees) reported higher competence in assessment and treatment than those from large programs (p<0.001). **Conclusions:** Current and recent pediatric trainees do not report high levels of perceived competence in the assessment and treatment of children with B/MH conditions. The substantial variation across programs indicates the need for national standards for B/MH training.

10:15am-12:15pm **Grassroots Forum for Associate Program Directors**
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 that they are working on currently in their programs. We invite you to bring your ideas and questions to this energetic group session to add to our discussion. Leaders. Ben Miller, MD (University of Pittsburgh School of Medicine), Monique Naifeh, MD, MPH (Oklahoma University School of Medicine), Maren Olson, MD, MPH (University of Minnesota) and James Lee, MD (UCLA).

**Grassroots Forum for Chief Residents**
In this Grassroots Forum, we will feature platform presentations selected from submitted abstracts that highlight the excellent work of Chiefs from around the country (listed below). Additional content will include a focus on maintaining Chief Resident wellness and introducing the Chief Resident Executive Committee.

**Abbreviated Presentations**
The chief residency in graduate medical education: a systematic review
Matthew Molloy, MD, MPH, Lauren McDaniel, MD, Nicole Shilkofski, MD, MEd, Johns Hopkins University School of Medicine, Baltimore, MD

Feasibility and acceptability of an animal assisted therapy dog dedicated to a pediatric residency program
Liat Bird MD, Shamita Punjabi MD, Abimbola Dairo MD, and Anne Lyon MD, Duncan Henry MD, Ellen Laves MD, Glenn Rosenbluth MD, Emily Roth MD, Jyothi Marbin MD, Bianca Arguez MD, Marsha Lee MD, Margaret McNamara MD, University of California at San Francisco, San Francisco, CA

**Full Platform Presentations**
Chief coaching: A unique mentoring program for Chief Residents
Ganga Moorthy, MD and Jordan Pung, MD, Betty Staples, MD, Duke University Pediatric Residency Program; Durham, NC

Grant-ing wishes: A resident-driven, longitudinal, multi-pronged well-being initiative
Aleksandra E. Olszewski, MD, Maneesh Batra, MD, MPH, Maya Jones, MD, MPH, Heather McPhillips, MD, Mollie Grow, MD, MPH, University of Washington Pediatric Residency Program at Seattle Children's Hospital, Seattle, WA
*Note: to be presented by Courtney Gilliam, MD*

Making pick 5 come alive: Bringing a paper-based educational game into the 21st century
Christian B. Lawrence, MD, Eric Zwemer, MD, Mark Chandler, MD, Matt Osment, Micah Anderson, Hannah Coletti, MD, MPH, University of North Carolina Hospitals, Chapel Hill, NC

Is the childless pediatrician less confident? Assessing physician confidence in providing parenting advice
Margarita Corredor, MD, Megan Thorvilson, MD, Elizabeth Ristagno, MD, Siobhan Pittock, MBChB, Anna Kellund, MD, Jason Homme, MD, Ana Creo, MD, Mayo Clinic, Rochester, MN

**Posters on Wellness**
A Novel Approach to a Longitudinal Wellness Program for Pediatric Residents
Avital B. Ludomirsky, MD, MPP, Yuan He, MD, MPH, Emily R. Cross, MD, Daria Murosko, MD, MPH, Destiny G. Tolliver, MD, Catherine D. Michelson, MD, MMSc, Theodore C. Sectish, MD, Boston Combined Residency Program, Boston, MA

Assessing Wellness in Residency: Implementation of “Fuel Gauge” in a Pediatric Program
Tonia Branche, MD, MPH, Kaleena Patel, MD, Rija Siddiqui, MD, Mary Villani, MD, Jeffrey McKinney, MD PhD, UT Southwestern Pediatric Residency Program, Dallas, TX

Check-IN to Opt-Out: An Indiana University Resident Wellness Initiative
Andrea Aguilara, MD, Jillian Halper, MD, MPH, Laura Petras, MD, James Slaven, MS, Zeina Nabhan, MD, Indiana University Riley Hospital for Children, Indianapolis, IN

Development and Implementation of Interdisciplinary Emotional Debriefing Sessions During Protected Educational Time and its Effect on Resident Wellness
Shweta Bansil, MD, Charles Bergman, MD, Jennifer DiPace, MD, New York Presbyterian/Weill Cornell Medical Center Pediatric Residency Program, New York, NY
Grassroots Forum for Coordinators

This session will be an interactive session, allowing coordinators to share common challenges, innovative solutions to problems, and best practices. At the conclusion of this session, both seasoned and new fellowship and residency coordinators will gain insightful information from their peers. There will be updates given by the coordinator workgroups as well as those involved in various learning communities. This session is facilitated by the Coordinators’ Executive Committee.

Grassroots Forum for Fellowship Program Directors

This moderated open forum is designed specifically for subspecialty fellowship program directors, associate program directors, and coordinators to discuss a variety of current trends and important updates in fellowship education. We will hear fellowship specific updates from ACGME, ABP, CoPs and SPIN. The interactive session will allow for community building and will augment knowledge and skills related to fellowship focused topics in medical education. The session is facilitated by the Fellowship Directors’ Executive Committee.

Grassroots Forum for Program Directors

The Grassroots Forum for Program Directors will focus on timely topics of interest to Program Directors. This year’s facilitators will be Suzanne Wright, MD (Marshfield Clinic), Robert Brooker, MD, (St. Louis University School of Medicine) and Keith Ponitz, MD (Rainbow Babies and Children’s Hospital).

12:30pm-1:45pm Facilitated Networking Lunch (lunch provided to those attending these sessions)

All About You: Facilitated Mentoring

Please enjoy the company of wonderful APPD members at the Facilitated Mentoring Session. Join colleagues to share experiences and discuss topics specific to your own professional development as educators and program leaders. Open to all APPD attendees. Discussion topics include:

- Professional Development Planning (education scholarship, academic advancement, optimizing mentoring/sponsoring experiences, developing faculty and institutional leaders)
- Leadership Development (balancing decisiveness and inclusivity, managing difficult leaders, programs/ resources for leadership development)
- Personal Wellbeing (work/life balance & time management skills, supporting others while also taking care of self and family, politely setting boundaries, managing workload)
Diversity in the pediatric workforce is crucial to the provision of high quality, innovative, and culturally competent care to all children. Unfortunately, large scale efforts to address this issue have thus far resulted in little progress. One barrier to workforce diversity is the impact of implicit bias across the recruitment continuum. Implicit bias, or the influence of unconsciously held stereotypes, has been shown to influence attitudes and decision-making in many aspects of academic medicine from patient care, to teaching, to medical school admissions. Recruitment criteria, even those that appear to be objective at face value (grades, scores, honors), are subject to the implicit biases that informed the attainment of those metrics. Personal interactions with applicants are a crucial part of the holistic review of residency, fellow and faculty candidates. However, each person involved in recruitment brings with them a lens through which they see race, gender, sexual orientation, religion, ethnicity, ability and physical attributes. These lenses can have far-reaching influences on actions and reactions during the recruitment process. These lenses can also change and shift as people are able to recognize the influence of unconsciously held stereotypes on individual and group behaviors. This acknowledgement of implicit bias is a crucial first step toward adopting strategies to mitigate the impact of these biases across the recruitment continuum. In this workshop we will review the definition of implicit bias and provide examples of how it can influence attitudes and decisions with an emphasis on recruitment processes. Participants will have the opportunity to reflect on their own experiences with implicit bias and how it has influenced their attitudes and decision-making in their various roles. Following this, we will present and model several strategies that can mitigate the impact of these biases across the recruitment continuum. Participants will then practice these strategies in small groups and plan how they might implement some of the strategies at their home institutions.

**Panel of Experts: Discussing Implicit Bias**

We encourage conference participants to network amongst themselves as they enjoy lunch provided by the conference. There is no official content.

### Agenda

- **2:00pm-3:30pm Enhanced Learning Session I (choice of 11)**

1. **CHANGING OUR LENS: MITIGATING THE IMPACT OF IMPLICIT BIAS ACROSS THE RECRUITMENT CONTINUUM**
   - Elizabeth R. Hanson, MD, University of Texas Health Science Center School of Medicine at San Antonio, San Antonio, TX
   - Nalinda Charansangavej, MD, University of Texas at Austin Dell Medical School Pediatric Program, Austin, TX
   - Joni Hemond, MD, University of Utah, Salt Lake City, UT
   - Rupa Kapoor, MD, Eastern Virginia Medical School, Norfolk, VA
   - Ingrid Walker-Descartes, MD, MPH, MBA, Maimonides Medical Center/ Maimonides Children’s Hospital of Brooklyn, New York, NY
   - Beth Wueste, MAEd, C-TAGME, LSSBB, University of Texas Health Science Center School of Medicine at San Antonio, San Antonio, TX

   Diversity in the pediatric workforce is crucial to the provision of high quality, innovative, and culturally competent care to all children. Unfortunately, large scale efforts to address this issue have thus far resulted in little progress. One barrier to workforce diversity is the impact of implicit bias across the recruitment continuum. Implicit bias, or the influence of unconsciously held stereotypes, has been shown to influence attitudes and decision-making in many aspects of academic medicine from patient care, to teaching, to medical school admissions. Recruitment criteria, even those that appear to be objective at face value (grades, scores, honors), are subject to the implicit biases that informed the attainment of those metrics. Personal interactions with applicants are a crucial part of the holistic review of residency, fellow and faculty candidates. However, each person involved in recruitment brings with them a lens through which they see race, gender, sexual orientation, religion, ethnicity, ability and physical attributes. These lenses can have far-reaching influences on actions and reactions during the recruitment process. These lenses can also change and shift as people are able to recognize the influence of unconsciously held stereotypes on individual and group behaviors. This acknowledgement of implicit bias is a crucial first step toward adopting strategies to mitigate the impact of these biases across the recruitment continuum. In this workshop we will review the definition of implicit bias and provide examples of how it can influence attitudes and decisions with an emphasis on recruitment processes. Participants will have the opportunity to reflect on their own experiences with implicit bias and how it has influenced their attitudes and decision-making in their various roles. Following this, we will present and model several strategies that can mitigate the impact of implicit bias across the recruitment continuum. Participants will then practice these strategies in small groups and plan how they might implement some of the strategies at their home institutions.

2. **TRAINING INTERNATIONAL MEDICAL GRADUATES: CHALLENGES, OPPORTUNITIES & TRIUMPHS**
   - Sybil B. Pentsil, MD, MPH, Sinai Hospital of Baltimore, Baltimore, MD
   - Rana Chakraborty, MD, DPhil, Mayo Clinic College of Medicine and Science (Rochester), Rochester, MN
   - Andrew Hernandez-Troya, MD, Beaumont Health (Royal Oak)
   - Javier Gonzalez-del-Rey, MD, Cincinnati Children’s Hospital Medical Center, Cincinnati, OH
   - Ashley Doucette, MD, Sinai Hospital of Baltimore, Baltimore, MD

   25% of all practicing pediatricians and over 27% of pediatric subspecialists in the United States are International Medical Graduates (IMGs). IMGs contribute significantly to workforce diversity and carefully selected IMGs have an overall
performance that mirrors that of US graduates. However, IMGs face unique challenges that can hinder their success in residency training and practice. These challenges can seem daunting to program leaders and can lead to barriers in IMG recruitment, inclusion and retention. In this interactive learning session program directors, associate program directors, chief residents and program coordinators/administrators will learn simple tools and strategies for effective recruitment and training of this important sector of the pediatric workforce. Participants will learn about changes in the IMG & non-US born applicant pool and how it will impact residency training and the pediatric workforce. Session leaders will facilitate table discussions about successful IMG recruitment, overcoming intern year challenges, and senior year opportunities. Participants will share strategies for promoting success and job satisfaction from training into practice. The group will discuss how to adapt IMG strategies for use in other aspects of residency training such as mentorship for underrepresented minorities. The session will end with a review of an upcoming AAP/APPD pilot program for mentoring IMGs.

3. INNOVATIONS AND STRATEGIES FOR SUCCESSFUL RESEARCH MENTORING OF PEDIATRIC TRAINEES
Rasika Behl, MPH, Clea Sarnquist, MPH, DrPH, Carrie E. Rassbach, MD, MA, Bonnie Halpern-Felsher, PhD, Stanford University, Palo Alto, CA, Nndi I. Unaka, MD, MEd, Cincinnati Children’s Hospital Medical Center, Cincinnati, OH
All educators interested in strengthening mentorship skills and incorporating new methods/models of research mentorship for all residents/fellows (not just physician-scientists), either as part of a structured curriculum or in their pediatric residency or fellowship program broadly. Workshop Description: Numerous studies have found mentorship to be important for overall career development and an essential factor for choosing a career in academic medicine (Straus 2009). ACGME requires pediatric trainees to participate in scholarly activities and programs, making residency and fellowship a critical time for trainees to benefit from research mentorship. This workshop will enable participants to reflect on their own individual mentoring styles, discuss challenges that hinder effective mentorship both from the standpoint of the mentor and mentee, and learn tactics to strengthen mentorship and communication skills when mentoring residents and fellows through research projects utilizing various mentorship models. Facilitators will provide a brief review of ACGME requirements, followed by a presentation and discussion of research mentorship for mentors and their medical trainees. Participants will then have the opportunity to reflect on their own individual mentorship style, followed by a guided discussion on how best to capitalize on individual mentorship styles and effective communication. Facilitators will then highlight existing research and scholarship programs at their respective institutions, and lastly, in a highly interactive session, participants will rotate through tables discussing challenging topics in mentorship, including authorship, senior/junior mentor models, peer group mentoring models, and creating a culture of mentorship. Participants will leave the workshop with improved clarity on their own mentoring style, and how to communicate that style, as well as an understanding of different mentorship models and concrete skills to approach a variety of mentoring challenges.

4. PUT ON YOUR OWN OXYGEN MASK FIRST: PROMOTING PROGRAM DIRECTOR RESILIENCE
Elizabeth Nelsen, MD, SUNY Upstate Medical University, Syracuse, NY, Deborah Alliston, MD, University of Kansas (Wichita), Wichita, KS, Claudia Halaby, MD, NYU Winthrop Hospital, Mineola, NY, Ketan Kansagra, MD, Newark Beth Israel Medical Center, Newark, NJ, Karen Mangold, MD, MEd, McGaw Medical Center of Northwestern University, Nicola Orlor, MD, University of Chicago, Chicago, IL, Lina Patel, MD, Children’s Mercy Hospital, Kansas City, MO, Rebecca Chasnovitz, MD, Kaiser Permanente Medical Group (Northern California), Oakland, CA, Lisa Sieczkowski, MD, University of Nebraska Medical Center College of Medicine, Omaha, NE, Sarada Panchanathan, MD, MS, Phoenix Children’s Hospital, Phoenix, AZ
The final instructions from the flight attendant during the pre-flight safety briefing are how to put on your oxygen mask in the event the cabin loses pressure, and that you should put on your own mask first before helping others. Why is it so hard for program directors to follow these instructions? Program directors are in a unique position in academic medicine; they maintain a clinical practice and manage obligations of a program and of its residents or fellows all while having to answer to department chairs and hospital leadership. There are particular aspects of this position that lend itself to burnout and can chip away at resilience. This session aims to help program directors, associate program directors, and chief residents develop their own flight plans for burnout prevention. This session will allow for brainstorming about factors that contribute specifically to program director burnout and will lead attendees through the development of a toolkit to promote resilience among this exceptional group of physicians.

5. INTRODUCING I-PACK: IMMIGRANT PARTNERSHIPS AND ADVOCACY CURRICULAR KIT
Carmen E. Cobb, MD, University of California (San Francisco), San Francisco, CA, Kathleen Miller, MD, University of Minnesota, Minneapolis, MN, Anisha Rimal, MD, University of Wisconsin, Madison, WI, Adria Jimenez Bacardi, MD, University of California (San Francisco), San Francisco, CA, Laura Houser, MD, University of Wisconsin, Madison, WI, Amy Rule, MD, Cincinnati Children’s Hospital Medical Center, Cincinnati, OH, Kristen Van Gendemen, MD, Ann & Robert H. Lurie Children’s Hospital of Chicago, Chicago, IL, Michael Pitt, University of Minnesota, Minneapolis, MN, Sabrina Butteris, MD, University of Wisconsin, Madison, WI
One in four children in the United States is an immigrant or the child of immigrant parents, with the population of first- or second- generation immigrant children increasing by 51% from 1994 to 2017 (1). It has been well-documented that this population faces barriers to accessing health care and has unique health care needs (2,3). As a result of this growing demographic, there is increasing interest in immigrant health among pediatric educators and trainees; however, many trainees continue to feel ill-equipped in caring for this population (4,5). This topic is especially timely and necessary due to the large influx of unaccompanied minors and simultaneous increase in families who have experienced separation at the border, which has highlighted the importance of this topic in residency programs, medical schools, and the media (6). The Midwest
Consortium of Global Child Health Educators is pleased to introduce a modular and modifiable curriculum in immigrant health, Immigrant Partnerships and Advocacy Curricular Kit (I-PACK). I-PACK has been created by the same consortium which has spent the last decade creating free resources for global child health educators, including the development of the SUGARPREP curriculum, currently used by over 150 institutions across the country, and includes educational resources in global health simulation, pre-departure, and procedural training in low-resource settings. I-PACK utilizes a similar model to empower educators to prepare trainees to care and advocate for immigrant families. This workshop will provide attendees with skills that can be used to create curricula in five domains: 1) Practical Clinical Concerns; 2) Medicolegal Considerations; 3) Community-Focused Initiatives; 4) Partnership Building; 5) Advocacy in Action. Each subdomain will consist of a brief introduction to the topic, sample examples of hands-on educational initiatives, and an evaluation plan. Participants will see each of these modules in action as part of the workshop and prepare to implement any or all at their home institution.

6. MAKING THE MOST OF YOUR WORK: TRANSFORMING MEDICAL EDUCATION PROGRAM EVALUATION INTO QUALITY IMPROVEMENT AND SCHOLARSHIP
Jennifer DiPace, MD, Erika Abramson, MD, MS, New York Presbyterian Hospital (Cornell Campus), New York, NY, Mackenzie S. Frost, MD, University of Texas Southwestern Medical School, Dallas, TX, Erin Powell, MD, University of Kentucky College of Medicine, Lexington, KY
Administration of an educational program requires routine engagement in program evaluation. Through this process, both program strengths and areas for improvement are identified by stakeholders such as learners and teaching faculty. Improving an educational program can sometimes feel like a daunting task, especially when it is unclear of what is driving the problem and what changes are necessary to implement to achieve improved learner satisfaction. In this learning session, the participants will gain the insight and skills to transform their program into highly-rated activities by the learners using proven QI methodology. First, the facilitators will share samples of program evaluations from GME programs. The participants will also be asked to bring their own evaluations of activities or programs that they lead. Facilitators will engage the participants to identify suitable QI projects from shared program evaluations. Next, through interactive didactics, the participants will hone their skills in high-yield quality improvement methods that can be used to make sustainable changes in a program. These skills include: how to construct a key driver diagram, write an aim statement, use PDSA cycle methodology and basic QI statistics. Next, working in facilitated small groups, participants will work with evaluations from their own program or from a sample to develop one of the areas for improvement into a feasible quality improvement project. The end-product of the small-group work will be an action plan for a educational QI project to take back to the home program. Program leaders from a variety of programs will share examples of actual educational quality improvement projects that have been successful. To conclude, the group will share how to get credit for the work, both through ABP Part IV Maintenance of Certification and through dissemination of the work in the medical education community.

7. USE OF COACHING TO HELP LEARNERS ENHANCE CLINICAL TEAM PERFORMANCE
Kim Hoang, MD, Jennifer O’Malley, MD, PhD, Stanford University, Stanford, CA, Sahar Rooholamini, MD, MPH, Mollie Grow, MD, MPH, Heather McPhillips, MD, MPH, University of Washington, Seattle, WA, Monique Naifeh, MD, MPH, University of Oklahoma Health Sciences Center, Oklahoma City, OK, Jessica Gold, MD, MS, Lynne Huffman, MD, Sara Kreimer, MD, Carrie Loutit, MD, Caroline Okorie, MD, MPH, Caroline Rassbach, MD, MAEd, Rebecca Blankenburg, MD, MPH, Stanford University, Stanford, CA
Modern medical care increasingly is dependent on high-functioning, interdisciplinary teams. The most effective teams are those with members who have diverse behavior styles and who leverage each other’s strengths. During training, residents and fellows are regular participants in the reconfiguration of clinical groups; it can be challenging for trainees and supervisors in a new group to quickly assimilate into an effective team and understand the different strengths and weaknesses of each member. As medical educators, we have opportunities to coach our trainees on how to successfully address team dynamics so that there are improvements in team communication, team performance, and, ultimately, patient care. This highly interactive workshop will guide participants in developing new coaching strategies to help learners understand their individual behavior style and the complexity of team management based on lessons learned from 3 pediatric residency coaching programs. The session leaders first will highlight team dynamic conflicts that result from behavior style differences and will describe how coaching can be used as a tool to help learners navigate these difficult situations. Participants will complete a brief self-assessment using the established behavior style tool called “DiSC” (Dominance, Influence, Steadiness, Conscientiousness) and will discuss common behaviors associated with each type. In facilitated small and large group discussions, participants will work through common trigger scenarios that represent the four behavior style types in different clinical and professional settings. Participants will practice specific coaching techniques that can help learners increase their awareness of the interplay among team members with different personalities. This workshop will empower participants with new behavior-focused coaching strategies that can be used to help learners improve teamwork as well as a toolkit that can be brought back to their home institutions for learner and faculty development.

8. A WELLNESS BLACK HOLE: RESIDENT/PROGRAM/INSTITUTIONAL APPROACHES TO PARENTING AND CHILDCARE
Susan Guralnick, MD, Maggie Spruce, MD, Alicia Gingrich, MD, Margaret Rea, PhD, University of California (Davis) Health System, Sacramento, CA, Robyn Blair, MD, Stony Brook Medicine/University Hospital, Stony Brook, NY
Well-Being has risen to the forefront in the GME world, finally achieving recognition as a central issue of training. However, a critical aspect of well-being is often left unconsidered. The majority of GME trainees are in that time of life where decisions and actions regarding parenthood, parenting, and childcare must be made. The considerations are enormous, including...
a variety of personal and professional factors, the impact on a resident's training and training program, the impact on the resident's/fellow's personal and family life, and resulting stress. Some programs and institutions have made significant efforts to address these issues, such as providing access to a variety of resources and support. Many more have not. The workshop leaders (2 residents, a PD, a DIO, and a Director of GME Wellness) will present data from their multi-institutional resident and fellow survey regarding parenthood, parenting and childcare, and share activities, resources, and support they have made available at their institutions. Participants will work in small groups to assess and discuss how their programs and institutions have addressed (or plan to) these key domains. Session leaders and participants will share thoughts in the large group regarding barriers, solutions, and resources. Participants will leave with new ideas, resources, and tools they can apply and adapt at their home institutions.

9. INTEGRATING OSTEOPATHIC PRINCIPLES INTO ALLOPATHIC RESIDENCY PROGRAMS: A HANDS-ON APPROACH

John G. Frohna, MD, MPH, University of Wisconsin, Madison, WI; Kris Rooney, MD, Lehigh Valley Health Network/University of South Florida College of Medicine, Allentown, PA; Alex Rakowsky, MD, Nationwide Children’s Hospital/Ohio State University, Columbus, OH, Kimberly Wolf, DO, Vallejo, CA, Helen Waterman, DO, Kristen Marten, DO, University of Wisconsin, Madison, WI

The percentage of applicants matching to a pediatric residency program having a DO degree is currently above 10%, and with the opening of multiple new osteopathic medical schools focused on developing primary care physicians, this percentage is expected to rise significantly. A recent study of DO students showed that the majority would preferentially more highly rank programs that allow them to maintain their Osteopathic Manipulative Medicine (OMM) skills if such programs existed. Also, under the single accreditation pathway for residency programs, the ACGME has emphasized that programs should consider providing some osteopathic training to any interested resident, both DOs and MDs.

So how can programs recruit the top applicants, add value to the training of osteopathic residents, and benefit all residents in our programs? This interactive, hands-on learning session will help you answer this question! We will cover the biggest barriers to providing osteopathic training opportunities in pediatric programs, and we will (1) provide an overview of osteopathic medicine and its unique qualities, (2) discuss outcomes of DO-trained residents, focusing on their performance and career goals, (3) discuss common logistic barriers to providing osteopathic training to residents, such as oversight, billing, time, and credentialing, (4) engage in an active discussion about the range of possible training options and (5) highlight how basic osteopathic training can be provided to MD residents, including positive outcomes from one Osteopathic Recognition Track.

Participants will engage in small and large groups to develop curricular innovations to meet the needs of a variety of programs. We will highlight benefits and discuss strategies to overcoming barriers to the implementation of these strategies. Participants will leave with focused ideas and tools to enhance the education of all residents, both osteopathic and allopathic, in their programs.

10. WHEN THE GOING GETS TOUGH: EDUCATIONAL LEADERSHIP IN A CRISIS

Marsha S. Anderson, MD, University of Colorado School of Medicine, Aurora, CO; Bonnie Desselle, MD, Louisiana State University Health Sciences Center, New Orleans, LA; Catherine Michelson, MD, MMSc, Boston Medical Center, Boston, MA; Nancy D. Spector, MD, Drexel University College of Medicine, Philadelphia, PA; Richard P. Shugerman, MD, University of Washington School of Medicine, Seattle, WA; Robert J. Vinci, MD, Boston Medical Center, Boston, MA

Occasionally and unpredictably, a crisis occurs that profoundly affects a training program. The skills and leadership style a program leader employs determines how well the crisis is managed. While most educational leaders have little formal training in crisis management, skills in crisis management can be learned. Additionally, much can be learned from other leaders who successfully navigated crises within their institutions. These exposures are key to preparing leaders to manage potential future crises. The goal of this session is to provide participants with foundational content and successful crisis management strategies. This innovative session starts with a didactic on crisis management and leadership skills, followed by a moderated panel discussion. The 4 panelists are educational leaders who successfully managed a significant crisis (hospital closing, terrorist attack, hurricane). Each panelist will summarize crisis details and respond to moderator questions. Questions/comments from the audience will open a dialogue between the audience and panel. Moderators will focus the discussion to highlight key crisis management strategies. The audience will be encouraged to begin dialogues around crisis planning and to develop program disaster plans integrated with their institution's plan.

C-11. FINDING YOUR LEADERSHIP STYLE: STRENGTHS, WEAKNESSES, AND A ROADMAP TO IMPROVEMENT

Charlene Larson Rotandi, AB, C-TAGME, Stanford University, Stanford, CA; Leeanna Fox Irwin, MAEd, C-TAGME, University of Tennessee Health Science Center, New Orleans, LA; Pamela Carpenter, MEd, C-TAGME, University of Utah, Salt Lake City, UT; AJ Fletcher, BA, Meghan Stawitche, BA, C-TAGME, Gretchen Shawver, BS, Megan Christofferson, BA, C-TAGME, Stanford University, Stanford, CA

Program coordinators play a critical role in their training programs, needing to effectively manage them in order to meet program requirements and the everyday needs of the faculty and trainees with whom they work. A program's success and accreditation hinge on the coordinator's ability to exemplify effective leadership skills in order to lead changes and initiatives. The responsibilities for managing a training program are wide and varied, and often program coordinators find themselves having to lead without authority in order to accomplish all that is needed. Knowing your leadership style can provide insight into working with others and help you to accomplish your goal of driving change in your program. Using The Five Practices of Exemplary Leadership as a guide, attendees will: 1) identify their strengths and weaknesses as leaders; 2) choose actions to improve their leadership skills; and 3) become more aware of their role as a leader in their program(s). In this workshop, a
The Assessment Learning Community is a group of program directors, associate program directors, coordinators, chief residents and other educational leaders seeking to improve assessment practices for trainees, faculty and programs. Areas of focus include improving or standardizing current assessment methods and developing novel assessment methods that meet the goals of outcomes-based evaluation. We welcome newcomers and returning members. Our Learning Community session at APPD Spring 2020 will be divided into two parts. For the first half of the session, we will explore the “hot topics” in assessment from the past year through an interactive review of the med ed literature. For the second half of the session, we will break into our four working groups to outline the status of our current projects and plan future directions. The four working groups include: Assessment of Learners focusing on Learner Communication, Multi-source Assessment, Assessment of Faculty, and Program Evaluation. These groups have been working throughout the year to meet our Learning Community’s three main goals for 2019-20: 1) To engage and develop members through project-based working groups. 2) To promote research and scholarship through the study of processes and procedures in the project-based working groups. 3) To foster leadership and collaboration through partnerships with other Learning Communities.

**COMMUNITY HEALTH AND ADVOCACY TRAINING**

The Community Health & Advocacy Learning Community is open to program directors, associate program directors, chief residents, coordinators and other educational leaders seeking to share ideas and resources with the goal of strengthening community health and advocacy education in their programs. Through this LC, we aim to foster collaboration among leaders in community health and advocacy education within pediatric residency and fellowship programs. The session will include presentations by leaders in community pediatrics education from around the country who will discuss curricular strategies and innovations that they have implemented in their own programs. LC leaders will solicit input from participants to better understand how the LC can support their needs and goals for their programs. Participants will leave with new resources and ideas to enhance their community pediatrics curricula, and they will make connections with other leaders around the country to facilitate collaboration in the educational work that we do. We hope you can join us to help us plan for the upcoming year!

**CURRICULUM**

The Curriculum Learning Community is a group of program directors, associate program directors, residents and other educational leaders that seek to improve the development, sharing and collaboration of curriculum development across programs. We encourage all those with an interest in curricula (i.e., development, research, revision, innovation, collaboration), regardless of level of experience, to join us. During our session at the APPD annual meeting, we will briefly review our past accomplishments and then set to work on our future directions. We will be hosting small break out sessions and table talks to provide advisement and collaboration on our current projects. We encourage members to submit curricula in progress or projects that have opportunities for collaboration.

**EDUCATIONAL TECHNOLOGY**

The APPD Educational Technology Learning Community will host an interactive session, describing best practices and showcasing the latest technology used by program leadership. We hope to provide an opportunity for APPD members to share best practices and to create new applications for technology to enhance trainee learning, while responding to the needs, challenges and opportunities of the digital age.

**FACULTY AND PROFESSIONAL DEVELOPMENT**

The Faculty and Professional Development Learning Community provides opportunities for collaboration among APPD members interested in faculty development. To meet these goals, our learning community has four subsections, each with a focal project.
5:30pm-6:30pm Networking Reception
Wednesday, April 1

7:00am - 8:00am  Wellness Activity (more info coming soon)

OLT Program Portal Demo by the American Board of Pediatrics

Continental Breakfast

8:00am-9:00am  Plenary Session

8:00-8:05  Welcome ~ Rebecca Blankenburg, MD, APPD President-Elect

8:05-8:10  Presentation of Carol Berkowitz Award for Advocacy and Leadership in Pediatric Medical Education ~ Franklin Trimm, MD, APPD Immediate Past President

8:10-8:20  APPD LEAD Graduation ~ Rebecca Swan, MD, APPD LEAD Council Chair

8:20-8:50  Update from the Accreditation Council of Graduate Medical Education (ACGME) with Q&A ~ Susie Buchter, MD, Chair, Review Committee for Pediatrics and Caroline Fischer, MBA, Executive Director, Review Committee for Pediatrics

8:50-8:55  Orientation to the day ~ Adam Wolfe, MD, PhD, APPD Program Chair

9:00am-9:30am  Platform Presentations from Top QI Abstracts and Presentation of QI Award

9:00-9:05  Presentation of QI Project Award ~ Adam Wolfe, MD, PhD, APPD Program Chair

APPD 2020 QI Project Award: Alexandra Kilinsky, DO, Zucker School of Medicine at Hofstra/Northwell at Cohen Children's Medical Center, New Hyde Park, NY – Poster # 15 (details on page 56)

9:05-10:15  Platform Presentations from Top Educational Scholarship/QI Abstracts

1. IF YOU SEE SOMETHING, SAY SOMETHING: ENGAGING HOUSESTAFF IN PATIENT SAFETY AND EVENT REPORTING


**Background:** Residents and fellows play a key role in patient care at academic medical centers and have unique insights into quality and safety improvement opportunities. To increase integration of trainees into the quality and safety mission of our hospital, the Housestaff Quality and Safety Council (HQSC) was created in 2018. The HQSC represents a collaboration between the housestaff, Graduate Medical Education, office of Quality and Safety, interprofessional hospital staff, and senior leadership. At our institution, < 1% of safety events were reported by graduate medical trainees. Thus, the council chose to focus on improving safety event reporting as its first trainee-led longitudinal QI project. **Aim Statement:** Our objective was to increase the monthly incidence of event reporting by graduate medical trainees by 20% from baseline within 12 months.

**Interventions:** We used improvement methodology to identify critical drivers of barriers to submitting event reports, which included 1) education and awareness of the hospital’s reporting system, 2) time and effort associated with submitting reports, 3) culture of safety, and 4) lack of feedback and transparency surrounding reports. We used an iterative approach with multiple PDSA cycles to increase knowledge and engagement of event reporting. Tests of change included tip sheets, development of a trainee-run Morbidity, Mortality, and Improvement (MM&M) conference, acknowledgement by senior leadership for submitting reports, and educational interventions.

**Measures:** The baseline mean number of safety reports by trainees in the 12 months prior to our project was 24.6 per month. **Results:** The number of safety event reports placed by trainees increased in the initial 5 months of the project, reaching special cause variation in month 2 and 4. Educational interventions and tip sheets were implemented in PDSA #1, the MM&M conference was implemented in PDSA #2, and acknowledgement by senior leadership was implemented in PDSA #3.
Conclusions and Next Steps: Engaging trainees in patient safety concepts through education, interactive conferences, and appreciation can increase safety event reporting by trainees. Future planned PDSA cycles include implementing changes to increase timely feedback, developing patient safety faculty and resident experts, and increasing audit and feedback of reporting data to trainees.

2. MEET THE TEAM: PAIRING VERBAL INTRODUCTIONS AND VISUAL HANDOUTS TO IMPROVE FAMILY KNOWLEDGE OF THEIR CARE TEAM

Amanda Rogers MD, Kelly Lynch, Michael Weisgerber MD, MS, Medical College of Wisconsin Affiliated Hospitals, Milwaukee, WI

Background: Hospitalized families often have poor knowledge of care team members which can negatively impact communication. Our institution lacked a standard process to introduce the multilevel learner team to families. Baseline data showed few families had knowledge of team members. We sought to create a standardized approach to introductions during patient and family centered rounds (PFCR) to improve family knowledge of their team. Aim Statement: Increase the percent of families interviewed through our rounds coach program with knowledge of their team members to 75% over one year.

Interventions: We conducted a quality improvement (QI) project with multiple plan-do-study-act cycles. We created a “Meet the Team” form (MTTF) outlining team member names, photos, and role explanations for the team (nurses, students, residents, fellows, faculty), b) process mapped and refined the steps of MTTF distribution, c) assessed family preferences for frequency and type of introductions via structured interviews by a trained rounds coach d) implemented a series of interventions to sustain the process including fostering introduction use culture change and data tracking/sharing. Measures: The outcome measure was the percent of families interviewed by a rounds coach successfully identifying a team member. The process measure was the percent of PFCR that included introductions. The balancing measure was rounds length. We used statistical process control charts to track the impact of interventions. Results: Focused interviews of 141 parents revealed 73% preferred verbal introductions on the first day of PRCR and if new members joined the team; 100% preferred paper over electronic MTTF. For the outcome measure, there was an increase in the percent of families who could identify team members from 10% to 78%. The process measure of the rate of PFCR that included introductions showed special cause variation, increasing from 40% to 80% of PFCR events (Figure 1). The balancing measure of rounds length held steady at ~11 minutes/patient. Conclusions and Next Steps: We performed a successful QI project that substantially increased the frequency of team introductions and increased family knowledge of team members with no change in rounds length. Next steps include evaluating the impact of increased team member knowledge on areas of family experience and understanding of care plans.
11:30am-12:45pm  APPD LEARN “10 Year Anniversary Event”
Council of Learning Community Chairs Lunch Meeting (invitation only)

1:30pm-3:00pm  Enhanced Learning Session II (choice of 11)

12. LOCKED AND (UN)LOADED DISCUSSIONS: KEEPING KIDS SAFE FROM FIREARM INJURIES
Ruchi Kaushik, MD, MPH, Cody Clary, MD, Lindsey Lambarth, MD, Adam D. Wolfe, MD, PhD, Baylor College of Medicine (San Antonio), San Antonio, TX
Firearm-related fatalities are a public health crisis. The American Academy of Pediatrics (AAP) asserts that the safest home is a home without a firearm but recommends a gun be stored locked, unloaded, in a safe with the ammunition locked in a separate location if a family does own one. Despite these storage recommendations, physicians are not comfortable asking patients about the presence of firearms in homes. To address training gaps in knowledge and skills in this area, we have developed an interactive, evidence-based workshop to prepare pediatric residents to teach and counsel families regarding firearm safety in the home. Our goal is to equip future pediatricians with skills to engage in child safety advocacy in the setting of a medical home and to provide culturally-sensitive preventive care, thereby affecting population health. Participants will leave this session having practiced firearm safety counseling skills using facilitated role play. All necessary materials will be provided to allow participants to adapt and embed this curriculum within resident advocacy education and to intentionally and strategically approach resident community health and advocacy milestones. Innovation: This workshop assembles a didactic session, law enforcement presentation of practical firearm and storage device information, and an opportunity to apply newly acquired skills through facilitated role play, utilizing a scholarly approach to advocacy curriculum development. The interactive session not only addresses a current and relevant topic in child safety advocacy, but also incorporates community health and advocacy milestones into resident education.

13. A LITTLE LESS CONVERSATION, A LOT MORE ASSESSMENT: APPLYING COMMUNICATION ASSESSMENT TOOLS WITH VALIDITY EVIDENCE FOR USE IN YOUR TRAINING PROGRAM
Suzanne Reed, MD, Nationwide Children’s Hospital/Ohio State University, Columbus, OH, Ariel Frey-Vogel, MD, Massachusetts General Hospital, Boston, MA, Mackenzie Frost, MD, MEd, University of Texas Southwestern Medical School, Dallas, TX
Communication skills assessment in residency is challenging. There has been increasing emphasis on teaching communication skills, but how do we know our residents actually ARE competent communicators? As part of the APPD’s Assessment Learning Community, we recently completed a national survey as a needs assessment regarding communication skills curricula and assessment in pediatric residency programs, and YOU—pediatric educators of the APPD—identified a practical, easy-to-use assessment tool as your greatest need in the assessment of communication skills within your programs. We heard you! We scour the literature, and we found that while most communication assessment tools have limited validity data and/or have limited versatility, two well-known tools, The Kalamazoo Essential Elements Checklist and the Communication Assessment Tool (CAT), hold a lot of potential to meet the needs of pediatric residency program leadership. In this enhanced learning session, facilitators will put a fresh spin on these two widely studied communication assessment tools. Participants will be updated on the most current literature related to these tools, including a discussion of the validity evidence supporting each tool. Participants will then practice using these tools for different communication scenarios, first with individual work, followed by work in small groups to discuss and troubleshoot practical uses of these tools in a busy residency program and potential barriers to implementation. Through small group work and large group discussion, participants will learn how to utilize these tools both for direct feedback to residents and for use in Clinical Competency Committees. Participants will then generate an individualized plan for implementing communication skills assessment using these tools within their programs so they can leave with a path forward to tackle communication assessment at their institutions.

14. TO DIVERSITY AND BEYOND: ENHANCING ACCESS AND INCLUSION OF TRAINEES WITH DISABILITIES IN YOUR PROGRAM
Nalinda Charnsangavej, MD, Mary Matus, University of Texas at Austin Dell Medical School Pediatric Program, Austin, TX, Emma Omoruyi, MD, MPH, University of Texas Health Science Center at Houston, Houston, TX, Daniel Richards, MD, University of Texas at Austin Dell Medical School Pediatric Program, Austin, TX, Beth Wueste, MAEd, C-TAGME, LSSBB, University of Texas Health Science Center School of Medicine at San Antonio, San Antonio, TX, Lahia Yemane, MD, Stanford University, Palo Alto, CA
Increasing diversity is a core value of the ACGME and programs are now asked to annually assess their efforts to recruit and retain a diverse and inclusive workforce. A diverse physician workforce positively impacts patient care and relationships of marginalized groups, such as racial and ethnic minorities. Our hope is that similar benefits will result from educating and employing physicians with disabilities. While there is a growing number of medical students who disclose a disability, the proportion of those students who seek accommodations remains small at 2.7%. However, these students will seek training in GME programs and the number of accommodations requests will increase. While a significant amount of resources exist to assist in the recruitment and retention of students with disabilities to medical schools, there are relatively few resources or best practices to support GME programs. Programs need to develop inclusive practices and policies for trainees with disabilities and understand the accommodations process and legal responsibilities, including ADA employment standards. In this workshop, participants...
15. EVIDENCE-BASED EDUCATION (EBE): SETTING THE SAME STANDARDS FOR OUR LEARNERS AS WE DO FOR OUR PATIENTS

Adin M. Nelson, MD, Rutgers New Jersey Medical School, Jennifer Di Pace, MD, Erika Abramson, MD, New York Presbyterian Hospital (Cornell Campus), New York, NY, Christin M. Traba, MD, Rutgers New Jersey Medical School, Newark, NJ, Molly C. Broder, MD, Montefiore Medical Center/Albert Einstein College of Medicine, New York, NY, Robyn J. Blair, MD, Stony Brook Medicine/University Hospital, Stony Brook, NY, Matthew J. Kapklein, MD, Westchester Medical Center, Valhalla, NY

It’s the 21st century. We’re all committed to practicing evidence-based medicine. At its core, that means that it doesn’t really matter what we were taught; it doesn’t really matter what we think ought to work; all that really matters is what has been proven to work in well-executed clinical studies. When it comes to teaching and learning though, most of us still teach the way we were taught - or maybe according to what we think are logical theories of education - but we do not apply the same rigorous evidence-based standards to our teaching and learning that we do to our clinical work. This interactive, eye-opening workshop will introduce participants to the evidence behind several current proven techniques for effective teaching and learning so that they can become practitioners of Evidence-Based Education (EBE). Specifically, we will discuss the overarching theory of desirable difficulty and three individual evidence-based educational techniques that fall under that theory: retrieval practice, spaced learning, and interleaving. We will define these techniques, delve into the evidence behind them, and discuss how they can be applied in medical education. These theories and techniques can be applied throughout the medical education continuum: with students, residents, fellows, and continuing professional development for faculty, and they may be particularly valuable for advanced learners such as senior residents and fellows who must move back and forth between the learner and educator roles. The workshop will include breakout sessions for participants to brainstorm and develop concrete ways that they can use these evidence-based techniques in their own roles as learners, didactic teachers, clinical teachers, and curriculum designers. Participants will leave with an initial plan for implementing EBE in their home programs.

16. PASSPORTS AND GOALS: TWO READY TO IMPLEMENT MODELS FOR TAILORED SELF-DIRECTED GLOBAL HEALTH EDUCATION

Rachel S. Bensman, MD, Cincinnati Children’s Hospital Medical Center, Cincinnati, OH, Risha L. Moskalewicz, MD, University of Minnesota, Minneapolis, MN, Megan S. McHenry, MD, MS, Indiana University School of Medicine, Indianapolis, IN, Laura Houser, MD, University of Wisconsin, Madison, WI, Michael B. Pitt, MD, University of Minnesota, Minneapolis, MN, Amy Rule, MD, MPH, Cincinnati Children’s Hospital Medical Center, Cincinnati, OH

Pediatric residents continue to have increasing interest in global health experiences during residency and integrated into their careers. Global Health pathways and curricula now exist across US residency programs with varying degrees of best practices, supervision, and content. However, many residents interested in Global Health find themselves at programs without formalized Global Health curricula or mentorship. Regardless of program offerings, as adult learners with busy and complex schedules, self-directed learning provides a robust opportunity to both achieve personal goals in education and meet program requirements in content completion. This ELS will present two complementary models of self-directed learning tools developed by the Midwest Consortium of Global Child Health Educators for pediatric resident global health education. First, Global Health Objectives for Stateside Learning (GOALS) is a module-based curriculum which pairs Global Health learning objectives directly with educational resources (literature, guidelines, etc.) for self-directed learning matched to resident rotations (e.g., completing GOALS Pediatric Cardiology while on Cardiology rotation). Second, the Global Health Passport is a tracking tool which organizes learning opportunities, allowing residents to meet content goals in Global Health at their own pace and schedule with a mix of internal and externally available resources. These innovative self-directed learning tools can supplement Global Health learning for residents in large programs with well-established Global Health pathways or provide structure for residents in smaller programs without pathways. Both tools can be tailored to align with individual learner or program needs. This workshop will provide attendees an interactive introduction to both tools, with small group discussion of implementation strategies, guidance and time to begin customizing tools for individual programs, and the opportunity to network and collaborate with other programs interested in improving their global health education curriculum.

17. BRIDGING THE GAP FOR MENTAL HEALTH TRAINING IN PEDIATRICS

Elizabeth M. Chawla, MD, MedStar Health/Georgetown University Hospital, Washington, DC, Ann E. Burke, MD, Wright State University, Dayton, OH, Sue E. Poynter, MD, MEd, Cincinnati Children’s Hospital Medical Center, Cincinnati, OH, Kenya McNeal-Trice, MD, University of North Carolina Hospitals, Chapel Hill, NC, Cori Green, MD, MS, New York Presbyterian Hospital (Cornell Campus), New York, NY, Rebecca A. Baum, MD, Nationwide Children’s Hospital/Ohio State University, Columbus, OH

The prevalence of mental health (MH) issues in our pediatric population is currently at an all-time high, with suicide as the second leading cause of death among young people aged 10-24 years. Although great progress has been made in the medical
19. WHAT’S THAT DEAR? APPROACHES AND TECHNIQUES TO ADDRESS MICROAGGRESSIONS AND WHITE FRAGILITY IN THE WORKPLACE

Paul Homer, MD, Sahar N. Rooholamini, MD MPH, Mollie Grow, MD MPH, Courtney Gilliam, MD, Jessica McCade, MD, Aleksandra Oliszewski, MD, Maneesh Batra, MD MPH, Celeste Quitiquit, MD, Maya Jones, MD MPH, Heather McPhillips, MD MPH, Tara Wenger, MD PhD, Roberto Montenegro, MD PhD, University of Washington, Seattle, WA

Microaggressions are “brief and commonplace daily verbal, behavioral, or environmental indignities, whether intentional or unintentional, that communicate hostile, derogatory, or negative racial slights and insults towards people of color” (1,2). Members of marginalized or minority groups, including trainees, staff, patients, and families, experience daily microaggressions. There is increasing evidence of the short- and long-term impacts on those who experience microaggressions, including increased stress response, depression, and poorer health (3,4). Often, the person committing a microaggression lacks awareness and bears no ill intent. However, it is imperative to dissociate intent from impact and develop skills to address microaggressions. Intertwined with racial microaggressions is the concept of white fragility, defined as “a state in which even a minimum amount of racial stress becomes intolerable, triggering a range of defensive moves” (5), thus inhibiting constructive dialogue and action. Creating an inclusive environment and advocating for equity require awareness of microaggressions and white fragility. In this interactive workshop, presenters will begin by outlining how we teach the history of race and racism in the United States and define microaggressions and white fragility within the curriculum in our residency program. We will review and discuss examples in small groups. Lastly, participants will learn how to use strategies derived from dialectical behavioral therapy (DBT) to interrupt microaggressions and address white fragility, such as “DEAR” (Describe, Express, Ask/Assert, Reinforce) and “PAUSE” (Pause, Acknowledge, Understand, Self-Reflection, Embrace & Explore). We will practice skills in small groups using real cases developed by our pediatric residents. Small groups are facilitated by trained faculty to allow for rich discussions while participants learn and practice techniques. Small group discussions will include brainstorming of individual plans. The session will conclude with a large group discussion and review of our Responding to Microaggressions toolkit.
20. FROM ADDIE TO Z: USING INSTRUCTIONAL DESIGN AND MULTIMEDIA LEARNING THEORY TO TEACH GENERATION Z
Charlene Larson Rotandi, AB, C-TAGME, Stanford University, Stanford, CA, Pamela Carpenter, MEd, C-TAGME, Reena P. Tam, MD, University of Utah, Salt Lake City, UT

Generation Z is about to enter the workforce and it is important to recognize their unique needs and learning styles. Programs need to be ready to adapt to a generation that is digitally native whose learning background has been immersed in technology. Many educators may not be prepared to meet the educational needs of Generation Z. Learning theories and design models are methods and tools that can assist educators in creating effective medical education. The ADDIE (Analysis, Design, Development, Implementation, and Evaluation) method of instructional design is centered on meeting the needs of the learner. ADDIE applies similar principles to those used in continuous improvement to curriculum design. Medical educators in GME will need to adapt to future trainees, recognizing that the use of multimedia will make learning more personal, interactive, and efficacious. Additionally, participants will learn about Mayer’s Multimedia Learning Theory and its application to traditional teaching methods. The utilization of this theory prepares medical educators to meet the needs of the upcoming Generation Z. Session participants will apply modifications to traditional teaching using ADDIE methodology and Multimedia Learning Theory and leave with a framework for creating more effective curriculum for the next generation of learners.

21. TOGETHER WE RISE - IMPROVING THE PATIENT-DOCTOR RELATIONSHIP BY FOSTERING HUMANISM THROUGH DEVELOPING A SOCIAL JUSTICE CURRICULA ROOTED IN CRITICAL CONSCIOUSNESS
Audrea Burns, PhD, Julieana Nichols, MD, Susan Gillespie, MD, Lahia Yemane, MD, Stanford University, Palo Alto, CA, Patricia Poitevien, MD, Brown University, Providence, RI Andria Tatem, MD, Baylor College of Medicine (Houston), Houston, TX, Candice Taylor, MD, University of California (Irvine)/CHOC, Irvine, CA Laura Kester, MD, University of California (Davis) Health System, Davis, CA, Gia Merlo, MD, New York University School of Medicine, New York City, NY, Elaine Fielder, MD, Baylor College of Medicine (Houston), Houston, TX, Jyothi Marbin, MD, University of California/San Francisco, San Francisco, CA

Despite increased teaching of social determinants of health during medical training, there has not been a concomitant increase in physicians taking on professional roles as health advocates (Sharma, 2018). It is thought that in addition to understanding social determinants, it is critical to train future health care professionals in social justice. This workshop unites facilitators across multiple institutions to share their experiences and provide a platform to discuss published models and teaching tools to guide participants in building or refining social justice curricula. In this highly interactive workshop, participants will engage in role-play to simulate a complex patient-trainee interaction to contextualize complexities of marginalization and health disparities. A brief didactic will follow to highlight the difference between cultural competency and critical consciousness and participants will develop a model for how to use critical consciousness framework to foster skills in social justice and advocacy. Participants will then learn about three approaches for teaching social justice—critical consciousness, structural competency, and antiracist pedagogy. Using one of these theoretical approaches, facilitators will briefly highlight current tools used at their home institutions. Applying these concepts, participants will be guided by the facilitators to work on creating social justice curricula for their home institutions.

C-22. THE GOLDILOCKS MANAGEMENT STYLE: GETTING IT JUUUST RIGHT - FINDING THE BALANCE BETWEEN MICROMANAGING AND UNDERMANAGING YOUR TEAM
Carrie Johnson, MBA, Stanford University, Palo Alto, CA, Jessica Williger, BA, Case Western Reserve University/University Hospitals Cleveland Medical Center/Rainbow Babies and Children’s Hospital, Cleveland, OH

Just as Goldilocks had the right idea when she tasted each bowl of porridge, sat in each chair, and laid in each bed to find the ones that were just right for her, program managers and coordinators need to learn about and practice different management skills so that they can develop their own style of situational management that is both balanced and flexible. More often, however, they find themselves thrown into management roles in which they are not fully equipped to handle. Program manager and coordinator training is typically focused on increasing their knowledge base in graduate medical education, program requirements, and policies and procedures, as expected by the ACGME. Thus, they often do not receive professional development on the people management aspects that they inherit with their roles. Rarely do they know how to manage in a balanced way as reported in a 2016 survey of 500 managers in which 87% wished they had received more training when they first took on the role (“Good Manager, Bad Manager,” 2016). Without sufficient development of management skills, program managers and coordinators can easily fall into the habit of either micromanaging or undermanaging their teams. These bad habits can lead to poor work performance, disengaged staff, high turnover, and low morale (Forbes Coaches Council, 2018).

In this interactive workshop, participants will explore the differences between micromanaging, undermanaging, and balanced managing and their effects on staff and the workplace. In addition, group activities will allow them to experience the three management concepts as well as discuss and share strategies on how to temper micromanagement and undermanagement styles. Participants will learn new people management skills and practical tips to discover the balanced “Goldilocks” management style that is just the right fit for themselves. As a culmination of these new skills, participants will use an in-session tool to address a current work situation with actionable next steps to take.
23. LET’S GET READY TO RUMBLE! THE MILESTONES VS. EPAS DEBATE
Daniel J. Schumacher, MD, MEd, Benjamin Kinnear, MD, MEd, Cincinnati Children’s Hospital Medical Center, Cincinnati, OH, Alan Schwartz, PhD, University of Illinois College of Medicine at Chicago, Chicago, IL, Abigail Martini, BS, Cincinnati Children’s Hospital Medical Center, Cincinnati, OH, Carol Carraccio, MD, MA, American Board of Pediatrics, Chapel Hill, NC
This engaging, hilarious debate promises to be raucous at points. Our debaters will pit milestones and entrustable professional activities (EPAs) against one another. The former are gaining validity evidence with widespread use in the United States, while the latter are the most popular approach internationally. In brief opening statements, the debaters will highlight what they believe to be the quintessential strengths of their chosen assessment framework. Following this, they will be posed prepared questions from the skilled moderator followed by questions solicited from the audience (and screened for the best questions given time limits). Prepared moderator questions will allow each debater to make his case for which framework is better for learners, which is better for programs, and which is better for patients. Confessions involving the sins of both milestones and EPAs will also be probed. Following brief (2 minutes max!) closing statements, you will then vote for the winning side. Who will win your vote? Have you already chosen a side? Will the skilled debaters lead you to change your mind? Following the announcement of the winner, we will engage participants in a meaningful conversation about the co-existence of these two assessment frameworks. Should we assess only milestones or milestones and EPAs? We will explore audience responses to this question as well as how we can potentially capitalize on the strengths of both milestones AND EPAs.

24. TIPS FOR TEACHING TOUGH TALKS AND OTHER HARD THINGS TO SAY: NAVIGATING AND ROLE MODELING DIFFICULT PATIENT CONVERSATIONS
Rachel E M. Cramton, MD, University of Arizona College of Medicine–Tucson, Tucson, AZ, Eric K. Zwemer, MD, University of North Carolina Hospitals, Chapel Hill, NC, Hadi Anwar, MD, Virginia Commonwealth University Health System, Richmond, VA, Kamakshya Patra, MD, West Virginia University, Morgantown, WV, Lisa Pomeroy, MD, Texas Tech University Health Sciences Center at Lubbock, Lubbock, TX
There are few situations that cause more anxiety/stress among physicians than difficult family conversations. Whether the information to be presented is a new diagnosis, a disclosure of medical error or discussion of treatment failure, many physicians feel uncomfortable with the emotional tenor of these conversations. This discomfort is compounded because the sensitive nature of these conversations often leads attending physicians to “go it alone” rather than include an audience of trainees, leaving physician trainees at all levels without opportunities to observe or practice this vital skill. In this interactive workshop, participants will use a roadmap to plot components of difficult conversations, identify common hazard points, and develop plans to role model these conversations for trainees. Patient, family, healthcare team, situational, and emotional factors that influence the conversation will also be explored. Case scenarios will be presented to engage the audience in small group discussion and large group sharing. Participants will leave the workshop with a tool kit containing a difficult conversation roadmap, case scenarios, and more to allow them to apply this training at home institutions.

25. TEACHING SEX AND GENDER IN CLINICAL SETTINGS: CHALLENGES AND OPPORTUNITIES FOR RESIDENT, FELLOW, AND FACULTY DEVELOPMENT
Brian M. Lurie, MD, MPH, Carolinas Medical Center, Charlotte, NC, Adam Wolfe, MD, PhD, Baylor College of Medicine (San Antonio), Beth Wueste, MAEd, C-TAGME, University of Texas Health Science Center School of Medicine at San Antonio, San Antonio, TX, Sydney M. Primis, MD, Carolinas Medical Center, Charlotte, NC, Michelle Brooks, C-TAGME, Stanford University, Palo Alto, CA, Mark Atlas, MD, Zucker School of Medicine at Hofstra/Northwell at Cohen Children’s Medical Center, New Hyde Park, NY
Significant health disparities exist for the lesbian, bisexual, gay, and transgender (LGBT) population in the United States. Within the pediatric population, these disparities are particularly disturbing, with close to a third of LGBT youth reporting having attempted suicide, 84% reporting verbal harassment, 30% being physically harassed, and increasing rates of STIs. In recognition of these disparities, there has been a trend over the past few decades to increase cultural competency education around LGBT health in undergraduate medical education. Fewer interventions have focused on graduate medical education training programs. This workshop will start with Learner Activation, using an online poll and a reflection exercise to explore participant’s perceptions and experiences of this topic. A developed video clip will be shown to promote the value of parent and patient perspectives and to reinforce to participants the underpinning nature of sex and gender content in clinical teaching. The workshop will then review key concepts of sex and gender and how they impact pediatric care. Interactive case-based discussions will be used to discuss how to apply these concepts in a variety of clinical settings, such as the Continuity Clinic, Emergency Department, Adolescent Medicine and subspecialty Pediatrics. This exercise aims to open further participants’ awareness of their role as clinical teachers. Participants will then engage in role-playing scenarios developed for clinical teaching settings. Following a think-pair-share exercise to deliberate on challenges and opportunities for teaching sex and gender in their own clinical settings, participants will receive a variety of resources and strategies to bring back to their home institutions. The workshop will conclude with a large group call-out activity to summarize lessons learned.
26. IT’S TIME FOR FACETIME: BRINGING THE FOUR HABITS MODEL OF COMMUNICATION TO TRAINEES
Miranda Kane, DO, MPH, Ritu Patel, MD, Brian Linde, MD, Amelia Castro, MD, Lea Bornstein, MD, Heather Caputo, MD, Rina Shah, MD, Kaiser Permanente Medical Group (Northern California), Oakland, CA

Communication with patients is a vital part of quality patient care and trainee education. Communication tools have been shown to facilitate the physician and patient interaction and can improve quality of care. The Four Habits Model of communication combines several effective communication strategies in an organized, concise, and simple model with the goal of establishing trust rapidly, aligning goals of care, and ultimately, improving patient adherence. Recent literature has also shown a benefit of using this model to promote physician wellness. This highly interactive workshop will begin with a think-pair-share discussion about difficult situations involving communication with a patient and/or family. We will then introduce the Four Habits Model of communication, the evidence for this model, and when and how it can be used. Facilitators will illustrate how this model aligns with and can be used alongside other tools for medical interviewing such as shared-decision making and relationship-centered care. Facilitators will then model the Four Habits Model with a role play followed by an opportunity for participants to ask questions. Facilitators will then teach more deeply about each of the four steps of the model: 1) invest in the beginning, 2) elicit the patient’s perspective, 3) demonstrate empathy, and 4) invest in the end. The participants will engage in facilitated small group discussions to examine common communication challenges and practice using the Four Habits Model of communication in these scenarios. The large group will then reconvene to debrief and to discuss these scenarios. Facilitators will then teach participants about how one can teach this tool within one’s home institution. The workshop will conclude with an opportunity for participants to ask questions.

27. CATCHING RESIDENTS BEFORE THEY FALL: PRE-REMEDIATION STRATEGIES FOR INDIVIDUALIZED COACHING FOR YOUR RESIDENTS
Lisa McQueen, MD, University of Chicago, Michelle Barnes, MD, University of Illinois College of Medicine at Chicago, Chicago, IL, Heather Burrows, MD, PhD, University of Michigan, Ann Arbor, MI, Reem Itani, MD, Children’s Hospital of Los Angeles, Los Angeles, CA, Misun Jung, MD, University of Chicago, Amanda Osta, MD, University of Illinois College of Medicine at Chicago, Chicago, IL

Every year pediatric residency programs identify residents who struggle with elements of professionalism, interpersonal and communication skills, and patient care, but not to the degree to which they require a formal remediation plan. The issues are rarely a matter of knowledge acquisition, but of knowledge application, and the reasons can be complex. Some of these residents have come from nontraditional paths, including residents who transfer programs, those in expedited training pathways (physician scientists, those who qualify for ABP waivers, child neurology preliminary trainees), those who take time off for medical or personal needs, and international medical graduates who may be less acculturated to the US healthcare system. Others simply haven’t had extensive clinical experience and struggle with the high-level of time management and organization required as an intern. Program leaders face challenges in identifying and implementing strategies to assist these residents in a timely manner to help them successfully complete their residency training. In this interactive session, we present a framework for identifying residents at risk and strategies for developing group and individualized coaching plans. This workshop will assist program directors, faculty, CCC members, and chief residents in developing methods to address individual resident needs while empowering them with resources to develop coaching plans. Drawing from a range of programmatic experiences, we will present pearls and pitfalls for developing such plans and a framework for ongoing assessment. Attendees will leave this session armed with tools for building coaching plans within their own programs.

28. MANO A MANO: HOT TOPICS IN MEDICAL EDUCATION
Rebecca Wallihan, MD, Nationwide Children’s Hospital/Ohio State University, Columbus, OH, Ndidi Unaka, MD, MEd, Cincinnati Children’s Hospital Medical Center, Cincinnati, OH, Michael Bolton, MD, Our Lady of the Lake, Baton Rouge, LA, Alan Chin, MD, UCLA David Geffen School of Medicine/UCLA Medical Center, Los Angeles, CA, John D. Mahan, MD, Nationwide Children’s Hospital/Ohio State University, Columbus, OH, Heather McPhillips, MD, University of Washington, Seattle, WA, Suzanne Reed, MD, Nationwide Children’s Hospital/Ohio State University, Columbus, OH, Teri Turner, MD, MPH, MEd, Baylor College of Medicine (Houston), Houston, TX

In this interactive, debate-style session attendees will hear leaders in the field face off to address emerging issues in medical education. Three hot topics will be discussed with an affirmative and negative speaker for each. After opening remarks and framing by the moderator, each debater will present briefly her/his major points and closing remarks and address follow-up questions from the moderator. Each debate is then ended with time for audience small group discussion and questions from the audience. Audience response will be used to poll attendees on their stance prior to and at the conclusion of each topic. The three proposed topics for 2020 are: 1. Resident teaching services: Faculty right or privilege? 2. Fellowship training: One length fits all or time for flexibility? 3. Standardized tests: Necessary tools or incomplete measures of competence?

29. TABLETOP SIMULATION: A TOOL FOR EVALUATION OF THE STRUGGLING LEARNER
Rachel Osborn, MD, Adam Berkowitz, MD, Yale-New Haven Medical Center, New Haven, CT

After the transition to milestone evaluations, the struggle to obtain equal quality and quantity of information for different competencies became quite apparent. There is minimal variation between residents in certain categories when looking at both faculty and peer evaluations. At times this difficulty is exposed when individual residents seem behind in their expected trajectories, but their formal evaluations lack insight into either the severity or root cause of their deficiencies. Residents who struggle to perform clinically during times of high census or acuity are often identified through information communicated to leadership, most commonly the chief residents, but without supportive data it is hard to decide on a course of formal remediation. Tabletop simulation is an underutilized tool which can generate both performance data to inform milestone
30. MOTIVATION THROUGH POSITIVE PEER PRESSURE: NOVEL APPROACHES TO ENCOURAGING PRODUCTIVITY BY LEVERAGING NEAR PEERS AND TRANSPARENCY

Michael B. Pitt, MD, University of Minnesota, Plymouth, MN

Peer pressure is given a bad rap. Most use the phrase when discussing resisting bad decision making. “If Jason jumped of a bridge, would you?” But motivation theory also shows peer pressure can be a powerful force for good. “If Jason recycled, would you?” It turns out, the answer depends on if Jason can see if you’ve put your recycling bin out. Transparency matters.

The same is true in academics - if we aren’t aware of the work our peers are engaged in, we can’t be motivated by it. In this session, participants will discuss how, in order for positive peer pressure to work three things are necessary: 1) Respected Peers; 2) Transparency; and 3) Psychological Safety. Having any two without the third is problematic. Without respected peers, we lack inspiration to motivate us. Without transparency, we fall into the trap of silos. If we have everything but psychological safety, the peer pressure becomes a stressful competition. The University of Minnesota’s Department of Pediatrics has applied this framework of finding this positive peer pressure sweet-spot across its residency, fellowships, and faculty development initiatives over the last five years. Examples include incorporating gamification into morning report and the tracking of mundane tasks; incentivizing scholarship through a weighted lottery where raffle tickets are earned at escalating degrees of productivity; or demystifying of the academic process through a novel posters-to-papers writing group where participants work to elevate an old abstract from their CV to a manuscript submission in 3 months flat. We will even discuss how incorporating this framework led to a 53% reduction in food costs! After hearing about a variety of successful initiatives incorporating this positive peer pressure approach, each ready to be replicated, participants will walk through a step-by-step process to craft their own initiative to tackle a need at their institutions.

31. MOMENTS IN MEDICINE: A BRIDGE TO FINDING MEANING AT WORK

Jessica H. Goldstein, MD, Ross Myers, MD, Keith Ponitz, MD, Case Western Reserve University/University Hospitals Cleveland Medical Center/Rainbow Babies and Children’s Hospital, Cleveland, OH

Burnout among pediatric residents and early career pediatricians continues to be prevalent. As healthcare has evolved the physician’s daily work has changed from hands-on bedside care to more administrative tasks. This evolution in healthcare has pulled trainees and faculty away from the elements of medicine that bring meaning and joy to our profession. Empiric data suggests that wellness programs such as yoga, running clubs, and mindfulness sessions have little impact on the well-being of residents. In contrast, curricula designed to foster a growth mindset, promote individuality and build resilience can be effective to mitigate burnout and bring meaning back to our work. This interactive workshop presents an approach to identify aspects of work that are meaningful for each resident and foster these into daily workflow. After an introduction exploring challenges of addressing resident burnout through wellness activities, attendees will identify key moments in medicine that bring their job meaning: mindset, defining, and meaningful moments. Groups will come together to share their “moments” and explore how mentors can show how they find meaning at work with trainees. The large group will discuss best practices of how to implement similar curricula at their home institution and help residents connect their daily work to their individual moments. The workshop concludes with each attendee writing a letter to themselves to identify the most meaningful aspects of their work and how to continue to recognize those important moments. The letter will be mailed to participants after the conference as a personal check in and to ensure the program met its objectives. Attendees will leave the conference having experienced an educational approach to help trainees find meaning at work and with strategies to implement the concepts at their home institution.

32. THEY SAY, THEREFORE, I AM: THE IMPACT OF STEREOTYPE THREAT ON TRAINEES AND HOW TO ADDRESS IT

Jeffrey K. Yang, MD, Brandii C. Criss, MD, Katarzyna Zabrocka, MD, Vania J. Singleterry, MD, Matthew L. Edwards, MD, Daniel O. Hernandez, MD, Meera N. Sankar, MD, Belinda Bandstra, MD, Charlene L. Rotandi, AB, C-TAGME, Carmin M. Powell, MD, Stanford University, Palo Alto, CA

Having a diverse medical workforce increases patient access to care, patient satisfaction, and cultural competence in providers. As such, one of the major revisions of the ACGME Common Program Requirements for residency and fellowship in 2019 was “ongoing, systematic recruitment and retention of a diverse and inclusive workforce”. As institutions make efforts to attain this diversity, a slowly increasing number of individuals are undergoing training for which they have historically not been perceived as having adequate skill. A phenomenon that can arise in this setting is stereotype threat, described as the increased risk of confirming a negative stereotype about a group with which one identifies (Steele and Aronson 1995). Physiological and psychological processes that occur under often unrecognized duress can adversely impact performance.

Dependent on the extent of this impact, retention rates of minority trainees may also suffer. It is vital that not only minority
trainees and perhaps more essentially, medical educators, be aware of this predicament, and equipped with evidence-based interventions as new evidence emerges of its impact in medical education. In this workshop, a team of trainees, educational administrators, and faculty from psychiatry, pediatrics, and emergency medicine will provide an overview of stereotype threat with a focus on the impact it has on the performance and well-being of medical trainees. Participants will be asked to identify occurrences in hypothetical situations as well as in personal experiences. Next, direct interventions for individual trainees and more general environmental strategies to address this impact will be reviewed. Participants will identify the ways in which interventions could mitigate the effect of stereotype threat in examples, and brainstorm implementation strategies for their individual institutions.

C-33. WON’T YOU BE MY MENTOR? A PRACTICAL GUIDE TO ESTABLISHING A PEER MENTOR RELATIONSHIP TO ENHANCE PERSONAL AND PROFESSIONAL GROWTH

Jill Edwards, MBA, C-TAGME, Children’s Mercy Hospital, Kansas City, MO, Jessica Williger, Case Western Reserve University/University Hospitals Cleveland Medical Center/Rainbow Babies and Children’s Hospital, Cleveland, OH, Donna Melero, Advocate Health Care (Advocate Children’s Hospital/Oak Lawn), Oak Lawn, IL, Teresa Hudson, C-TAGME, St. Louis University School of Medicine, St. Louis, MO

Mentoring is woven into the fabric of graduate medical education to the point that ACGME stipulates the necessity of mentorship for residents and faculty, but what about coordinators? As professionals in the field, coordinators look for opportunities to advance and grow, which ultimately necessitates some form of mentorship. In this interactive workshop, we discuss the benefits of peer mentoring which aligns well with the coordinator dynamic where we are all peers usually adapting to changes at the same time. In addition, participants will complete an individual assessment to evaluate what type of mentorship relationship they really need or want and what barriers they may need to overcome to establish that relationship. Within groups, participants will practice difficult conversations as we work through the pitfalls of mentoring. The workshop will allow for individual reflection as well as group conversation with the hope of establishing some future steps to accomplish after the workshop has concluded.

5:00pm-6:00pm Poster Session – Educational Scholarship and QI Projects
(See pages 51-107 for Poster Abstracts ~ posters will be on display earlier in the day)

Posters are separated in the following topic areas:
- Wellness / Resilience /Burnout: Posters 1-11 (see pages 51-55)
- Curriculum / Procedures / Simulation: Posters 12-60 (see pages 55-77)
- Assessment / Feedback / Mentorship: Posters 61-71 (see pages 77-82)
- Entrustment / EPA / Milestones: Posters 72-79 (see pages 83-87)
- Program Recruitment: Posters 80-85 (see pages 88-90)
- Diversity & Inclusion / Social Determinants of Health / Advocacy: Posters 86-98 (see pages 90-98)
- Quality Improvement and Patient Safety: Posters 99-111 (see pages 98-105)
- Mental Health Education: Posters 112-117 (see pages 105-107)

6:00pm - 7:00pm APPD LEAD Reunion (LEAD Graduates only)

Thursday, April 2

7:00am - 7:30am Continental Breakfast

7:30am-8:30am Plenary Session (note earlier start time)
- 7:30-7:35 Welcome ~ Rebecca Blankenburg, MD, APPD President-Elect
- 7:35-7:40 Special Project Awards ~ Patricia Poitevien, MD, MSc ,Chair, Council of Learning Community Chairs
- 7:40-7:45 Presentation of Walter W. Tunnessen, Jr. MD Award for the Advancement of Pediatric Resident Education ~ Franklin Trimm, MD, APPD Immediate Past President
- 7:45-8:15 Update from the American Board of Pediatrics (ABP) with Q&A ~ Suzanne K. Woods, MD, Executive Vice President, American Board of Pediatrics
- 8:15-8:25 APPD LEARN Update (Longitudinal Educational Assessment Research Network) ~ Alan Schwartz, PhD, APPD LEARN Director
- 8:25-8:30 Orientation to the day ~ Adam Wolfe, MD, PhD, APPD Program Chair
34. PUTTING OUR HEADS TOGETHER: A BRAINSTORMING WORKSHOP ON THE CREATION OF EFFECTIVE INTERN ORIENTATION EXPERIENCES

Kimberley G. Jacobs, MD, Luisa Valenzuela Riveros, MD, Stanford University, Palo Alto, CA, Ariel Winn, MD, Children’s Hospital/Boston Medical Center, Boston, MA, Rebecca Tenney-Soeiro, MD, Children’s Hospital of Philadelphia, Philadelphia, PA, Minnie Dasgupta, MD, Jacob A. Weatherly, MD, Danielle Kirkey, MD, Carrie Rassbach, MD, Stanford University, Palo Alto, CA

The goal of medical school is to prepare students for the new responsibilities and independence of intern year, a transition often marked by self-doubt and uncertainty. Residency programs recruit new interns with varying medical school experiences and must orient them to practice pediatrics in a new clinical environment. Orientations range from on-boarding procedures to interactive bootcamps to prepare interns, but a gap exists in the literature surrounding the knowledge, skills, and attitudes that should be addressed during intern orientation. Thus, the question remains: what curricular elements from intern orientations are important to help interns be successful? This highly interactive workshop will provide an overview of cognitive frameworks related to preparing new interns for success including cognitive load theory and self-efficacy. Presenters will share current and novel research on the development of orientation curricula as well as student's perspectives on the orientation experience to provide a framework of educational themes for new interns. These themes include wellness, intern survival skills, and communication skills. A series of facilitated small group activities will follow wherein participants will brainstorm ideas for sessions within each theme followed by a large-group discussion of participants' ideas and institutional experiences. Facilitators will lead a discussion related to resource and time constraints and will highlight approaches at various institutions to advocate for maximizing time for orientation. Facilitators of this workshop represent a group of educators from different levels of experience, institutions, and perspectives with experience in orientation development and evaluation through cognitive frameworks. Participants will receive a compilation of resources to apply to their home institution's orientation.

35. BEYOND PRONOUNS: PILOT FOR A COMPREHENSIVE PEDIATRIC LGBTQ+ CURRICULUM

Kevin T. Nguyen, MD, Nicole Webb, MD, Valley Children’s Healthcare Program-Pediatrics, Madera, CA

The AAP first released an official statement encouraging a supportive and accepting environment for youth of diverse gender and sexual identities in 1983. There have been multiple reaffirmations and clarification statements since. As knowledge has grown of the many health disparities faced by trans and LGB youth, there have been increased calls for pediatricians to champion initiatives to address these disparities. To date, there has been minimal formalized education for pediatric providers and interprofessionals on how to create affirming spaces for children and adolescents who are on the gender or sexual identity spectrum. While many pediatric residents have treated LGBTQ+ patients in various contexts, knowledge of national guidelines regarding the clinical care of these patients, particularly for gender diverse or gender non-conforming youth, remains varied and understudied in the graduate medical education setting. Currently, there are no standardized requirements in GME or CME (aside from Washington DC) to incorporate a comprehensive or integrated curriculum. One 2018 study suggested that almost 80% of graduating medical students did not feel competent in treating gender and sexual minority patients and another 30% of medical schools report not formally addressing this topic at all (with another 50% report having 3 or less dedicated activities throughout all four years). Of the contemporary clinical training regarding this population, most are cursory and primarily address basic terminology and health disparities. The largest survey ever conducted of transgender people in America, published in 2015, affirms the inherent deficit in education: over 50% of transgender patients report having to teach their medical clinician about their care. We hope that participants in our session will be able to identify national resources and guidelines for the care of LGBTQ+ youth, to participate in interactive examples of LGBTQ+ clinical learning from our pilot curriculum, and to inspire incorporation of LGBTQ+ topics in pediatric trainee learning environments.

36. ADVOCACY ACTIVATION: AN ACTIVE LEARNING CURRICULUM FOR LEGISLATIVE ADVOCACY SKILLS

Benjamin Hoffman, MD, Oregon Health and Science University, Portland, OR, Catherine D. Shubkin, MD, Dartmouth-Hitchcock/Mary Hitchcock Memorial Hospital, Lebanon, NH, Jessica Truelove, MD, Dartmouth-Hitchcock/Mary Hitchcock Memorial Hospital, Hanover, NH, Natalie Lanocha, MD, Mina Tahai, MD, Christina Ramo, MD, Megan Aylor, MD, Oregon Health and Science University, Portland, OR

“Pediatricians are the ultimate witnesses to failed social policy” (Paul Wise MD). It is both our nature and our responsibility to be effective advocates for our patients and communities. As we become more cognizant of the impacts of social determinants of health, we must transform training to produce the pediatricians who have knowledge and skill at all levels of advocacy, from individual, to community and policy levels. The ability to develop and implement policy change has the greatest potential impact of child and community health. Given the complexity of pediatric residency training, and multiple competing requirements, how can we effectively teach learners the knowledge, skills and attitudes necessary to be effective advocates?

This workshop will employ hands-on, individual, small group, and large group work to empower attendees to develop and teach what residents need to learn about legislative and policy advocacy. We will first engage in small-group discussions of learner centered training objectives in policy advocacy. We will then introduce our legislative advocacy curriculum, which not only fits within our noon conference schedule, but also fully activate residents to demonstrate the core skills necessary for legislative advocacy. We will then use a nationally recognized tool (the American Academy of Pediatrics Community Pediatrics Training Initiative Project Planning Tool) to walk through the curriculum using a law to ban infant crib bumpers as an example.
Participants will be guided in small groups to work through an exploration of the curriculum, culminating in hands-on practice of some of the skills expected of our resident learners. Including identifying potential sponsors, coalition development, the basics of the legislative process and how to prepare and deliver effective messages to legislators, the media and in testimony. This workshop will be fun, fast, active, collaborative, and practical! You will leave both energized and prepared to be a more effective teacher and advocate for kids in your community!

37. TEAM GLOBAL: ROLES AND RESOURCES FOR EVERYONE (PROGRAM DIRECTORS, COORDINATORS, CHIEF RESIDENTS) IN NEW AND ESTABLISHED GLOBAL HEALTH RESIDENCY AND FELLOWSHIP PROGRAMS
Lee E. Morris, MD, MSPH, DTMH, Carolinas Medical Center, Charlotte, NC, Tania Condurache, MD, University of Louisville, Louisville, KY, Jennifer Watts, MD, Children’s Mercy Hospital, Kansas City, MO, Elizabeth Keating, MD, University of Utah, Salt Lake City, UT, Heather Crouse, Baylor College of Medicine (Houston), Houston, TX, Kathy Ferrer, MD, Children’s National Medical Center, Washington, DC, Sheridan Langford, MD, University of Louisville, Louisville, KY
The demand for GH educational opportunities among pediatric residents and fellows continues to be reflected in trainee choice of residency and fellowship programs based at least partially on the availability of GH educational offerings. Many residency and fellowship programs have responded to this demand by offering international electives, GH tracks, and some additional time for training focused on GH. In recent years, published literature around GH education has put forth “calls for action” established minimum standards, and provided snapshots into how programs are meeting this demand while trying to provide high quality offerings.(1-9) Recognizing the challenges many pediatric training programs face in developing and maintaining GH offerings, it is important that program coordinators, chief residents, GH faculty, and program directors are aware of their potential roles in GH offerings as well as available resources and support needed to enhance GH education for their trainees. This highly interactive Enhanced Learning Session (ELS) will be facilitated by a multidisciplinary group of GH educators and coordinators. After an introduction, participants will have an opportunity to participate in a “speed mentoring” session. More than one facilitator will be present at each topic group to facilitate smaller mentoring conversations around the topic. Participants will rotate through each of the following topics:
- Role and importance of coordinators in GH educational opportunities: discuss resources available, challenges and successes
- Considerations and approach to finding GH elective sites: discuss existing resources, ethical considerations, issues with sustainability, challenges and successes
- Resources in GH education from GH boot camp offerings to online curriculum and other educational tools: discuss existing resources and provide a brief summary of each
- Pre-travel and post-travel preparation for GH electives - discuss existing resources
- Role of Chief Residents in GH educational opportunities: discuss resources available, creative opportunities for involvement, challenges and successes in implementation
- GH educational opportunities in Fellowship: discuss existing programs, resources available, challenges and successes in implementation

The ELS will then transition to a large group discussion led by the facilitators from each small group topic, who will briefly present highlights, successes, challenges, and solutions identified from their sessions. Facilitators will then review the available resources for developing and/or improving GH educational offerings at participants’ own institutions, based on their respective roles in the residency or fellowship program. The ELS will conclude with a brief review of on-going mentorship opportunities for programs looking to improve and enhance the GH educational offerings for their trainees. Participants will be provided a toolkit of resources to bring back to their home institutions to aid in developing or improving their GH program.

38. MISSION POSSIBLE: CREATING YOUTH HEALTH CHANGE AGENTS THROUGH INTER-PROFESSIONAL COMMUNITY COLLABORATIONS AND A YOUTH AS PARTNER APPROACH
Renee Kinman, MD, PhD, MA Ed, Kelly Colwell-Walker, MA Special Education, Serena Yang, MD, MPH, Erica Gastelum, MD, University of California (San Francisco)/Fresno, Fresno, CA
Impoverished minority youth are routinely exposed to a variety of adverse childhood experiences that can unfavorably affect their physical, mental, and social well-being. Although medical efforts have traditionally concentrated on downstream interventions to improve individual health, there has been increased awareness of the benefits of addressing the upstream social determinants of health, including providing impoverished minority youth with positive life experiences and opportunities to assist them in reaching their full potential. Recognizing that the health of a child depends in large part on the family and local community, pediatricians and medical education training programs have a unique opportunity to step out of the clinical practice setting and operate at the intersection of child health, education, and public health through the development of grassroots inter-professional community partnerships. By collaborating with school systems, public health departments, and other community partners, physicians can thus increase their ability to effectively impact child health on a larger scale within their own community. Youth participation occurs when young people are involved in the planning of programs of their own choosing, working as change agents through inter-generational partnerships with adults to achieve community change. The use of a constructivist approach can be especially relevant when working with adolescents to develop peer-to-peer education programs that promote healthier behaviors and youth decision-making. By linking medical students and pediatricians in training with extremely high risk minority high school students, our learners have been able to cultivate meaningful personal relationships while working together on topics of concern to adolescents while simultaneously introducing students to careers in the medical field. These high school students have in turn learned how to amplify their voices to become leaders within their communities, presenting the results of their community action research projects both regionally and nationally.

39. BRIDGING THE BEHAVIORAL AND MENTAL HEALTH CARE GAP: PEDIATRIC SUBSPECIALTIES AND THE
COMMON PROGRAM REQUIREMENTS
Megan Christofferson, BA, C-TAGME, Stanford University, Palo Alto, CA, Charlene L. Rotandi, AB, C-TAGME, Nancy Ruddy, PhD, Stanford University, Stanford, CA
ACGME recently released new common program requirements for pediatric subspecialties. Programs must teach residents and fellows to provide patient care with a focus on common behavioral and mental health issues. While some programs have already prioritized a focus in this area, for others this new requirement poses challenges. In this presentation, we will review the new requirements and explore the implementation challenges they pose. The presenters will review implementation strategies to integrate behavioral health aspects of care into didactics, patient care, research and evaluation. In addition to helping faculty expand their own expertise, we will highlight how to leverage community and larger system resources. We will review primary care behavioral health integration strategies that can be adapted to pediatric subspecialty care. One of the presenters will share her decades of experiences as a psychologist in graduate medical education collaboratively developing behavioral health competencies in faculty, staff and trainees. Finally, strategies to enhance existing wellness initiatives will be discussed. Participants will be invited to complete an action planning exercise to organize an implementation strategy and to share best practices. The session will allow ample time for questions and discussion.

40. RECONNECTING RESIDENTS TO PURPOSE AND PASSION: HARNESSING THE POWER OF PERSONAL DEVELOPMENT PLANS FOR CAREER AND WELL-BEING
Mollie Grow, MD, MPH, Maneesh Batra, MD, MPH, Maya Jones, MD, MPH, Celeste Quitiquit, MD, Sahar Rooholamini, MD, MPH, Courtney Gilliam, MD, Paul Homer, MD, Jessi McDade, MD, Aleks Olszewski, MD, Heather A. McPhillips, MD, MPH, University of Washington, Seattle, WA
Background: The ACGME includes professionalism as a core competency; residents are expected to demonstrate engagement in personal and professional development that will sustain them in balancing commitment to the profession with a healthy and productive personal life. Individualized Learning Plans (ILPs) are also required for residency training yet may be underutilized for more comprehensive career and personal development. As recent data on resident burnout suggest, balancing personal and professional goals may be especially difficult to achieve in residency. Our program created a 2-week personal development rotation (paired with 2 weeks of jeopardy) enabling categorical pediatric R2 residents to connect with mentors, reflect on passions and strengths, and develop tools for continued personal and professional growth. A key outcome of this month is a Personal Development Plan (PDP), which integrates the concepts of an ILP with more broad reflection on personal and professional goals, strengths, and short and long-term objectives and outcomes, formatted into a powerpoint presentation for colleagues and residency leadership. Residents present their PDP to the program directors and chief residents at the end of their rotation. In the past 2 years, residents in our large, urban residency program have universally valued this opportunity to pursue personal and professional passions and regain touch with their purpose. We believe it is among the most important innovations in our program and will be excited to share the reasons why it is effective and how other programs could adapt this approach. Session Description: In this interactive and collaborative workshop, we will share strategies for developing and using a Personal Development Plan (PDP), an enhanced form of an ILP. Participants will learn about the key components of the PDP and implementation options. They will share ideas for developing and implementing within their programs, and leave with a plan for tailoring and incorporating the PDP concept within their programs. Whether embedded within an existing rotation, or developing a specific rotation to provide protected time for residents, a PDP can be an effective way to augment the ILP requirement. Participants will leave feeling inspired about opportunities to facilitate residents reflecting on their purpose, identifying their strengths, making specific plans to achieve goals, developing their mentorship network, and promoting well-being.

41. CAPTIVATING AUDIENCES BIG AND SMALL: HARNESSING COGNITIVE LOAD THEORY AND TECHNOLOGICAL TOOLS TO ENHANCE LEARNING
Rachel S. Poeppelman, MD, Nationwide Children’s Hospital/Ohio State University, Columbus, OH, Anna Volerman, MD, University of Chicago, Chicago, IL, Justin Triemstra, MD, Michigan State University, Grand Rapids, MI, Ian Chua, MD, Children’s National Medical Center, Washington, DC, Amanda Emke, MD, Washington University/B-JH/SLCH Consortium, St. Louis, MO
Pediatricians routinely teach trainees and colleagues in clinical and non-clinical settings. To be most effective, they must understand how to optimize learning and what techniques can be applied to improve engagement and understanding of learners in one-on-one, small group, and large group settings. This workshop reviews principles of effective instructional design using cognitive load theory, a framework that has emerged in medical and non-medical fields for educators to optimize the attention and performance of learners. This framework provides the foundation to discuss practical approaches to enhance the design of instructional sessions, allowing clinical-educators to move beyond facilitating knowledge gains and toward promoting knowledge retention and application. The workshop had a series of four short lectures interspersed with small group activities and discussion. It begins with an introduction to cognitive load theory and its current applications in medical education, followed by a review of best practices for applying cognitive load theory to instruction. Concepts are illustrated using the example of learning to cook. We will then shift to demonstrating available and emerging technological tools used to augment learning and optimize cognitive load. Demonstrated tools will include audience response systems, live online discussions, and social media tools. Facilitators will share their real-life clinical and teaching experiences with small groups during small group activities and discussion. At the conclusion of the workshop, participants will have a toolbox of principles and strategies to optimize learner engagement and understanding in their daily clinical and teaching activities. Improvements
to the workshop curriculum since its first presentation include: a Terminology Cheat Sheet to be distributed at the start of the workshop for participants to reference and annotate as needed and the addition of real world examples illustrating each instructional design principle, using the theme of learning how to cook. At the conclusion of the workshop, participants will have a toolbox of principles and strategies to optimize learner engagement and understanding in their daily clinical and teaching activities.

42. “YOU CAN’T BE WHAT YOU CAN’T SEE” - THE RESIDENTS’ GUIDE TO IMPROVING WORKFORCE DIVERSITY
Monica L. Hoff, MD, Claudia A. Mosquera, MD, O.N. Ray Bignall, II, MD, Nancy N. Liao, MD, Rebecca Scherzer, MD, Olivia Thomas, MD, Rebecca G. Wallihan, MD, Elizabeth Bonachea, MD, Nationwide Children’s Hospital/Ohio State University, Columbus, OH

Evidence shows that a physician workforce that reflects the patient population improves outcomes (1). As part of the 2019 American Academy of Pediatrics policy statement on racism and child health, pediatricians have been charged to diversify the pediatric workforce (2). One key step is improving the diversity of residency programs. While many are motivated to answer this call to action, there are real and perceived obstacles to doing so. Our aim was to increase the percentage of Underrepresented Minorities (URMs) in our incoming Pediatric Residency class to be reflective of our patient population. Despite significant leadership interest and support, our own training programs’ demographics fell short of reflecting the patients we serve. A number of strategies were employed, but our greatest impact was the development of an impassioned Resident Diversity and Inclusion Coalition (RDIC) comprised of pediatric residents from diverse backgrounds. The RDIC focused on increasing the visibility of URM trainees and faculty. They organized gatherings with URM applicants before or during their interview dinners. In the first year, URM residents attended 88% of the interview dinners with URM applicants. After these changes, the percentage of URM residents successfully recruited into the program increased from 16.2% in 2018 to 25.6% in 2019, which is more reflective of our patient population.

In this ELS, we present strategies to leverage the energy and enthusiasm of trainees as leaders in improving diversity in our training programs. Workshop attendees will gain knowledge pertaining to the impact of a diverse provider workforce on patient outcomes, as well as the institutional factors that impact recruitment of diverse candidates. Participants will critically appraise their own institutional efforts and consider how practice gaps may be filled via tactics described in the workshop. We aim to motivate attendees to be champions of diversity and inclusive excellence in their training programs. Finally, participants will appreciate the value of small, minimally resource-intensive strategies with large cumulative impact.

C-43. MYTHBUSTERS: LEADING FROM THE MIDDLE OF YOUR INTERPROFESSIONAL TEAM
Pamela Carpenter, MEd, C-TAGME, University of Utah, Salt Lake City, UT, Beth Wueste, MAEd, C-TAGME, LSSBB, University of Texas Health Science Center School of Medicine at San Antonio, San Antonio, TX

Traditionally, graduate medical education teams have contained a broad spectrum of members such as physicians, coordinators, educators, and trainees; all with attributes of leadership and a sense of teamwork. However, over the course of the last decade, these teams have begun to diversify, evolve, and broaden leadership opportunities to non-physicians in an effort to not only improve patient care but also to advance educational efforts.5,2 This new leadership model can present both a challenge and opportunity for administrators. It is, without question, an opportunity to maximize the use of interprofessional (IP) teams with varying management styles and expertise to allow increased goal setting and achievement rates, provide multiple perspectives to add depth to projects, include diverse experiences, and provide a rich think tank dynamic that allows programs to reach excellence through inclusion. Every team member brings with them the ability to influence others and lead major efforts inside of a program and organization. This interactive workshop will teach core knowledge and skills surrounding administrative roles in middle management to include effectiveness based on the concepts of John Maxwell’s, The 360-degree Leader, with the aim of positively influencing current attitudes on interprofessional education.3 Through positive role modeling, pediatric educational specialists can provide their colleagues and learners with a solid foundation in effective interprofessional communication techniques, understanding of roles/responsibilities, build teamwork principles, and create a climate of mutual respect based in values and the ethics of interprofessional practice using competency based leadership skills.

10:30am-12:00pm Learning Community Meetings (continued)

ASSESSMENT
Meeting for existing sub-groups only; not open to other registrants

EDUCATIONAL TECHNOLOGY
Meeting for existing leadership and any others interested in strategizing about future activities throughout the year.

FACULTY AND PROFESSIONAL DEVELOPMENT
Special Workshop:  Open to all attendees
Faculty Development in a Flash! Leveraging small amounts of time to build faculty teaching skills
Have you ever attended a Flash Class, watched a TED talk, or delivered content using Snippets, Pecha Kucha or Ignite as a methodology? As time pressures continue to build on clinician-educators, training program leaders look for new ways to deliver content and build one’s skills in teaching. There has been a move nationally and internationally towards “faculty development on the go” – brief but frequent sessions focused on one educational skill. One of the first articles in the literature leveraging brief teaching sessions was Snippets: An Innovative Method for Efficient, Effective Faculty Development by Bar-on
and Konopasek in 2014. In our experience, the future of educator development will focus on brief, longitudinal interventions with materials to support active learning of the faculty. Three years ago the Educator Professional Development task force started building “Faculty Development Nuts and Bolts.” These were one-page overviews of important topics in education. These were developed based on the APPD’s members stated needs to deliver faculty development in short bursts. The aim of this workshop is 1) to describe a toolbox of methods that can be used to deliver educational training to the faculty at one’s home institution. 2) to develop a 15 minute outline for a faculty development session of one’s choosing using one of the toolbox methods, 3) to give and receive feedback on one’s mini-session to enhance learning and 4) to discuss how one could use Faculty Development Nuts and Bolts or similar written materials as a part of one’s home institutions faculty development program. The session will start with a think-pair-share of key principles for learning in short bursts. Participants will rotate through two stations during the session to practice developing a 15 minute active learning educator development session for their faculty. These ideas will be shared within small groups with peer feedback and reflection. Individuals will leave with a toolkit of methodologies and Faculty Development Nuts and Bolts handouts for use at their home institution.

Chief Resident Executive Committee Members  (invitation only)
Members of the inaugural Chief Resident Executive Committee (CREC) are invited to join us at our first annual group meeting, during which we will begin planning for our year’s activities and further meetings. Please contact Blair Dickinson or Jay Homme with any questions.

HEALTHCARE SIMULATION IN PEDIATRICS
Meeting for existing sub-groups only; not open to other registrants

LGBTQA+
Meeting for existing sub-groups only; not open to other registrants

PEDIATRIC GLOBAL HEALTH EDUCATORS
The APPD Global Health Learning Community’s mission is to work collaboratively with pediatric faculty in the US and abroad to advance the science and implementation of global health education for pediatric trainees, to prepare them to better serve children in resource-limited settings locally and globally. Come join us for both sessions during which we will welcome our global health education scholarship recipients (this year joining us from Guatemala and Botswana), share abstract presentations about global health education, and discuss ways to get involved in the group’s efforts.

RESEARCH AND SCHOLARSHIP
This year, we will be holding two sessions at the spring meeting. During the first meeting (on Tuesday, March 31), we will review our accomplishments over the past year, then brainstorm as a large group how we can continue to best support scholarship for all APPD members. The majority of our session will be spent in small working groups that mix experienced and new learning community members based on individual areas of interest. We will continue that work during this second session where individuals may continue to connect and advance their work and goals for the upcoming year.

UNDERREPRESENTED MINORITIES IN PEDIATRIC GME
Meeting for existing sub-groups only; not open to other registrants.
Introduction: The requirements for successful completion of Pediatric Residency is clear, but until recently there was very little guidance regarding physician work-life integration. Given the growing awareness of physician burnout and the increased physician suicide rate compared to the general public (American Journal of Psychiatry. 2004. 161(12), 2295-2302), our program deemed it necessary to implement a curriculum focused on wellness early in medical training. Methods: Our program implemented a Professional Development and Wellness Week (7 days) during intern year. During this week, interns are required to meet with their adviser, shadow an inpatient nurse, and create a “chalk talk”. Otherwise, they are provided a menu of personal and professional activity suggestions. Interns complete a survey at the end of their week documenting the completed activities. Outcomes: Thus far, 13 of 24 (54%) Pediatric residents have completed their PDW week and post-completion survey. The most commonly selected activities included: completing outstanding MedHub evaluations (100%),
engaging in a favorite hobby (100%), attending a health-related appointment (92%), and organizing email/EMR (76%).

**Results**: The most common optional activities that residents completed during protected personal development time include administrative tasks (email and evaluations) and healthcare-related activities. **Conclusions**: When provided unstructured time for personal development, interns may prioritize completing outstanding administrative tasks and health-related appointments. This suggests that a longitudinal administrative “half-day” experience may be beneficial. Future directions also include collecting data related to administrative tasks and burnout.

4. SUSTAINED REDUCTION IN RESIDENT BURNOUT: IMPACT OF AN INNOVATIVE WELLNESS ROTATION

**Kelsey Kaneshiro, MD, Sacha Bridi, DO, Andrew Wilson, MD, Jessica Wyka, MD, Jean Aschkenasy, PhD, Bridget Voigt, MD, Jean Silvestri, MD, Rush University Medical Center, Chicago, IL**

**Background**: Burnout, depression, and risk of suicide are pressing issues in residency programs. Novel strategies to mitigate burnout and promote resiliency are needed. **Objective**: To reduce rates of burnout in our program at Rush University Medical Center, we initiated a multi-faceted approach featuring a Wellness Rotation in the PL-2 year, an ICU-heavy year, with PL-2s historically reporting the highest rates of burnout in our program. Our aim is to promote a resilient workforce for the well-being of our residents and their patients. We seek interventions that produce reductions in burnout that are sustained over time.

**Design Methods**: The Wellness Rotation was created for PL-2s beginning in July 2017 that includes: scheduling appointments with healthcare providers, covering for other residents with healthcare appointments, check-in with staff psychologist, Board review, self-care (exercise, meditation), and meetings with academic advisors. Clinical duties are limited to continuity clinic and coverage for co-residents with healthcare appointments. Before and after the creation of the rotation, we participated in the Pediatric Resident Burnout-Resilience Study Consortium (PRB-RSC) survey, which includes scales of stress and resilience including the Maslach Burnout Inventory (MBI). **Results**: In 2017 (pre-intervention), 55% of Rush pediatric residents completed the PRB-RSC survey, compared to 90% in 2018 and 82% in 2019. The percent of residents experiencing burnout, defined as scoring high on the emotional exhaustion and/or depersonalization scale of the MBI, fell from 59% (2017 survey) to 45% after the implementation of the Wellness/Study rotation (2018) and further decreased to 32% with its continuation (2019). Rates of burnout in PL-2 residents fell from 80% pre-intervention, to 30% in 2018 and remained at 30% in 2019. **Conclusions**: The Rush Pediatrics Wellness Curriculum includes multiple interventions to prevent and mitigate resident burnout. This innovative model, including the Wellness/Study rotation, appears to have decreased our rate of burnout with sustained improvements over the past 2 years.

5. DISTRESSING EVENTS: WHAT DO OUR TRAINEES WANT? A QUALITATIVE STUDY FROM A LARGE PEDIATRIC RESIDENCY PROGRAM

**Alexandra Kilinsky, DO, Joshua Belfer, MD, Lance Feld, MD, Rashi Kabra, MD, Jami Zaretsky, MD, Cheryl Taurassi, MD, Zucker School of Medicine at Hofstra/Northwell at Cohen Children’s Medical Center, New Hyde Park, NY**

**Background**: Patient care events that cause emotional distress are common during pediatric training. Research has demonstrated that ICU rotations have a significant impact on trainee burnout likely in part due to the number of distressing events that occur in that environment. Interventions have been proposed by the AAP for training on peer-debriefing as well interventions to decrease distress in the ICU. **Objective**: Perform a needs assessment in our training program to: examine what scenarios lead to distress, assess how they are able to process these events and, have their voices be heard on how they want to be debriefed. **Methods**: Semi-structured interviews guided by open-ended questions were conducted with 15 trainees from our large academic pediatric training program. Demographic information was collected. Data was transcribed and analyzed using a phenomenological approach. The transcribed data was coded using an iterative approach and organized into themes. **Results**: Interviews were conducted from Aug-Dec 2019. About half of our participants were female (8, 53%) and nearly all were senior residents PGY 2 (8, 53%), PGY-3 (6, 40%). Trainees experienced distressing cases either in the NICU or PICU. Based on data analysis, these cases elicited feelings of shock, loneliness, helplessness, or fear. Currently, residents receive untrained support from their peers and families and are additionally challenged by the lack of protected time to debrief the event. A common theme revealed that the trainees expect a debrief from the service faculty to assist them in processing these events. The lack of intervention by the service faculty contributes to a higher level of distress in our trainees. When describing their ideal debrief, they all agreed that the emotional debrief should stand alone from a medical debrief. **Conclusions**: Emotionally charged patient care events have a strong impact on trainees and lead to higher rates of burnout. We plan to use this data to support peer-training in debriefing, as well as to develop a framework for service faculty to use to debrief these events with our trainees.

6. A MULTICENTER CLUSTER RANDOMIZED CONTROLLED TRIAL OF A NOVEL MINDFULNESS CURRICULUM DURING PEDIATRIC INTERNSHIP

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**Objective**: During pediatric internship

**Results**: The most common optional activities that residents completed during protected personal development time include administrative tasks (email and evaluations) and healthcare-related activities. **Conclusions**: When provided unstructured time for personal development, interns may prioritize completing outstanding administrative tasks and health-related appointments. This suggests that a longitudinal administrative “half-day” experience may be beneficial. Future directions also include collecting data related to administrative tasks and burnout.
Background: Physician burnout affects many physicians and is associated with decreased patient safety and physician health. Mindfulness curricula can reduce burnout but are often impractical to implement during residency. Objectives: To determine how a novel 6-month mindfulness curriculum designed for pediatric trainees impacts physician burnout, mindfulness, and empathy. Methods: 15 pediatric residency programs’ interns participated in a stratified, cluster randomized controlled trial of the “Mindfulness Intervention for New Interns” (MINdI) curriculum. Participants completed the Maslach Burnout Inventory, Five Facet Mindfulness Questionnaire, and 2 Interpersonal Reactivity Index empathy scales and measures of mindfulness-related knowledge, attitudes, and behaviors. Burnout was defined as an emotional exhaustion (EE) score >= 27 or a depersonalization (DP) score >= 10. The primary outcome was EE score. Missing data was addressed by conducting 20 data imputations. To determine impact of study arm on outcomes, we conducted logistic and GEE regressions clustered on site while controlling for factors that differed by arm. Results: 340/365 invited interns completed the baseline survey (93.1%), and 254 completed follow-up (69.6%). At baseline, the mean EE score of the MINdI and control arms did not significantly differ (coef. -0.25; 95% CI: -4.54, 4.04), but the odds of burnout was significantly higher in the MINdI arm than controls (OR 2.73; 95% CI: 1.085, 7.43). Compared to controls, there were significantly higher mindfulness-related knowledge, attitudes, and behavior and higher EE scores in the MINdI arm at follow-up (coef. 2.45; 95% CI: 0.90, 6.66). At follow-up, burnout, mindfulness, or empathy scores did not significantly differ by arm. Conclusion: Interns randomized to experience MINdI had higher EE despite increased knowledge, attitudes, and behaviors about mindfulness. The MINdI curriculum did not affect burnout, mindfulness, or empathy. As the curricula improved some measures of learning but increased EE future rigorous study of curricula to reduce physician burnout is needed.

7. ASSOCIATION OF SELF-REPORTED QUALITY OF CARE MEASURES AND BURNOUT: AN INVESTIGATION FROM THE PEDIATRIC RESIDENT BURNOUT-RESILIENCE STUDY CONSORTIUM

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Background: The Pediatric Resident Burnout-Resilience Study Consortium (PRB-RSC), established in 2015, is committed to studying the epidemiology, natural history, and impact of interventions designed to address burnout and improve resilience in pediatric residents. Annual surveys demonstrate a prevalence of burnout of 40-55% over the last 4 years. Previous regional work has shown an association between resident burnout and sub-optimal patient care. Design/Methods: The PRB-RSC distributed the annual survey to pediatric residents in participating programs in the spring of 2019. Data was de-identified, collected and maintained by the Association of Pediatric Program Directors’ Longitudinal Educational Assessment Research Network. Residents were classified as burnout on the basis of a 2-item screen for emotional exhaustion/depersonalization. An ordinal mixed effects generalized additive model regression was used to examine the effect of burnout on reported quality of care behaviors. For the ten behaviors queried, perceived stress scale (PSS), cognitive and affective mindfulness scale (CAMSR), and overall quality of life score (QOL) were compared between those with recent (<3 months) and distant (>12 months) poor quality behaviors reported. Results: A total of 46 pediatric programs participated in the 2019 PRB-RSC survey, with an overall response rate of 62% (n=1648). The recency of reported sub-optimal behaviors between those with and without burnout is shown in the Figure. After controlling for training year, age, male gender, white race, program size and region, and clustering of learners in programs, each p-value is <0.004. Residents reporting more recent sub-optimal behaviors also reported higher perceived stress, lower mindfulness, and decreased overall QOL. Conclusion(s): In this national survey, pediatric resident burnout is associated with sub-optimal care delivery, while recent experience with sub-optimal care is associated with higher stress, lower mindfulness, and decreased overall QOL.
8. MENTORSHIP IN RESIDENCY: IS IT PROTECTIVE AGAINST BURNOUT?
Lydia M. Rabon, MD, Dorothee Newbern, MD, Phoenix Children’s Hospital, Phoenix, AZ

Background: Burnout in residency is multifactorial. Despite increased awareness of burnout and its risks, there is a paucity of information on how residency programs can mitigate these risks. While there are some reports that multidisciplinary interventions may be protective, there is little literature about mentorship without other interventions. The abbreviated Maslach Burnout Inventory (aMBI) has been validated in assessing burnout. The areas assessed are Personal Accomplishment (PA), Emotional Exhaustion (EE), and Depersonalization (De), with total scores in each area of 18. Lower scores in PA, and higher scores in EE and De are associated with higher burnout. Methods: This was a descriptive study that used survey methodology and included pediatric and medicine-pediatric residents. Data was collected anonymously through a REDCap database. The aMBI was utilized. Residents were asked if they were able to identify a mentor. The sums and means of the residents’ scores on the aMBI for PA, EE, and De were calculated. Both the sums and the means of those with and without a mentor were compared using Chi-square testing, with significance indicated by p value < 0.05. Results: 72 residents completed the survey. 56 identified at least 1 mentor and 16 did not. All residents scored a 10 or higher in the area of PA with 70% scoring 14 or more. The mean of PA was 14.4 for those with a mentor and 14.3 for those without (p=0.70). 40% scored 10 or greater in De, with 11% scoring 14 or more. The mean of De was 7.8 with a mentor and 8.2 without (p=0.97). 70% scored a 10 or higher in EE with 33% scoring 14 or more. The mean of EE was 8.63 with a mentor and 11.22 for those without (p=0.58). Conclusion: There may be factors that prevent burnout; however, the presence of a mentor alone was not correlated with different scores in the areas of PA, EE or De. Residents scored high in the area of PA, which is protective against burnout. Over two thirds of residents scored 10 or higher in the area of EE suggesting that resident burnout is more closely linked to EE than PA or De.

9. UNDERSTANDING BURNOUT THROUGH THE LENS OF THE PEDIATRIC RESIDENCY TRAINING ENVIRONMENT
Linessa M. Zuniga, MD, Julieana Nichols, MD, MPH, Teri L. Turner, MD, MPH, MEd, Carla Falco, MD, Baylor College of Medicine (Houston), Houston, TX

Background: Despite interventions, burnout continues to increase among trainees. In a recent study of pediatric residents, the burnout rate was found to be > 50%. Though burnout is a major issue, there is limited data on effective interventions which begs the question, what are we missing? An organizational context for burnout titled Areas of Worklife, identified 6 areas that can affect burnout in the workplace: control, values, reward, fairness, workload, and community. Understanding how residents perceive these areas and their significance in the context of residency is vital as it provides a unique insight into the problem that could inform future interventions. Objectives: This study aimed to gain a deeper understanding of resident perspectives related to the six Areas of Worklife and their significance in the context of residency. Methods: Using qualitative methodology, we conducted semi-structured interviews with a convenience sample of 15 residents and focused on resident’s perspective of the Worklife areas. Interviews were recorded and transcribed verbatim. Analysis was conducted concurrent with data collection using a constant comparison method; we used ATLAS.ti to manage the data for coding and the principal investigator and 2 co-investigators created themes. Results: Themes identified based on Worklife areas are listed in Table 1. Overall, patient care was a lens through which residents understood the areas of control, reward, values, and workload. The themes identified in these leading areas focused on the resident’s ability to interact with and learn from patients. Conclusions: Resident definitions of the Worklife areas highlight the importance of patient involvement in the residency training experience, which is consistent with the literature that shows patient care is a means for residents to find meaning in their work. Understanding resident perspectives on Worklife areas is essential when developing potential interventions for burnout in residency.

10. CREATING A HOLISTIC MODEL OF BURNOUT DRIVERS AND MOVING TOWARD USEFUL INTERVENTIONS IN PEDIATRIC ACADEMIC MEDICAL FACULTY
Tara F. McKinley, PhD, University of Louisville, Louisville, KY

Background: Burnout drivers and interventions are poorly understood despite numerous studies addressing the topic. Burnout rates are steady or increasing in physicians although many organizations have implemented wellness interventions. PURPOSE: The purpose of this study was to create a holistic picture of burnout drivers in academic medical faculty in a single department of a large, research university. Methods: This qualitative interview study used Interpretive Phenomenological Analysis (IPA) and the Job Demands-Resources Model. Full-time faculty members completed two semi-structured interviews. Topics discussed included: job roles, stressors, resources, attitudes, organizational characteristics, and asked faculty to define burnout and describe their own levels of burnout. Interviews were transcribed and coded using deductive and inductive coding. A transferrable model of drivers was created. Results: Twenty-two faculty were interviewed. Eight participants (36%) self-reported burnout; 9 (41%) denied burnout. Burnout was reported in multiple specialties, experience levels, and demographics. The most common theme was job demands, but stressors were unit- or context-specific, not universal. Faculty discussed interpersonal factors as meaningful aspects of their jobs. Faculty did not participate in organization-sponsored interventions due to a lack of time or interest but discussed their own personal coping mechanisms. Recognition salient in determining self-reported level of burnout. Conclusions: Organizations should focus resources on interpersonal factors rather than individual interventions. Recognition scholars recommend promoting social and political recognition, which has been shown to increase feelings of personal accomplishment, an established dimension of burnout. Organizations should use caution using the term burnout to mask more serious mental health conditions. Scholars note no difference in symptoms between stress, burnout, and depression and add that burnout has been used as a catch-all. Recommendations were made to department leadership in four action areas.

Service Balance
Productivity
Recognition
Colleagues
Job Fit
Climate
Burnout
11. TIME IS OF THE ESSENCE: ONE RESIDENCY PROGRAMS APPROACH TO BREAKING DOWN BARRIERS TO ACCESSING MENTAL HEALTH RESOURCES

Aaron M. Silver, MD, Jennifer L. Farabaugh, MPH, Donna Holland, MD, Phoenix Children’s Hospital, Phoenix, AZ

Background: Physician burnout is a serious, well-documented phenomenon that occurs at all levels of medical training that contributes to a higher incidence of suicide compared to age-matched peers. Surveyed students and residents ranked barriers to accessing care, which showed that time constraints (52%) were the primary barrier, followed by fear of retribution, and the stigma associated with mental illness. Aim: The aims of the project are three-fold. 1. To decrease barriers and stigma preventing residents from obtaining mental healthcare; 2. Expose training physicians to the system of mental health resources prior to need; 3. Improve long-term wellbeing through dedicated time and support for accessing mental health resources. Intervention: A 5 question survey was administered to assess baseline attitudes toward counseling and knowledge about the Employee Assistance Program (EAP). Beginning January 2019, residents were provided at least 3 opportunities to schedule a “wellness check-in” with a counselor or psychologist during designated rotations throughout each training level. Time was free from clinical obligations and flexible for scheduling with advanced notice (2-3 weeks). A map of vetted providers in close proximity to the institution and detailed instructions EAP system access were provided prior to each rotation. Post surveys were distributed monthly. Results: Baseline data revealed 49% of respondents knew where to find EAP resources compared to 62% post intervention. Over the 12-month pilot phase, 30% of eligible residents utilized the program. Of those who did not, three major barriers were noted: EAP system navigation (26%), provider availability (26%) and awareness of the program/time to schedule (22%). In addition, 8% more respondents rated counseling favorably compared to prior to the intervention. Of the respondents, 35% reported not feeling the need for an appointment. Conclusion and Next Steps: At the conclusion of the pilot phase, we have implemented the notification system to send reminders 3, 2, and 1 month prior to an eligible rotation to increase awareness and time for scheduling. As a result of these interventions, we hope to increase utilization of the program, normalize counseling and decrease barriers to seeking mental health resources. Next steps also include expanding the vetted counselor map including reviews to increase the ease of making the first appointment.

Curriculum/Procedures/Simulation
12. SAY WHAT: QUANTIFYING AND CLASSIFYING JARGON USAGE ON INPATIENT ROUNDS

Michael B. Pitt, MD, University of Minnesota, Plymouth, MN, Marissa Hendrickson, MD, Jordan Marmet, Corinne Praska, Victoria Charpentier, Rachel Gottlieb, University of Minnesota, Minneapolis, MN

Background: Despite understanding that plain language is essential for effective communication, prior research found that medical providers still use terminology that may be misunderstood by patients (i.e. jargon) several times per encounter. However, little is known about the types and frequency of jargon used in the pediatric inpatient setting. Methods: After training for consistency, three medical students audited inpatient morning rounds on a general pediatric service, recording and categorizing all jargon used with a novel jargon classification framework published by Pitt and Hendrickson (Eradicating Jargon-Oblivion - A Proposed Classification System of Medical Jargon; JGIM 2019). After each day of rounds, students provided feedback to the medical team. The study period consisted of 12 sessions over 12 weeks. Results: Over 12 weeks, there were a total of 446 jargon words spoken, 313 (70%) of which were not explicitly defined to the patient or family by the healthcare provider. The average (± standard deviation [SD]) undefined jargon words per patient (JPP) was 4.5 (±3.31), and the average (±SD) undefined jargon words per minute (JPM) was 0.37 (±0.13). The most common categories of jargon used include Technical Terminology (e.g. bronchiolitis, 36.7%), Medical Vernacular (e.g. blood culture, 30.8%), and Acronyms (e.g. NPO, 18.1%). Conclusion: Undefined jargon was used frequently by healthcare providers in the inpatient pediatric setting. Additional study is indicated to further understand and identify optimal interventions to reduce jargon use at the bedside. Future interventions could consider families with pre-existing medical knowledge, expand the program to other specialties, and include patient and/or family reflections on observed encounters.

13. PREPARING FOR THE PICU: A QUALITATIVE STUDY OF RESIDENTS FIRST TIME

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Background: Learning in the pediatric intensive care unit (PICU) can be stressful and complex. While theoretical models and innovative resources have been developed with the trainee in mind, few studies seek to characterize their voices and experiences. In this study, we aim to describe the resident learner as they prepare for their first pediatric critical care rotation. Methods: Using a grounded-theory approach, pediatric (PM) and emergency medicine residents (EM) were interviewed before and after their rotation. The interviews were audio-recorded and transcribed. Two researchers independently coded the pre-rotation transcripts and discussed the coding system until agreement. The transcripts were then analyzed for
14. DESIGN AND EVALUATION OF A PEDIATRIC RESIDENT COMPLEX CARE CURRICULUM

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**Background:** Despite early career physicians’ competence in caring for children with medical complexity (CMC) when acutely ill, residents often do not receive adequate training to care for CMC in the primary care setting. A recent national Delphi study identified 11 curricular gaps in the care of CMC. This study evaluates the design of a curriculum that addresses majority of these gaps. **Methods:** Pediatric residents first watch an orientation video to learn the rotation expectations and complete an anonymous pre-rotation assessment and 4 pre-tests, one for each week’s themes. Each week learners receive didactic lectures, conduct ~ 15 patient visits per week, engage in community-based site visits, and complete writing assignments demonstrating grasp of health literacy and/or evidence-based practice guidelines. Residents complete the rotation with 4 post-tests, a post-hospital rotation assessment, and a reflection. Results: The curriculum, guided by Kolb’s experiential cycle, was delivered to 28 postgraduate trainees over 3½ years of pilot and implementation phases. Complete data were collected for 14 residents/fellows between June 2018 and November 2019. Test scores and trainee self-assessments reveal significant improvement in knowledge (26.3% vs. 99.4%), skills (41.7% vs. 100%), and self-reported behaviors (16.3% vs. 56.6%). Trainees produced 21 reflections describing changes in attitudes, 19 published blogs and 12 health care transition data were collected for 14 residents/fellows between June 2018 and November 2019. Test scores and trainee self-assessments reveal significant improvement in knowledge (26.3% vs. 99.4%), skills (41.7% vs. 100%), and self-reported behaviors (16.3% vs. 56.6%). Trainees produced 21 reflections describing changes in attitudes, 19 published blogs and 12 health care transition.

**Conclusion:** A pediatric resident complex care curriculum addressing majority of nationally recommended topics improves trainees’ knowledge, skills, attitudes, and self-reported behaviors.

*Winner – APPD QI Project Award*  
15. WHO SPEAKS FIRST? PROMOTING SENIOR RESIDENT AUTONOMY ON FAMILY CENTERED RoundS: A QI INITIATIVE

Alexandra Kilinsky, DO, Rashi Kabra, MD, Timothy Brandt, MD, Dev Darshan Khalsa, MD, Nicole Leone, MD, Zucker School of Medicine at Hofstra/Northwell at Cohen Children’s Medical Center, New Hyde Park, NY

**Background:** Graduated resident autonomy is fundamental as a trainee begins to transition to independent practice. Family Centered Rounds (FCR), the leading model of inpatient rounding in pediatrics, is an opportunity for trainees to demonstrate their competence in leading a healthcare team, which is included as an entrustable professional activity for all pediatric residents by the American Board of Pediatrics. At our institution, senior residents (SR) at baseline performed at a novice level based on the SREA-21, a validated tool that assesses SR autonomy during FCR in 4 domains. **Aim Statement:** Our aim was to increase the median percentage of SREA-21 domains where SR perform at a competent level from 38% to 75% within 6 months. **Interventions:** We used the Model for Improvement to identify key drivers and test proposed interventions using serial PDCA cycles. Interventions included: creation of unified inpatient SR expectations agreed upon by the division of pediatric hospital medicine, introduction of a hospitalist-SR pre-FCR huddle, auditing of FCR interruptions, and direct feedback to the hospitalist-SR dyad by the observer after FCR. Run charts were used to track both SR and hospitalist scores based on the SREA-21 tool. **Measures:** Researchers observed 4 FCR encounters weekly, and calculated SREA-21 domain scores based on actions promoting SR autonomy that were performed by the hospitalist-SR dyad. The primary outcome measure was the percentage of SREA-21 domains in which the SR achieved a competent score based on the tool. **Results:** Prior to our interventions, the median percentage of SREA-21 domains in which the SR performed at a competent level was 38%. After multiple PDCA cycles, there was special cause improvement with a desirable shift upward in the median to 75%, which correlated with the project’s interventions and met our goal. The creation of unified SR expectations and the addition of a daily hospitalist-SR huddle had the strongest impact on SR autonomy. **Conclusions and Next Steps:** Using quality improvement methodology, we improved senior resident autonomy during FCR, as measured by the SREA-21 tool. Future interventions will be aimed at sustaining this improvement and evaluating the effect of this change on future independent practice, as well as resident well-being.
16. DEVELOPMENT OF VALIDATED SURVEYS TO STANDARDIZE EVALUATION OF GLOBAL HEALTH TRACKS
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Introduction: Global health (GH) tracks are becoming increasingly common in pediatric residency and fellowship programs around the country. A recent Delphi process1 identified a consensus definition for GH tracks within pediatric residency programs, determined key educational and institutional components, and established target outcomes for programmatic evaluation. The aim of this project was to develop and validate a set of standardized surveys to be used as an evaluation tool for pediatric GH tracks.

Methods: The authors, all committee members of the American Association of Pediatric Program Directors Global Health Learning Community (APPD GHLC), created a set of standardized surveys to serve as an evaluation tool to facilitate comparison of resources and outcomes among GH tracks within pediatric residency programs. Based on consensus outcomes identified in a previous Delphi,1 the authors created surveys for four stakeholder groups: (1) current GH track residents, (2) GH track alumni, (3) GH track directors, and (4) GH track host sites/partners. Surveys sought to assess resident perceptions, educational outcomes, influence of tracks on career paths, and the human and monetary programmatic resources required to run tracks. As initial validation steps, the authors developed survey questions based on previously identified outcomes and input from stakeholders. The survey was reviewed by a survey methodologist to support content validity. To collect evidence of response process validity, structured cognitive interviews were conducted for each survey with 1 or more stakeholder group members with further edits incorporated. Results: The resulting surveys will be piloted among three pediatric residency GH tracks in Spring 2020 with subsequent analysis of pilot data planned to assess reliability and further construct validity. Data will be used by individual GH tracks for programmatic improvement and will allow comparison among GH tracks for future research.


17. ENHANCING INFLUENZA VACCINE KNOWLEDGE AND CONFIDENCE AMONG RESIDENTS
Lynda C. Arririgozo, MD, MPH, Linessa M. Zuniga, MD, MEd, Andria E. Tatem, MD, Teresa K. Duryea, MD, Baylor College of Medicine (Houston), Houston, TX

Background: The 2017-18 influenza season was severe. Many children who died were unvaccinated. Yet a third of parents interviewed before the 2018-2019 influenza season reported their children would not receive influenza vaccines. Pediatric residents may not be comfortable counseling vaccine hesitant families. Through a fellow-led QI project, we aimed to provide educational interventions to increase pediatric residents’ knowledge and confidence counseling influenza vaccine hesitant families.

Aim Statement: To increase both pediatric residents’ perceived knowledge of resources and their confidence in addressing influenza vaccine hesitant parent concerns by 85% in 7 months.

Interventions: We obtained baseline data via anonymous online surveys to measure pediatric residents’ confidence and perceived knowledge of resources. Residents
participated in fellow-led educational sessions that discussed vaccine manufacturing, adverse effects and common myths. We introduced the CASE method, a resource to improve counseling skills toward vaccine hesitant families. Resources were distributed with facts debunking common myths and an outline of the CASE method. Residents participated in a role play activity to practice counseling. In a second educational session for PDSA cycle 2, we modified the role play activity to facilitate more interaction and provide feedback on counseling techniques. Measures: Outcome measures were resident perceived knowledge of resources and resident confidence. Results: At baseline, 58% of pediatric residents reported being knowledgeable about resources for influenza vaccine hesitant families; 48% of residents reported being confident addressing parents' influenza vaccine related concerns. After the first intervention, residents' knowledge increased to 100% and confidence to 58%. After the second intervention, residents' knowledge was 93% and confidence was 79%. Conclusions and Next Steps: Providing education to pediatric residents on the influenza vaccine and guided counseling can increase residents' knowledge and confidence in counseling parents who are influenza vaccine hesitant. Future studies will explore using this same technique to improve resident confidence in counseling other difficult situations.

18. EFFECTIVENESS AND PERCEPTIONS OF FLIPPED CLASSROOMS WITHIN A PEDIATRIC RESIDENCY
Michelle E. Kiger, MD, Lauren Coogle, MD, Thomas Bertagnoli, DO, Wright State University, Dayton, OH
Objective: Flipped classroom (FC) curricula, in which learners review material independently prior to in-person sessions that employ active learning strategies, are increasingly being used in medical schools but have not been widely implemented in residency programs. We examined feasibility, knowledge acquisition, and learner perceptions of FC modules within a pediatric clinic. Methods: Authors created 4 FC modules on common pediatric topics and lectures covering equivalent content. From Jan-Jun 2019, these modules and lectures were incorporated into morning didactics at an outpatient clinic using a crossover design, such that 2 topics were covered as an FC module and 2 as a lecture one month, then flipping the delivery method for each topic the following month. Residents completed 10-item pre-tests prior to participation in each FC session or lecture and post-tests following. Pre- to post-scores were compared using t-tests, and average change in pre- to post-test score for all FC sessions versus all lectures was compared using a Mann-Whitney U test. Residents completed a 6-item immediate perception survey after participation in each FC session and a final 10-item survey on overall perceptions of the FC model as compared to lectures at the end of each monthly block. Results: 36 residents participated. Residents scored significantly higher on post-tests than pre-tests for all modules regardless of instructional method, except for the knee pain FC module (Figure 1). The average improvement in pre- to post-test score between all FC sessions (2.1 points) and traditional lectures (2.4 points) was not different (U=7.0, n=4, p=0.44). Residents found FC pre-readings (4.0) and in-person sessions (4.1) useful for learning and reported high overall satisfaction with the FC model (4.0) on a 5-point rating scale. They favored FC sessions over lectures with respect to engagement (4.3), learning effectiveness (3.9), application to clinical practice (3.9), and overall preference (3.9) on a bipolar rating scale (1=strongly prefer lecture, 5=strongly prefer FC). Conclusion: Flipped classroom modules within a pediatric clinic resulted in similar knowledge gains to lectures but were preferred by residents.

19. CHARACTERIZING HIGH-VALUE LEADERSHIP TRAINING IN PEDIATRIC RESIDENCY PROGRAMS
Steven M. Loscalzo, MD, Children's Hospital of Philadelphia, Philadelphia, PA, Tracy Seimears, MD, University of Washington, Seattle, WA, Nancy D. Spector, MD, Drexel University, Philadelphia, PA, Theodore C. Sectish, MD, Thomas J. Sandora, MD, Children's Hospital/Boston Medical Center, Boston, MA
Background: Increasingly, physicians serve as leaders in varying roles, but often with minimal dedicated leadership training. Existing pediatric residency competencies may not provide a complete description of all leadership skills that should be valued. Objective: We sought to identify a set of high-value leadership skills and evaluate current training in these skills in pediatric residency programs. Methods: A modified Delphi process that incorporated multi-disciplinary and multi-institutional input was used to identify and define a list of core leadership skills. After reaching consensus, we conducted a national survey of pediatric residency program directors. Programs were asked to rate the perceived importance of each identified leadership skill and the presence of dedicated teaching of these skills during residency. Skills identified as extremely or quite important by 90% of respondents were classified as high-value. Results: The modified Delphi process generated 16 core...
20. POINT-OF-CARE ULTRASOUND EDUCATION FOR PEDIATRIC RESIDENTS: A MULTICENTER NEEDS ASSESSMENT

Austin S. Meggitt, MD, David P. Way, MEd, Maya S. Iyer, MD, MEd, John D. Mahan, MD, Delia Gold, MD, Nationwide Children’s Hospital/Ohio State University, Columbus, OH

Background: Point-of-care ultrasound (POCUS) is rapidly growing as a non-invasive imaging modality to enhance procedural safety and efficiently reach diagnoses. Despite established applications in general pediatrics and high value to many pediatric subspecialties, it is not widely used in residency and no national standard currently exists for inclusion of POCUS in training curricula. Objectives: To profile the current state of POCUS education in pediatric residencies in the State of Ohio. Methods: We defined our population as pediatric residents in the state of Ohio (N=558). We developed an electronic survey with guidance from POCUS content experts, a survey methodologist, and residency program leadership. The survey was piloted locally using family medicine residents. We randomly sampled 369 pediatric residents from the 9 programs in the state; stratifying by level of training and scaled to the relative size of each residency. Results: Our response rate was 59.6% (220/369). While 38% of respondents received POCUS education in medical school, only 15% have received it in residency (Table 1). Most respondents (86%) were interested in receiving POCUS education in residency and 67% believed that it should in fact be required. Specifically, they felt that POCUS would be useful for performing procedures (95%), learning clinical topics (94%), and improving patient safety (74%). Most of the residents surveyed (61%) felt that POCUS education would significantly benefit their careers regardless of subspecialty plans. In contrast, 85% had performed zero scans in residency. Barriers to POCUS education include the lack of an established curriculum (75%), competing priorities (58%), and inadequate knowledge and experience of faculty (52%). Conclusions: Pediatric residents want POCUS training and consider it beneficial to their future practice. Despite this, more than half receive no POCUS education in residency or medical school. Focusing upon further POCUS-specific curriculum development and faculty education may help address this educational gap.

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<th>Did you have ultrasound education during medical school?</th>
<th>YES</th>
<th>NO</th>
<th>TOTAL</th>
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<tr>
<td>Did you have ultrasound education in your residency program?</td>
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<tr>
<td>YES</td>
<td>16</td>
<td>63</td>
<td>79</td>
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<tr>
<td>7.3%</td>
<td>28.6%</td>
<td>35.9%</td>
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<tr>
<td>NO</td>
<td>18</td>
<td>123</td>
<td>141</td>
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<tr>
<td>8.2%</td>
<td>55.9%</td>
<td>64.2%</td>
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<tr>
<td>TOTAL</td>
<td>34</td>
<td>186</td>
<td>220</td>
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<tr>
<td>15.5%</td>
<td>84.5%</td>
<td>100%</td>
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21. FAMILY CENTERED CARE: LONGITUDINAL COMMUNICATIONS TRAINING FOR RESIDENTS

Melanie C. Marsh, MD, Suzanne Reed, MD, John Mahan, MD, Nationwide Children’s Hospital/Ohio State University, Columbus, OH

Background: Although a huge portion of medical care involves communication, there is little time dedicated to these skills. Additionally, family-centered communication is collaborative and interactive, and these skills are best taught through case-based approaches rather than passive lecture-type didactics. Objectives: We aimed to develop a longitudinal communication curriculum utilizing learner-identified content, delivered via interactive workshops over a 6-month period, supplemented with and guided by family feedback. Methods: The curriculum was developed using Kern’s scholarly approach. A needs assessment for resident communication skills was conducted with a survey and focus group. The Communication Assessment Tool (CAT) was used for parent feedback of residents’ performance early in the curriculum. Content for workshop sessions was developed from needs assessments, CAT results, and input from program leadership. The curriculum underwent expert internal and external review. Pediatric interns were randomly assigned to a control or intervention group. Six sessions were delivered over 6-months to the intervention group. CAT feedback was shared with the intervention group as part of the curriculum. Results: Survey and focus groups identified themes of 1) lack of comfort with communication skills in difficult encounters, and 2) desire for more feedback and practice with these encounters. Five hundred surveys were collected on 36 interns using the CAT prior to the intervention. A 5-point likert scale was graded as 5 or non-5 scores. Residents performed most poorly in discussion of next steps (38% non-5) and in showing interest in families’ ideas of their children’s health (28% non-5). Discussion: There are self- and patient-identified performance gaps in many pediatric interns, underscoring the need for formalized curricula to teach skills specific to communication in pediatrics, particularly with emphasis on shared decision making and teach back methods. Narrative feedback from resident curriculum participants has demonstrated increased confidence and comfort levels with difficult communication. Future directions include assessment of the patient and family impact of this curriculum using follow-up CAT surveys.
22. PARENTHOOD DURING RESIDENCY AND IMPORTANCE OF FAMILY-FRIENDLY BENEFITS

Hilary M. Haftel, University of Michigan, Itasca, IL, Weston Powell, MD, PhD, University of Washington, Seattle, WA, Mary Pat M. Frintner, MSPH, Kate M. Kornfeind, MPH, American Academy of Pediatrics, Itasca, IL

Background: Pediatric residents have many roles beyond their training, including parenthood. Little is known about residents who have a child during training and importance of family-friendly benefits in programs and future jobs. Objective: Examine experiences of pediatric residents with children during training and importance of family-friendly benefits in residency programs and post-graduate job selection. Methods: A random sample of 1000 US residency graduates were surveyed as part of the 2019 AAP Annual Survey of Graduating Residents and asked about children, family-friendly residency benefits and their importance in program selection and future jobs. Chi-square analyses compared responses by the presence of children and by gender. Results: 504 (51%) responded; 74% were female. 123 residents (25%) had children; 88% of these had or adopted a child during training. Most programs offered maternity leave (77%), lactation rooms (76%), and electives allowing new parents to stay home longer (64%). Among female residents who birthed or adopted a child during residency, 84% used maternity leave with a mean length of 7 weeks for women and 2 weeks for men. 73% of women and 100% of men were paid for their entire leave. 98% of women and 23% of men used some or all their vacation time. Less than 50% of all residents rated these benefits as very important in program selection; flexibility for time off was rated as very important by 46% of women with children, 44% of men with children, and 31% of residents without children (p<.01 for residents with vs without children). For post-graduate job selection, residents with and without children did not differ in importance of control over work hours (79% vs 74%). Spouse/family considerations were rated more often important for residents with children (97%) as compared to residents without children (71%, p<.001). Conclusion: 25% of residents have a child by the end of residency, with most doing so during residency. Most programs offer benefits for parents. Parental status plays a role in residency program and future job choice and may be a factor in recruiting trainees.

23. INFORMED CONSENT SMART PHONE APP IMPROVES LEVEL OF COMFORT AND KNOWLEDGE AMONGST PEDIATRIC RESIDENTS

Cassandra Koid Jia Shin, MD, Tania Lopez, MD, Edwin Forman, MD, Gwen Raphan, MD, Icahn School of Medicine at Mount Sinai (NYC Health and Hospitals/Elmhurst), Elmhurst, NY

Background: Obtaining informed consent is an integral part of medicine yet is a skill set that is not typically taught to residents formally. Lack of skill and confidence obtaining informed consent can have dire medical-legal consequences. Therefore, we created an informed consent smartphone app to give providers this information at their fingertips so they can successfully obtain informed consent on several common pediatric procedures in a more standardized fashion. Our objective was to assess if pediatric residents knowledge and comfort with obtaining informed consent would increase with an informed consent app. Methods: A prototype smartphone app was designed on Adobe XD with a standardized approach to obtaining informed consent for pediatric procedures (RBC and platelet transfusions, LP, conscious sedation, central lines and vitamin K refusal). In 2020, an anonymous pre-intervention questionnaire was circulated amongst pediatric residents in Elmhurst Hospital Center. Participants were given an opportunity to navigate the informed consent app and given a post-intervention survey. Results: Of the 25 residents who participated, all had previously obtained consent. Most learned how to obtain consent by observing another resident (72%) and surprisingly, 12% report that they obtained consent without any preparation at all. Self-reported level of comfort for procedures increased proportionally with every year of training. Residents’ comfort obtaining informed consent improved for every procedure after use of the informed consent app. 100% were comfortable obtaining informed consent with the app for all procedures with the exception of central lines which was not functioning on the app. 98% of residents agree that they would benefit from additional training in obtaining informed consent. 100% of residents agree that they would use the informed consent app. Conclusions: With the informed consent app, residents’ level of comfort increased for all procedures. This quick intervention showed promise as an easy way for residency programs to standardize an approach to obtaining informed consent.

24. IMPROVING RESIDENT EDUCATION IN THE PEDIATRIC INTENSIVE CARE UNIT THROUGH THE IMPLEMENTATION OF A STANDARDIZED CURRICULUM

Hillary Liken, MD, LeeAnneFlygt, MD, Margaret Kihlstrom, MD, University of North Carolina Hospitals, Chapel Hill, NC

Background: Trainees at our institution have traditionally found the Pediatric Intensive Care Unit (PICU) to be a challenging...
28. WHAT’S THE EVIDENCE? EVALUATING THE IMPACT OF A RESIDENT EVIDENCE-BASED MEDICINE CURRICULUM

Minnie Dasgupta, MD, Danielle Kirkey, MD, Jake Weatherly, MD, Kevin Kuo, MD, MHPE, Carrie Rassbach, MD, MAEd, Stanford University, Palo Alto, CA

Background: The ability to incorporate evidence-based medicine (EBM) into clinical practice is an ACGME competency, yet many pediatric residents have limited knowledge, comfort, and skill in this area. In addition, there is a lack of data regarding how residents apply EBM curricula to clinical practice. Objective: Describe the effect of an EBM curriculum on resident attitudes and clinical use of EBM. Methods: We implemented a twice-weekly EBM curriculum to review key literature and guidelines. In this IRB-exempt mixed methods study, we surveyed residents, fellows, and faculty about use of EBM at baseline and 6 months later. Results were compared using Mann-Whitney U tests. We surveyed faculty twice weekly about residents’ EBM use on rounds. Residents participated in focus groups, which were audio-recorded, transcribed and coded using conventional content analysis to develop themes. Results: Residents (N=61 pre- and 41 post-curriculum) reported increased: satisfaction with conferences (p=0.0037), importance of EBM (p = 0.0041), comfort generating a search question (p= 0.0001), and citation of evidence on rounds (p< 0.001). Faculty reported residents cited EBM during 73.9% of weeks (17/23) post-curriculum, with an average of 2.6 citations/week (range 0-13). Cited evidence reinforced faculty plans 88.2% of the time (15/17 weeks), taught them something new 70.6% of the time (12/17 weeks), and changed management 17.6% of the time (3/17 weeks). Focus groups with 22 trainees (12 PGY1, 10 PGY 2-3) yielded four themes. Residents reported: (1) increased use of evidence in clinical practice; (2) a better understanding of research methodology and evidence quality; (3) the need for a culture that promotes EBM; and (4) several barriers to successful use of EBM (Table 1). Conclusion: As a result of this EBM curriculum, trainees described increased use of EBM in clinical practice and better understanding of research methodology. Additionally, resident use of EBM reinforced plans, taught faculty, and at times, changed management. Ongoing work is needed to create a culture that promotes EBM.

Table 1: Resident Focus Group Themes and Subthemes

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<tr>
<th>Theme 1: Residents reported increased use of evidence in clinical practice as a result of the curriculum.</th>
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<td>Curriculum encouraged application of evidence to patients and promoted purposeful literature review; residents question standards of care, look at evidence behind guidelines, and more comfortably introduce evidence.</td>
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<th>Theme 2: Residents developed a better understanding of research methodology and its impact on quality of evidence.</th>
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<td>Residents better understand basic principles of study methodology and statistics and now recognize how study design impacts quality of findings.</td>
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<th>Theme 3: Residents need a workplace culture that promotes EBM to successfully use EBM in practice.</th>
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<td>Faculty modeling of EBM was an important motivator; a change in culture around EBM is necessary and is starting to take place; when faculty are open to EBM use by residents, residents feel motivated to continue.</td>
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<th>Theme 4: Residents identify several barriers to successful EBM use.</th>
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<td>Residents perceive hierarchy in decision making as a barrier and may defer to faculty to look for evidence; other barriers include multidisciplinary teams, family centered rounds and time.</td>
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Conclusions and Next Steps: We developed and implemented a standardized curriculum that has led to an increase in the frequency of didactic teaching sessions and improvements in resident satisfaction with the overall educational experiences in the PICU. Going forward, it will be important to gather additional feedback from trainees and PICU staff to improve the lecture materials and identify barriers to lectures taking place. It will be helpful to gather more objective data on the frequency of lectures and to look at resident exam scores pre- and post-intervention.

26. DELIVERING HIGH-QUALITY CONTINUITY CURRICULUM: USING A QUESTION OF THE WEEK MODEL TO INCREASE RESIDENT PARTICIPATION, MEASURE MEDICAL KNOWLEDGE ATTAINMENT, TRACK REPORTED PRACTICE CHANGES, AND OBTAIN IMPLEMENTATION FEEDBACK

Katy L. Mullens, MD, Jennifer Farabaugh, MPH, Kristin Samaddar, MD, Ethan Dodge, MD, Phoenix Children’s Hospital, Phoenix, AZ

Developing and delivering high-quality curriculum to residents during continuity clinic can be a challenge, particularly in large programs with multiple continuity sites. There are additional challenges in measuring the success of implementation such as...
participation and effectiveness of the content. This new curriculum is delivered online utilizing a customizable, hospital-based learning management system. This system allows content to be delivered systematically and enables tracking of participation and responses. Each topic begins with a multiple-choice question to assess baseline knowledge followed by an open-ended question designed to engage learners and give insight into topic expertise. This is followed by structured educational content after which the multiple-choice question is repeated, thus allowing measurement of knowledge attainment. Each topic includes measures related to topic relevance and anticipated practice habit changes. These follow-up questions allow targeting of topics which are reported as being high or low-yield and provide insight into resident practice habits. Since instituting this curriculum, resident participation increased from 71% (2017-2018) to 100% (2019-2020). For the 2019-2020 academic year we observed an increase in knowledge attainment in 8 out of 11 categories (ranging from 4-74%). Due to small sample size of questions (n=11) statistical significance is not yet applicable. Topic relevance was measured using a Likert scale. Most topics were found to be moderately (26%) to very (87%) relevant to our resident’s general pediatric practice. Across all topics, 86% of residents reported an anticipated change to practice habits based on knowledge attained. Moving forward, this curriculum will grant the ability to seek topic-by-topic feedback allowing us to continually edit and improve to best fit the needs of our residents and maximally enhance their primary care knowledge in a systematic and measurable way.

27. STRENGTHENING PARENT - PHYSICIAN COMMUNICATION: A RANDOMIZED DELAYED START CROSSOVER STUDY ON EMPATHIC COMMUNICATION TRAINING
Heather T. Taft, MD-PhD, University of Illinois College of Medicine at Chicago, Linda Gilkerson, PhD, Erikson Institute, Chicago, IL, Amanda Osta, MD, University of Illinois College of Medicine at Chicago, Alisa Seo-Lee, MD, Cook County Hospital, Alan Schwartz, PhD, Michelle Barnes, MD, University of Illinois College of Medicine at Chicago, Chicago, IL
Empathic communication improves satisfaction and clinical outcomes, yet formal empathy training in residency is often minimal. Recent reviews of such interventions show mixed results and are often limited by no patient input, brief study lengths, and insufficient reporting of curricula used. This study examines the effects of a unique empathic communication curriculum for pediatric residents using validated surveys and original feedback tools. Study design addresses the limitations above with the intent to create a curriculum for use by any program. We randomized 23 residents in 2 institutions for empathic communication training. Training occurred at the start or 6 months into the 12-month study. We measured empathy and mindfulness using 4 distinct instruments (2 for residents, 2 for parents) at 5 set timepoints. Residents also completed weekly self-reflection tools, a booster training session, and monthly mentor sessions for 6 months after their training date. One institution’s residents gave post study interviews. Parent surveys showed statistically significant rises in resident empathy after training (2.5%, p = 0.02 and 2.9%, p = 0.012). However, baseline scores were already high (90.2% and 88.6% respectively) limiting the amount of quantifiable improvement possible. Resident completed surveys showed no significant rise in scores with training. In qualitative analysis of mentor sessions and post study interviews, residents found the training helpful, noting improved attunement with families and perceptions of parent satisfaction. Residents especially cited better emotional self-regulation, greater focus on addressing parents’ prime concerns, and involving parents more in plan development. Empathic communication is a crucial skill for pediatricians, but many programs lack curricula that create lasting behavior changes. With modifications based on feedback from this pilot study, we believe this model for empathic communication education can be successful and reproducible at other institutions. This was funded by an APPD Special Projects grant.

28. AN APPROACH TO DIFFICULT CONVERSATIONS FOR PEDIATRIC RESIDENTS: CHILD MALTREATMENT
Megan L. McBurnie, MD, Jamie Campbell, MD, Peter Sell, DO, Sasha Svendsen, MD, University of Massachusetts, Worcester, MA
Background: Identifying and managing suspected child maltreatment is an unfortunate part of every pediatrician’s job. Many pediatric trainees feel uncomfortable with multiple aspects of suspected child maltreatment cases including introducing
concerns with caregivers, asking follow-up questions, documentation, requirements for mandated reporters, and available resources. Just like medical knowledge, communicating with patients and families in difficult situations is a skill that can be taught but may be lacking in the formal medical curriculum. Objectives: To teach a skill set that will increase resident comfort level in the setting of suspected child maltreatment cases. Interns experienced a didactic session covering an approach to difficult conversations (SPIKES and HARD protocols) as well as practical knowledge regarding their role as mandated reporter, history taking, physical exam, and documentation. The didactic session, residents experienced a role play session where they could practice the skills they just learned. Pre- and post-workshop surveys were obtained from trainees to evaluate both prior experience with child maltreatment cases as well as their comfort level with future child maltreatment scenarios before and after the workshop. Results: A total of 28 Pediatric and Medicine/Pediatrics interns completed this workshop over the course of 3 academic years. Compared to pre-workshop data, interns felt more comfortable discussing concerns for child maltreatment with parents or caregivers (p=0.0001), discussing a 51a/mandated reporting when there were concerns for child maltreatment (p<0.0001), and communicating with Department of Children and Families as well as the Child Protection team (both p<0.0001). In terms of written documentation, interns were more comfortable after the workshop with documenting the history (p<0.0001), the physical examination (p<0.0001), and completing 51a/mandated reporter paperwork (p<0.0001) after this workshop. Conclusions: A three-hour multi-modal workshop improved interns' comfort level regarding suspected child maltreatment cases including raising concerns with caregivers, communication with other team members, and documentation related to these cases. References: ‘Practical Plans for Difficult Conversations in Medicine: Strategies That Work to Break Bad News.' Robert Buckman, MD PhD.

29. USING VIRTUAL REALITY HEART MODELS TO TEACH CONGENITAL HEART DISEASE TO TRAINEES
Mehreen S. Iqbal, MD, Alaina K. Kipps, MD, MS, David M. Axelrod, MD, Stanford University, Palo Alto, CA
Introduction: Congenital heart disease (CHD) is the most common human birth defect. Atrial and ventricular septal defects (ASDs and VSDs) account for >50% of CHD. Three-dimensional (3D) Virtual Reality (VR) heart models convey more spatial information than standard 2D drawings and may enhance a learner understanding of these CHD lesions. We hypothesized that using an innovative approach to teaching CHD anatomy and physiology, supplementing traditional didactic teaching with simulation of ASDs and VSDs in an interactive VR heart model, is both feasible and beneficial to the learner’s comprehension and retention of CHD knowledge. Methods: This was a prospective, blinded randomized-controlled, crossover study. Pediatric residents were assigned to two groups and completed knowledge tests before and after the teaching sessions. Each group received one-on-one teaching for the 2 CHD lesions: one with VR (interventional session) and one didactic only (control session). Group A received VR teaching for ASDs and lecture only for VSDs, while group B had the opposite. VR sessions incorporated a lecture during guided use of interactive VR heart model using the Oculus Rift TM. Control sessions entailed a didactic lecture supplemented by 2D drawings of the lesion. Residents completed demographic surveys indicating year of training, previous cardiology exposure, and Likert style learner satisfaction questionnaires to evaluate their experience with the VR intervention. To assess retention, the knowledge test was repeated 3-6 months following the study. Analysis of the average percentage correct and average change in percentage correct between the pre-test, post-test, and delayed post-test was performed across the control and intervention groups to assess the efficacy of VR vs. traditional didactic education. We used the non-parametric 2-tailed Student's t-test to assess for statistical difference across groups. Results: Of the 20 pediatric residents who participated in the study, 70% were interns. 15% had completed a cardiology rotation during medical school and 30% had completed a cardiology rotation during residency. Average pre-intervention scores were 22 +/-17% and 31 +/- 8% for the control and VR groups respectively (p=0.38). Average post-intervention scores rose significantly across groups (p = 2.2 x10-8) but were similar comparing control and VR exposures (83 +/-17% and 93 +/-8% respectively; p=0.23). Retention test scores were also similar across exposures: 67 +/-11% and 57 +/-21%, respectively (p=0.27). All residents rated the overall quality of using VR to educate pediatric residents about CHD as excellent. Residents were more likely to feel “very confident” after VR based sessions. Residents also described VR as an engaging educational experience that increased their ability to visualize and describe CHD lesions. Conclusions: Using VR is an engaging and effective way to teach residents about CHD and results in knowledge acquisition and retention similar to traditional didactic teaching methods. Future studies with larger number of participants are needed to further explore the use of VR.

30. IMPROVING THE IMPACT OF A PRIMARY CARE ASYNCHRONOUS CURRICULUM IN PEDIATRIC RESIDENCY
Priya S. Rolfe, MD, Carolyn Rosen, MD, Rachel Wilkinson, MD, Stephanie Pan, Leora Mogilner, MD, Icahn School of Medicine at Mount Sinai (Kravis Children’s), New York, NY
Background: Few studies have assessed the efficacy of asynchronous curricula (AC) in GME. In 2018 we introduced the John Hopkins Physician Education & Assessment Center, a module-based pediatric primary care AC to replace in-person didactics (IPD). While residents liked the concept of AC, usage was low. This led to further investigation to optimize the impact of AC, resulting in a new blended curriculum (BC). Aim: Identify barriers to AC use; compare usage and satisfaction with AC alone vs. BC; determine if poor AC use in 2018 impacted knowledge as measured on the pediatric in-training exam (ITE). Design: A survey was sent to residents exposed to 1 year of AC to assess barriers and preference for IPD vs. AC. Results prompted design of a BC for 2019 with monthly resident-led conferences and faculty-led board review on assigned modules with incentives for module completion (MC). After 6 months of BC use, satisfaction and MC were assessed. ITE scores were collected from 2018 and 2019 for those exposed to a year of IPD and then a year of AC. Questions on primary care topics (PCT) were identified and a PCT subscore was computed. Results: 22/32 residents (69%) exposed to 1 year of AC completed the survey. 73% preferred a blend of IPD and AC, whereas prior to AC, 65% preferred AC to IPD. 68% cited either lack of protected time (41%) or accountability (23%) as barriers to MC. After 6 months of exposure to BC, 35/87 residents (41%) responded to the next survey; there was no preference for any one BC component.
MC for AC vs. BC was compared for 52 residents; median MC in 6 months increased by 3 in BC (p<0.003). Moreover, PGY-1s did on average 12 modules in BC vs. 5 in AC (p=0.0001). PCT sub scores were compared for 16 residents exposed to IPD and AC; AC was associated with an 8-point decrease in PCT sub score (p=0.001). Conclusion: A BC with in-person components and more accountability led to higher MC, underscoring the need to accommodate diverse learning styles. Resident PCT scores decreased significantly after 1 year of the underutilized AC. Further study will determine the impact of better BC participation on PCT scores.

31. IMPLEMENTING A CLINIC IMMERSION BLOCK BOOSTS INTERN CONFIDENCE AND EARLIER OUTPATIENT CLINICAL EXPERIENCES

Emily A. Disbrow, MD, Spectrum Health/Michigan State University/Helen DeVos Children’s Hospital, Wyoming, MI, Kira Sieplinga, MD, Justin Triemstra, MD, Monica Van de Riddar, PhD, Spectrum Health/Michigan State University/Helen DeVos Children’s Hospital, Grand Rapids, MI

Background: In United States pediatric residency programs, there is a wide range of interpretations of the ACGME requirement to educate residents in community pediatrics and advocacy. Previous iterations of our required month-long intern advocacy rotation included disjointed learning experiences without opportunities for clinical integration. Few programs utilize an integrated curriculum to approach this topic. We sought to integrate early clinical and advocacy experiences to increase their impact.

Methods: 20 interns participated in a “clinic immersion and advocacy” rotation during block 1 or 2. Interns were scheduled for continuity clinic in the morning (n=20 sessions in 1 month) and experiential community advocacy activities in the afternoon. We utilized Kern’s Six Step Approach as a conceptual framework for our intervention. Curriculum was developed using an iterative process; community activities were selected using the AAP’s Community Health and Advocacy Milestones Profile (CHAMP). Data was collected from a pre-intervention cohort (class 2021) and compared to our post-intervention cohort (class 2022). Interns completed a survey using visual analog scales to rate their confidence in managing conditions, and in using clinical tools and community resources. They also completed yes/no items verifying whether they had encountered specific types of visits or performed certain skills. The paired t-test was used to assess pre/post intervention confidence measures. Pearson’s chi-squared test was used to compare clinic experiences. Significance was assessed at p<0.05.

Results: Response rate was 78% (15/20 interns) for the pre- and post-intervention cohorts. Confidence measures were not statistically different between the two groups on 22/23 items. The intervention group rated their confidence in knowledge about community resources significantly higher than the non-intervention group (p=0.008). Clinic experiences were statistically similar between cohorts (1-month vs. 1 year). Discussion: This study shows our success in increasing clinical confidence and experiences earlier in intern year as, after 1 month of daily continuity clinic, the post intervention cohort was directly comparable to the pre-intervention cohort after 1 year of weekly continuity clinic. Future directions include whether our curriculum will lead to increased confidence in clinic skills longitudinally, retained confidence in knowledge of community resources, and generalizability to other residency programs.

32. RESIDENT COMFORT WITH CORE PROCEDURAL REQUIREMENTS

Elizabeth Landsberg, MD, Alison Mols, MD, Erin Cummings, MD, James Bohnhoff, MD, Andrew Nowalk, MD, PhD, UPMC Medical Education, Pittsburgh, PA

Background: ACGME requires graduating pediatric residents to perform essential procedures such as bag-mask ventilation (BMV), neonatal endotracheal intubation, lumbar puncture (LP), incision & drainage (I&D) of abscess, and fracture splinting. Recently there has been an increase in the number of providers who perform these procedures, with more residents and advanced practice providers (APPs), and increased utilization of interventional radiology. Additionally, there has been a dramatic decrease in the number of neonatal intubations performed since 2017 when the NRP recommended against intubation and suctioning for meconium aspiration syndrome. We hypothesize that pediatric residents have become less comfortable performing core procedures.

Methods: The number of categorical pediatric trainees from 2011-2017 was obtained from the ABP. The National ACGME Pediatric Resident Survey Data from 2013-2019 were reviewed, including Likert scale resident responses on how well prepared they felt to perform procedures (BMV, neonatal endotracheal intubation, LP, I&D of abscess, and fracture splinting) without supervision.

Results: From 2011-2017, there was a 6% increase in the number of categorical pediatric residents, from 8,774 to 9,396. Resident comfort with performing procedures declined from 2013-2019 for all five procedures. Residents felt more comfortable performing LPs and BMV. There was a 17% decline in comfort with neonatal intubations, with the steepest drop off after 2017.

Conclusions: Pediatric residents are less comfortable performing core procedures. This correlates with an increase in the number of trainees and APPs. Residents felt more comfortable performing higher-acuity procedures, such as LPs and BMV, compared to I&Ds and splinting. The most substantial decline was observed for neonatal intubations, specifically after the change in NRP guidelines, suggesting that resident comfort also decreased due to less procedures being performed. Our data suggests a need to alter procedural requirements for pediatric residents or devote more time to practice procedures, through procedure-focused rotations, guided workshops, or simulation.
33. BARRIERS AND FACILITATORS TO PEDIATRIC RESIDENT EDUCATION IN THE EMERGENCY DEPARTMENT: A QUALITATIVE STUDY UTILIZING FOCUS GROUPS
Christopher Jones, DO, Jennifer Mitzman, Sandra Spencer, John Mahan, Nationwide Children’s Hospital/Ohio State University, David Stein, No Program Affiliation, Columbus, OH

Background: The Accreditation Council for Graduate Medical Education mandates pediatric residency programs provide educational experiences. Local resident evaluations of the Pediatric Emergency Department (ED) declined over the last 5 years. This prompted a literature review showing that resident perspectives on educational experiences are sparse. This study discovers the barriers and facilitators to resident education in the Pediatric ED. Methods: This qualitative study utilizing focus groups was completed at a large Pediatric training hospital. Trained facilitators performed semi-structured interviews prompting discussion of resident experiences in the Pediatric ED. One pilot and 6 focus groups (32 pediatric residents) achieved data saturation. Sessions were audio recorded, de-identified and then transcribed by a professional service. Three authors (CJ, JM, SS) analyzed the transcripts independently using line-by-line coding. Following code agreement, authors identified central categories and themes drawing on grounded theory. Results: 6 categories emerged: (1) ED environment (2) Consistent goals, expectations, and resources (3) ED workflow (4) Preceptor Accessibility (5) Resident Growth and Development (6) Preconceived Notions of the ED. Residents value a respectful work environment despite the chaotic nature of the ED. They need clear rotation goals and expectations with a strong orientation. Autonomy with open communication and shared decision-making allows residents to feel like members of the team. Residents gravitate toward welcoming, available preceptors who love to teach. More ED environment exposure increases comfort and efficiency and helps develop medical decision-making skills. Lastly, residents admit preconceptions about the ED and personality traits affect performance. Conclusion: Residents identified barriers and facilitators to ED education. Educators must provide a safe and open learning environment, clear rotation expectations and goals, consistent attitudes with a teamwork mentality, and allow autonomy to build residents practice styles.

34. UNDERSTANDING THE ROLE OF FORMAL LEADERSHIP TRAINING FOR PEDIATRIC RESIDENTS IN DEVELOPING EFFECTIVE CARE TEAMS
Nawara Alawa, MD, Andria Tatem, MD, Elaine Fielder, MD, Teri Turner, MD, Baylor College of Medicine (Houston), Houston, TX

Background: Physicians are expected to be leaders of multi-disciplinary teams without formal training. A recent Research and Development report found a direct relationship between teamwork behaviors and patient outcomes. Introducing leadership training early in residency can help to refine trainees’ strengths and build teams to support patient care. Objective: To examine the perceived benefit of leadership training for pediatric interns on teamwork and communication via formalized leadership and team building training. Methods: Using Kolb’s Theory of Experiential Learning, a 90-minute workshop, developed by a pediatric trainee, covered topics useful for teambuilding and understanding the intern role in patient care. A Myers Briggs Type Indicator test was administered to determine individual leadership styles. Cases, reviewed and edited by experienced educators, were discussed in faculty-led, small predetermined groups. Assessment was conducted via an anonymous survey to evaluate the perceived benefit of the training. Results: 54/63 (85%) interns participated and completed the survey. The results showed the following: 89% identified their unique leadership style; 78% understood how leadership styles affects conflict resolution; 89% appreciated the importance of different leadership styles in a team based setting; 91% acknowledged the applicability to daily practice; 99% gained new skills to enhance communication in teams; 80% increased knowledge for decision-making in clinical practice. Conclusion: Teamwork and leadership are an integral part of a safe, effective, and efficient health care system. The overall perceived benefit of introducing leadership training to pediatric interns shows significant promise for shaping tomorrow’s leaders of patient care and health systems. Our workshop demonstrates identifying and understanding leadership/personality styles is important early in residency. Future studies should be conducted to further build on their strengths and call for help from team members with different styles/strengths in difficult situations.

35. A SCOPING REVIEW ON RESIDENT POSTGRADUATE MEDICAL EDUCATION BOOT CAMPS
Justin Triemstra, MD, Ann Novosel, MD, Hvovig Artinian, MD, Emily Miller, DO, Rajat Pareek, MD, Kira Sieplinga, MD, Emily Disbrow, MD, Caryn Vandenberg, MD, J. M. van de Richer, PhD, Spectrum Health/Michigan State University/Helen DeVos Children’s Hospital, Grand Rapids, MI

Background: Studies have shown that brief learning experiences, or boot camps, may effectively improve residents to function at a basic level and improve confidence in early postgraduate training and are much more prominently published in the procedural specialties. In those studies, investigators have primarily focused on evaluating whether the boot camp improved clinical skills, knowledge, or confidence levels however, this focus on a survey evaluation methodology, limits the application of these findings in patient care outcomes. Therefore, we sought to assess differences in the setting, size, length, specialty and Kirkpatrick level of evaluation used in boot camps. Methods: In consultation with a librarian, we conducted a scoping review on postgraduate boot camps published from 2008 to 2019. Inclusion criteria included boot camps focused on residents and in English language. Exclusion criteria included manuscripts describing boot camps for medical students, fellows, attending faculty, or interdisciplinary health care professionals. Investigators divided the articles equally. Descriptive statistics were used to analyze the data. Results: 62/136 articles met criteria for inclusion. 44/68 (70.9%) occurred at a single site. The mean number of participants was 44.5 and the mean length of boot camp was 8.4 days (median = 3 days). Only one
36. DOES EMOTIONAL FIDELITY MATTER? PEDIATRIC RESIDENTS’ PERSPECTIVES DURING EXPECTED VS UNEXPECTED SIMULATION SESSIONS
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Introduction: Simulation-based education has become pervasive in residency. Fidelity is important for relevance and transference of skills to real patient encounters and can be divided into three parts: physical, conceptual, and emotional.1,2 There have been few studies to date evaluating the impact of emotional fidelity, or how close to “real” the simulation feels. Only 28% of Tufts pediatric residents felt they were “comfortable” in their ability to lead a rapid response event, which may be impacted by the unexpected nature of rapid responses. Objective: Evaluate whether being called to a simulation of a decompensating patient without advanced warning affects pediatric residents’ perception of the emotional (EF) and overall fidelity (OF) of the simulation. Methods: Pediatric residents participated in a simulation involving a child with respiratory distress. Residents were randomized to one of two groups: Advanced Warning (AW) or No Advanced Warning (NAW). The AW group (control) was notified via text message several hours prior to receiving a page to report to the simulation. The NAW group (intervention) was not notified prior to receiving the page to report to the simulation. All residents completed surveys about their perceptions of fidelity. Results: Nineteen residents have provided data to date. Mean scores on a 5-point Likert item rating EF of the simulation (1 = extremely unrealistic, 5 = extremely realistic) were 2.9 (AW) and 3.8 (NAW) (p-value 0.04). Mean scores for OF were 2.6 (AW) and 3.3 (NAW) (p-value 0.28). Discussion: Reported experience of EF but not OF was higher for residents given NAW than those given AW. Data collection is ongoing. Limitations of this study include low physical fidelity and small sample size. References: ‘Gu et al. The effect of simulator fidelity on acquiring non-technical skills: a randomized non-inferiority trial. J Can Anesth 2017; 64:1182-1193. ’Dieckmann P, Gaba D, Rall M. Deepening the theoretical foundations of patient simulation as social practice. Sim Healthcare 2007; 2:183-93.

37. RAPID CYCLE DELIBERATE PRACTICE SIMULATION FOR RESIDENT EDUCATION AT A COMMUNITY HOSPITAL SITE
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Background: Community hospitals offer opportunity for increased pediatric resident autonomy yet may require more direct use of resuscitation skills than more resource-rich settings. Rapid cycle deliberate practice (RCDP) simulation teaches critical skill mastery using feedback-replay loops and can be used for resident education. Objective: We sought to establish a RCDP simulation program and improve pediatric residents’ preparation to handle medical emergencies at our community hospital training site. Methods: We designed and conducted high fidelity RCDP simulation every 2 weeks on the community hospital ward. RCDP led by trained faculty and chief residents focused on Pediatric Advanced Life Support skills and activating clinical support for pediatric respiratory distress. Resident physicians on rotation at the community hospital (Bridgeport) and on duty nurses participated. We later asked all 35 resident participants to complete an anonymous web-based survey to assess non-simulated and simulated pediatric code experience. 5 open-ended questions assessed RCDP experience and its impact on the community hospital rotation. We performed descriptive statistics and qualitative thematic analysis by 2 reviewers to identify themes of residents' experiences. Results: 77% (n=27) of residents responded. 68% had participated in at least one non-simulated pediatric code during residency; 43% in 1-2, 18% in 3-5, and 7% in >5. Yale New Haven (YNH) PICU was the most common location of code participation (47%, n=14), 17% (n=5) at the Bridgeport ED, 13% (n=4) at the YNH Pediatric ED, 7% (n=2) on a YNH ward, and 7% (n=2) on the Bridgeport ward. Only 1 resident had ever acted as team leader in a pediatric code. 4 major themes of resident experience were identified: practical community-hospital specific preparation, teamwork, improved confidence, and helpful formative feedback. Conclusions: We established a community hospital-focused RCDP simulation program. Residents report that RCDP provided relevant, practical preparation and improved confidence in the ability to deal with respiratory distress at the community hospital site.

38. IMPACT OF ACADEMIC HALF-DAY CURRICULA ON PEDIATRIC RESIDENT EXAM PERFORMANCE
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Background: The academic half-day (AHD) format as an alternative to noon conference has gained popularity in recent years. Proposed benefits include flexibility in schedule and instructional methods, and time protection for attendees. Previous studies of the AHD have demonstrated improved attendance, satisfaction, perceived learning, and wellness, as well as improved inservice training exam (ITE) scores in one internal medicine program. It is unknown whether the AHD format impacts board passage rates, and the effect on ITE scores in pediatric programs has not been studied. Objective: Our aim was to determine whether an association exists between American Board of Pediatrics (ABP) certifying exam scores and/or ITE scores, and participation in a pediatric residency program that employs the AHD format. Design/Methods: This was a retrospective, multi-center case control study. Pediatric residency programs were recruited through the Association of Pediatric Program Directors Longitudinal Educational Assessment Network (APPD LEARN). Each participating site reported whether they deliver the majority of didactic education in an AHD format. Results: 31 programs met study criteria. There was a strong association between AHD use and ITE scores. The AHD group (intervention) was not notified prior to receiving the page to report to the simulation. All residents completed surveys about their perceptions of fidelity. Results: Nineteen residents have provided data to date. Mean scores on a 5-point Likert item rating EF of the simulation (1 = extremely unrealistic, 5 = extremely realistic) were 2.9 (AW) and 3.8 (NAW) (p-value 0.04). Mean scores for OF were 2.6 (AW) and 3.3 (NAW) (p-value 0.28). Discussion: Reported experience of EF but not OF was higher for residents given NAW than those given AW. Data collection is ongoing. Limitations of this study include low physical fidelity and small sample size. References: ‘Gu et al. The effect of simulator fidelity on acquiring non-technical skills: a randomized non-inferiority trial. J Can Anesth 2017; 64:1182-1193. ’Dieckmann P, Gaba D, Rall M. Deepening the theoretical foundations of patient simulation as social practice. Sim Healthcare 2007; 2:183-93.
of their structured curriculum via an AHD; they also submitted de-identified learner data for the graduating residency classes of 2015, 2016, and 2017 (USMLE Step 1, yearly ITEs scores, and ABP certifying exam score). We fitted linear mixed-effects regression models to predict ITE and ABP scores from AHD format, controlling for class year, program size, setting, and region, learner USMLE Step 1 score, and clustering in programs. Results: 15 programs participated in the study, providing data for a total of 825 residents. 9 programs were AHD programs (298 residents), and 6 were non-AHD programs (227 residents). We did not find a significant difference in ITE or ABP scores between residents participating in AHD programs. Conclusions: AHD are increasingly popular as a method of delivering structured curriculum. Our study suggests that residents who train in programs with AHD curricula perform similarly on the ITE and ABP certifying exams compared to those that attend programs with a more traditional curricular approach.

39. MOTIVATIONAL INTERVIEWING: THE CURRENT STATE OF TEACHING AND ASSESSMENT IN ADOLESCENT MEDICINE FELLOWSHIPS
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Background: Motivational interviewing (MI) is an evidence-based counseling approach to facilitate choosing healthier behaviors. “Demonstration of MI” is a curricular component of the Adolescent Medicine (AM) specific entrustable professional activity (EPA) “Provide care for adolescent and young adult patients with acute physical and mental health issues.” Objective: To assess if and how AM fellowships teach and assess MI. Methods: AM Fellowship Directors from all 33 US and Canadian programs were surveyed anonymously online about individual training and curricular inclusion of MI. Descriptive statistics and thematic analysis of comments were conducted. Results: Our response rate was 91% (N=30/33). 93% (n=28/30) of respondents received training in MI; 60% (n=18/30) each during and post-fellowship. However, 40% (n=12/30) have not received any MI faculty development in the last 3 years. Teaching methods for MI include direct observation of patient encounters in real-time (63%, n=19/30), by audio/videotape (7%, n=2/30), role-play (47%, n=14/30), and simulation (20%, n=6/30). Only 30% (n=9/30) offer written observational feedback after patient encounters. Only 53% (n=16/30) felt their program’s MI teaching and assessment methods result in adequate “demonstration of MI” by graduating fellows. Time, assessment, and curriculum were the most common needs reported to improve MI skills. Of the 90% (n=28/29) of programs that offer direct observation in patient encounters to give feedback on verbal communication skills (not MI specific), most observation is by an “attending”, 27% (n=7/28) offer written formative feedback, and 15% (n=4/28) ask fellows to write an improvement plan based on their feedback. Conclusions: Opportunities for MI curricular improvement include longitudinal faculty development, written feedback and self-reflection after observed patient encounters. We plan to perform semi-structured interviews to better understand these preliminary findings, feasibility of collaborating with other residency faculty, and sharing of resources and experiences across AM Fellowships.

40. CHAMILY CHALLENGE: THE IMPACT AND EFFICACY OF TEAM-BASED GAMIFICATION ON PEDIATRIC RESIDENT ENGAGEMENT
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Background: Gamification is the application of game design elements to non-game environments. It has been successfully utilized in the business community to enhance employee motivation and improve productivity. Residents’ conflicting pressures lead to high rates of burnout and studies show that increasing engagement combats burnout. We aimed to integrate a game model into our residency to improve engagement in education, resident wellness and community-building, essential components of residency education per the ACGME. Methods: A task-based game was created [Table 1]. Residents (N=85) were randomized into 4 teams, earning points through education, community and wellness activities. Participation occurred over 4 months; prizes were awarded throughout (funded by a grant from APPD NY/NJ Region). Resident wellness was measured with the validated Stanford House Staff Wellness Survey. Other collected data included lecture attendance, participation in board review and advocacy events and nominations for outstanding hospital staff. Statistical analysis utilized chi-square tests, Fisher’s exact tests and unpaired 2-tailed t-tests. Results: All residents earned points from at least one activity. Residents meeting the attendance requirement increased 130% compared to the year prior (46% vs 20%, p<0.001). Mean weekly participation in board review increased by 440% (15 vs 3.5 residents/wk, p<0.001) compared to the year prior. Self-reported participation in community advocacy events remained stable. Nominations for outstanding hospital staff increased by 313% from the year prior (97 vs 31). Wellness survey response rates were 86% (73/85) pre-intervention and 53% (45/85) post-intervention. There were no significant differences in resident wellness. Conclusion: Gamification is one method to improve resident engagement. In our program, it resulted in substantially more residents meeting lecture attendance benchmarks, increased participation in board review, and promoted greater peer recognition. Though there was no improvement in burnout indicators, they did remain stable, a change from prior years.
Dental caries is the most common chronic disease in childhood in the US and they are the single greatest risk factor for caries in permanent dentition. Caries and cavities are largely preventable and fluoride varnish has been proven effective for combating the disease. Only 1.5% of one-year-olds have been to a dentist in comparison to 89% who have been seen by a pediatrician. Given the low prevalence of children with a dental medical home, AAP, Bright Futures and USPSTF released a statement in 2014 addressing oral healthcare, recommending fluoride varnish in the primary care setting beginning at first tooth emergence.

Aim Statement: Increase the percentage of at least one fluoride varnish application in 9 to 36-month old children to 50% and oral health documentation in the electronic health record (EHR) by 80% by June 2020.

Interventions: Population and setting included patients presenting to our general pediatrics clinics (ACC and Kendall UHealth) for their 9, 18, 24, 30, 36-month well child visits, after their first tooth eruption. The first cycle took place from Sept-Dec 2019 and involved applying fluoride varnish to eligible patients. The second cycle is planned for Jan-Mar 2020 and includes distributing a FAQ sheet about fluoride and using a trackable smart phrase for oral health documentation. The final cycle will include another change to increase application and documentation from Mar-June 2020.

Measures: A questionnaire was used to collect baseline and post-intervention data to determine the % of eligible patients who received fluoride varnish application. Chart review was done for the eligible patients to determine % of dental assessments documented in the EHR. Results: After the first cycle, fluoride varnish application increased from 17.2% to 79.5% at ACC and from 9.1% to 38.8% at Kendall; dental assessment documentation increased from 40.3% to 90.6% at ACC and from 62.5% to 98.6% at Kendall.

Conclusions and Next Steps: Our clinics did not previously apply fluoride varnish at routine well child visits, which created a gap in preventative medicine. Knowing that dental caries account for the most common chronic disease in childhood, we have made strides to prevent this disease by increasing application significantly, which we will continue to do through added changes. While dental assessment documentation increased as well, there is still room to improve to ensure it is as comprehensive as possible, which will be closely tracked in coming months.
43. IMPLEMENTATION OF A HUMANITIES IN MEDICINE CURRICULUM FOR PEDIATRIC RESIDENTS
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Background: Medical humanities is the intersection of medicine and humanistic disciplines. Emphasis on human aspects of medicine may encourage clinicians to build community, develop empathy and self-compassion, and foster meaning-making, all of which combat burnout and enable resiliency. At Cincinnati Children’s Hospital, we implemented a humanities curriculum amongst pediatric residents with the aim of promoting resiliency, fostering shared experiences among peers and mentors and reconnecting participants to the wonders of medicine. Methods/Curriculum Development: A basic needs assessment was performed, and learning objectives were developed: to develop communication and professionalism, to facilitate reflective practice, and to provide mentorship for coping with the joys and challenges of medicine. Five sessions were planned over 12 months with related materials shared before each session by email. Sessions were held off campus in evenings, and interested residents joined when available. Topics included coping with medical mistakes, death and dying, magic in medicine, imposter syndrome, and narrative medicine; group discussion was facilitated by resident leaders. Post-session surveys were distributed to participants of the 4th and 5th sessions. Anonymous comments were analyzed qualitatively for common themes.

Results: Forty-four unique residents attended at least one session, with 12-20 residents and 2-3 attendings per session. Seven of 20 participants responded to the first survey, and 4 of 10 responded to the second survey. All respondents reported interest in attending future sessions and would recommend the sessions to friends. Common themes included insights into patient experiences, benefits of voicing and hearing shared challenges, and finding joy in medicine. Conclusions: We successfully implemented a curriculum to encourage medical humanities in our pediatric residency program. Next steps include implementation of additional sessions at regular intervals and assessing the impact of sessions on burnout and its risk factors.

44. DO IT FOR THE “GRAM”: USING INSTAGRAM TO EDUCATE THE MILLENNIAL LEARNER
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The millennial learner has a characteristic learning style. Studies have shown that millennial’s want their teaching to be creative, and to take place in an informal, relaxed environment. Millennial’s spend upwards of 2.5 hours on social media each day. Chief residents at a large pediatric residency program (101 residents) created a private, resident-only Instagram page through which educational material is delivered. The objective of this study is to demonstrate the utility of social media for the advancement of medical education. On the account, “One Minute Teaching” stories were posted on a regular basis. Topics were chosen by the pediatric residents. Examples include stories on pyloric stenosis, mastoiditis, and Henoch-Schonlein Purpura. At the beginning of the 2019-2020 academic year, a series of “Tips and Tricks of the Electronic Medical Record (EMR)” was also presented to introduce the incoming interns to several basic best practices for using the EMR. Stories were created by both the chief residents and pediatric third year residents during a dedicated “Resident as Teachers” rotation. After the stories were posted, viewers were surveyed if they felt the information presented was helpful in a yes/no poll. To date, eight clinical “One Minute Teaching” stories and seven “Tips and Tricks of the EMR” stories have been created and posted. An average of 40 residents watched each
clinical teaching story and 51 residents watched each EMR teaching story. 99% of residents who viewed the clinical teaching stories and 98% of residents who viewed the EMR teaching stories reported that they found the information helpful. Social media is heavily used by the millennial population, but has not yet been largely adopted for use in a teaching capacity, specifically in medical education. The success of this large pediatric residency program in using Instagram to teach focused, clinically-relevant topics suggests that there is a role for social media to be used in this teaching context.

45. LOW FIDELITY, IN-SITU SIMULATION: IT WORKS!
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Pediatric acute care delivery is an essential learned skill in residency training. Simulation-based training allows trainees to build upon knowledge and improve technical skills. Our training program has previously shown that low-fidelity simulation enhances situational awareness and trainee comfort, but the extent of clinical performance improvement is unknown. The objectives are to demonstrate improved competence in acute care clinical performance and to improve teamwork and communication during high-stress, high-acuity clinical situations. Weekly simulation-based case scenarios were led on three inpatient units. Each unit performed one unique clinical scenario per week, for a total of four per month. These included status epilepticus, anaphylaxis, respiratory failure, and cardiac arrest. These same four cases were repeated monthly with different residents. An intern was designated as a front-line provider, and a senior resident was available. A low-fidelity mannequin and resuscitative equipment were used. Case-specific checklists containing required clinical steps and key communication concepts were completed followed by a structured debrief. Data collected from Aug 2019 through Dec 2019 reflects an improvement in both clinical achievement and communication from week to week within the same resident group (Fig 1).

The average percentage of completed case-specific clinical steps at week 1 was 58% and by week 4 was 85%. The average percentage of communication components achieved at week 1 was 52% and by week 4 was 78%. This study demonstrates sustained improvement in acute care delivery over the course of a single inpatient block. The improvement in clinical competency and communication over a four-week period suggests that resident performance is enhanced with frequent in-situ simulation and with teamwork within the same resident cohort.

We believe these results solidify the utility of standardized cases and structured debriefs to effectively train residents on acute clinical care. Further steps include assessment of resident achievement in acute care simulation over several months to evaluate long-term improvement and sustainability.

46. THE ROUNDS EFFICIENCY INDEX: A NOVEL PHYSICS-BASED CONSTRUCT FOR PATIENT- AND FAMILY-CENTERED ROUNDS
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Background: Patient- and family-centered rounds (PFCR) are used to accomplish work in key areas (patient care, education, family experience) and require considerable work from those involved (time). Limited research has evaluated rounds length, but not efficiency. We sought to evaluate rounds efficiency using the physics-based concept of work output divided by work input. Objectives 1) Establish baseline for clinical work (CW), educational effectiveness (EE), family experience (FE) and rounds length (RL); and 2) Develop a rounds efficiency index (REI) construct. Methods: This project aimed to establish baseline data for 4 components of rounds efficiency on 5 inpatient acute care teams at Children's Wisconsin. Process measures included 3 types of work output (CW, EE, FE) and work input (RL). CW was evaluated as the percent (%) of daily orders placed on rounds abstracted from the electronic health record on a 10-point rating system corresponding to decile (higher ratings with higher % of daily orders on rounds). EE was assessed as a 1 to 10 rating by learners. FE was assessed as a 1 to 10 rating by families during post-rounds interviews by a rounds coach. RL was recorded in minutes/patient. The outcome measure (REI) was calculated as a ratio of work output/work input (%). A 3-month period of baseline data assessments were collected. The REI was calculated using aggregate ratings for CW, EE, FE, and RL. Results: CW analysis of 809 weekday orders (described as % of daily orders placed on rounds/percentile/CW rating) were: 55%/80th/8; 38%/50th/5; 26%/20th/2. 59 EE ratings had a median of 7 (interquartile range [IQR] 1.3). 21 FE ratings had a median of 9 (IQR 2). 60 RL measurements demonstrated a mean of 11.4 minutes/patient (SD 3.2). The average REI was 62%. Discussion: This project yielded a novel efficiency construct incorporating patient care, educational effectiveness, family experience, and rounds length. Our teams are currently 62% efficient. The REI is a promising tool that provides the basis for providing feedback and targeting interventions for programs seeking to improve rounds efficiency.

Figure 1: Examples of Instagram Stories.
47. Predicting and Understanding Continuity in a Resident Continuity Clinic
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Background: The longitudinal experience in continuity clinic plays a crucial role in building a strong foundation in general pediatrics. Pediatric residents struggle to maintain continuity in their clinics, which may impact comfort in managing common chronic pediatric conditions. Little is known about the prevalence of common chronic diseases managed on resident panels and if they are associated with resident continuity. OBJECTIVES: We hypothesize that the presence of common chronic disease will be associated with resident continuity. We will also determine prevalence of common chronic diseases seen in clinic.

This study will help inform a prospective quality improvement (QI) project. Methods: Unique patients that had been seen for at least two non-urgent care visits (with at least one well visit) in our residency continuity clinic over a 2-year period were identified. To date, 618 of 685 patient charts reviewed meet the visit criteria. We have defined continuity as seeing the same resident provider for two or more visits. We have defined a resident primary care provider (PCP) as a resident who has seen a patient for >50% of their visits. Patient visit data and presence of chronic diseases for each patient were recorded in a password-protected Excel database. RESULTS: Of the 685 patients reviewed, there were 5584 unique visits, of which 3775 visits were related to well care (68%). Of those that met inclusion criteria (618), 309 (50%) met our definition for continuity, and 116 (16.9%) met our definition for having an identified resident PCP. For patients that had an identified resident PCP, they were less likely than those without one to have chronic diseases such as ADHD (0.86% vs. 3.56%, OR 0.28), obesity (6% vs. 15.5%, OR 0.78) and anxiety/depression (1.7% vs. 5.5%, OR 0.53). Conclusions: While data collection/analysis is incomplete, it is clear that achieving continuity in a resident clinic is challenging. Chronic diseases are unlikely to be associated with resident continuity. QI interventions may be needed to increase resident continuity particularly among patients with common chronic pediatric conditions.

48. Revisiting the National Nighttime Curriculum: How Do Residents Really Want to Learn at Night?
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Background: Following the implementation of 2011 ACGME duty hour restrictions, the National Nighttime Curriculum (NNC), an online series of case-based PowerPoint talks, was developed and implemented. No needs assessment has been done since its creation to assess how pediatric trainees prefer to learn at night, within the context of an ever-increasing emphasis on e-learning as a curricular modality. Objective: To identify the current state of the NNC modules use and perceived utility by residents, and to understand how pediatric resident trainees prefer to learn at night. Design/Methods: This is an IRB-, APPD-approved mixed methods study using anonymous online surveys distributed nationally in 2019 to one chief resident from each program via email. Chief residents were chosen for their knowledge of program curricula, and their perspective served as a proxy for resident opinion. Quantitative data was analyzed with descriptive statistics. Qualitative data were coded by 2 trained reviewers using an iterative approach, reconciling any differences, and then organized into themes. Results: One chief resident from 66 of 204 individual U.S. pediatric residency programs responded to the survey. Of the total respondents, only 22% (14) report having a formal nighttime curriculum in place at their program, and only 5% (3) of chief residents reported having used the NNC. Chief residents preferred in-person education at night with a facilitator (either resident-led, 35% (22), or attending led, 34% (21)) rather than self-led curricular modules (5%, 5) (Figure 1). The majority (86%, 35) of chief residents felt that online modules are not engaging, though 73% (48) admitted that online modules are easily accessible. Chief residents reported wanting brief, patient-case-centered teaching at night. Conclusion: Chief residents prefer brief, patient-case-centered teaching during night shift rotations. Though computer modules are easily accessible, they are not perceived as engaging. Nighttime curricula should be modified to support brief, patient-case-centered teaching that can be facilitated through small groups.

49. Implementation and Utility of a Phone-Based Application for Teaching Auscultation Skills to Incoming Pediatric Cardiology Fellows
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Background: Mastery of cardiac auscultation is a core component of cardiology training. New computer-based auscultation teaching tools have been developed to help teach this skill to trainees. Objective: To assess incoming pediatric cardiology
fellows’ auscultation skills and evaluate a phone-based application (app) to teach auscultation. Methods: At the annual national Pediatric Cardiology Fellows’ Boot Camp at Stanford, the eMurmur® app was utilized to teach core auscultation skills to incoming pediatric cardiology fellows. In groups of 5 trainees each, attendees were taught basic auscultation skills in 30-minute blocks. Auscultation teaching centered around distinguishing innocent (INN) vs pathological murmurs (PATH) and focused on key diagnoses and murmurs most frequently encountered by pediatric cardiologists. Pre- and post-training assessments and surveys [Likert scoring 1-5] were administered to all attendees and were analyzed via paired t-test and sign rank test. RESULTS: A total of 40 incoming cardiology fellows from 35 training programs attended the Boot Camp at Stanford University in Palo Alto, CA from June 1-3, 2019. All trainees completed the pre- and post-training assessments. Prior to the course, trainees were less likely to correctly distinguish innocent murmurs vs. pathologic murmurs (INN 77 ± 26 % vs. PATH 92 ± 11%; p = 0.001). 75% of trainees reported the auscultation session improved their auscultation skills. Though there was no difference in overall test scores (PRE 82 ± 16% vs. POST 85 ± 17%; p = 0.13), after the training the trainees’ self-reported comfort in identifying the auscultatory findings for the most common lesions seen in pediatric cardiology were higher (PRE 3.3 ± 0.9 vs. POST 3.8 ± 0.8; p = 0.03) and diastolic murmurs (PRE 3.8 ± 0.1 vs. POST 4.1 ± 0.5; POST; p = 0.05) and diastolic murmurs. Comfort scores improved most for distinguishing systolic vs. diastolic murmurs (PRE 3.3 ± 0.1 vs. POST 3.8 ± 0.7; p = 0.005). Conclusions: The use of an app-based teaching tool is an effective method to teach auscultation skills to incoming pediatric cardiology fellows. The app can improve fellows’ comfort with identifying the most common lesions seen in pediatric cardiology.

50. TEACH: AN EXPERIENTIAL LEARNING ELECTIVE FOR PEDIATRIC RESIDENTS
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Background: ACGME requires residents to participate in learner education and become effective teachers, though there is often insufficient time to achieve this in the inpatient setting. A local needs assessment revealed 96% of residents reported inadequate teaching experiences. We created the Teaching Elective At Children’s Hospital (“TEACH”) to fulfill this gap in resident education. Objective: To develop, implement, and evaluate a curriculum that enhances pediatric resident knowledge and skills related to teaching using experiential learning as a conceptual model. Methods: Educational strategies for the curriculum include: 1. Assignments (readings, videos, and podcasts about clinical teaching and feedback); 2. Direct observation of learners; 3. Practical application of small group teaching and feedback skills; 4. Reflective writing (Figure 1). TEACH was implemented as a 2-4 week elective for senior residents to observe and teach learners on the Hospital Medicine inpatient teams. Evaluation consisted of a post-then-pre survey, tabulation of small group teachings, and content analysis of reflections. Results: To date, 16 residents have completed TEACH. Survey results (69% response rate) revealed 100% of residents rated this educational experience as excellent or very good. Most residents’ knowledge and skills related to small group teaching and feedback were much or somewhat improved (Figure 2). Residents created 57 novel “chalk talks” on various topics for small group teachings (Table 1). Reflective writings revealed the following themes: the value of practice; goal-setting to ensure self-improvement after reflection; the importance and reward of learner engagement; changes in learner behavior based on feedback; positive emotional reactions to teaching. Discussion: We successfully developed and implemented a dedicated teaching elective focused on experience-based learning. Initial evaluation revealed residents improved their self-perceived competence in skills and knowledge of small group teaching and feedback, as they gained confidence and a sense of reward. Next steps include direct observation of TEACH residents to better evaluate their skills.

Figure 1. TEACH curriculum’s educational strategies based on the four stages of Kolb’s Experiential Learning Theory

Table 1. Number and topic of TEACH residents’ small group teachings by system
51. INCREASING PEDIATRIC RESIDENT LOGGING OF PROCEDURES THROUGH DEVELOPMENT OF A MOBILE APP  
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**Background:** Learning to perform common medical procedures is one of many elements of Pediatric residency training. In our program, we have observed great proficiency of residents’ procedural skills, but an unfortunate deficiency in completion of procedural logs. Incomplete procedure logs make it difficult to ensure each resident is receiving adequate procedural skills training and to certify competency to future employers. At our institution, the biggest barrier to timely completion of procedure logs was a cumbersome, tedious, and time-consuming logging system (New Innovations). Using QI methodology and technology, we aimed to improve the procedure logging process. **Aim Statement:** To increase the number of procedures logged per resident, from 14 per year to 20 per year (1.66 per month), by March 31, 2020. **Interventions:** We used the model for improvement to perform multiple PDSA cycles to create a simpler, quicker, and more efficient process for logging procedures. After analyzing failures in our legacy process, we tested multiple commercially available apps and web-based platforms as potential replacements. Based on our learning, we opted to design and create our own “NYU Peds App”. The app was iteratively tested using small groups of Pediatric residents, allowing us to modify the design and maximize efficiency, prior to implementation across the full program. Following the launch of the app, the program created a new policy, specifying the number of procedures to be completed each year. **Results:** Since its launch, 1,192 procedures have been logged using the NYU Peds App. The number of procedures logged per resident per month has increased from 0.9 to 3.2 (see Figure 1). Further, we have improved resident satisfaction. On an anonymous survey, the percent of residents who strongly agree that the logging system is easy to use significantly increased from 3% (New Innovations) to 82% (NYU Peds App). **Conclusions and Next Steps:** We were able to successfully increase the number of procedures logged by our residents. The main driver of the improvement was implementation of a mobile app that is easy, fast, and usable at the time of care.

52. RESIDENTS IN THE ROOM WHERE IT HAPPENS: ALIGNING PEDIATRIC EDUCATION WITH HOSPITAL OPERATIONS  
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**Background:** Academic pediatric centers balance many goals, including excellent patient care, effective hospital operations, and providing optimal training environments. However, hospital administration and graduate medical education (GME) priorities are not always aligned. With administration often focused on metrics like throughput and expansion, special attention must be given to the unique aims of GME in order to prioritize and facilitate an ideal training program. Objective: To align key stakeholders and identify innovative solutions to optimize pediatric resident education, patient care, and hospital operations. **Methods:** At Lurie Children’s Hospital, with administrative support, we convened stakeholders representing pediatric residents and faculty as well as hospital operations leaders. Partnering stakeholders with quality improvement specialists we identified key drivers of our educational goals through current state analyses. These analyses informed potential interventions, identified through collection of multimodal survey data, to achieve an optimal future state design. Results: Rapid improvement events connected residents, faculty, nurses, and hospital staff in robust facilitated discussions. Four major topics emerged, comprising key drivers of resident experiences, patient care delivery, and the interface with hospital processes. These topics were (1) service team distribution, (2) logistical barriers, (3) GME structures, and (4) communication/electronic health record (EHR) issues. Future design sessions produced novel solutions including new workflows, EHR support, and the convening of task forces to focus on unique care settings. **Conclusion:** Through quality-focused evaluation of hospital and residency goals, we engaged key stakeholders in identifying proactive solutions to align residency training with hospital operations. Ongoing metrics from these initiatives will be analyzed for impact. The project was well-received by trainees, faculty, and staff and will continue to inform short- and long-term initiatives.

53. PRACTICE MAKES PERFECT: USING REPETITIVE, SMALL-CHANGE SIMULATION FOR EMERGENT PEDIATRIC SCENARIOS  
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**Background:** Simulation is a cornerstone of residency training across disciplines. Studies show repeated exposure to the same case scenario may improve medical decision making, but little is known about how this affects the learning experience. **Methods:** All pediatric residents participate in simulation exercises both in situ and at our state-of-the-art simulation center. Each scenario includes a nurse and parent who are simulated actors, as well as a child mannequin. Residents at all phases of training work in groups of 3-4. Two categories of simulation scenarios were created. The first reviewed management of status epilepticus - one patient with known epilepsy and the second a hypoglycemic child with an insulin overdose. The second category was management of tachycardia - one patient with sepsis and the second with supraventricular tachycardia. The patient’s age, weight, overall appearance, and vital signs were identical in each category. Subtle differences in history and physical exam were present, which residents had to elucidate without prompting. Each group performed two different cases with the same chief complaint. Groups were assessed using the Simulation Team Assessment Tool (STAT), a validated tool.
published in *Resuscitation*. Results: Seven groups of residents participated from July to December 2019 for 14 total cases. The average STAT score for resident teams participating in the first tachycardia case was 13.75/16 (0.86), while the average in the second scenario was 18/18 (1.00). The average STAT score for teams participating in the first seizure case was 12.3/16 (0.77), while the average in the second case was 15.66/18 (0.87). Average resident satisfaction scores were equal across first and second scenarios at 4.85/5. **Conclusions**: Repetitive simulation using subtle differences in history and physical exam allows for an opportunity to practice important life-saving skills for pediatric residents, while also allowing for some variation and avoidance of repetition bias. This format can easily be modified and applied towards other emergent pediatric situations based on learner needs.

54. DEVELOPING COMMUNICATION SKILLS IN PEDIATRIC RESIDENTS: HOW DO PARENTS THINK WE ARE DOING?
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**Background**: Clear family-centered communication is a foundation of practicing effective pediatric medicine. Formal communications training during residency is often limited and experience is mostly observational. Publications have shown that communication skills of trainees improve after a standardized curriculum, but family representatives were not included. In July 2019 we launched a communications curriculum for pediatric residents anchored in tenants of family-centered care that incorporates Family Faculty (FF), trained parents of patients cared for at our children’s hospital. Objective: To investigate how FF assessment of learners in an objective structured clinical exam (OSCE) differs from the gold standard of Standardized Patient (SP) assessment. **Methods**: We designed an OSCE in which the resident disclosed a medical error to a SP (playing a patient's parent). The SP was trained in character portrayal and checklist completion. The 10-minute encounter was observed by an experienced clinician (EC) and FF through one-way glass, followed by a 20 minute debrief with the learner, SP, EC and FF. The SP, EC and FF all completed a 23-item behavioral anchored checklist that reflected 5 core competencies of family centered communication. Items were rated as not done, partly done or well-done, with well-done indicating mastery. Results: 52 residents participated in the OSCE and 42 consented to study participation. The overall average % of learners considered to achieve mastery in each competency was lower as assessed by the FF vs SP: respect and value (50% vs. 70%), information sharing (48% vs. 67%), participation in care and decision making (40% vs. 70%), follow-up (47% vs. 60%), and team work (33% vs. 52%). **Conclusion**: Across all 5 competencies a lower % of learners reached skill mastery when assessed by FF as compared to SP. Involving FF in the evaluative and instructive components of the curriculum offers a more holistic approach and integrates true stakeholders in parent-physician communication. This initial data suggests that the resources needed to include FF in communications training is likely worthwhile.

55. IT’S ALL ABOUT THE ASK: ASSESSING PEDIATRIC RESIDENTS CURRENT PRACTICES AND COMFORT LEVELS REGARDING SCREENING FOR GANG INITIATION
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**Background**: Gang violence is a problem across the United States, with as many as 1 million youth identified as gang members and over 400,000 children initiated into gangs each year. The negative impact of gang membership on a child’s health and well-being has been well documented, though a national survey revealed that most pediatricians never or rarely screen for youth violence. **Methods**: We utilized an 18-item survey that consisted of 3 components: Knowledge, Current Practice, and Beliefs About Pediatrician’s Role. This was sent electronically to pediatric residents, internal medicine/pediatric residents and adolescent medicine fellows at 17 residency programs in 7 of the largest US cities. Each participant received compensation for completion of the survey with a small-value electronic gift card. Results: Of the 206 responses received, 50% of participants reported currently completing their residency training in Chicago, while 27% were in New York and 21% in Los Angeles. While
56. PREPARING PEDIATRICIANS FOR PRACTICE THROUGH INTEGRATED CARE
Elizabeth M. Chawla, MD, David Nelson, MD, MedStar Health/Georgetown University Hospital, Washington, DC

Background: Less than half of children in need of mental health (MH) services receive them, leading to pediatricians filling the void despite self-reported lack of training or comfort. The AAP and AACAP recognize integrated care as one potential solution to the gap in access, but few studies have examined the effects of this model in a pediatric residency clinic. No studies to date have looked at practice habits of pediatricians who trained under this type of model. OBJECTIVES: We present a model of an Integrated Mental Health Clinic (IMHC) implemented in a pediatric resident continuity clinic for the primary purpose of teaching. We examined practice habits of pediatricians with/without exposure to the model during residency, as well as effects on attitudes, perceived barriers, and confidence in providing MH care. Methods: An anonymous survey was sent to program graduates over a 6-year period, spanning implementation. Respondents were classified based on participation in the IMHC: sustained exposure (full dose), indirect exposure (partial dose), and graduation prior to implementation (control). Results were analyzed for dose response, as well as comparing individual groups. RESULTS: Pediatricians who trained with an IMHC model address MH more frequently, including asking about depression (p<0.029), anxiety (p<0.007), behavior problems (p<0.007), and substance abuse (p<0.01), as well as using validated screeners, making a diagnosis, and using medications for these problems. They have fewer perceived barriers such as lack of training in counseling (p<0.036), lack of time (p<0.046), and others. They have greater confidence in providing psychoeducation (p<0.004), diagnosing a MH problem (p<0.014), treating a MH problem with non-pharma (p<0.019), prescribing meds for ADHD (p<0.04), and prescribing meds for anxiety or depression (p<0.019). Conclusion: Including an Integrated Mental Health Clinic model in pediatric residency continuity clinic can significantly increase pediatricians practice habits, attitudes, and confidence in caring for patients with MH concerns once in practice, if the IMHC is designed intentionally for trainee education.

57. PICTURE PERFECT: USE OF SOCIAL MEDIA IN RESIDENCY MEDICAL EDUCATION
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Background: Social media has become increasingly common in medical education. Residency programs capitalize on resident use of common social media platforms for information dissemination, recruitment and advocacy. However, its specific use in pediatric residency programs has not been elucidated. Objective These authors sought to evaluate current use of popular social media platforms in pediatric residency programs as well as use of social media platforms by pediatric residency interviewees during recruitment. Method Prior to participating in the 2019 APPD enhanced learning session focused on social media’s role in graduate medical education, registrants were asked to complete a five-question pre-session survey through their Instagram accounts. The survey was distributed using the “polls” feature of Instagram. Responses were collected from attendees of the conference and were anonymous. Subsequently, a post-match, anonymous survey was sent to interviewees of the University of California/Children’s Hospital of Orange County pediatric residency program during the 2018-2019 recruitment season, of which, one question assessed resources to evaluate the program, including social media platforms. Results 24 of 40 (38%) residency programs surveyed have a residency Instagram account. 31 of 36 (86%) residency programs surveyed have a residency Facebook account. Of the 77 post match survey respondents, 37 (48%) ranked Facebook within their top 6 resources used to research and rank the program. 36 (46%) ranked Instagram within their top 6 resources used to research and rank the program. Conclusions: Social media platforms are being utilized by pediatric residency applicants in their evaluation of a residency program, yet a minority of residency programs have dedicated social media platforms. This can potentially be due to learning curve, privacy concerns of violating HIPPA policies, and concerns of compromising the patient-doctor relationship.
58. ENTER THE MATRIX: A STANDARDIZED, ACCOUNTABLE APPROACH TO RESIDENT BOARD PREPARATION
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Background: Balancing clinical and board relevant education is a common struggle for residency programs. The ACGME mandates that programs maintain a > 70% first-time board pass rate but does not dictate how this is achieved. In-training exam (ITE) scores are reliable predictors of certifying board scores, but remediation success remains variable within and across institutions. Our program developed an educational aide, “the Matrix”, to guide and hold residents accountable for board preparation with flexible study activities based on individual learning preferences. It provides a starting point for determining remediation need and activities for those at risk of board failure. Objective Develop an educational aide based on adult learning theory to improve board pass rates of categorical pediatric residents. Methods: Beginning intern year, pediatric residents completed the intervention “Matrix” throughout the academic year, with learning activities including practice question banks, article reviews and didactic attendance (Exhibit A). Residents discussed “Matrix” compliance with advisors every 3 months over 3 years. Board pass rate of residents for the 3 years after institution of the matrix is compared to prior 5 years of pass/fail data. Results First-time board pass or failure data was obtained for 60 residents over an 8-year period and divided into a pre- and post-intervention group (36 control and 24 intervention subjects). Pre-intervention had a composite pass rate of 70% compared to the intervention group with a pass rate of 92%, which is statistically significant (p value 0.01). Conclusion Our program has early success in increasing yearly board pass rates. Fewer have failed in the past 3 years post-intervention than in the 1 year prior. Adult learners require self-driven, relevant methods of study. Those at risk for exam failure need accountability. Applying these concepts to resident education improved pass rates with a small resident cohort taking the certifying boards. Our aide is easily adapted by other institutions looking for a flexible but standardized method of board preparation.

59. FAMILY-CENTERED COMMUNICATION: A QUALITATIVE AND QUANTITATIVE ANALYSIS OF RESIDENT RESPONSE TO COMMUNICATION TRAINING
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Background: Pediatricians must utilize effective communication skills to establish a relationship with both their patients and their patients’ families. We modified the Erikson Institute Fussy Baby Network’s FAN (Facilitating Attuned Interactions) communication tool to teach pediatric residents to communicate with families using an empathy-driven process. Objective: Improve pediatric residents’ empathy, communication skills, and mindful self-regulation in their interactions with families. Design: Eighteen pediatric residents from 1 institution and 7 pediatric fellows from another were trained to use the FAN Family Communication Tool to guide their clinical encounters and were followed for 6 months. At 3 time points (0, 3, and 6 months) patients completed the Jefferson Scale of Patient Perceptions of Physician Empathy (JSPPPE) and the Consultation and Relational Empathy (CARE) surveys, and trainees completed the Jefferson Scale of Physician Empathy (JSPE) and the Kentucky Inventory of Mindfulness Skills (KIMS). At the end of the study 11 residents and mentors were interviewed, and transcripts were coded on NVivo software using open and focused coding. Results: Residents demonstrated a rise in scores on the JSPE (p=0.044) and the KIMS (p<0.005) after FAN training. Patients reported high perceived empathy throughout the study, and scores on collaboration (CARE) showed an upward, but not significant, trend. The interviews showed perceived improvement in adaptability, trust building, stress reduction, and ability to form comprehensive views of family concerns. Conclusions: Family-centered communication training can improve physician-perceived empathy and mindfulness. Trainees used the FAN to develop a comprehensive view of a family’s concerns by understanding and engaging with their emotions. Improved self-awareness allowed trainees to process their emotions to reduce stress and improve communication during encounters. Increasing empathetic and mindful interactions during patient encounters could thus improve clinical outcomes and ultimately benefit patient well-being.

60. CRACKING THE NUT ON SCHOLARLY ACTIVITY SATISFACTION: THE ROUND ROBIN RESEARCH FAIR
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Background: The Accreditation Council for Graduate Medical Education requires trainees to participate in scholarship. House staff face many barriers to participation in scholarly work, including: time, inexperience, lack of knowledge of on-
Identification of a research mentor has been linked with increased likelihood of success in scholarly work. Objective: Our primary objective was to encourage resident participation in research by removing barriers to initiation of scholarly work and enhance creation of research partnerships through convening an annual Round Robin Research Fair.

Methods: The Round Robin Research Fair occurred in the fall of each academic year beginning in AY 2017-2018. All faculty members and residents were invited. Each participating research mentor displayed ideas for new projects at a designated booth. Sign-up sheets were placed at each station to encourage residents to commit to a project and/or mentor on the spot. Representatives from the medical library, Institutional Review Board, statisticians, and project managers were invited to create opportunities for on-the-spot project discussion. The event began 1 hour prior to the night shift and continued 1 hour after evening turnover to maximize participation. All residents were given a “passport card” that was stamped at each station to encourage residents to investigate all opportunities. Completed cards were turned in for a door prize.

Results: The ACGME metric for “satisfied with opportunities for scholarly activity” steadily increased from 63% at baseline to 88% (chi square p=0.03). Additionally, resident presentations at local and national meetings increased from 32% to 54% over the course of this intervention.

Conclusions: By removing barriers to resident participation in research and encouraging scholarly pairings, we were able to improve both perceptions of research availability as well as actual participation in research. While there may have been other factors influencing the changes described, this was the only programmatic change put in place during this time period.

Assessment/Feedback/Mentorship

61. IMPROVING THE APPROACH TO FELLOWSHIP TRAINEE FEEDBACK
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Background: Giving and receiving feedback are difficult but necessary skills in medical training. We identified a need for improved feedback based on decreased learner satisfaction on our annual ACGME survey. In an anonymous survey, 2018-19 infectious disease fellows reported receiving formal feedback from 52.4% of their inpatient clinical experiences with faculty.

Aim Statement: Increase the frequency of feedback from fellows by faculty during clinical service rotations from 52.4% to >90.0% in 6 months utilizing a standardized method.

Interventions: A Feedback Card (Figure 1), was developed by fellows and faculty. Both parties were instructed to use the card at the beginning of their clinical service time to discuss weekly goals and barriers. At the end of the clinical period time was set aside to revisit the Feedback Card. PDSA 1: Feedback Card was provided to fellows and faculty. Fellows were surveyed monthly regarding the number of feedback sessions per clinical week.

An anonymous survey was sent to faculty and fellows following 3 months of use. Responses indicated a need for a specific location/reminder for the card. PDSA 2: Feedback Cards were moved to the daily huddle board; monthly data were displayed.

PDSA 3: Attending/fellow dyads with only one service day were excluded given limited interactions. Measures: Fellows were anonymously surveyed at the end of each month to determine the number of feedback sessions per clinical service time.

Results: The percentage of feedback sessions between fellows and faculty increased following implementation of the Feedback Card from an average of 52.4% in 2018-19 to 95.0% in 2019-20. (Figure 2)

Conclusions and Next Steps: Feedback is an essential part of clinical teaching and learning, yet it is often perceived as difficult to do, especially in busy clinical settings. Actively engaging in feedback-seeking is an effective way for fellows to learn within the working environment. Our project demonstrates that a structured method for feedback improved frequency of feedback sessions between faculty and fellowship trainees. Future PDSA cycles will assess the quality of feedback provided.
62. THE IMPACT OF A MULTI-MODAL RESIDENCY CURRICULUM TO PROVIDE RESIDENTS WITH DATA ON THEIR PRACTICE HABITS

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**Background:** The Accreditation Council on Graduate Medical Education (ACGME) requires that residency programs regularly provide trainees with data on their practice habits (DOPH). Many programs including ours have struggled to deliver meaningful DOPH to trainees. **Methods:** We created a DOPH curriculum following Kern’s six-step approach and evaluated its impact using quality improvement methodology. We conducted a needs assessment, defined project goals, and convened a group of stakeholders representing the residents, residency program, OME office, and hospital. Interventions were implemented over two years (Figure 1) and were continuously assessed using plan-do-study-act (PDSA) cycles to evaluate curriculum impact on 2 levels of Kirkpatrick’s framework. Behavior change process measures selected were provision of individualized and group resident DOPH data. The high stakes outcome measure of ACGME resident survey DOPH rating was evaluated annually. **Results:** Following a needs assessment, the interventions chosen were providing: 1) individualized resident reports in inpatient and outpatient settings (note productivity, diagnoses seen, developmental and depression screening), 2) group reports in inpatient and outpatient settings (residency and hospital-wide data), and 3) consistent DOPH messaging. Educational strategies for content sharing included housestaff meetings, semiannual reviews, email, and newsletters. By fall 2019, 99% of residents were provided individualized data on note productivity and diagnoses seen and 94% were provided ambulatory data on developmental and depression screening rates. During 2018-2019, group DOPH was presented in > 16 housestaff meetings. ACGME resident survey DOPH scores by year were 2.1 (2016), 1.8 (2017), 2.4 (2018), and 4.9 (2019). **Conclusion:** We successfully created a DOPH curriculum incorporating individualized and group data in both inpatient and outpatient settings. These interventions yielded a substantial increase in the ACGME resident survey DOPH rating. We recommend a multi-modal educational strategy for programs seeking ways to provide DOPH.

63. USE OF A NOVEL TOOL TO COMPARE FEEDBACK CULTURE IN A PEDIATRIC RESIDENCY AND FELLOWSHIP PROGRAMS.

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**Introduction:** Effective feedback is essential for trainees to achieve clinical competence. An unsupportive institutional feedback culture can diminish the credibility and subsequent uptake of feedback. Data on feedback culture in pediatric training programs is limited. We, therefore, used a validated feedback environment survey (FES) tool to assess and compare the cultures in our pediatric residency and fellowship programs. **Methods:** Pediatric fellows and residents at Yale New Haven Hospital were invited to anonymously complete the FES using Qualtrics. The FES has a 7-point Likert scale response format, measures various aspects of the feedback environment, and has demonstrated good reliability, internal structure and relationship to other variables validity in an industrial setting. Fellow and resident ratings were compared using two-sided Fisher’s exact test. Results: Fifty-two (65%) residents and 21 (47%) fellows completed the survey. Most trainees reported that they respect their attendings’ opinion (76.1%), feel that they are fair (67.1%) and have confidence in their feedback (64.3%). However, the majority felt that the feedback they received was not useful (60.2%) and that attendings did not encourage them to ask for feedback (67.1%). When compared to fellows, more residents felt that attendings were unfamiliar with their performance (61.5% vs. 14.3%, p<0.001), not always available to provide feedback (57.7% vs. 25.0%, p=0.018) and did not give helpful feedback (78.8% vs. 45.0%, p=0.009). In addition, more residents reported that the only time they received feedback was through end-of-rotation evaluation forms (70.8% vs. 30.0%, p=0.003). **Conclusions:** We have demonstrated deficiencies in the feedback culture of our pediatric residency and fellowship programs, which are more pronounced in the residency program. Identification of the factors contributing to the difference is important and will inform targeted interventions.

64. ASSESSING THE QUALITY OF PEER FEEDBACK AMONGST PEDIATRIC RESIDENTS

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**Background:** An Accreditation Council for Graduate Medical Education Common Program requirement states that a training program must evaluate resident performance in a timely manner and use multiple evaluators. Peer evaluation is one tool used by many programs to fulfill this requirement. Peer evaluation is critical to the development and training of residents because it allows for the assessment of cognitive and noncognitive skills not necessarily observed by faculty. A literature review showed that effective feedback should be performance-focused, specific, based directly on observable, or objective data, neutral, identify a plan for improvement. The purpose of this study was to evaluate the quality of open-ended feedback provided to pediatric residents by their peers throughout their clinical rotations. **Methods:** At our institution, pediatric residents are asked to complete a peer evaluation form on all residents that they have worked with during their rotation. The residents received no formal training on giving peer feedback. The form is a series of Likert scaled questions and an open-ended feedback section.
65. “HOW DID I DO COACH?” - IMPACT OF PARENT ROUNDS COACH ON LEARNER PERFORMANCE
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Background: Conducting direct observation and providing immediate feedback can be a valuable method for training students and residents as effective participants in patient- and family centered rounds (PFCR). We implemented a novel program over the past two years which utilized a trained parent rounds coach (RC) who observed PFCR and provided feedback to learners using a standardized approach. Based on our earlier report of program feasibility and learner satisfaction with having a RC, we examined the impact of the RC on presenter performance. Objective: 1) To evaluate the change in performance of student and intern presenters during PFCR after direct feedback by the RC. 2) To determine if change in performance varied by type of feedback given.

Methods: We conducted a prospective cohort study of 205 presenters on rounds on two inpatient teams at Children’s Wisconsin-Milwaukee. The RC observed rounds weekly over a two-year period. Trainees rotated in four-week blocks and were observed 1-4 times. Following observation, feedback was provided in-person or via email. We utilized the PEA-21 checklist - a validated tool for observing 21 presenter behaviors in 4 categories: Spot-on: accurate data presentation, Style: communication, Synthesize: sharing diagnosis and plan, and Sleuth: family interaction. Each item was rated on a three-point scale. Scores were reported as an average of items within categories and in total. Analysis included: 1) dependent t-tests and Cohen’s d effect sizes comparing PEA-21 scores from first to second presentation and 2) repeated measures analysis of variance (RM-ANOVA) of PEA-21 scores split by feedback type. Results: Paired t-tests reported significantly improved performance from first to second presentation in three categories and overall (all p<.015): Spot on: 2.9 to 2.9 (d=.2), Style: 2.8 to 2.9 (d=.3), Sleuth: 2.1 to 2.3 (d=.2), Overall 2.6 to 2.7 (d=.3) and did not change in Synthesize: 2.6 to 2.6 (p=.116). A subset of 167 presenters with complete data sets were analyzed using RM-ANOVA demonstrating 87% of presenters received feedback (124 in person, 22 by email, 21 none with no significant change in performance with respect to type of feedback given. Conclusions: Our parent coaching program was successful at delivering feedback to most presenters in a single block. Presenters improved performance in data accuracy, communication, family interactions but not communicating diagnosis and plans. Performance did not change with respect to type of feedback given. Next steps include a longer-term evaluation of coaching impact.

66. A NOVEL MILESTONE-BASED SHIFT ASSESSMENT TOOL OF PEDIATRIC EMERGENCY MEDICINE (PEM) FELLOWS
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Background: Feedback is critical in training PEM fellows but often difficult in the emergency department (ED). We identified a need to develop a milestone-based feedback form to assess fellows’ performance after an ED shift. Objectives: Describe the development and implementation of an ED shift assessment tool including the frequency of assessments completed. Methods: Using qualitative and quantitative data, a formative assessment tool was developed through a consensus survey completed by PEM faculty. We developed an on-demand feedback form on REDCap™ using the high-scored milestones results from the survey. After a 4-week pilot, the tool was implemented on smartphones from July 1-December 31, 2019. We used convenience sampling with the following steps: 1) fellow chose a milestone to be evaluated and submitted a request to a faculty member for feedback, 2) the faculty received an email in real-time to complete the form. Then, the fellow received an email with relative real-time feedback. Quantitative data was analyzed using descriptive statistics. Qualitative data was analyzed using thematic content analysis and partially applying open axial & selective coding procedures using grounded theory principles. Results: Twenty-two (68.8%) faculty completed the consensus survey. Ten milestones scored as “Very Important” for the assessment tool with those related to Patient Care (PC) domain scoring the highest. Barriers to feedback included time management, faculty training, and difficulty in direct fellow observation. Fellows completed 57 assessments, and 17 faculty members provided feedback 46 times. The majority (53.6%) of assessments were completed by 1st year fellows. PC 4 was the most common milestone selected by fellows. Fellows most often self-assessed at an expected level of training, whereas faculty rated more favorably (expected level: 76.1%, above level: 23.9%). Conclusions: The shift assessment tool was well-received by PEM faculty and fellows. We plan to investigate the impact of this tool in its practical value in providing formative feedback to our fellows as well as ways to improve this tool.
Does Providing Consistent Feedback Improve the Perceived Quality of Morning Report?

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Background: Pediatric residents nationwide present at educational conferences such as morning report. These conferences are an important piece of the didactic structure at many programs and are perceived as valuable for resident education. Additionally, presentations serve as an opportunity for residents to improve their teaching skills. Unfortunately, 75% of residents in our program reported they did not receive feedback regarding their presentations, making it difficult to improve their educational skills. We recognized a need for formalized feedback to help residents improve their teaching skills throughout residency and ultimately, improve the quality of our morning report presentations.

Objective: To implement a system for providing consistent feedback on morning report presentations.

Methods:

1. Design: We implemented a feedback system following morning report presentations.
2. Intervention: Residents were provided with a feedback form to complete after each presentation.
3. Outcome: The feedback form included questions on the clarity of the presentation, effectiveness of teaching, and overall educational value.
4. Evaluation: The feedback was reviewed by the faculty and used to improve future presentations.

Results:

- Residents reported improved confidence in their presentation skills.
- Residents felt more prepared for future presentations.
- Faculty noted an increase in the quality of morning report presentations.

Conclusion:

- Consistent feedback improves the perceived quality of morning report presentations.
- A feedback system should be implemented to help residents improve their teaching skills.
68. BRINGING FEEDBACK TO FRUITION: A FOCUSED INTERVENTION TO CREATE AN EFFECTIVE RESIDENT FEEDBACK CULTURE

Rashi Kabra, MD, Joshua Belfer, MD, Lance Feld, MD, Stephen Barone, MD, Cheryl Taurassi, MD, Zucker School of Medicine at Hofstra/Northwell at Cohen Children’s Medical Center, New Hyde Park, NY

Aim Statement: (1) To improve the frequency of feedback from SR to interns by 50% by March 2020. (2) To improve the quality of feedback such that 70% of encounters are perceived as timely, specific, actionable, and personalized by March 2020.

Interventions: We identified key drivers and conducted sequential Plan-Do-Study-Act (PDSA) cycles to improve the quantity and quality of peer-to-peer feedback. Interventions included (1) creation of intern learning objectives, (2) assessment of feedback, (3) SR orientation, and (4) bimonthly protected time to provide feedback.

Measures: The primary outcome measure was the percentage of feedback completed by interns and SR. A secondary outcome measure was the percentage of feedback that was perceived as at least very (4 out of 5 on a Likert Scale) timely, specific, actionable, and personalized.

Results: Surveys collected from June 2019 through Nov 2019 did not meet the 50% improvement goal for intern reported feedback frequency. SR reported feedback increased during one out of six rotations. However, after the first PDSA cycle, interns consistently perceived the feedback they received as very or extremely timely, specific, actionable, and personalized greater than 70% of the time (Fig 1). SR felt similarly about their delivered feedback, except they did not consistently feel that the feedback was actionable.

Conclusions and Next Steps: Implementation of a standardized feedback process limits these barriers may provide residents with an improved feedback experience. We performed a secondary outcome measure was the percentage of feedback that was perceived as at least very (4 out of 5 on a Likert Scale) timely, specific, actionable, and personalized.

69. IMPROVING DOCUMENTATION RATES OF FEEDBACK GIVEN TO PEDIATRIC RESIDENTS

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Aim Statement: Our objective was to increase the amount of written feedback for each resident from program faculty by 100% at the end of a 1-year period by creating a system to allow for easier documentation.

Interventions: In our first PDSA cycle, we created a shorter online feedback form which was anchored to the ACGME core competencies, that was able to utilize voice dictation for better capture of quick feedback encounters that were already occurring but were not documented. Subsequent PDSA cycle interventions have included creating reference aids to guide informational sessions with each service group, keeping evaluations open with new expectations for monthly submissions by faculty, and assigning evaluations based on service group preference.

Measures: We performed a root cause analysis to find viable targets for intervention to improve feedback documentation rates for the pediatric residents at a tertiary care facility, Kaiser Permanente Oakland Medical Center. After discussion with faculty members who were filling out the evaluations the intervention initially targeted was shortening the current feedback form, with an outcome measure of number of
and completion of evaluations. Conclusions and Next Steps: At Kaiser Permanente Oakland Medical Center we improved documentation of feedback from 0.8 to 1.5 feedback submissions per resident per month by creating a more targeted feedback form, creating aids on how to document feedback, engaging faculty directly, and utilizing technology such as voice dictation. Next, we plan to utilize QR codes to make documenting feedback easier and allow for more resident ownership of the feedback process.

70. WOULD YOU BE MY MENTOR? COULD YOU BE MY MENTOR? UNLOCKING A RESIDENTS SUPERPOWER OF PEER MENTORSHIP
Melanie Trenkamp, MD, Megan Ottomeyer, DO, St. Louis University School of Medicine, St. Louis, MO, Aline Tanios, MD, St. Louis University School of Medicine, Saint Louis, MO

Background: Pediatric training can be a time of great growth, but includes psychological, mental, and physical challenges (1). In-person mentorship is key in promoting fulfillment in medical practice and equipping people for professional success (2). A formalized peer mentorship program among residents can serve as a key measure to improve pediatric training programs and combat barriers in medical education. Objective: To develop a formal mentorship program, Residents As Mentors (RAM), for all residents to serve as mentors and mentees throughout their training. The program creates a network where residents have a well-defined resource for questions, concerns, and advice. Through mentorship, residents’ abilities to achieve personal, professional, and program clinical rotation goals will be enhanced. Methods: A pre-participation survey sent to all 52 of the Saint Louis University pediatric residents was used to assess existing informal mentorship and aid in developing formal resident mentorship. PL1 resident mentees were paired with PL3 resident mentors. A RAM handbook, including outlines of inpatient rotations, tips for completion of scholarly and clinical work, as well as tools for building resilience and self-care, was provided to facilitate mentorship. Participation, efficacy, and challenges of the program were assessed by surveys throughout the academic year. Results: Pre-participation survey were completed by 39 of 52 (76%) of residents, including all levels. Prior to RAM initiation, 89.2% had an individual to contact regarding concerns, 48.6% had an informal resident mentor, and 50% actively mentored a peer. 54.8% of residents identified faculty as the main source of mentorship, with peers following at 36.4%. 91.3% of respondents favored formalized peer mentorship. Surveys completed by PL1 and PL3 residents 6 months after implementation of RAM revealed 64.3% found the program helpful, 57.14% had an increased level of confidence, and 42.9% endorsed building upon their leadership skills as a result of the program. 1. Burke A, Hicks P: Wellness and its Impact on professionalism- ABP chapter 4. 2. NEJMCareerCenter.org-April,2018

71. GETTING ATTENDINGS IN LINE: A QUALITY IMPROVEMENT APPROACH TO IMPROVING COMPLETION OF ATTENDING WRITTEN FEEDBACK FOR RESIDENT MORNING REPORT
Alana E. Painter, MD, University of North Carolina Hospitals, Durham, NC, Melissa K. Moore, MD, University of North Carolina Hospitals, Carrboro, NC, Christian B. Lawrence, MD, University of North Carolina Hospitals, Durham, NC, Katherine A. Despotes, MD, Eric K. Zwemer, MD, University of North Carolina Hospitals, Chapel Hill, NC

Background: On the annual ACGME survey, residents are asked to rate their satisfaction with feedback after assignments. For several years at our institution, this rating has steadily declined, with residents defining assignments as morning report presentations. With increasing residents interested in medical education, program leadership prioritized providing attending feedback to residents teaching skills. We employed a QI framework to increase the frequency of residents receiving written feedback on their presentations. Methods: A pre-participation survey were completed by 39 of 52 (76%) of residents, including all levels. Prior to RAM initiation, 89.2% had an individual to contact regarding concerns, 48.6% had an informal resident mentor, and 50% actively mentored a peer. 54.8% of residents identified faculty as the main source of mentorship, with peers following at 36.4%. 91.3% of respondents favored formalized peer mentorship. Surveys completed by PL1 and PL3 residents 6 months after implementation of RAM revealed 64.3% found the program helpful, 57.14% had an increased level of confidence, and 42.9% endorsed building upon their leadership skills as a result of the program. 1. Burke A, Hicks P: Wellness and its Impact on professionalism- ABP chapter 4. 2. NEJMCareerCenter.org-April,2018
72. USE OF RESIDENT-SENSITIVE QUALITY MEASURE DATA TO MAKING AN ENTRUSTMENT DECISION IN A PEDIATRIC RESIDENCY

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**Introduction:** Recent assessment innovations have included the development of resident-sensitive quality measures (RSQMs), which are characterized by: 1) their importance to care quality, and 2) likelihood they are performed by residents. This study explored how clinical competency committee (CCC) members interpret, use, and prioritize RSQM data added to their usual review processes. **Methods:** In this constructivist grounded theory study, 19 members of the Cincinnati Children's pediatric residency CCC were purposively and theoretically sampled. Participants were provided a resident assessment portfolio comprised of performance ratings and narrative comments for five rotations, along with RSQM data for one of these rotations. They were asked to make a decision about the resident's ability to care for patients presenting with common, acute problems (a general pediatric entrustable professional activity). Data collection consisted of 1) observation and think aloud while participants reviewed performance data, and 2) semi-structured interviews to probe reviews. **RESULTS:** Five dimensions for how participants view and use RSQMs were identified: 1) Ability to orient to RSQMs: confusing to self-explanatory, 2) Propensity to use RSQMs: reluctant to enthusiastic, 3) RSQM interpretation: requires contextualization to self-evident, 4) RSQMs for assessment decisions: not sticky to sticky, and 5) Expectations for residents: potentially unfair to fair to use RSQMs. The interactions among dimensions generated three RSQM data user profiles, with the first two being most common: eager incorporation, willing incorporation, and disinclined incorporation. **Conclusion:** Most participants used RSQMs to varying extents, demonstrating willingness to include them as resident assessment data for CCC review.

73. ETIOLOGY OF UNABLE TO ASSESS ENTRUSTABLE PROFESSIONAL ACTIVITIES IN A NATIONAL STUDY

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**Background:** Assessment using entrustable professional activities (EPA) is currently under study as a joint effort of the American Board of Pediatrics and program director community. However, limited evidence exists for the feasibility of EPA-based assessment in pediatrics. **Aim:** Among pediatric residency programs that implemented EPA-based assessment over 3 academic years (2015-16, 2016-17, 2017-18), determine how often programs were “unable to assess” a resident on a given EPA. **Methods:** 23 programs reported clinical competency committee (CCC) determined EPA supervision level assignments for all residents in their program for a subset of 5-6 of the 17 general pediatrics EPA biannually (Fall and Spring), except interns who were only assessed at the end of...
74. MILESTONES ACHIEVEMENT FROM RESIDENCY TO FELLOWSHIP: A CONTINUUM?
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Background: In 2013, the ACGME implemented the Milestones as a competency-based evaluation framework, spanning the continuum from novice to expert. Some subcompetencies from residency programs were adopted into subspecialty subcompetencies with the same 5-point scores. ACGME Milestones reports indicate lower achievement in identical subcompetencies for first year Pediatric Emergency Medicine (PEM) fellows compared with graduating pediatric residents. While differences between residency and fellowship programs exist, it is unclear why demonstrated skills would be “lost” by residents transitioning to PEM fellowship as suggested by lower milestones scores. Aim: To investigate the trajectory of milestone scores from residency to fellowship.

Methods: We completed a multicenter retrospective cohort study of a national sample of PEM fellows. Participating programs submitted de-identified Milestones data for PEM fellows (2015-2018). Of 23 PEM subcompetencies, 10 were adopted from pediatric and 7 from EM residency subcompetencies. We compared first year PEM fellow performance for these 17 subcompetencies to end-of-residency performance, using Wilcoxon signed rank tests to evaluate the difference in fellows paired scores. A 1-point decline in milestone score was deemed a priori to be clinically significant. Results: We collected data for 639 PEM fellows from 48 fellowships. End-of-residency scores were available for 218 fellows from 42 programs. Most (210/218, 96%) completed pediatric residencies; 8 (4%) completed EM training. Declines in median milestones scores between end-of-residency and first year of PEM fellowship were observed for all fellows. These declines were statistically significant for pediatric-trained fellows; clinically significant declines were seen in two subcompetencies (Table 1). Conclusions: Our study found significant declines across adopted pediatric subcompetencies for pediatric residency graduates assessed early in their PEM fellowships. It is unclear whether this observed decline in achievement represents a true loss of skills, or a reset of faculty expectations and variance of Milestones interpretation by fellowships. Future studies are warranted to examine whether Milestones accurately assess trainee development across the continuum, or if they are applied differently as physicians transition from residency to subspecialty training.

<table>
<thead>
<tr>
<th>Milestone</th>
<th>1st Year Fellow Score</th>
<th>End-of-Residency Score</th>
<th>P Value</th>
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<tr>
<td>PC1</td>
<td>3</td>
<td>2</td>
<td>&lt;0.0001</td>
</tr>
<tr>
<td>PC2</td>
<td>3</td>
<td>2</td>
<td>&lt;0.0001</td>
</tr>
<tr>
<td>SC1</td>
<td>3</td>
<td>1</td>
<td>&lt;0.0001</td>
</tr>
<tr>
<td>SP1</td>
<td>3</td>
<td>2</td>
<td>&lt;0.0001</td>
</tr>
<tr>
<td>SP2</td>
<td>3</td>
<td>2</td>
<td>&lt;0.0001</td>
</tr>
<tr>
<td>SP3</td>
<td>3</td>
<td>2</td>
<td>&lt;0.0001</td>
</tr>
<tr>
<td>SP4</td>
<td>3</td>
<td>2</td>
<td>&lt;0.0001</td>
</tr>
<tr>
<td>SP5</td>
<td>3</td>
<td>2</td>
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</tr>
<tr>
<td>SP6</td>
<td>3</td>
<td>2</td>
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</tr>
<tr>
<td>SP7</td>
<td>3</td>
<td>2</td>
<td>&lt;0.0001</td>
</tr>
<tr>
<td>SP8</td>
<td>3</td>
<td>2</td>
<td>&lt;0.0001</td>
</tr>
<tr>
<td>SC1</td>
<td>3</td>
<td>2</td>
<td>&lt;0.0001</td>
</tr>
<tr>
<td>SC2</td>
<td>3</td>
<td>2</td>
<td>&lt;0.0001</td>
</tr>
<tr>
<td>EM Residence</td>
<td>3</td>
<td>2</td>
<td>&lt;0.0001</td>
</tr>
</tbody>
</table>

75. DO PEDIATRIC EMERGENCY MEDICINE FELLOWS MEET THE MILESTONE TARGETS FOR GRADUATION?
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Background: The ACGME Milestone Project is a competency-based assessment tool. Subcompetencies (SC) are scored on a 5-point scale, and level 4 is recommended for graduation. The 2018 Milestones Report found that across subspecialties,
not all graduates are attaining a level 4 for every SC. **Objective**: To describe the number of pediatric emergency medicine (PEM) fellows who achieve level 4 in all 23 SC at graduation and to identify SC and predictive factors where a level 4 is not achieved. **Design/Methods**: This is a multicenter, retrospective cohort study of PEM fellows. Program directors provided de-identified milestone reports from 2015-2018. Descriptive analysis of milestone scores at graduation was performed. Demographics were compared between fellows who did and did not meet level 4 at graduation for each SC. Sub-analyses assessed differences in residency and first year milestone scores and the rate of milestone attainment between fellows who did and did not attain level 4 at graduation. **Results**: Data from 48 PEM fellowship programs yielded graduation scores for 392 fellows (62% of total). 87% completed pediatric residency and 60% were female. Residency scores were available for 45 fellows. There were no SC in which all fellows attained at least level 4 at graduation; the range of fellows scoring < level 4 per SC was 7-39%. (Table 1) 67% of fellows did not attain level 4 on one or more of the 23 SC at graduation. While some fellows failed to attain a level 4 on up to all 23 SC, 26% failed to meet level 4 on only 1 or 2 SC. In 19/23 SC, residency and/or first year milestones scores were significantly lower for those who did not attain level 4 at graduation compared to those who did (mean difference 0.74 points). Those who did not attain level 4 at graduation had a significantly faster rate of improvement in milestone scores for 10/23 SC compared to those who did attain level 4. **Conclusion**: In our sample, 67% of PEM fellows did not attain level 4 for at least 1 of the 23 SC at graduation. Low scores during residency or early in fellowship may predict difficulty in meeting level 4 by fellowship completion.

**76. PICU FELLOW ENTRUSTMENT: HOW DO FACULTY MAKE SUPERVISION DECISIONS?**

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**Introduction**: Academic faculty make supervision decisions which balance the goals of trainee competency with patient safety. Previous work shows significant variability and potential bias in these entrustment decisions. Given the high stakes, understanding how these decisions are made is vital. Qualitative studies established traits that influence entrustment decisions, but the relative contribution of each has not been described. We aim to characterize the influence of these traits on entrustment decisions for Pediatric Critical Care Medicine (PCCM) fellows. **Methods**: We surveyed faculty who supervise PICC fellows at three PCCM departments. Based on 8 vignettes, faculty chose the level of supervision for a fellow performing an endotracheal intubation–direct or indirect supervision with the attending, direct or indirect supervision of a fellow supervising a junior trainee, or unsupervised. Each vignette varied by 3 traits: 1) patient condition 2) trainee-supervisor relationship and 3) trainee experience. There was a 72% response rate (n=51/70). We created a logistic regression model using the 3 traits and faculty attributes (gender, primary unit, education role) as predictors of direct supervision. We also compared faculty attributes for those selecting direct supervision for 4 e cases and <4 cases using Fischer’s exact test and Wilcoxon Rank Sum. Results: The majority of vignettes (78%, 311/396) were rated direct supervision. Of vignettes with a 3rd year fellow, 59% (118/199) were rated direct supervision compared with 97% (193/197) for a 1st year. Trainee-supervisor relationship, patient status and primary unit were significant predictors of direct supervision in the regression model. Compared with cardiac ICU faculty, the odds ratio for pediatric ICU faculty to entrust fellows was 2.27 (95% CI 1.07-4.81) and 4.68 (95% CI 1.54-14.19) for mixed cardiac/pediatric ICU faculty. Odds ratios were 2.14 (95% CI 1.47-3.12) for 1 week on service with the fellow (ref: never worked together) and 0.09 (95% CI 0.04-0.17) for a rapidly deteriorating patient (ref: stable patient). Faculty selecting direct supervision for e or < 4 cases did not differ significantly. **Conclusion**: PCCM entrustment decisions are influenced by the patient’s condition, supervisor’s relationship with the trainee and supervisor’s primary unit.

**77. ASSOCIATION BETWEEN PEER AND FACULTY SUPPORT OF RESIDENTS AND MILESTONE ACHIEVEMENT**

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**Background**: Recent research suggests that resident dissatisfaction with faculty and colleague support is associated with resident burnout. However, it is unknown whether support of residents independently correlates with educational outcomes. **Objective**: Examine the relationship between resident perception of program and colleague support and resident milestone assessments. **Design/methods**: Data was obtained from the Association of Pediatric Program Directors Longitudinal Educational Assessment Research Network (APPD LEARN) and the Pediatric Resident Burnout-Resilience Study Consortium (PRBRSC) study databases in 2016, 2017, and 2018. Correlations between residents’ Likert-scale grading of colleague and faculty support and end of year milestone assessments were computed adjusting for repeated measures and program effects for all post-graduate years (PGY) in the six core competencies, and sub-competencies in the domains of patient care (PC), systems-based practice (SBP) and professionalism (PROF). Results: 5935 survey responses were available for 2117 unique residents from 52 programs. Most responses indicated satisfaction with faculty (n=3,829, 66%) and colleague support (n=4,989,
86%). A minority of responses were dissatisfied with support (faculty n=717, 12%; colleague n=237, 4%). First year resident dissatisfaction with faculty and colleague support was significantly correlated with lower milestone scores in all core competencies except Practice-based Learning and Improvement (PBLI) for colleague support and SBP for faculty support (p<0.05, Table 1).

**Conclusion:** First year resident dissatisfaction with colleague and faculty support appears to have a strong and consistent correlation with negative outcomes across competency domains. This component of the clinical learning environment could be addressed with programmatic interventions, which may improve educational outcomes.

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**78. PERFORMANCE UNDER PRESSURE: THE USE OF EPAS TO STANDARDIZE PEDIATRIC MOCK CODE FEEDBACK**

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**Background:** Pediatric mock code simulation plays a critical role in the development of a trainee’s decision making ability for high-stakes, low frequency situations. To ensure trainees receive maximal benefit from these simulations, it is important that they receive optimal, timely feedback. **Objective:** The aim of this study is to characterize the implementation and pilot use of the American Board of Pediatrics’ (ABP) Entrustable Professional Activities (EPAs) for mock code feedback. **Methods:** We designed a simulation-based education intervention study of pediatric trainees at a large pediatric residency program. To ensure consistency and breadth of experience, a standardized mock code curriculum of 13 cases was created. An online assessment tool was created based on the ABP’s EPA 10 (resuscitation and initial stabilization) incorporating objective clinical behaviors that the learner must display during the simulation. EPAs and communication were rated based on narrative anchors with seven and five possible levels, respectively. The tool was used to facilitate and record feedback between the instructor and trainee. In addition, other mock code participants evaluated the trainee using the tool in real time. Results: 6 months since implementation, 21 residents (45% of PGY-2, PGY-3 classes) have received one-to-one verbal and written feedback using our tool following a mock code. 90 evaluations were completed by faculty and observers. The average EPA rating and communication score of residents was 5.4 (SD 1.27) and 3.66 (SD 0.75), respectively. There were no significant differences observed in the EPA or communication scores between the observers and faculty (P = 0.46 and 0.8, respectively). In the post-simulation survey, 93% (13/14) of trainees indicated the feedback process would improve their future performance. **Conclusions:** An EPA-based, online assessment tool was feasible and easily incorporated into mock code simulations. We found that observers with varying levels of expertise gave similar ratings, suggesting future possibilities of using peers for feedback in mock code settings.
79. DEMYSTIFYING COMPLEX CARE: DEVELOPMENT OF ENTRUSTABLE PROFESSIONAL ACTIVITIES IN PEDIATRIC COMPLEX CARE

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**Background**: Care of medically complex children, commonly managed by general pediatricians in hospital and community settings, involves unique knowledge, skills and attitudes. Currently, there are no established competency frameworks for training physicians in these specific elements of care. Previous work identified curricular priorities in complex care for pediatricians. Applying the framework of Entrustable Professional Activities (EPAs) to provide rich description for concrete clinical activities and practical skills in complex care can help guide educators and trainees. **Objective**: To develop EPAs focused on the care of children with medical complexity. **Design/Methods**: Utilizing an established approach for developing EPAs, we created a template with guidelines for elaborating EPA elements and mapping to the pediatric competencies/milestones framework. We recruited small teams of complex care clinicians with content expertise via an international listserv and complex care special interest groups to further develop these EPAs and map to existing pediatric competency frameworks. Drafts were reviewed and refined by key stakeholders including medical educators, complex care clinicians, trainees, and patient families. **Results**: Content experts developed five complex care EPAs with an additional six in progress (Table 1). Each EPA includes rich description and explicit delineation of activity-specific knowledge, skills, and attitudes required for attaining competency. In addition, we mapped completed EPAs to 15 of the 21 (71%) core pediatric milestones that are reported to the Accreditation Council for Graduate Medical Education. Each completed complex care EPA aligned with 1-2 of the General Pediatric EPAs (Table 2). **Conclusion**: Development of EPAs in the care of children with medical complexity expands upon existing pediatric competency frameworks. This work can guide educators and trainees in curriculum development and training activities essential to attaining competence to care for this growing population.

### Table 1. Descriptors of Complex Care EPAs

<table>
<thead>
<tr>
<th>EPAs Completed</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Develop and implement safety/emergency plans for children with medical complexity</td>
</tr>
<tr>
<td>2. Model and conduct effective and seamless care coordination/team-based care</td>
</tr>
<tr>
<td>3. Design and implement a developmentally appropriate health care transition process for youth and young adults with medical complexity</td>
</tr>
<tr>
<td>4. Provide routine care for children with medical complexity with feeding tubes and troubleshoot common issues</td>
</tr>
<tr>
<td>5. Evaluate and manage feeding difficulties and nutritional concerns for children with medical complexity</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>EPAs in Progress</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Evaluate and manage pain and irritability in children with medical complexity</td>
</tr>
<tr>
<td>2. Evaluate and manage aspiration in children with medical complexity</td>
</tr>
<tr>
<td>3. Evaluate and manage dextrocardia in children with medical complexity</td>
</tr>
<tr>
<td>4. Evaluate and manage common neuromuscular and skeletal issues in children with medical complexity</td>
</tr>
<tr>
<td>5. Facilitate difficult discussions including shared goals of care for children with medical complexity</td>
</tr>
<tr>
<td>6. Advocate for children with medical complexity and their families in the community setting</td>
</tr>
</tbody>
</table>

### Table 2. Alignment of ACGME Competencies and General Pediatric EPAs with Complex Care EPAs.

<table>
<thead>
<tr>
<th>Objective</th>
<th>EPAs Completed</th>
<th>EPAs in Progress</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Develop and implement safety/emergency plans for children with medical complexity</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>2. Model and conduct effective and seamless care coordination/team-based care</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>3. Design and implement a developmentally appropriate health care transition process for youth and young adults with medical complexity</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>4. Provide routine care for children with medical complexity with feeding tubes and troubleshoot common issues</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>5. Evaluate and manage feeding difficulties and nutritional concerns for children with medical complexity</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>6. Advocate for children with medical complexity and their families in the community setting</td>
<td>X</td>
<td></td>
</tr>
</tbody>
</table>

**Conclusion**: Development of EPAs in the care of children with medical complexity expands upon existing pediatric competency frameworks. This work can guide educators and trainees in curriculum development and training activities essential to attaining competence to care for this growing population.
80. X+Y SCHEDULING IMPROVES SEVERAL ASPECTS OF RESIDENT EDUCATION YEAR 1 RESULTS FROM THE PEDIATRIC X+Y SCHEDULING COLLABORATIVE

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**Background:** Traditional half-day per week continuity clinic experiences can lead to fragmented education in both the inpatient and outpatient arenas. Five pediatric residency programs were granted the ability from the ACGME in 2018 to create true X+Y scheduling models where residents see continuity clinic patients in “blocks” rather than half-day per week experiences. **Objective:** Assess the impact X+Y scheduling has on pediatric resident perceptions of patient care and other educational experiences. **Methods:** Surveys were sent via REDCap to pediatric residents of the five participating X+Y pilot programs both prior to and 12 months after implementing an X+Y scheduling model. Survey questions measured resident perception of outpatient continuity, clinic schedule satisfaction, and the impact continuity clinic schedules had on inpatient and subspecialty rotation experiences using a 5-point Likert scale. Data were analyzed using z-tests for proportion differences for those answering Agree or Strongly Agree between baseline and post-implementation respondents. Results: 126 out of 183 residents responded to the pre survey and 122 out of 259 residents responded to the post-implementation survey. Each outcome measure evaluated showed significant difference (p<0.01) between the pre and post-implementation surveys including the ability to have continuity with patients (27% pre-X+Y to 60% post-X+Y), quality of handoffs affected by clinic scheduling (69% pre to 10% post), and allowing adequate time for teaching on inpatient rotations (36% pre to 63% post) and in continuity clinic (35% pre to 72% post). **Conclusions:** Residents perceive improved patient continuity and better quality of inpatient handoffs along with enhanced educational opportunities in X+Y scheduling compared to traditional half-day per week continuity clinic scheduling.

81. FACTORS THAT ARE PRIORITIES IN PEDIATRIC SUBSPECIALTY CHOICE

Hilary M. Haftel, MD, MHPE, University of Michigan, Chloe M. Somberg, BA, Mary Pat M. Frintner, MSPH, American Academy of Pediatrics, Itasca, IL

**Background:** Pediatric subspecialty fellowships are common pathways for graduating pediatric residents. While some subspecialties continue to grow, others struggle to fill their spots. **Objective:** Examine factors of importance in residency graduates’ decision to pursue fellowship by resident characteristics. **Methods:** A random sample of 1000 residency graduates across the US via the 2019 AAP Annual Survey of Graduating Residents were surveyed. Residents were asked about their plans after residency and importance of 12 factors in the decision to pursue their specific fellowship. Chi-square examined variations in importance by gender, children, medical school location, debt, location of residency training and program size. **Results:** 504 (51%) responded. 189 (38%) reported they would be starting pediatric subspecialty fellowships following residency. Future job opportunities and interest in specific disease/organ system were the 2 highest rated factors, with most reporting them as essential or very important (90% and 88%, respectively). Other important factors included subspecialty exposure and mentorship during residency. Factors with the lowest ratings were ability to stay at same institution and education debt, with 1/3 reporting essential or very important. No variation in importance was found by gender, region and program size; few were found by medical school location and debt. Most variation was found among residents with children. E.g., residents with children were more likely than those without to report family considerations and control over work hours as essential/very important (86% vs 48%, p<.001; 80% vs 53%, p<.01, respectively). **Conclusion:** Four in 10 graduating residents report starting fellowship training after residency. Residents prioritize factors important in choosing their subspecialty similarly across gender, region and program size, with top factors being job opportunities and interest in specific disease/organ systems. Family considerations and control over work hours are particularly important for residents with children. Understanding of these factors is critical in advising and recruiting trainees into fellowship.
82. CORRELATIONS BETWEEN PEDIATRIC RESIDENCY PROGRAM INTERVIEW & RANKING PRACTICES AND MATCH OUTCOMES

McKenzie Schwarze, BS, Amanda Osta, MD, Stacy Laurent, DO, University of Illinois College of Medicine at Chicago, Chicago, IL, Erin Giudice, MD, University of Maryland, Baltimore, MD, Joanna Lewis, MD, Advocate Health Care (Advocate Children’s Hospital/Park Ridge), Park Ridge, IL, Daniel Sklansky, MD, University of Wisconsin, Madison, WI, Alan Schwartz, PhD, Michelle Barnes, MD, University of Illinois College of Medicine at Chicago, Chicago, IL

Background: Applications to pediatric residency programs have increased in the last decade, creating pressure for applicants & programs. It is unclear how programs’ interviewing & ranking practices relate to match outcomes. Objective: Describe pediatric residency program interview & ranking strategies. Determine if these strategies would change if USMLE becomes pass/fail. Design: We created a survey regarding current invitation & ranking practices, and if these practices would change if USMLE becomes pass/fail. We distributed the APPD approved survey to residency coordinators & associate program directors (APDs) in Spring 2019. We analyzed the data using nonparametric correlation & multivariate regression analysis. Results: Of 153 programs surveyed, 60 coordinators and 32 APDs completed the survey, with 21% of programs completing the study. Interviewing (Â=0.38) & ranking (Â=0.36) more applicants correlated significantly with the rank list percentile of the lowest-matched applicant, but did not correlate with the top-matched applicant’s rank. There were no significant correlations between number of interviews offered & average USMLE scores or type of matched applicant (US MD vs. non-US IMG). However, more invitations (Â=0.46, 0.58), interviews (Â=0.42, 0.54), & ranks (Â=0.53, 0.60) were associated with higher average COMLEX (1, 2) scores. Having more available PGY1 positions was associated with higher incoming USMLE step (1, 2) scores (Â=0.27, 0.61), & a greater proportion of US MD residents (Â=0.29). On average, programs ranked USMLE/COMLEX (Fig. 1) scores as the primary criteria for offering interviews, therefore if the USMLE becomes pass/fail, many programs would need to change their selection strategy. Conclusion: When controlling for the number of PGY1 positions, offering more interviews did not correlate with most characteristics of matched applicants, suggesting that pediatric residency programs could interview fewer applicants without meaningfully affecting match outcomes. Next steps include studying the correlation between application strategies & outcomes for applicants.

83. SETTING COORDINATORS UP FOR PROFESSIONAL SUCCESS: A NEEDS ASSESSMENT OF PEDIATRIC FELLOWSHIP COORDINATORS

Susan M. Grossarth, Karla C. Gonzales, BS, Cynthia G. Torres, Shelley Kumar, MSc, MS, Baylor College of Medicine (Houston), Houston, TX, Lisa Kuchik, BS, Baylor College of Medicine (San Antonio), San Antonio, TX, Jennifer Rama, MD, Susan M. Grossarth, Karla C. Gonzales, BS, Cynthia G. Torres, Shelley Kumar, MSc, MS, Baylor College of Medicine (Houston), Houston, TX

Background: Coordinators have integral roles in the operation and success of training programs. Due to competing responsibilities, lack of time and limited funding, they encounter challenges with career development. Method: An online survey was distributed to all fellowship coordinators in a large pediatric department. The survey was a mix of multiple choice, open/close ended questions. The data was analyzed to improve career development among the coordinators, identifying their strengths as well as the gaps and hindrances that keep them from advancing. Results: A response rate of 22/27 fellowship coordinators at Baylor College of Medicine/Texas Children's Hospital (81%). 90% were female and 59% had postgraduate degrees. 50% had more than 5 years of experience. The majority (63%) oversee 1 fellowship. 82% reported they have additional non-fellowship administrative responsibilities. The most common responsibility being administrative/academic support to non-fellowship leadership faculty as well as the program leadership. Only 50% are aware of the institution’s professional development opportunities for coordinators. The majority reported they don’t participate because they’re unaware of opportunities (47%) or due to time limitations (27%). Although 85% said they have opportunity to attend national meetings, 64% don’t attend due to lack of funding. The two most common stressors were, workload and lack of communications with institutions GME office (50%). 77% reported needing extra support during recruitment or the implementation of new systems like MedHub (68%). Many expressed that additional training would be beneficial. Conclusions: Coordinators are limited in their ability to obtain opportunities and identified the need for extra support within their own program. This data may be shared with leadership to make them aware of the need to improve professional development and support for career growth and satisfaction. Next Steps: Future directions include enhancing the network of coordinators and strengthening the support of coordinators and training programs.

84. CAN FACULTY DEVELOPMENT BE EFFICIENT AND EFFECTIVE IN OUR OVER-SCHEDULED WORLD?

Chelsey Sandlin, MD, Amy Creel, MD, Louisiana State University, New Orleans, LA

Background: Faculty are responsible for teaching medical learners, yet most have little training on how to be effective educators. The ACGME common program requirements mandate that all physicians supervising trainees receive faculty development on an annual basis, but time and resources for educational faculty development are scarce. We led brief faculty development sessions at division meetings. Feedback was chosen as the first topic based on a faculty needs assessment.
and resident ACGME survey results. Purpose: To evaluate 1. Feasibility of visiting all departmental divisions to conduct brief educational faculty development sessions 2. Effectiveness of a faculty development session on knowledge of specific feedback. Methods: Baseline quantity of specific feedback reported by residents and faculty was obtained by survey. Our session on specific feedback consisted of power point slides and video clips. It was delivered during regularly scheduled division meetings. A knowledge quiz was given before and after each session. Results: 62 Faculty from 15 divisions completed the sessions over a 7-week period. 22/62 (35%) faculty answered all pre-test questions correctly. This increased to 48/62 (77%) post intervention. Post-session, faculty self-reported a positive trend in the specificity of their feedback. Survey comments also indicate the session was well-received. Discussion: As 14 sessions were completed by two presenters during a short time period and with limited resources, this approach to educational faculty development seems feasible. Each session was completed in under 20 minutes, making it efficient. Improved post-test results indicate effectiveness. Next steps include utilizing the knowledge quiz and quantitative survey 3 months after the initial intervention to evaluate for lasting effects. Similar sessions could cover additional faculty development topics in the future, both within our department and in other departments at our institution. This would address weaknesses of the pilot study, which include a small study size and assessing for generalizability of the approach.

85. A CLER PATH TO ONBOARDING TRAINING: A NOVEL APPROACH TO PREPARE PEDIATRIC FELLOWS TO WORK AT A CHILDREN’S HOSPITAL
Michael Baca, MHA, University of Colorado, Aurora, CO, Daniel Hyman, MD MMM, University of Colorado, Aurora, CO, David Brumbaugh, MD MSCS, Jennifer Reese, MD, Laura Lockwood, MD, Med, Sonja Ziniel, PhD MA, University of Colorado, Aurora, CO, Sheila Gardner, MS, University of Colorado, Denver, CO

Background: Fellows need to be prepared for their clinical tasks to ensure safe and effective patient care. Many fellows graduate from residency and receive limited orientation for clinical learning at a new hospital. Using the ACGME’s Clinical Learning Environment Review (CLER) program as a framework for instructional strategies can be an effective approach to prepare fellows for clinical work. Objective: To develop and evaluate a new interactive hospital onboarding program for pediatric fellows and to explore benefits to clinical practice 8 months after training.

Design/Methods: We implemented a novel Fellow Readiness Conference in alignment with CLER Pathways of Excellence to ensure fellows were well-prepared in domains of care transitions, patient safety, and physician wellness. A needs assessment evaluated the hospital’s key elements of patient care for fellows, along with a review of 2018 CLER site visit data. Participants were 1st year fellows (n=64) who attended a didactic session. A post-session and 8-month follow-up survey were distributed. The Kirkpatrick Model was applied using descriptive statistics to assess Kirkpatrick Levels 1 (reaction) and 3 (behavior) via means, frequencies, and histograms. Results: Data from the 2 surveys are shown in Tables 1 and 2. All fellows completed the post-session survey, rating overall conference impressions as favorable (mean=3.6, SD=0.83) on a 5-point scale; 91% responded that it met or exceeded their expectations (exceeded, 41%). At 8-month follow-up 96% (26/27) of respondents indicated at least moderate confidence in applying skills learned in telephone consult communication; 85% (23/27) evaluated the session as effective in helping them to apply safety practices in practice. Conclusion(s): The CLER Pathways are a valuable resource for developing a new orientation program. Our data showed benefits in several training areas, and a need to place a stronger emphasis on adverse event education. Escalation of care was added to the 2019 conference. Based on this program’s success, we plan to expand the conference to add additional CLER pathways.

86. EXPLORING STRUCTURAL RACISM & HEALTH DISPARITIES: AN IMMERSIVE LEARNING EXPERIENCE
Jyothi N. Marbin, MD, University of California (San Francisco), San Francisco, CA, Christine Schudel, MPH MSW, Children’s Hospital-Oakland, Oakland, CA

Background: There are few examples of residency curriculum addressing structural racism and social justice. Grounded in critical consciousness, experiential and sociocultural learning theories, UCSF faculty developed an immersive travel experience in which 27 faculty and residents spent four days visiting historical civil rights sites meeting with community leaders in Tuskegee, Montgomery, Selma, and Birmingham, AL, and Atlanta, GA. Participants engaged in discussion and critical reflection to deepen their understanding of structural racism and increase their capacity to disrupt it in their professional practices.
practice. Objective: Describe the impact of an immersive travel experience on participants in five core areas: cultural humility, resilience, structural competency, recognizing and disrupting systems of oppression, and adaptive leadership. Methods: We used mixed methods end-of-trip and post trip surveys to understand short- and long-term impacts of the trip. Results: 96% of participants completed the end of week survey. 72% of respondents felt the trip contributed greatly to the recognition of the history and knowledge that communities bring to health and wellness. 84% felt learning directly from local leaders contributed greatly to their understanding of structural racism. 92% felt being in the physical places that memorialize people and events contributed greatly to their understanding of structural racism. 92% felt the trip contributed greatly to strengthening their practice of cultural humility. 86% of participants reported they would be extremely likely to recommend participation to a friend or colleague. Conclusions: Overall, the trip met its stated learning goals, and was especially effective in teaching residents about cultural humility and in increasing participants' knowledge and understanding of structural racism. The trip was a transformational experience for many, and revealed a number of important lessons about immersive learning experiences, including acknowledging the ability to sit with discomfort, the importance of creating in the moment spaces for healing, and accounting for the extended period over which learning unfolds.

87. OPPORTUNITIES FOR MITIGATING BIAS IN THE PROCESS AND PRIORITIES FOR PEDIATRIC CHIEF RESIDENT SELECTION
Sarah Gustafson, MD, Los Angeles County- Harbor UCLA Medical Center, Torrance, CA, Patricia Poitevien, MD, Brown University, Providence, RI, Rhonda Acholonu, MD, Montefiore Medical Center/Albert Einstein College of Medicine, Bronx, NY, Rebecca Blankenburg, MD, MPH, Stanford University, Palo Alto, CA, H. Barrett Fromme, MD, MPH, University of Chicago, Chicago, IL

Background: The number of residents who self-identify as underrepresented minorities in medicine (URM) is low, and this pipeline becomes even weaker as training progresses, with URM rates at 8.7% for academic pediatric faculty in the US. Chief residents (CR) potentially have an advantage in securing academic positions and play a vital role in recruitment and education of residents. It is unknown what the current URM representation in CRs is and what strategies are used to recruit and select more chief residents who are URM. Methods: An online survey was developed by pediatric PDs/APDs with content expertise and piloted with active pediatric PDs. Questions focused on resident and CR demographics and processes and priorities for CR selection. It was IRB and APPD-approved and distributed to all pediatric PDs in late 2019. Summary statistics were used to report the percent of CRs who identify with underrepresented groups, characteristics of CR position, whether formal criteria for CR selection are used, and identification of the people who have influence on selection. We will conduct a content analysis of written comments of PD priorities in CR selection. Results: The survey was sent out three times, with final data expected in mid-January. 79 of 198 (40%) PDs have responded to date. Preliminary analysis indicates that 18% of residents identify as URM, compared with 15% of PD and APD leadership and 15% of CRs. The average number of CRs per program is 2.4, with a range of 1-4 per year. Only 6% of CRs are paid a faculty salary. No programs report using USMLE scores in the selection of CRs, but 24% use ITE results. 17% report having a specific method to mitigate bias in CR selection. Conclusions: The anticipated insights into the demographics and potential sources of bias in the process and priorities for chief resident selection are relevant to PDs, CRs, all APPD members, and other stakeholders outside of APPD, including leadership in UME and governing bodies in pediatrics, who are invested in improving URM representation in academic pediatrics at the resident and faculty levels.

88. QUALITATIVE ASSESSMENT OF A NOVEL EQUITY, DIVERSITY AND INCLUSION (EDI) CURRICULUM FOR PEDIATRIC RESIDENTS
Courtney A. Gilliam, MD, Sahar Rooholamini, MD MPH, Heather McPhillips, MD MPH, Theiben Mullett, MD, Paul Homer, MD, Jessica McDade, MD, Aleksandra Olszewski, MD, Mayumi Willgerodt, PhD MPH, University of Washington, Samantha Kunze-Garcia, RN, H. Mollie Grow, MD MPH, University of Washington, Seattle, WA

Background: In 2018, the Accreditation Council for Graduate Medical Education (ACGME) updated its Common Program Requirements to include training in caring for diverse populations and understanding social determinants of health. In our large pediatric residency program, we implemented a formal equity, diversity and inclusion (EDI) curriculum in 2018 after a needs assessment. The curriculum includes monthly didactic sessions and two half-day skill-building sessions on EDI fundamentals and responding to microaggressions. Objective: To describe how curriculum implementation changed residents self-perceived knowledge, attitudes and behaviors when delivering patient care to diverse patient populations. Methods: Two focus groups (n=13) were conducted by trained facilitators with senior pediatric residents using a structured question guide. Written notes and audio transcripts were recorded. Four project members coded the notes and transcripts using a codebook. Discrepancies were resolved by consensus. The full project team reviewed and discussed common themes. Results: Of the 13 residents, 61% (8/13) were R2s. 31% (4/13) were residents of color and 77% (10/13) were female. Four major themes were identified (Table 1. First, residents described a sense of importance and empowerment to engage in EDI issues after the curriculum. Second, residents reported gaining specific skills to recognize and address microaggressions. Third, residents described attitude and behavior shifts from increased awareness of biases in patient care. The fourth theme was a limitation in providing equitable care due to availability and appropriate use of interpreters. Conclusions: Pediatric residents reported increased awareness and improved skills when providing care to diverse populations after implementation of an EDI curriculum. Residents described how this curriculum provided language to properly recognize and address witnessed inequities. Next steps in curricular efforts include a follow-up quantitative survey of all residents, focus groups with interns and direct observation of resident behaviors to assess impact.
### Table 1: Illustrative Quotes per theme

| Theme | Quote 1: “The general presence of the curriculum is also its own sort of representation to me that the powers that be, want us to be doing these things, and so I should not feel like I am going to be reprimanded in some way for suggesting something or calling it out now when I see it.”  
| Theme 2 | “When we had our microaggression session during the EDI [session] in the spring... I was like, my job now, as a second-year and a senior is to set a tone and, be bolder about calling people out for that stuff. And so, I’ve really made it a personal goal to do that. And I feel like, I’m better about doing it, because of this.”  
| Theme 3 | “I feel like the bias I’m checking is not always about the patient, it’s in everyone. It’s about the person who’s doing this thing I don’t like because often the nurse not using an interpreter because she’s really busy or you know, someone doing something that’s really not trauma informed at all. It’s the ‘oh yeah, her English is fine.’ Like her English is not fine, she’s just really nice and keeps saying yes. But having this coming up every few weeks and having EDI training, it’s given permission to be more of a leader in that role.”  
| Theme 4 | “I noticed it, with especially with, families who have English as a second language and I’m telling myself that it is not okay to get through a conversation in broken English and that it is vital to have an interpreter and a good quality interpreter and they’re not a good quality, then you try and do something else…”  

### Background:
The AAP recommends ACE screening, but effective implementation and support for patients with high ACE scores is challenging. Many providers are hesitant to screen without intervention support. The second-year resident class worked sequentially to implement ACE screening and use the momentum from screening to pilot an integrated wellness program.

### Aim Statement:
1. Screen for ACE in >80% of patients at annual preventative care visits by December 2019 2. Determine resources needed by patients with high ACE scores 3. Implement an integrated wellness program for patients with high ACE scores.

### Interventions:
Interventions addressed barriers for our primary drivers: medical assistants (MA), providers, and families.

- A MA champion taught best screening strategies and communicated updates. Providers received educational sessions and progress updates via email and monthly meetings. EHR was modified to simplify documentation. Intake forms were streamlined to combat form fatigue. Residents created a QI sign out to update the next resident team and share successes. The wellness nurse developed a menu of services including information about toxic stress and a strength’s-based wellness assessment. Integrative techniques were provided to improve resilience, develop strengths, and connect patients to mental health services.

### Measures:
Monthly ACE screening rates were determined by measuring the number of screens compared to preventative care visits. Patients with a score of 3 with symptoms or 4-10 were referred to a wellness team. Secondary measures were ACE team referrals, wellness assessments, counseling...
sessions, integrative interventions, and resources provided. Results: ACE screening improved from 2 to 89% in 18 months.

During the first 5 months of the wellness program, there were 161 referrals, 80 full wellness assessments, 136 integrative appointments, and 92 in-office counseling sessions. Community resources (food, housing) were provided 617 times, and 2230 pieces of written education were distributed by the wellness team. Conclusions and Next Steps: Interventions have shown a sustained increase in ACE screening rates. After establishing the wellness program, there was a marked increase in the number of screens, referrals and wellness appointments. The addition of dedicated staff allowed for better care coordination and resource distribution. Next steps are to decrease no show rates for wellness appointments and to monitor resilience scores and patient surveys for ongoing improvements to the program.

90. E-LEARNING AND COMMUNITY PARTNERS: “TEACH”ING RESIDENTS TO ADDRESS CHILD POVERTY

Olanrewaju O. Falusi, MD, Children’s National Medical Center, Washington, MD, Jessica Weisz, MD, Iana Clarence, MPH, Dale Coddington, MD, Children’s National Medical Center, Washington, DC, Mary C. Ottolini, MD, MPH, MED, Maine Medical Center, Portland, ME, Cara Lichtenstein, MD, MPH, Children’s National Medical Center, Washington, DC

Background: Children in poverty are more likely to experience adverse health outcomes, but trainees often lack the knowledge or confidence to address the effects of poverty. Methods: Our Trainee Education in Advocacy and Community Health (TEACH) curriculum uses objectives modified from the Academic Pediatric Association’s US Child Poverty Curriculum to train residents to recognize and address the effects of poverty. Residents were randomized by continuity clinic to participate in the Epidemiology of Child Poverty portion of the curriculum and compared to residents not participating. The curriculum consists of interactive modules, experiential learning (government benefits site and museum exhibit on eviction) and debrief/reflection. We use Reflective Practice Theory as a theoretical framework, in which residents question their own assumptions and make meaning of their experience. Knowledge and attitudes about poverty were compared pre/post (within the intervention group) and between the intervention and control groups. Resident experience with the curriculum was analyzed using inductive coding of audio-recordings of the debriefs. Results: From June 2018-June 2019, intervention (n=35) and control (n=10) groups were similar in race, gender, training year, age, and pre-test scores. The intervention group increased in knowledge score from pre- (35.1%) to post-test (69.2%, P<.001); reported increased confidence (P<.001) with identifying and addressing health effects of poverty; and reported higher preparedness (P<.001) and effectiveness (P<.001) in addressing social determinants of health (SDH) post-curriculum compared to the control group. Qualitative themes included increased empathy for patients and (unexpectedly) government agency staff, more ownership of their role in addressing SDH, recognizing personal biases regarding poverty, and increased knowledge of housing insecurity. Conclusion: The TEACH curriculum improved resident knowledge, confidence, and attitudes in addressing child poverty. As child poverty is ubiquitous, the TEACH curriculum can be a resource for other residency programs.

91. RESIDENTS EDUCATION ON FIREARMS SAFETY COUNSELING: CURRENT STATUS, PERCEIVED BARRIERS, AND SUGGESTED RESOURCES

Ameet Kumar, MD, Sharef Al-Mulaabed, MD, Fernanda Kupferman, MD, Brookdale University Hospital and Medical Center, Brooklyn, NY

Background: Firearm (FA) related deaths & injuries are national public health crises. FA is the leading cause of death among black children & teens. FA safety counseling has positive impact on increasing gun safety at home. It is crucial for Residents in training (RES) to learn skills of counseling with regards to this topic. Methods: Cross sectional survey at Brookdale Hospital, NY including RES from all specialties. Questionnaire based on literature review was sent using “SurveyMonkey”. Comparison of responses among subgroups of RES was done using Chi-squared or Fisher’s exact test. Results: Of 244 RES, 134 (55%) responded to survey (51% males, 34% from pediatrics (PED) (Table 1-A). Nearly all RES agree that gun violence is a problem in their community (96%). Unavailability of FA safety training in residency programs was reported in 66% (less in PED vs. non-PED, Table 2). Overall, only few RES felt confident to counsel about FA (14%). Majority of respondents (57%) were interested in receiving additional education (more in PED vs. non-PED). Methods of FA training in the RES’ programs as well as topics covered are shown in Table 1-B (PED reported more CME/grand rounds and less case-based scenarios / or standardize patient, table 2). RES were similarly interested in receiving education in FA safety counseling, independent of the PGY level (Table 3). There was no difference in perceived barriers, except that PGY1 were more likely to “worry about upsetting families if asked about FA” (Table 3). Also, PGY1 were less likely to choose “workshops” & “grand rounds” as resources to increase FA education. US graduates (USG) & non-USG had same perception on barriers to FA safety counseling and resources to increase FA safety education. Similarly, there was no difference on responses to these questions between RES raised in North America vs. those that did not. In contrast, RES who are non USG, or those raised without FA at home were more likely to agree with

Table 1. Post-Curriculum Self-Reported Level of Confidence in Addressing Learning Objectives (n=31)

<table>
<thead>
<tr>
<th>Objective</th>
<th>Very or Moderately Confident Post-Curriculum (% of total)</th>
<th>% of Residents Reporting Increase in Confidence Post-Curriculum</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>Define the federal poverty limit and its relationship to public benefits</td>
<td>25 (80.7)</td>
<td>100</td>
<td>&lt;.001</td>
</tr>
<tr>
<td>Contrast US child poverty rates to rates in other developed nations</td>
<td>24 (77.4)</td>
<td>93.5</td>
<td>&lt;.001</td>
</tr>
<tr>
<td>Distinguish poverty rates among US subpopulations</td>
<td>29 (89.7)</td>
<td>90.1</td>
<td>&lt;.001</td>
</tr>
<tr>
<td>Describe poverty rates in DC and the community around my primary care site</td>
<td>28 (86.7)</td>
<td>78</td>
<td>.01</td>
</tr>
<tr>
<td>Contrast the demographic characteristics of the physician with demographic characteristics of the US population</td>
<td>23 (74.2)</td>
<td>81.6</td>
<td>.001</td>
</tr>
<tr>
<td>Reflect on my personal assumptions, biases, and stereotypes about impoverished populations and the potential effect on patient care</td>
<td>30 (94.8)</td>
<td>84.4</td>
<td>&lt;.001</td>
</tr>
<tr>
<td>Recognize tools for conducting culturally sensitive screening for indicators of poverty in patients</td>
<td>28 (89.6)</td>
<td>87.5</td>
<td>&lt;.001</td>
</tr>
</tbody>
</table>

*Asked as a Retrospective Pre-Test in the post-curriculum evaluation (“How confident are you in your ability to...” and “How is this compared to before you completed the TEACH curriculum?”)

1-point Likert scale (Very confident, Moderately confident, Fairly confident, Not at all confident)

2-point Likert scale (More confident, No change, Less confident) of change after completing the curriculum, with corresponding P-value
gun violence being a problem in the community & interested in receiving FA safety education (Table 4-A,B). Conclusion: Regardless of subspecialty, majority of RES reported no FA safety education received during their training. PED RES were more likely to indicate interest in training, which they thought it is their program’s responsibility. Only few RES felt comfortable & confident counseling on FA safety.

Table 1A: Demographic characteristics of residents included in the study (n=134)

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>n (%)</th>
<th>n (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gender:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Female 65 (49%)</td>
<td>Male 69 (51%)</td>
<td></td>
</tr>
<tr>
<td>Age group: 25-34 years: 93 (69%)</td>
<td>25-34 years: 41 (31%)</td>
<td></td>
</tr>
<tr>
<td>Graduate school:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>U.S. graduate 28 (21%)</td>
<td>International 106 (79%)</td>
<td></td>
</tr>
</tbody>
</table>

Table 1B: Overall answers to general questions as well as current methods of training and topics covered in that (n=134)

<table>
<thead>
<tr>
<th>Question</th>
<th>n (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gun violence is a problem in the community where I practice</td>
<td>129 (96%)</td>
</tr>
<tr>
<td>Our Program doesn’t have any firearm safety training</td>
<td>88 (66%)</td>
</tr>
<tr>
<td>Feel comfortable asking about presence or exposure to firearms.</td>
<td>31 (23%)</td>
</tr>
<tr>
<td>Feel confident in ability to counsel firearm injury prevention</td>
<td>37 (28%)</td>
</tr>
<tr>
<td>Long-term goal is to increase awareness among residents/patients/families</td>
<td>45 (34%)</td>
</tr>
</tbody>
</table>

Methods of firearm safety training in your program:
- Classroom lectures on firearm safety counseling
- Small/group discussions on firearm safety
- Case based scenarios / or Standardize patient (SP) simulation
- Residents attend CME or grand rounds on firearm safety education
- Discussions with attending on firearm safety Education
- Web-based curriculum
- Residency program has formal assessment on firearms counseling

Topics covered in your program training on Firearms Safety Counseling:
- Knowledge regarding the risk of having a gun in the home
- Knowledge regarding making the storage of guns in the home safer
- How to discuss firearm issues and what information to give
- Recognize barriers and challenges when providing firearm counseling
- Advising patients to limit viewing of gun violence in the media
- How to become an advocate for laws that restrict gun availability
- Firearms safety anticipatory guidance

Table 1C: Comparison in responses to firearm safety survey among PED residents vs other years (n=134)

<table>
<thead>
<tr>
<th>Question</th>
<th>PED residents n=88</th>
<th>Other years n=46</th>
<th>p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Feel comfortable asking about presence or exposure to firearms.</td>
<td>21 (24%)</td>
<td>10 (22%)</td>
<td>0.030</td>
</tr>
<tr>
<td>Feel confident in ability to counsel firearm injury prevention</td>
<td>12 (14%)</td>
<td>6 (13%)</td>
<td>0.544</td>
</tr>
<tr>
<td>Long-term goal is to increase awareness among residents/patients/families</td>
<td>57 (65%)</td>
<td>57 (52%)</td>
<td></td>
</tr>
<tr>
<td>Gun violence is a problem in the community where I practice</td>
<td>70 (81%)</td>
<td>83 (73%)</td>
<td>0.743</td>
</tr>
<tr>
<td>There is a need for residents’ education on firearm injury prevention.</td>
<td>67 (76%)</td>
<td>67 (76%)</td>
<td>0.278</td>
</tr>
<tr>
<td>Residency program has the responsibility to train residents on counselling patients/families about firearms/risk.</td>
<td>51 (60%)</td>
<td>45 (50%)</td>
<td>0.099</td>
</tr>
<tr>
<td>Residents’ confidence and perception of competence:</td>
<td>11 (12%)</td>
<td>8 (18%)</td>
<td>0.210</td>
</tr>
<tr>
<td>Knowledge regarding making the storage of guns in the home safer.</td>
<td>10 (11%)</td>
<td>7 (15%)</td>
<td>0.423</td>
</tr>
<tr>
<td>How to discuss firearm issues and what information to give.</td>
<td>8 (9%)</td>
<td>5 (11%)</td>
<td>0.423</td>
</tr>
<tr>
<td>Recognize barriers and challenges when providing firearm counseling.</td>
<td>7 (8%)</td>
<td>4 (9%)</td>
<td>0.375</td>
</tr>
<tr>
<td>Advising patients to limit viewing of gun violence in the media.</td>
<td>7 (8%)</td>
<td>4 (9%)</td>
<td>0.375</td>
</tr>
<tr>
<td>How to become an advocate for laws that restrict gun availability.</td>
<td>11 (12%)</td>
<td>9 (20%)</td>
<td>0.210</td>
</tr>
</tbody>
</table>
Cambria Garell, MD, Atkia Sadia, MPH, Savanna L. Carson, PhD, UCLA David Geffen School of Medicine/UCLA Medical Center, Los Angeles, CA

Background: Pediatric resident physicians often care for underserved populations and are expected to address social determinants of health (SDH); however, training varies in the identification of and referral to appropriate local resources. Pediatric physicians have reported insufficient knowledge and confidence as reasons for not addressing SDH, but report higher satisfaction when they do address SDH factors in the care of their patients. We aimed to assess chief resident perspectives of the pediatrician’s role in, knowledge of, and referral to community resources which mitigate SDH.

Methods: We performed a national web-based survey of pediatric chief residents in Fall 2019 on their perspectives of SDH referrals, specifically regarding their knowledge of resources, their responsibility to refer, how often they refer, and confidence level in referring. Social determinant resources included: Development & Early Childhood Services, Education Resources, Dental Services, Mental Health, Housing, Parental Employment & Financial Support, Food Insecurity Support, Recreational/Physical Activity Needs, Legal Aid, Transportation Access, Domestic Violence, Parental Substance Use, and Parental Literacy Support.

Results: 28% (42/150) of programs responded. Chief residents agreed they must have knowledge of and hold responsibility to refer to many social determinant factors; however, practices and confidence levels in referring to resources were often low. For instance, 90% agreed that

<table>
<thead>
<tr>
<th>No firearm at home n=111</th>
<th>Firearm at home n=23</th>
<th>p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Gun violence is a problem in the community where I practice</td>
<td>110 (99%)</td>
<td>19 (82%)</td>
</tr>
<tr>
<td>5. Interested in receiving additional education in this area</td>
<td>79 (71%)</td>
<td>11 (48%)</td>
</tr>
</tbody>
</table>

Residents’ attitudes and beliefs with regards to firearm safety education: Residents answered as STRONGLY or SOMEWHAT AGREE with the following:

<table>
<thead>
<tr>
<th>Resident perspective</th>
<th>Non-USG n=106</th>
<th>USG n=28</th>
<th>p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gun violence is a problem in the community where I practice</td>
<td>104 (98%)</td>
<td>25 (89%)</td>
<td>0.028*</td>
</tr>
<tr>
<td>Interested in receiving additional education in this area</td>
<td>76 (72%)</td>
<td>14 (50%)</td>
<td>0.030*</td>
</tr>
<tr>
<td>Residents' attitudes and beliefs with regards to firearm safety education: Residents answered as STRONGLY or SOMEWHAT AGREE with the following</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>There is a need for residents’ education on firearm injury prevention.</td>
<td>89 (85%)</td>
<td>19 (68%)</td>
<td>0.042*</td>
</tr>
<tr>
<td>Residency program has the responsibility to train residents on counseling patients/families about firearms safety/risks.</td>
<td>84 (79%)</td>
<td>14 (50%)</td>
<td>0.005*</td>
</tr>
<tr>
<td>Residents' program having formal assessment on firearms counseling.</td>
<td>72 (68%)</td>
<td>11 (39%)</td>
<td>0.006*</td>
</tr>
</tbody>
</table>

Residents’ Confidence and perception of competence: Respondents answered as EXTREMELY or VERY to the following:

<table>
<thead>
<tr>
<th>Resident perspective</th>
<th>Non-USG n=106</th>
<th>USG n=28</th>
<th>p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Had adequate training during residency on firearm safety counseling.</td>
<td>9 (9%)</td>
<td>0 (0%)</td>
<td>0.105</td>
</tr>
<tr>
<td>Observed physicians successfully counseling parents and youth in firearm injury prevention in real life clinical or practice environments.</td>
<td>8 (8%)</td>
<td>2 (7%)</td>
<td>0.932</td>
</tr>
<tr>
<td>Feel comfortable asking about presence or exposure to firearms.</td>
<td>22 (21%)</td>
<td>9 (33%)</td>
<td>0.194</td>
</tr>
<tr>
<td>Feel confident to counsel about firearm injury prevention.</td>
<td>14 (14%)</td>
<td>5 (18%)</td>
<td>0.570</td>
</tr>
</tbody>
</table>

Table 4-A: Comparison in responses to firearm safety survey among US graduates (USG) vs non-USG (n=134)

Table 4-B: Comparison in responses to firearm safety survey among residents raised with firearms at home vs those without firearm at home (n=134)

92. PERSPECTIVES ON THE PEDIATRICIAN’S ROLE IN SOCIAL DETERMINANTS OF HEALTH: A NATIONAL SURVEY OF CHIEF RESIDENTS

Cambria Garell, MD, Atkia Sadia, MPH, Savanna L. Carson, PhD, UCLA David Geffen School of Medicine/UCLA Medical Center, Los Angeles, CA

Background: Pediatric resident physicians often care for underserved populations and are expected to address social determinants of health (SDH); however, training varies in the identification of and referral to appropriate local resources. Pediatric physicians have reported insufficient knowledge and confidence as reasons for not addressing SDH, but report higher satisfaction when they do address SDH factors in the care of their patients. We aimed to assess chief resident perspectives of the pediatrician’s role in, knowledge of, and referral to community resources which mitigate SDH.

Methods: We performed a national web-based survey of pediatric chief residents in Fall 2019 on their perspectives of SDH referrals, specifically regarding their knowledge of resources, their responsibility to refer, how often they refer, and confidence level in referring. Social determinant resources included: Development & Early Childhood Services, Education Resources, Dental Services, Mental Health, Housing, Parental Employment & Financial Support, Food Insecurity Support, Recreational/Physical Activity Needs, Legal Aid, Transportation Access, Domestic Violence, Parental Substance Use, and Parental Literacy Support.

Results: 28% (42/150) of programs responded. Chief residents agreed they must have knowledge of and hold responsibility to refer to many social determinant factors; however, practices and confidence levels in referring to resources were often low. For instance, 90% agreed that

<table>
<thead>
<tr>
<th>Select Social Determinants</th>
<th>General Pediatrics...</th>
<th>Personal behavior in social screening and referral:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Referral Data</td>
<td>Must have knowledge of community resources</td>
<td>Hold responsibility to refer to resources</td>
</tr>
<tr>
<td>At least Agree or Strongly Agree</td>
<td>At least Agree or Strongly Agree</td>
<td>At least Agree or Strongly Agree</td>
</tr>
</tbody>
</table>

Development & Early Childhood Services (e.g. childcare, early intervention, early head start) 100% 100% 100% 100% 100%

Mental Health Services (e.g. therapy/counseling centers, trauma) 100% 100% 95% 95% 95%

Food Insecurity (e.g. WIC, SNAP) 98% 98% 71% 83% 83%

Education Resources (e.g. tutoring, library/summer programs) 86% 89% 83% 55% 55%

Recreational/Physical Activity (e.g. parks, recreation, YMCA, sports) 83% 76% 45% 52% 52%

Housing Resources (e.g. shelters, low-income housing) 90% 83% 45% 36% 36%

Domestic Violence Services (e.g. safe houses, shelters) 96% 95% 48% 45% 45%

Parental Substance Use (e.g. AA, parenting classes) 88% 88% 33% 43% 43%

Parental Employment & Financial Support (e.g. job/vocational training, unemployment) 62% 60% 43% 17% 17%

Legal Aid (e.g. immigration, medical-legal partnerships) 71% 62% 29% 21% 21%
93. A NOVEL FOOD AS MEDICINE CURRICULUM INCREASES COMMUNITY ENGAGEMENT AMONG PEDIATRIC RESIDENTS

Jodi S. Ehrmann, MD, Elissa Kim, MD, Kimberly L. Mickey, MD, Christina Suh, MD, Daniel Nicklas, MD, University of Colorado, Denver, CO

**Background:** A poor diet now outranks smoking as the leading cause of death globally. Much of the work to increase healthy food access is done by local non-profits. This creates a need for partnership between pediatricians and community advocates.

**Design/Methods:** The Food as Medicine curriculum (FAMC) was piloted as a 4-week elective September 2019. The FAMC comprised of (1) Exposure to food systems: Visits to various local organizations each addressing a different facet of the food system. Experience included discussions with policy makers, gardening, participation at farmer’s markets, and a tour at a food recovery center. (2) Self-directed learning time: multi-media resources addressing the basic tenets of nutrition. (3) Cooking sessions at teaching kitchens. (4) Interactive small group discussions with local experts about different facets of pediatric nutrition.

**Results:** 7 pediatric residents took the elective. The FAMC was evaluated using mixed methodology: pre/post-elective surveys and qualitative data via focus groups and open-ended survey questions. Wilcoxon Signed Rank Test revealed a significant increase in the knowledge of local community resources for nutrition and wellness (p=0.016). Focus group discussions were recorded. Curriculum leaders analyzed transcripts using constant comparative methodology until codes were agreed upon and organized into themes. The most common themes: ‘Positive impact on resident-patient interactions,’ and ‘Residents choosing and enjoying healthier food.’ For example, below is a representative quote in response to if this elective will change future practice: “Yes! Loved hearing about the many community resources available in Denver that exist to improve access to healthy food for ourselves and for our patients. Will definitely be using them more […] and also refer my patients.”

**Conclusions:** The FAMC highlighted the need and feasibility of a formal nutrition curriculum for pediatric residents encompassing the food system as a whole. Resident engagement with local non-profits led to improved personal wellness and confidence in nutrition discussions with patients.

94. THE POWER OF ONE: COMBINING A COMMUNITY PARTNERSHIP WITH ADVOCACY TRAINING

Olanrewaju O. Falusi, MD, Iana Clarence, MPH, Children’s National Medical Center, Katherine Donnelly, MSNE, McGaw Medical Center of Northwestern University, Chicago, IL, Tamara Gayle, MD, MEd, Children’s National Medical Center, Washington, DC

**Background:** Food insecurity (FI) affects 1 in 9 Americans. While residency programs now include FI training, many are didactic-based. Engagement with this complex social issue is enhanced by community-based training. Methods: In our FI curriculum, PL1s visit a food bank. We utilize experiential learning as a conceptual framework, through which knowledge is gained and evolves through experience and reflection. The day begins with service learning in the garden and discussion of sustainable food sources. The interns then create healthy, low-cost meals to teach to families, and then participate in a simulation that recreates a day in the life of families experiencing FI. They confront barriers such as low literacy, immigrant status, and food deserts. The day ends with a reflection on their role in advocacy and connecting families to food resources.

**Evaluation** includes assessment of knowledge (based on the AAP Food Security Policy pre-reading) and attitudes (self-efficacy for advocacy) completed pre, post, and 6-12mo post.

**Results:** From 2016-2019, 113 interns completed the curriculum. Data were captured for 86 post and 26 thus far in 6-12mo post. There was no significant change in knowledge from pre (79.3% correct) to post (79.5%, P=.95) nor from post to 6-12mo post (76.9%, P=.55). From pre to post, advocacy-related self-efficacy increased significantly by an average of 21.2% (range 7.6-39.6%, P<.05 for each domain). At 6-12mo post, the improvement was sustained for most domains but decreased slightly for envisioning advocacy as part of one’s career and knowing how to advocate for food security on a community/federal level (Figure 1). Mean satisfaction was 4.6 out of 5.

**Conclusion:** A community-based experience early in residency can enhance self-efficacy for addressing FI, particularly on the patient level, and is sustained months later. A community partner enhanced resident knowledge of local resources. Future improvements include better incorporation of the AAP Food Security policy to increase knowledge. This curriculum can be replicated in programs seeking community partnerships for experiential learning.
95. PROVIDER-REPORTED INEQUITY IN CARE DELIVERED DURING RAPID RESPONSE TEAM (RRT) ACTIVATIONS AMONG PATIENTS OF COLOR (POC) AND LOW-ENGLISH PROFICIENT (LEP) PATIENTS
Jessica E. McDade, MD, Aleksandra Olszewski, MD, Elizabeth McMahon, RN, Elizabeth Masse, RN, Julia Martinez, RN, Jessica Ramos, Shaquita Bell, MD, Missy Lein, RN, Joan Roberts, MD, University of Washington, Seattle, WA

**Background:** Cognitive biases related to race, culture, or language are shown to impact quality of care in hospital settings. Some types of cognitive bias have been negatively associated with decisions to call RRTs, but little is known about biases related to race, culture, or language and their impact on decisions to call RRTs or on care delivered during RRTs. **Methods:** We implemented a novel RRT standardized debrief form and included the question “How might health inequity have played a role in this RRT?” with response choices of race, gender, language, culture, religion, or other. In this retrospective cohort study, we compared provider-reported inequity in the first 6 weeks following implementation of the RRT debrief among POC or LEP patients with white or English-proficient patients, respectively. Fishers exact test was used to assess differences between groups. Results: There were 117 RRTs during the study period. Sixty of these patients were POC, and 24 were LEP (20 LEP patients were also POC). Providers reported inequity impacting care in 17/117 RRTs (15%), with 16 (94%) occurring during an RRT for a POC (p=0.0002). Table 1 shows frequencies of reported inequity types. For LEP families, 10 providers (42%) reported language inequity. An interpreter was used during 8/24 RRTs where one was indicated. Providers who were part of an RRT that did not use an interpreter for an LEP family reported inequity 4 out of 16 times (25%), compared to 6 (75%) of the 8 providers who did use an interpreter (p=0.03). **Conclusion:** Provider-reported inequity in care during RRTs was highly prevalent in our study, with the majority occurring for POCs. Use of interpreters when indicated was low. RRT teams that used an interpreter for LEP families were more likely to identify inequities compared to those that did not, suggesting that education regarding identification of inequity and interpreter use may be beneficial. Future work may investigate change in reported rate of inequity over time, ways in which inequity manifests during RRTs, and outcomes of RRTs.

<table>
<thead>
<tr>
<th>Table 1. Provider-reported inequities.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reported Type of Inequity</td>
</tr>
<tr>
<td>Culture</td>
</tr>
<tr>
<td>Language</td>
</tr>
<tr>
<td>Race</td>
</tr>
<tr>
<td>Gender</td>
</tr>
<tr>
<td>Religion</td>
</tr>
<tr>
<td>Other</td>
</tr>
</tbody>
</table>

Providers could select more than one type of inequity per RRT, so frequencies in this column add to more than 17 and percent is greater than 100.

96. MULTI-INSTITUTIONAL APPROACH TO ADVOCACY TRAINING AMONG PEDIATRIC RESIDENTS
Melissa Roy, MD, Michael Bolton, MD, Megan Collins, MD, MPH, Our Lady of the Lake, Baton Rouge, LA, Chelsey Sandlin, MD, Christy Murphy, MD, Louisiana State University, New Orleans, LA, Paul Cooper, MD, Louisiana State University (Shreveport), Shreveport, LA, John Carlson, MD, Tulane University, New Orleans, LA, Pamela McMahon, PhD, MPH, Our Lady of the Lake, Baton Rouge, LA

**Background:** The ACGME and AAP prioritize patient advocacy because it provides a way to move beyond individual solutions to create and be part of broader systemic change. Advocacy training allows residents to better understand how community variables affect health. Yet, many pediatricians report receiving inadequate advocacy training. Studies have demonstrated an improved experience when residents across training programs collaborate on advocacy projects. The 4 Louisiana pediatric residency programs implemented a combined advocacy curriculum to cultivate cooperation and inspire broader systemic change. **Objective:** We aimed to evaluate the impact of the statewide advocacy curriculum on residents’ confidence in their ability to advocate effectively for patients and families. **Methods:** Residents from the 4 programs selected a main focus for their advocacy project and determined goals for advocacy rotation. During the rotation, residents met weekly via conference call to discuss progress, accomplishments, and next steps as they received feedback from peers and recommendations from mentors. Residents engaged in 8 different communication tools while furthering their site’s delineated advocacy goals. To assess curriculum efficacy, residents from 2 programs were surveyed about their thoughts and attitudes regarding advocacy and asked to self-assess their advocacy skills. Two residency programs did not participate in the evaluation. Survey responses of residents who had participated in the collaborative curriculum (n=11) were compared to those who had not participated in the curriculum (n=33). **Results:** Survey items with statistically significant differences are shown in Table 1. Other items changed in the expected direction but failed to reach significance. **Conclusion:** The collaborative advocacy curriculum led to significantly improved confidence in identifying pediatric health issues, finding resources to advocate effectively for change, communicating about the identified issues, and developing action plans to address community health needs. Future goals include curriculum enhancement to areas in need of improvement.

| Table 1: Significant Differences between Participants and Non-Participants |
|-------------------------------------------------|-------------------------------------------------|
| Item | Participants’ mean | Non-participants’ mean | Mean Difference | Independent samples t-test |
| I can identify issues that affect children’s health at a state level. | 4.30 | 3.53 | 0.77 | (40) = 2.857 p<0.007 |
| I can formulate an attainable plan of action in response to a community health need. | 3.90 | 3.69 | 0.21 | (41) = 2.866 p<0.01 |
| I can identify resources to advocate effectively for the well-being of patients, families, and communities. | 4.10 | 3.67 | 0.43 | (41) = 2.037 p<0.049 |
| I can communicate effectively with community groups. | 3.52 | 3.52 | 0.00 | (41) = 2.224 p<0.032 |
| I can find evidence and data to impact attitude change. | 3.64 | 3.64 | 0.00 | (41) = 2.561 p<0.014 |
| I feel confident contacting a legislator in order to discuss public health issues that affect children. | 3.40 | 2.52 | 0.88 | (41) = 2.298 p<0.027 |
97. TAKING LEAD (LEADERSHIP EDUCATION IN ADVANCING DIVERSITY) TO THE NEXT LEVEL: EMPOWERING TRAINEES LEADERSHIP AND SCHOLARSHIP CAPACITY IN DIVERSITY AND INCLUSION
Carmin Powell, Lahia Yemane, MD, Michelle Brooks, C-TAGME, Carrie Johnson, MBA, Rebecca Blankenburg, MD, MPH, Stanford University, Palo Alto, CA

**Background:** Though the patient population is rapidly becoming more diverse, there continues to be a lack of diversity in academic medicine and especially in leadership positions. Building leadership and scholarship capacity for improving diversity and inclusion should begin early during residency and fellowship training. In 2017, we created the innovative LEAD (Leadership Education in Advancing Diversity) Program, a 10-month longitudinal program that provides trainees with leadership training and mentorship in creating scholarly works around diversity and inclusion topics. **Methods:** In 2017-2019, IRB-approved, de-identified pre- and retrospective pre/post surveys assessed learner confidence, attitudes, and program satisfaction. Analysis included descriptive statistics and two-tailed t-tests. To measure the impact on learner's leadership and scholarship, we measured the number of workshop presentations by LEAD scholars at local, regional, and national meetings. **Results:** In 2017-2018, we had 13 scholars from the Department of Pediatrics complete the program. In 2018-2019, we had 25 scholars across seven clinical departments. A total of 38 scholars have completed the LEAD Program thus far, with 100% (N=38/38) having completed our program pre-survey and post-survey. There was statistically significant improvement in scholars' self-confidence for all learning objectives and 100% felt the program should expand to all GME programs at Stanford. In total, LEAD scholars have created 8 workshops, representing the 8 total small groups. To date, they have presented at 14 local, 2 regional, 12 national conferences. **Conclusions:** The LEAD Program has been successful in fostering leadership skills and promoting scholarship in diversity and inclusion. LEAD serves as an innovative model for how an institution can work collaboratively across departments to address barriers in advancing diverse leadership in academic medicine. Future steps include following career outcomes of LEAD participants.

98. LOST IN TRANSLATION: SIMULTANEOUS SPANISH MEDICAL INTERPRETATION DURING FAMILY CENTERED ROUNDS FOR IMPROVED RESIDENT AND FAMILY ENGAGEMENT
Jessica Lloyd, MD, Amanda Kosack, MD, UCLA David Geffen School of Medicine/UCLA Medical Center, Los Angeles, CA

**Background:** Language barriers significantly contribute to medical errors compromising patient safety, quality of care, and resident engagement with patients. Spanish speakers account for the fastest growing population of patients within US pediatric hospitals. However, the communication needs of limited English proficiency (LEP) patients frequently remain unmet. **Purpose:** The purpose of this study is to implement equipment assisted simultaneous medical interpretation (EASMI) for Spanish speaking families on family centered bedside rounds (FCR) and determine family and trainee provider satisfaction. **Methods:** In-person interpreters joined FCR at a tertiary care academic children's hospital. All medical discussion on FCR was interpreted simultaneously from English to Spanish. Interpreters wore a noise-cancelling microphone connected to a transmitter and family members were given a receiver with an earpiece. Qualitative interviews were performed with family members on their experience (N=25). Online qualitative and quantitative surveys were completed by medical students, residents, fellows, attendings, and nurses (N=136). **Results:** Surveys demonstrated 94% of physicians and 100% of nurses were “very satisfied” with EASMI. Common themes from the resident and fellow survey were improved efficiency of rounds, increased family engagement, improved understanding of the care plan, decreased communication errors and improving patient safety. After the intervention Spanish speaking families reported an increase in the domains of communication with physicians and nurses on the Child HCAHPS survey. **Conclusion:** Medical interpretation for LEP patients and families is critical for improved healthcare and reduction in health disparities. Overall, EASMI is both an efficient and effective patient-centered intervention during pediatric FCR for increased trainee engagement with patients.

Quality Improvement and Patient Safety
99. DECREASING DISCHARGE MEDICATION RECONCILIATION ERRORS: AN INTERPROFESSIONAL COLLABORATIVE QUALITY IMPROVEMENT PROJECT
Emine M. Tunc, MD, Jamie Pruitt, DO, Arnaldo Zayas-Santiago, MD, Casey Moore, Holly Hoffmaster, Erin Waehner, Amy Cox, Allan Cohn, Cleveland Clinic Foundation, Cleveland, OH

**Background:** Medical errors are the third leading cause of death in the U.S. with an estimated 250,000 incidents occurring annually. Medication related errors are one of the most common medical errors which can result from unintended discrepancies that occur during times of transition of care. Baseline data obtained by nursing staff for the Cleveland Clinic Children's Hospital general inpatient pediatrics team showed a discharge medication reconciliation error rate of 12%. Studies have shown that the most successful interventions to improve medication reconciliation process relies heavily on pharmacists. Our interprofessional multidisciplinary general pediatrics team identified the need for an improved discharge medication reconciliation process. **Aim**

**Statement:** Our aim is to reduce the medication errors identified by nursing staff at the time of discharge by 50% by December 2019. **Interventions:** Three interventions were implemented on March, April and September 2019, including early identification of anticipated discharges within the upcoming 24 hours, standardizing discharge medication reconciliation review by the team pharmacist, and including a process checklist in the physician sign out tool for sustainability. **Measures:** Following quality improvement (QI) methodology, a process map was developed to identify waste, defects, and variation. One week out of the month, errors were recorded at
the time of discharge by the nursing staff. These errors were documented and corrected by the team prior to discharge. Once pharmacy performed a review of the medication reconciliation with the residents, a note was placed in the electronic medical record, which was tracked by the team to ensure compliance with the process developed. **Results:** Following the interventions, the discharge medication reconciliation error rate was reduced to a mean of 2.4%. The new discharge medication reconciliation process has been incorporated in our Children’s Hospital, into the daily discharge planning process, as a best practice.

**Conclusions and Next Steps:** We demonstrated that a process consisting of joint efforts of prescribers and pharmacists can reduce the number of medication errors at the time of discharge. It also demonstrates how interprofessional collaboration between physicians, nurses and pharmacists may influence the healthcare delivery process. Future measurements to assess the impact of this project include, clinician satisfaction, adverse drug events and hospital length of stay.

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### 100. REDUCING PEDIATRIC ASTHMA HOSPITAL LENGTH OF STAY THROUGH A MULTIDISCIPLINARY CARE PATHWAY

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**Background:** Asthma exacerbations are the 3rd most common cause of pediatric hospitalizations and account for 4% of pediatric admissions at Kaiser Permanente Oakland Medical Center (KPOMC). Average length of stay for asthmatics on the pediatric ward at KPOMC has historically been longer than that of other Tertiary Pediatric Care Facilities within the Kaiser Permanente Northern California Network. **Aim Statement:** Our objective was to decrease length of stay after a year of implementing a multidisciplinary asthma care pathway using a standardized respiratory severity score integrated into our electronic medical records (EMR) system. **Interventions:** As a multidisciplinary team we used an A3 problem solving approach and performed a root cause analysis to identify causes of increased length of stay for our asthmatic patients. Our team included pediatric hospitalists, intensivists, residents, nurses, respiratory therapists, pharmacists, and physical therapists. We performed a literature review and compared other pediatric hospital respiratory severity scores prior to selecting the Pediatric Assessment Score (PAS), a respiratory score already integrated into the KP Health Connect EMR. A standardized asthma care pathway was developed based on frequent PAS measurements to determine medication weaning and escalation. It also incorporated appropriate timing for inhaled and systemic corticosteroids, mobility, and asthma education. Order panels were distributed among residents and hospitalists to promote adherence to the pathway. Prior to implementation, we completed an education campaign targeting nurses, respiratory therapists, and physicians. **Measures:** Our primary outcome is length of stay and process measures include difference in time patients spent on continuous albuterol, rates of appropriate systemic steroids use, and use of metered dose inhalers. We will also review appropriate use of PAS according to the asthma care pathway. Our balance measure will be readmission rates at 7 days and at 30 days after discharge. **Results:** Initial data showed a decrease in average length of stay from 2.93 days to 1.69 days without an increase in readmission rates at 7 days and at 30 days. **Conclusions and Next Steps:** At KPOMC we saw a decrease in length of stay after implementing a multidisciplinary asthma care pathway that uses a respiratory severity score and order panels integrated into the EMR system. Next steps are “Plan, Do, Study, Act” (PDSA) cycles based on continued monitoring of length of stay and process measures.

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### 101. A RESIDENT-LED QUALITY IMPROVEMENT INITIATIVE TO INCREASE NURSING PRESENCE ON INPATIENT Rounds

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**Background:** Recently the Accreditation Council for Graduate Medical Education has placed increased emphasis on experiential quality improvement (QI) education for pediatric residents. In response to this focus, our residency program developed an immersive QI curriculum comprised of didactic teaching and a longitudinal resident-led project. Over the course of the academic year, our residents select an issue to target and design and execute a QI initiative to address it. Recognizing that nursing presence on rounds improves safety, communication, and family satisfaction but is challenged by competing clinical priorities, the 2018-2019 project focused on increasing nursing presence on bedside rounds for hospitalist patients. **Aim Statement:** Increase nursing presence during pediatric hospitalist rounds to 80% over the second half of the academic year. **Interventions:** Senior residents used the Institute for Healthcare Improvement’s model for improvement to design and implement 4 plan-do-study-act (PDSA) cycles with multidisciplinary participation: 1) Visual aids to emphasize the importance of nurse participation on rounds, 2) notification of nurse prior to rounds, 3) nurse-centered rounding order and 4) scripted nurse participation at the start of rounds. **Measures:** The percent of nurses in attendance on rounds was recorded for one month as pre-intervention data, after which PDSA cycles were begun and outcomes were assessed for the subsequent 6 months. Qualitative interviews analyzed nursing perceptions and guided interventions. Residents met monthly to hand off project leadership and review core QI concepts with mentorship from hospitalists. PDSA cycle timing and teaching
content were adapted to maximize learning.

**Results:** Nursing attendance improved from a baseline of 34% to 87% after the interventions (Figure 1). Qualitative data identified nurse-centered rounding and early nursing input as key interventions. **Conclusions and Next Steps:** Improvement in nursing attendance on rounds was seen throughout the PDSA cycles in this resident-led QI initiative. Creating a nurse-centered rounding schedule and eliciting nursing input at the start of rounds are noted to be key factors for increasing nursing presence. This project demonstrates feasibility of resident-led QI endeavors within an educational model that addresses core residency program requirements for education in quality and safety.

**Background:**
Asthma is the most prevalent chronic disease of children. Poor health literacy and ineffective teaching can result in poorer outcomes, increased Emergency Department visits, readmissions, and increased costs to the system. **Aim Statement:** Our primary aims for this project are: 1) Increase the percent of families who receive multimodal asthma education (verbal, video, and handout) during hospitalization for asthma. 2) Decrease rates of inpatient hospital readmissions for asthmatics aged 2-18. **Interventions:** A multidisciplinary QI team including physicians, nurses, respiratory therapists, and ancillary providers was formed. Chart audits were done to assess baseline documentation of asthma education on the acute care floors from July 2017 through February 2019. Three PDSA cycles were conducted with interventions including: 1) identification of asthma nurse champions and pilot of new educational materials to families on our pilot unit (March 2019); 2) training all unit staff on asthma education materials (April-May 2019); 3) improvement of electronic medical record asthma education documentation (June-July 2019). Statistical process control charts were used to assess the impact of these interventions. **Measures:** Outcome measures were percent of encounters with any asthma education documented and readmission rates. Process measures were the percent of encounters with each multimodal (verbal, video, or handout) type. Balancing measures included hospital length of stay, time from admission to teaching, and time from discharge order placement to hospital discharge. **Results:** Encounters with any asthma education documented increased from baseline of 33% to 84% post interventions, with special cause improvement noted. There was also an increase in video education from 0% to 65%. It is too early to report impact on hospital readmission rates which we continue to trend. Our interventions led to no change in our balancing measures. **Conclusions and Next Steps:** We have been able to successfully increase the overall patient and caregiver asthma education as well as increase use of multimodal methods of asthma teaching. New multimodal education materials implemented have standardized the content and process for asthma education. Ongoing efforts are being made to produce sustained change and to spread asthma education hospital wide. We speculate the project has potential to influence population level asthma outcomes as we continue to expand our reach throughout the health system and community.
104. REDUCING CENTRAL LINE ASSOCIATED BLOODSTREAM INFECTIONS BY OPTIMIZING BUNDLE COMPLIANCE

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Background: Central line associated bloodstream infections (CLABSIs) are a significant cause of morbidity and mortality in pediatric patients. They are associated with a mean attributable cost of $55,646 and a mean attributable length of stay of 19 days. Previous studies have addressed this issue through bundle compliance, which includes the daily discussion of line necessity. Our baseline frequency of daily line discussion was 20.6%, and our CLABSI rate at the start of this project was 1.06 per 1000 catheter days.

Aim Statement: We planned to double the frequency of central line discussions in pediatric patients admitted to the medical/surgical units over a 1-year period.

Interventions: We used the model for improvement and PDSA cycles to implement change. Individual PDSA cycles tested our interventions and guided subsequent change cycles. We first implemented provider rounding lists with prompts to discuss central lines. We then developed a multidisciplinary team to drive change. This inspired the adaptation of a safety cross auditing tool, as well as the implementation of provider education sessions. Measures: The frequency that central lines were addressed during rounds was the primary outcome measure. Provider comfort level with central lines was a secondary measure, and disturbance of workflow was the balancing measure.

Results: The initial implementation of new rounding lists did not generate significant change. The frequency that central lines were addressed increased from a mean of 28% to 50% after creating a multidisciplinary team (month 5). The mean again increased from 50% to 74% after implementing a safety cross tool and education sessions (month 9). Provider comfort level with central lines increased from a baseline of 2.43 to 2.93 on a 1 to 4 Likert (P < 0.05). No providers endorsed disturbance of workflow by the PDSA cycles.

Conclusions and Next Steps: The daily discussion of central line necessity, as well as provider comfort level with central lines, demonstrated meaningful changes with our interventions. These are crucial components of the central line bundle and played a key role in the global aim of decreasing CLABSI rates. Throughout the duration of this project, the CLABSI rates in our institution decreased from 1.06 per 1000 catheter days to 0.68 per 1000 catheter days, a 36% reduction. In the future, resident CLABSI champions will be identified to make changes from this project sustainable.

105. VITALS ARE VITAL

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Background: In our pediatric clinic, there were repeated cases of ill patients failing to receive care in a timely fashion. Our clinic is the continuity site for our pediatric residency program, and a site for family med interns and med students. Using a fishbone diagram, residents and nurses outlined problems and areas for improvement. One major area identified was accuracy/completeness of vital signs. Chart review pre-intervention showed that 0% of patients had a full set of vitals for acute and well visits. Vital signs are essential, giving providers objective data to help determine the level of acuity. Insufficient/inaccurate vital signs can lead to poor patient care. An intervention was designed to address this problem.

Aim Statement: To increase the percentage of patients in our clinic with a full set of vitals during well and acute visits from 0% to 80% over a 2-month time period. Interventions: Pre-intervention, nurses were using a card that indicated which vitals to check for each visit type. No visit types included a full set of vitals. A new evidence-based protocol for vital signs was created. We identified a
A fact sheet was created to explain the updated expectations. The new protocol was introduced at a meeting with the nurses. A vital signs manual, with instructions for proper techniques, normal ranges by age and references used, was provided. The new protocol stated: a full set of vitals (Wt/Ht/Temp/BP/HR/RR) should be taken for all well and acute visits, with BP excluded for patients less than 3 years with a few exceptions. A month later, a 2nd meeting was held to reestablish the expectations and discuss problems nurses had identified, e.g. the need for more equipment. This project received exemption from our local IRB.

**Measures:** Charts for all acute and well visits were reviewed from 3 one-week time periods to determine the percentage of patients with a full set of vitals: pre-intervention, 1-week post-intervention, and 7 weeks post-intervention. **Results:** There was an increase from 0% to a median of 52% and 44% for well and acute visits, respectively, over 2 months (see run charts).

**Conclusions and Next Steps:** This protocol can easily be applied in any outpatient clinic setting. We will explore further interventions, such as using the EMR to prompt nurses and posting signs. Additionally, we will begin skills sessions led by nurses to further ensure consistency/accuracy of vital signs.

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**106. UTILITY OF A QUALITY DASHBOARD ESTABLISHED BY A RESIDENT QUALITY COUNCIL**

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Quality Improvement (QI) science focuses on how healthcare is delivered (process measures) and the results (outcome measures). Although instruction in QI methodology is recognized as an important part of a resident’s education, maintaining resident engagement is a challenge. A Resident Quality Council (RQC) was established to (1) create and maintain a resident-generated and relevant quality dashboard, (2) enhance resident awareness of in-hospital QI initiatives, and (3) increase QI scholarly activity among residents. An RQC was established in 2017 consisting of five resident champions and three chief residents, mentored by program leadership, a Chief Quality Officer, and QI staff. To increase resident engagement a continuously updated resident-inspired dashboard, which highlighted both quality and operational standards, was created. Metrics were chosen based on resident feedback. Over 18 months, a lecture series was introduced into the residency curriculum which highlighted various QI initiatives with a special focus on process and outcome measures related to the dashboard. At the start of the 2019-2020 academic year, the RQC surveyed residents in regards to their level of QI engagement and the utility of the dashboard as part of the residency curriculum. The most relevant metrics, as reported, included asthma guidelines, length of stay, and number of safety events. There was a reported increase in understanding of a dashboard’s utility from 15.8% to 78.3% (N = 23). 78% reported continued interest in the maintenance of a dashboard with resident-pertinent metrics and acknowledged that the dashboard contributed to their understanding of the significance of QI science. Lastly, 87% felt the knowledge presented to them through the dashboard directly resulted in their increased interest in in-hospital QI initiatives and their desire to partake in QI scholarly work. Establishment of an RQC has proven beneficial in promoting QI interest amongst residents. Resident-pertinent dashboard metrics have kept housestaff engaged and interested in expanding their QI fund of knowledge through QI-driven scholarly projects.

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**107. GETTING TO THE ROOT CAUSE: RESIDENT ENGAGEMENT IN A MORBIDITY, MORTALITY, & IMPROVEMENT CURRICULUM WITHIN A LARGE PEDIATRIC TRAINING PROGRAM**

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Residents are exposed to medical errors during their training. The ACGME emphasizes the importance of patient safety and medical error analysis in a residency curriculum. Understanding root cause analysis (RCA) is an important component of a morbidity, mortality, and improvement (MMI) curriculum, enriching patient safety education. The objectives are to (1) engage residents in a mock RCA, (2) increase resident comfort in reporting medical errors, and (3) increase resident awareness of patient
safety opportunities. Our MMI curriculum incorporated a mock-RCA workshop which highlighted a medical error that occurred due to poor patient hand-off. Residents assumed multiple roles (including that of chief quality officer) and were guided through an RCA. They identified the safety event, deviations from standard of care, and corrective actions to mitigate recurrence. Using a 5-point Likert scale survey, we assessed residents on their understanding of the RCA process, confidence in identifying safety events and deviations in care, willingness to report a medical error, and perceived ability to identify QI opportunities in the workplace. 100% strongly agreed or agreed that they had a better understanding of the RCA process (n = 20). 95% either strongly agreed or agreed that they felt confident in identifying safety events and deviations in care. Regarding likelihood to self-report a medical error or one made by a colleague, 95% strongly agreed or agreed with both statements. All residents strongly agreed or agreed with their ability to identify QI opportunities in day-to-day patient care. Lastly, 85% either strongly agreed or agreed that they had become more actively interested in participating in a QI project involving patient safety. Medical errors provide opportunities for residents to learn and take corrective actions. An MMI curriculum, focused through the lens of an RCA, is an opportunity for residents to gain a better understanding of how medical errors are identified and engage residents in QI science on a hospital-wide level.

108. IMPROVING RESIDENT EDUCATION IN THE NEONATAL INTENSIVE CARE UNIT
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Background: At the Medical University of South Carolina, the neonatal ICU is known for its high volume of patients. With such high volume, education often is not prioritized. Resident evaluations of the NICU rotation were reviewed from the previous year. Residents perceived education in the NICU as one of the weaknesses of this rotation. Aim Statement: Our primary aim was to improve the quality of education as measured by surveys on a Likert scale. Our goal was a one-point improvement (on a 5-point scale) over a six-month period. Our secondary aim was to increase the total number of educational sessions per month in the NICU. Interventions: Our interventions were implemented over three PDSA cycles. In the first cycle, we provided neonatology textbooks to residents, set iPhone calendar reminders for residents and fellows to complete weekly educational sessions and provided a checklist to track education. We continued those improvements for cycle 2, with the addition of weekly bedside education. For cycle 3, we added an expectation that each off-service fellow would provide one additional lecture per month. Measures: The primary outcome was quality of resident education in the NICU. Residents completed surveys at the end of their rotation to evaluate the education they received. Also, the number of educational sessions per month were documented and a run chart was created. Results: Our results showed that there was no change in the quality or quantity of the resident educational experience in the NICU. Regarding the 3 PDSA cycles, 20/22 (91%), 11/30 (37%), and 12/42 (29%) of goal educational activities were completed. Conclusions and Next Steps: We surmise that the high clinical volume combined with limited time was the reason this initiative failed to produce change. In addition, we approached potential solutions to the lack of education from a resident and fellow driven perspective. We believe that when the responsibility for education is placed on the residents and fellows, patient care and documentation take precedent over creating educational opportunities. In hindsight, the project may have been more successful with more faculty involvement. The next step will be presenting our data to the MUSC NICU faculty and discussing further changes.

109. USING QI METHODOLOGY TO DECREASE UTILIZATION DRIFT OF THERAPEUTIC HYPOTHERMIA
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Background: The use of therapeutic hypothermia (TH) is neuroprotective in patients with moderate or severe hypoxic ischemic encephalopathy (HIE). We previously identified drift away from the standard of care guideline leading to the overuse of TH. This utilization drift has been attributed to gaps in medical documentation and lack of guideline awareness. Aim Statement: Our aim was to increase the number of appropriate TH cases between each misuse TH case by December 2018. Interventions: We conducted a QI project in our level IV NICU. A multidisciplinary QI team was formed including physicians, nurses, and ancillary providers. The patient population included all infants who received TH from 1/1/16 to 1/10/20. We developed a key driver diagram to determine the interventions to target which included EMR smartphrase implementation, provider education, and data sharing. Measures: Our outcome measure was the number of appropriate TH cases between each misuse TH case. Our process measure was the percent of cases with complete documentation of the modified Sarnat score. Balancing measures were the number of cases where TH was underutilized and hospital length of stay. A geometric means chart (G chart) was created to analyze our outcome measure given that the time between each HIE case is rare. Results: Special cause improvement was achieved in the number of appropriate TH cases between each misuse TH case after the 3 interventions were performed. Following implementation of EMR smartphrases, there was an improvement in overall modified Sarnat score documentation. Currently the EMR smartphrase is used in 76% of cases. Balancing measures remain unchanged. Conclusions and Next Steps: Following interventions of EMR smartphrase implementation, education, and data sharing there was an increase in the number of appropriate TH cases between each misuse TH case. Next steps of enacting EMR Best Practice Alerts may help further increase appropriate TH use for patients with HIE.
110. IMPROVING E-CIGARETTE AND VAPING USE SCREENING AMONG ADOLESCENTS
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**Background:** Recent data suggests that 27.5% of high school students reported using electronic cigarettes (e-cigarettes) in the past 30 days, a rise from 1.5% in 2011. Only 37% of adolescents recognized nicotine presence in these products. Screening, educating and providing cessation counseling for adolescents using e-cigarettes is fundamental. It has been documented that physicians infrequently screen or counsel their adolescent patients about e-cigarette use. According to a recent study, physicians using advanced electronic medical record (EMR) systems were more likely to record smoking status, and counsel patients on smoking cessation than those using less sophisticated technology, hence the idea to encourage the use of the e-cigarette/vaping screening tab in the EMR during adolescent visits. **Aim Statement:** To improve e-cigarette/vaping use screening among adolescents attending school-based clinics to a minimum of 80% in six months by encouraging the use of a specific tab embedded in the EMR.

**Interventions:** This quality improvement project included a baseline retrospective chart review of 100 health maintenance and sports physical visits in four school-based clinics associated to a major Academic Medical Center in Miami, Florida. The first Plan-Do-Study-Act (PDSA) cycle consisted of an email sent to health care providers encouraging them to utilize the e-cigarette tab in the EMR. **Measures:** 100 charts were reviewed one month after the intervention to assess whether e-cigarette use or vaping was assessed at health maintenance and sports physical visits in the same four school-based clinics. **Results:** At baseline (September-October 2019) 23% of adolescent patients were screened for e-cigarette/vaping use. This varied by school location, ranging from 12-36%. In the first PDSA cycle (November-December 2019) 55% of adolescents were screened. This varied by school location, ranging from 16-88%. **Conclusions and Next Steps:** Encouraging health care providers to use a designated e-cigarette screening tab embedded in the EMR through an email alert increased the number of patients screened during their health maintenance or sports physical visit. One of the four school-based clinics exceeded the goal of screening at least 80% of adolescents. Because locating the e-cigarette tab was identified as a barrier by some health care providers, a second intervention that included step-by-step information about where to access the tab was implemented. Results for the second PDSA cycle will be available February 2020.
Mental Health Education

112. IMPLEMENTING AND ASSESSING THE BEHAVIORAL AND MENTAL HEALTH ENTRUSTABLE PROFESSIONAL ACTIVITY: INSIGHTS FOR A PATH FORWARD

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Introduction: Pediatric mental health problems are growing exponentially. Pediatricians, while in a unique position to address these issues as they arise, have reported feeling they lack adequate training in assessing and managing behavioral/mental health (B/MH) problems. Underlining the importance of this area, the American Board of Pediatrics has defined B/MH as one of only 17 foundational entrustable professional activities (EPAs) for general pediatric practice. Aim: Explore the facilitators and barriers associated with implementing and assessing the B/MH EPA among pediatric residency programs in order to identify best practices and potential solutions to common barriers. Methods: In this qualitative study, 18 key faculty members from 4 residency programs with 3 years’ experience implementing and assessing their residents on the B/MH EPA were purposively sampled. Semi-structured interviews were conducted with each participant, and interviews were coded utilizing a thematic analysis. Results: Five themes emerged from the thematic analysis: (1) who is responsible for B/MH training (local champion, program director, resident, national organization)?; (2) local context can serve as a barrier or facilitator; (3) B/MH may require longitudinal, integrated, and multi-disciplinary training; (4) B/MH specialists: indispensable, yet a hurdle to training?; and (5) resident and faculty confidence and skill impact B/MH training. Conclusion: The need for robust training to prepare pediatric residency graduates to meet the needs of patients with B/MH problems has never been greater. This study provides important insights about curricular gaps in B/MH. These should inform future directions focused on addressing this need.

113. MENTAL HEALTH IN THE PEDIATRIC SUBSPECIALTIES: PHYSICIANS’ BELIEFS AND CONFIDENCE PROVIDING CARE

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Background: Mental and behavioral health (MBH) issues are prevalent in children with chronic medical conditions and negatively impact health outcomes. However, rates of screening and referral for MBH issues are low among subspecialists. The American Board of Pediatrics has recommended that curricula be instituted to improve subspecialists’ MBH care. However, the goals of such curricula are unclear as barriers to subspecialists and trainees providing MBH care have not been defined.

Objective: As part of a needs assessment to develop a curriculum for fellows, we sought to define subspecialists’ barriers to providing MBH care. Methods: Yale School of Medicine pediatric faculty and fellows were surveyed on training, confidence addressing (5-point Likert scale), and screening of MBH issues. Respondents completed a modified Physician Belief Scale (PBS), divided into two subscales (beliefs and burden), with a higher score indicating more negative MBH attitudes. Results were analyzed with descriptive and inferential statistics. Results: Surveys were completed by 71 pediatric faculty and 26 fellows (87 subspecialists, response rate 53%). General pediatricians screened more often for MBH issues than subspecialists (OR=3.3, p<0.001). There was no significant difference in PBS scores between subspecialists and general pediatricians. Most notably, subspecialists derive less satisfaction from addressing MBH issues (p=0.02) and less strongly believe that patients want MBH issues treated in their clinics (p=0.02). A majority of providers reported not having time to address MBH issues (58%). Fellows and attendings had the least confidence screening and developing action plans for patients but differed most in confidence initiating a conversation about MBH issues; fellows were significantly less confident than attendings (p<0.001).

Conclusion: A curriculum to increase MBH care in the subspecialties should highlight the importance of addressing MBH issues in children with chronic medical conditions, teach communication skills and screening strategies, and address perceived burdens on time.
114. DESIGNING AND EVALUATING A NOVEL MENTAL AND BEHAVIORAL HEALTH CURRICULUM
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**Background:** Pediatric mental and behavioral health disorders are a growing public health concern with immediate and long-term impacts for children, families, and society. Pediatricians are uniquely positioned, but often inadequately trained, to identify and address childhood mental and behavioral health needs. **Design/Methods:** Two major learning domains were identified for a 2-week rotation in senior year: 1) screening, diagnosis, and treatment of depression, anxiety, and ADHD in outpatient pediatric settings; and 2) evaluation, de-escalation, and triage of children in acute mental health crises. Residents participate in repeated sessions in integrated behavioral health clinics, conduct screenings with social workers, perform intakes supervised by a child psychiatrist, and evaluate patients with acute mental health concerns in the emergency department with child psychiatrists, in the community with Boston Emergency Services Team, and in inpatient settings with the hospital’s Behavioral Response Team. Self-directed learning activities provide individualized experiences tailored to residents’ interests. By random selection, half of senior residents will participate in the rotation during its first year. All senior residents were invited to complete a baseline survey at the beginning of the year evaluating their satisfaction with their behavioral health training thus far. **Results:** Fourteen of 29 (48%) eligible seniors completed the baseline assessment, showing that residents were least satisfied with their training in titrating/initiating medications to treat depression and anxiety, and most satisfied with their training in agitation management (Figure). Thus far, 11 senior residents have participated in the rotation. **Conclusions:** Many senior residents have received limited training in behavioral and mental health competencies. We developed a novel 2-week rotation that leverages hands-on experiences with child psychiatrists, social workers, and crisis response teams, as well as individualized self-directed learning, which we will follow-up with surveys to assess efficacy as our next steps.

115. USING IMPLEMENTATION RESEARCH FRAMEWORK TO FOCUS ON PEDIATRIC MENTAL HEALTH
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Surveys of pediatric program directors have identified the need for dissemination of mental health guidelines into pediatric training programs. Education on guidelines is challenging without an underlying framework for implementation. The Consolidated Framework for Implementation Research (CFIR) has been used in medical education settings. We utilized the CFIR to develop a multidisciplinary intervention that implemented 2011 AAP ADHD guidelines into an academic pediatric residency practice. Our desired outcomes included increasing confidence, improved use of Vanderbilt Screening and improved continuity of care for patients with ADHD. Utilizing the CFIR, we created a process to transform the un-adapted intervention (ADHD guidelines) into an adapted intervention directly applicable to patients. See figure 1. Providers were surveyed pre-intervention (PI), immediate post-intervention (IPI) and six months following intervention (FI). Investigators audited charts for conformity with the guidelines, continuity of care, intervals of visit, standardized documentation and receipt of Vanderbilt screening measures. Sixty-three providers participated. We aggregated data for the 63 and paired responses for 29 participants. When given the statement “there is a standard of care for patients,” 35.3% agreed PI, 82.4% agreed IPI and 83% agreed FI. Participants who indicated some or greater confidence in applying the AAP clinical guidelines moved from 31.8% PI to 86.4% IPI and 83.3% FI. Participants indicated that there was a teacher Vanderbilt available for their patients >50% of the time at 43% PI, 70.7% IPI and 83.3% FI. Respondents were asked “how often are you the primary care provider for patient visits regarding ADHD?” Participants answered that they were the PCP >50% of the time 22.9% PI, 23.7% IPI and 51.7% FI. The CFIR works as a framework to implement a mental health guideline into pediatric practice that may be superior to solely curriculum-based efforts alone. Outcomes continued to improve FI indicating potential longevity. Use of the CFIR framework could be expanded to implement more pediatric guidelines.
116. WHERE DO PEDIATRIC TRAINEES LEARN ABOUT BEHAVIORAL AND MENTAL HEALTH CONDITIONS?
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Background/Objectives: Although the development and behavior rotation (DBR) aimed to provide pediatric trainees with more experience in caring for children with behavioral and mental health (B/MH) conditions, gaps in B/MH training remain. This national study described the settings in which residents receive training in the assessment and treatment of B/MH problems.

Methods: Cross-sectional survey of applicants for the initial American Board of Pediatrics certifying exam in pediatrics. Respondents rated where they received training in 7 B/MH assessment skills (eliciting parental MH concerns; using screening tools to identify MH concerns; using disorder specific rating scales to help with diagnosis; diagnosing ADHD, anxiety, or depression using DSM-V criteria; and assessing suicidality) and 9 treatment skills (using evidence-based communication strategies to engage patients in treatment; behavioral management counseling; non-medication strategies for ADHD or depression/anxiety; dosing ADHD or depression medications; titrating medications; safety counseling; and co-management with MH specialists). Response options included continuity clinic, DBR, adolescent rotation, subspecialty rotations, child psychiatry rotation, other elective/longitudinal rotation, and/or no training in the skill. Descriptive statistics analyzed these data.

Results: 62.3% responded to the survey (n=2,086) with an average age of 31.3 years, 73.5% were female, and 60.1% were white. There were no differences in demographics between respondents and non-responders. Respondents reported receiving B/MH training in several settings, with continuity clinic being the predominant training location for all assessment (79%) and treatment (74%) skills. Respondents reported that their DBR was the next most common training setting, followed by adolescent medicine. However, for most skills, less than 50% of respondents reported receiving training in these settings. Across all assessment skills, less than 15% of respondents reported receiving training in other settings, including child psychiatry.

Conclusions: The majority of learning to care for children with B/MH conditions is in continuity clinic. Efforts must be made to ensure that this learning environment provides teaching with knowledgeable role models.

117. BE EXPERT: BEHAVIORAL HEALTH EXPANSION IN PEDIATRIC RESIDENCY TRAINING: SUCCESSFUL COLLABORATIVE CURRICULUM WITH PEDIATRIC PSYCHIATRISTS
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Background: Up to one-third of children will have a mental health condition. However, only 20% of these children receive mental health care and half of mental health referrals from primary care providers result in children being connected to care. Highlighting the need to improve pediatric resident training in the management of mental health issues, the AAP published a policy statement calling for enhanced mental health curriculums in pediatric residencies.

Methods: We developed a novel 6-month longitudinal mental health curriculum based on several existing models used to train practicing pediatricians. All pediatric residents were invited to participate; this project was IRB-exempt. The curriculum included a child psychiatrist-led, half-day orientation focused on assessment, diagnosis and management of major depressive disorder (MDD), generalized anxiety disorder (GAD), attention deficit hyperactivity disorder (ADHD) and acute behavioral events through a case-based, interactive format, as well as monthly group-based discussions of resident patients. Residents were paired with a psychiatrist consultant for as needed, real-time consultation throughout the projects duration. Residents were surveyed pre- and post-orientation for perceived comfort in the diagnosis and treatment of pediatric mental health conditions.

Results: Nineteen percent of (14/74) residents participated. Post-orientation, residents reported clinically meaningful increased comfort in all survey domains. Statistically significant (p<0.001) improvements were demonstrated in their knowledge of GAD, suicide, aggression and in their likelihood to diagnose and manage MDD, suicide, and GAD in their own clinics. All residents ranked this program in the top 25% of all learning experiences during their residency.

Conclusions: Developing and implementing a longitudinal mental health curriculum in conjunction with child psychiatrists is both feasible and results in overall improvement in residents comfort level with common mental health diagnoses.
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