APPD 2018
Annual Spring Meeting
March 20-23, 2018
Face-to-Face: Making the most of the APPD Spring Meeting
Atlanta, Georgia
Atlanta Marriott Marquis

This activity has been approved for AMA PRA Category 1 Credit™
Welcome to the 2018 APPD Annual Spring Meeting in Atlanta!

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 in the exciting city of Atlanta.

Special preparation and thought have gone into this year’s meeting planning. Recognizing that funds and time for travel to national meetings have become increasingly scarce, we have worked to highlight meeting activities that must occur in person. Our theme this year of Face-to-Face reflects a careful effort to maximize opportunity for in-person connection, collaboration and inspiration. We also have heard your feedback loud and clear and have worked to offer the content you have requested as efficiently as possible.

You will notice some changes this year in our program offerings. Because networking is one of the key opportunities that the Spring Meeting provides, we have worked to increase time for this crucial activity. Recognizing that exciting work happens when people come together around shared interest, we will launch a new Table to Able session this year. This activity will feature informal discussions led by content experts on a variety of topics related to best practices. We encourage you to join a table group both to learn and to share your ideas. Facilitated Networking, APPD’s newest mentoring session format, will provide opportunities to connect with potential mentors around four topics of mutual interest. Finally, what were once Workshops are now Enhanced Learning Sessions. While workshops will certainly be among them, these sessions will feature other formats, such as panel discussions, that may better suit the learning objectives of the session. We look forward to hearing your thoughts about these changes.

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 find plenty of each of these over the next few exciting days here in Atlanta.

WiFi Access for Conference Attendees

APPD is pleased to provide Wifi access for all conference attendees in meeting rooms. Please look for APPD_Annual_Spring_Meeting network and use the following password to log-on: APPD2018
# Schedule-At-A-Glance

**APPD 2018 Annual Spring Meeting**  
March 20–23, 2018 ~ Atlanta, GA

Program Details begin on page 14

<table>
<thead>
<tr>
<th><strong>Tuesday, March 20, 2018</strong></th>
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<tbody>
<tr>
<td>7:30am-12:15pm</td>
<td>APPD LEAD Meeting (LEAD Cohort Only)</td>
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<tr>
<td>8:00am-12:00pm</td>
<td>APPD Board Meeting</td>
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<tr>
<td>8:00am-5:30pm</td>
<td>Forum for Chief Residents</td>
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<tr>
<td>10:00am-5:30pm</td>
<td>Coordinators’ Session</td>
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<tr>
<td>1:00pm-3:00pm</td>
<td>APPD LEAD Council Meeting</td>
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<tr>
<td>1:00pm-5:30pm</td>
<td>Pre-Conference Workshops (choice of 4)</td>
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<thead>
<tr>
<th><strong>Wednesday, March 21, 2018</strong></th>
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<tbody>
<tr>
<td>7:15am-8:00am</td>
<td>Wellness Yoga (limited to first 25 pre-registrants)</td>
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<tr>
<td>7:15am-8:00am</td>
<td>Wellness Zumba (limited to first 25 pre-registrants)</td>
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<tr>
<td>7:30am-8:00am</td>
<td>Wellness Walk through Centennial Olympic Park</td>
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<tr>
<td>8:00am-9:00am</td>
<td>Continental Breakfast</td>
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<tr>
<td>9:00am-10:00am</td>
<td>Plenary Session</td>
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<tr>
<td>10:15am-12:15pm</td>
<td>Grassroots Forum for Associate Program Directors</td>
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<tr>
<td>10:15am-12:15pm</td>
<td>Grassroots Forum for Coordinators (breakout PC/FC)</td>
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<tr>
<td>10:15am-12:15pm</td>
<td>Grassroots Forum for Fellowship Program Directors</td>
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<tr>
<td>12:00pm-1:00pm</td>
<td>APPD LEAD Council Lunch Meeting</td>
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<tr>
<td>12:15pm-1:45pm</td>
<td>Networking Lunch (on your own)</td>
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<tr>
<td>12:30pm-1:30pm</td>
<td>Council of Regional Chairs Lunch Meeting</td>
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<tr>
<td>1:45pm-3:15pm</td>
<td>Enhanced Learning Sessions I (choice of 11)</td>
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<tr>
<td>3:30pm-5:00pm</td>
<td>Enhanced Learning Sessions II (choice of 11)</td>
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<tr>
<td>5:00pm-6:00pm</td>
<td>Networking Reception</td>
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<tr>
<td>6:00pm-7:00pm</td>
<td>APPD LEAD Reunion</td>
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### Thursday, March 22, 2018

<table>
<thead>
<tr>
<th>Time</th>
<th>Event</th>
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<tbody>
<tr>
<td>7:15am-8:00am</td>
<td>Wellness Yoga - SESSION FULL</td>
<td>L508</td>
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<tr>
<td>7:15am-8:00am</td>
<td>Wellness Zumba (limited to first 25 pre-registrants)</td>
<td>L506-507</td>
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<tr>
<td>7:30am-8:00am</td>
<td>Wellness Walk through Centennial Olympic Park</td>
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<tr>
<td>8:00am-9:00am</td>
<td>Continental Breakfast</td>
<td>Marquis Ballroom Foyer</td>
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<td></td>
<td>Community-Based Continuity Clinic – Open Discussion</td>
<td>L405-L406</td>
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<tr>
<td>9:00am-10:00am</td>
<td>Plenary Session</td>
<td>Marquis A-C</td>
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<tr>
<td>10:10am-11:55am</td>
<td>“Table to Able” Session</td>
<td>(see page 27)</td>
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<tr>
<td>12:00pm-1:15pm</td>
<td>Regional Lunch Meetings</td>
<td>(see page 27)</td>
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<tr>
<td>1:30pm-3:00pm</td>
<td>Learning Community Meetings</td>
<td>(see pages 28-29)</td>
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<tr>
<td>3:15pm-4:45pm</td>
<td>Facilitated Networking Sessions</td>
<td>(see page 30)</td>
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<tr>
<td></td>
<td>Forum for Directors of Small Programs and Affiliate Chairs</td>
<td>L401-L403</td>
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<tr>
<td></td>
<td>Coordinators’ Mentoring Session</td>
<td>Imperial A</td>
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<tr>
<td>4:45pm-6:15pm</td>
<td>Poster Session</td>
<td>Marquis A-C</td>
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### Friday, March 23, 2018

<table>
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<tr>
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<tr>
<td>7:00am-8:00am</td>
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<tr>
<td>8:00am-9:00am</td>
<td>Plenary Session</td>
<td>Marquis A-C</td>
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<tr>
<td>9:00am-10:15am</td>
<td>Platform Presentations / Research Awards</td>
<td>Marquis A-C</td>
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<td>10:30am-12:00pm</td>
<td>Enhanced Learning Sessions III (choice of 10)</td>
<td>(see page 34-37)</td>
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<td>12:00pm-1:30pm</td>
<td>Networking Lunch (on your own)</td>
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<tr>
<td>1:30pm-3:00pm</td>
<td>Enhanced Learning Sessions IV (choice of 9)</td>
<td>(see pages 38-40)</td>
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CME Information

Accreditation Statement
In support of improving patient care, this activity has been planned and implemented by Amedco and the Association of Pediatric Program Directors. Amedco is jointly accredited by the American Council for Continuing Medical Education (ACCME), the Accreditation Council for Pharmacy Education (ACPE), and the American Nurses Credentialing Center (ANCC), to provide continuing education for the healthcare team.

Credit Designation Statement
Amedco designates this live activity for a maximum of 21.0 AMA PRA Category 1 Credits™. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

Satisfactory completion
Participants must complete an evaluation form to receive a certificate of completion. Your chosen sessions must be attended in their entirety. Partial credit of individual sessions is not available.

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<tr>
<th>APPD</th>
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<th>Session Title</th>
<th>Credit Hours</th>
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<tr>
<td>Tuesday, March 20</td>
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<td>Pre-Conference Workshops</td>
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<td>Plenary Session</td>
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<td>10:15am-12:15pm</td>
<td>APPD Grassroots Forum for PDs, APDs or FPDs</td>
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<td></td>
<td>1:45pm-3:15pm</td>
<td>Enhanced Learning Sessions I</td>
<td>1.5</td>
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<tr>
<td></td>
<td>3:30pm-5:00pm</td>
<td>Enhanced Learning Sessions II</td>
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<td>Thursday, March 22</td>
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<td>Plenary Session</td>
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<td>10:10am-11:55am</td>
<td>“Table to Able” Session</td>
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<td>Learning Community Meetings</td>
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<td>3:15pm-4:45pm</td>
<td>Facilitated Networking Session/Forum for Directors of Small Programs &amp; Affiliate Chairs</td>
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<tr>
<td>Friday, March 23</td>
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<td>Plenary Session</td>
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<td>9:00am-10:15am</td>
<td>Platform Presentations of Top Educational Scholarship and QI Abstracts</td>
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<td>10:30am-12:00pm</td>
<td>Enhanced Learning Sessions III</td>
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<tr>
<td></td>
<td>1:30pm-3:00pm</td>
<td>Enhanced Learning Sessions IV</td>
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<td><strong>TOTAL</strong></td>
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Nationwide Children's Hospital/Ohio State University

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APPD Fund Contributors
APPD thanks the following individuals who have generously donated to the APPD Fund in the past year:

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APPD Supporter ($250-$499)
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Samuel Zinner, MD
Charlene Larson Rotandi, AB, C-TAGME
Ketan Kansagra, MD
Erin Reade, MD, MPH
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Adam Rosenberg, MD, Program Co-Chair
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Connecticut Children’s Medical Center
Angela Veesenmeyer, MD, MPH
Valley Children’s Healthcare
Rebecca Wallihan, MD
Nationwide Children’s Hospital/Ohio State University
Adam Wolfe, MD, PhD
BCM/Children’s Hospital of San Antonio

Special Thanks To:
Debra Boyer, MD
Boston Children’s Hospital
Heather Burrows, MD, PhD
University of Michigan
Jason Custer, MD
University of Maryland Medical System
Sanaz Devlin, MD
Children’s Hospital of the King’s Daughters
Alston Dunbar, MD
Our Lady of the Lake
Monique Naifeh, MD
OU Health Sciences Center
Sue Poynter, MD
Cincinnati Children’s Hospital Medical Center
Sahar Rooholamini, MD
University of Washington/Seattle Children’s Hospital
Allison Rose, MD
Emory University School of Medicine
Betty Staples, MD
Duke University Medical Center
APPD Regions

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 Thursday, March 22 from 12:00pm-1:15pm (see page 27 for location of your region’s meeting).

www.appd.org/activities/regions.cfm

APPD Council of Regional Chairs

Chair, Council of Regional Chairs
Jason Homme, MD (2017-2019)
Program Director, Mayo School of Graduate Medical Education
homme.jason@mayo.edu

Mid-America Region
Kimberly Boland, MD (2015 - 2018)
Pediatric Program Director
University of Louisville
k.boland@louisville.edu

Sue Poynter Wong, MD (2015 - 2018)
Director, Pediatric Residency Program,
Cincinnati Children’s Hospital Medical Center
sue.poynter@cchmc.org

Maria Ramundo, MD (2015 - 2018)
Director, Pediatric Residency Program
Children’s Hospital Medical Center of Akron
mramundo@chmca.org

Nancy Phuong (2015 - 2018)
Program Coordinator Pediatric Residency, MetroHealth Medical Center
nphuong@metrohealth.org

Mid-Atlantic Region
David Rappaport, MD (2017-2020)
Assoc Program Dir/Thomas Jefferson Univ, AI duPont Hospital for Children
David.Rappaport@nemours.org

Tracey Clark, MD (2017-2020)
Pediatric Residency Program Director, Sinai Hospital of Baltimore
tclark@lifebridgehealth.org

Midwest Region
Heidi M. Sallee, MD
Program Director Chair-Elect (2017-2020)
St. Louis University/SSM Cardinal Glennon Children’s Hospital
heidi.sallee@health.slu.edu

Eydad Hanna, MD, MME (2015-2018)
Associate Program Director
University of Iowa Children’s Hospital
Eyad-hanna@uiowa.edu

Southwest Region
Tammy Camp MD (2014 - 2020)
Pediatric Residency Program Director
Texas Tech University Health Sciences Center
tammy.camp@ttuhsc.edu

Alisa Acosta, MD, MPH (2017-2020)
Associate Program Director, Texas Children’s Hospital
alisa.acosta@bcm.edu

Mary Matus (2016-2019)
Program Manager
UT Austin Dell Medical School Pediatrics
mkmatus@seton.org

New England Region
Christina Hermos, MD (2017-2020)
Associate Pediatric Program Director
Umass Memorial
christina.hermos@umassmemorial.org

Marianne Custer, BS (2017-2020)
Senior Fellowship Program Coordinator
Connecticut Children’s Medical Center
mcuster@connecticutchildrens.org

New York Region
Matthew Kapklein, MD, MPH (2014 - 2020)
Program Director, Maria Fareri Children’s Hospital
matthew_kapklein@nymc.edu

Aesha Diggs, BA (2017 - 2020)
Fellowship Coordinator, Maimonides Infants and Children’s Hospital of Brooklyn
adiggs@maimonidesmed.org

Southeast Region
Kenya McNeal-Trice, MD (2016-2019)
Director, Pediatric Residency Training Program, UNC Pediatrics
kmtrice@med.unc.edu

Jennifer Crotty, MD, FAAP (2016-2019)
Associate Program Director, Vidant Medical Center/East Carolina University
crottyj@ecu.edu

Western Region
Lynne C. Huffman, MD (2017-2019)
Associate Fellowship Program Director, Stanford University
lynne.huffman@stanford.edu

Laura Kester, MD, MPH (2017-2019)
Associate Director, Pediatric Residency Program, University of California, Davis, Medical Center
lkester@ucdavis.edu

Lanier Lopez, MD (2017-2019)
Program Director, University of New Mexico
LNLopez@salud.unm.edu

Meghan Stawitcke, BA (2017-2019)
Program Director, Stanford Children's/Stanford Pediatrics
meghans4@stanford.edu

Sylvia Yeh, MD (2015-2019)
Program Director, Los Angeles County-Harbor UCLA Medical Center
syeh@uclacvr.labiomed.org
Join an APPD Learning Community!

Learning Community meetings will be held on Thursday, March 22 from 1:30pm-3:00pm. Come and see what the learning communities are all about (see pages 28-29 for room locations). All are welcome!

www.appd.org/activities/learningCommunities.cfm

**ASSESSMENT**

The Assessment Learning Community is a group of program directors, associate program directors, coordinators, and other educational leaders seeking to improve assessment practices for trainees, faculty and programs. We welcome newcomers and returning members alike. The Assessment Learning Community has four main working groups: Assessment of Learners focusing on Learner Communication, Assessment of Learners focusing on Peer Assessment, Assessment of Faculty, and Evaluation of Programs. Our Learning Community has three main goals for 2017-2019: 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 a new collaborative, established in 2018, and is seeking members, including PDs, APDs, coordinators, and all educational leaders interested in developing curricula and assessment tools for graduate medical education training to meet the emerging and evolving needs in pediatric behavioral and mental health. Expertise in behavioral health is not expected or required; anyone with a desire to improve this aspect of education in residency and fellowship training is welcome to participate and collaborate. As a new LC, we plan to partner with other LCs to address the needs of APPD members by creating a repository of motivated individuals with similar goals for collaboration in the design of innovative training curricula in this area and share these ideas within forums such as the APPD Share Warehouse.

Our learning community aims to:
- Familiarize members with content of the ABP EPA #9: Assess and manage patients with common behavior/mental health problems
- Provide a platform to discuss specific needs and challenges with providing meaningful and adequate experiences for resident trainees in Behavioral and Mental Health
- Develop curricula for implementation within residency training programs to enhance the exposure and clinical training in Behavior & Development and Mental Health
- Identify and develop innovative assessment tools for evaluating resident competency in Behavioral and Mental Health training
- Disseminate scholarly initiatives and best practices amongst the membership to address this important educational topic and growing health care need
- Partner with stakeholders in Behavior and Mental Health training and care provision (i.e. American Board of Pediatrics, American Academy of Pediatrics, patients and families)

**COMMUNITY HEALTH AND ADVOCACY TRAINING**

The Community Health and Advocacy Training Learning Community was established in 2017 to foster collaboration among leaders in community health and advocacy education within pediatric residency programs. Through this LC, participants work together to share ideas and resources with the goal of strengthening community health and advocacy education in their programs. The LC serves as a forum to disseminate peer-reviewed educational tools and curricula among programs to increase the visibility of educational work in community health and advocacy. The LC will increase engagement of new and existing members by providing a setting for community health and advocacy educators (who may not have previously attended APPD) to discuss their work. Community Health and Advocacy Training LC leaders will continue their ongoing collaborations with the Community Pediatrics Training Initiative section of the AAP, as well as with the APA’s Advocacy Training SIG, facilitating APPD’s goal of addressing Influence and Representation. As a new LC, we have not as of yet partnered with other LCs, however we anticipate collaborating with the Curriculum and Assessment LCs as participants work to develop educational tools in these areas. Further, we may collaborate with the Under-Represented Minorities and/or Global Health LCs in the future, expecting that some of our content may align. We are eager to have our first LC meeting in March, and from there, we will plan how we will interface with other LCs in the future.

**CURRICULUM**

The Curriculum Learning Community recognizes we are in an incredibly innovative and evolutionary period of graduate medical education and is in line with the APPD’s vision for change and growth. For the next year we plan to focus on several specific goals with three overarching themes: engaging our membership as much as possible, building of a needs assessment, and collaboration. Currently, the needs assessment is being conducted as part of a broader survey in collaboration with the AAP. Using that needs assessment, we may adjust and/or add to these goals as needed, but for now we are excited to:
- Create a curricular consult process that can serve our membership.
  - Any APPD member may request a consult on the development of curricula at his/her site
• A junior member of the Learning Community will be paired with a senior member of the Learning Community to review the curriculum
• Participation as members of the APPD ShareWarehouse review committee
• Investigate the need and potential for developing a national Core Pediatric topics curriculum
• Core Pediatric topics will be covered through development of educational sessions that incorporate contemporary educational theory and tools
• The educational sessions could be used by faculty to lead teaching sessions or by residents synchronously and asynchronously

EDUCATIONAL TECHNOLOGY
The APPD Educational Technology LC is a group of technology interested members who desire to collaborate on educational projects. This community will identify and evaluate technology, including software, computers, personal digital assistants, telecommunication devices, mobile applications, and wireless technologies. In addition, the Educational Technology LC will promote APPD technological resources and provide the APPD membership with platforms to share best practices using technology in graduate medical education. The APPD Educational Technology LC welcomes all interested members to join, regardless of technological expertise.

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 the Healthcare Simulation in Pediatrics Learning Community is to serve as a resource in simulation for residency and fellowship programs to help advance everyone’s work in simulation, regardless of level of expertise. We aim to promote collaboration, mentorship, and resource sharing related to simulation throughout the APPD community.
Specific objectives:
1. Develop and administer an IRB approved survey to all APPD members about the current state of simulation education for residents to share nationally what is happening with respect to simulation in pediatrics
2. Present two enhanced learning sessions at the APPD Annual Meeting as a learning community to provide an educational and networking opportunity for individuals interested in simulation
3. Develop a mentorship program for people interested in various aspects of simulation to help encourage program advancement and scholarship
4. Create an electronic forum for people to post simulation projects and resources to promote collaboration and knowledge sharing

We believe that these align well with the APPD Strategic Plan specifically in the areas of mentorship and scholarship. We look forward to serving as a resource to others involved with simulation and are always open to additional ideas on how to best support the APPD community’s simulation needs.

LESBIAN-GAY-BISEXUAL-TRANSGENDER-QUEER/QUESTIONING-ALLY+ (LGBTQA+)
The APPD LGBTQA+ Learning Community has been in existence since 2013. It is composed of medical educators who either identify with the community themselves or are wholly committed to improving life and health within these marginalized communities. Past accomplishments include the development of a standardized LGBT+ curriculum for pediatric residents, partnering with medical school organizations to discuss common issues among the trainees we serve, and creation of a biannual newsletter to better network and provide information relevant to the community within the APPD. In the future, the learning community expects to present at other national conferences (for example the ACGME) on inclusion and creating safe share space training in medical education. The Learning Community also intends to continue working with other learning communities
on creating diversity and inclusion trainings for our member institutions, which could be distributed. With this in mind, we will continue working with the APPD’s Vision 2020 Enhance Mentorship and Enhance Diversity project teams to ensure that LGBT+ communities are well represented as the APPD develops its mission through 2020. With this broad reach, the learning group would also like to ensure that the trainees themselves are as involved in this mission as possible, and will continue to include trainees in authorship opportunities, social events, and community development.

PEDIATRIC GLOBAL HEALTH EDUCATORS
The APPD Pediatric Global Health Educators 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. Our vision is for high quality global health education in all pediatric training programs. Our work is undertaken through active work-groups, regional consortiums, and frequently in collaboration with other global health or pediatric organizations. We develop and disseminate shared resources for curriculum and implementation, organize faculty and professional development opportunities, undertake projects in research and program evaluation, and advocate for global health education in pediatrics. More details are available at our website: https://appdgh.wordpress.com/

RESEARCH AND SCHOLARSHIP
The goals of the APPD Research and Scholarship Learning Community are to: a) understand the needs of the 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 successfully meet these goals, the Research and Scholarship Learning Community engages in a variety of activities, including developing and leading workshops focused on medical education research topics at the APPD Annual Spring Meeting, reviewing APPD meeting abstracts and enhanced learning session proposal submissions, reviewing research surveys intended for the 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.

UNDER REPRESENTED MINORITIES IN PEDIATRIC GRADUATE MEDICAL EDUCATION
The Learning Community (LC) for Underrepresented Minorities in Graduate Medical Education was launched in 2015, first designed as a response to the dearth of Underrepresented Minorities in Academic Pediatrics. The group soon became a home for like-minded individuals interested in fortifying the pipeline of URMM trainees in Pediatrics, but also interested in creating an inclusive environment for URMM learners and for tackling issues like bias and social justice in academic medicine. Our three (3) subcommittees include: (a) Curriculum Development (b) Recruitment and (c) Retention and Support which all work to support the following goals of the LC:
- Describe the state of underrepresented minorities (URM) in pediatric graduate medical education
- Describe the relevance of a lack of diversity within the pediatric workforce Develop an increased understanding of the challenges of recruitment and mentorship of URM house staff
- Define a framework for mentorship and support of URM within pediatric training programs
- Design tools for program directors to support diversity at their programs
- Underline the need for pediatric graduate medical education around health care equity and social justice
- Catalog pediatric specific curricula that address health care disparities, cultural competency and implicit bias in medical education

We have collaborated with the LGBTQA+ LC to design and hold workshops on Diversity and Inclusion, Implicit Bias and Social Justice in Medicine at APPD and PEACC conferences and we have hosted two (2) Special Topic Symposia on Diversity and Inclusion at our APPD Spring Meetings in 2016 and 2017. We welcome new members passionate about our vision and moving forward we hope to continue working with other LCs and the APPD Vision 2020 Diversity and Inclusion project team to make the environment of academic medicine a more inclusive one.
APPD Council of Learning Community Chairs
Rebecca Blankenburg, MD, MPH, Chair CoLCC (2016-2019)
Stanford Children’s/Stanford Pediatrics

Assessment Learning Community
Caroline Rassbach, MD
Chair (2017-2019)
Stanford Children’s/Stanford Pediatrics

Jennifer DiPace, MD
Vice Chair (2017-2019)
New York Presbyterian - Weill Cornell

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

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

Curriculum Learning Community
Helen Barrett Fromme, MD, MHPE
Chair (2016-2018)
University of Chicago

Nicole Paradise Black, MD, MEd
Vice Chair (2016-2018)
University of Florida

Educational Technology Learning Community
Pamela Carpenter, MEd, C-TAGME
Chair (2017-2019)
University of Utah

Michelle Miner, MD
Vice Chair (2017-2019)
Southern Illinois University SOM

Facility and Professional Development Learning Community
Erin Giudice, MD
Chair (2017-2019)
University of Maryland

Kimberly Gifford, MD
Vice Chair (2017-2019)
Dartmouth-Hitchcock Medical Center

Healthcare Simulation in Pediatrics Learning Community
Ariel Frey-Vogel, MD
Chair (2014-2019)
Massachusetts General Hospital

Amanda Rogers, MD
Vice Chair (2017-2019)
Medical College of Wisconsin

Lesbian-Gay-Bisexual-Transgender-Queer/Questioning-All (LGBTQ+) Learning Community
Michelle Brooks, C-TAGME
Chair (2014-2019)
Stanford Children’s/Stanford Pediatrics

Beth Payne, MAEd, C-TAGME
Vice Chair (2016-2019)
UTHSCSA

Pediatric Global Health Educators Learning Community
Christiana Russ, MD
Chair (2014-2018)
Boston Children’s Hospital

Tania Condurache, MD, MSc
Vice Chair (2014-2018)
University of Louisville School of Medicine

Research and Scholarship Learning Community
Su-Ting Li, MD, MPH, Chair (2016-2018)
University of California (Davis) Health System

Erika Abramson, MD, Vice Chair (2016-2018)
New York Presbyterian - Weill Cornell

Under Represented Minorities in Pediatric Graduate Medical Education Learning Community
Patricia Poitevien, MD, MSc, Co-Chair (2015-2018)
NYU School of Medicine / Bellevue Hospital Center
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
Alan Chin, MD
Share Warehouse Team Leader
University of California-Los Angeles

Emily Borman-Shoap, MD
University of Minnesota

Ashweena Gonuguntla, MD
Hurley Medical Center / Michigan State University

Robert Lee, DO, MS
Winthrop University Hospital

Tara McKinley, MA
University of Louisville

Michelle Miner, MD
Southern Illinois University

Sydney Primis, MD
Carolinas Medical Center - Levine Children's Hospital

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

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

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

A call for applicants for Cohort 7 is underway. The deadline for applications for this group is April 20, 2018. Visit www.appd.org/ed_res/LEAD.cfm for details. For more information about LEAD, look for the “Ask Me About APPD LEAD” buttons worn by attendees, APPD LEAD information near the registration area, and on page XX of this program.

LEAD Council Members / Faculty
Su-Ting Li, MD, MPH, Chair
University of California (Davis) Health System

Marsha Anderson, MD
University of Colorado

Hilary Haftel, MD, MHPE
University of Michigan

Richard Mink, MD, MACM
Harbor-UCLA Medical Center

Richard Shugerman, MD
Seattle Childrens’ Hospital / University of Washington

Rebecca Swan, MD
Vanderbilt University School of Medicine

Linda Waggoner-Fountain, MD, MEd
University of Virginia

Robert Vinci, MD
Boston Medical Center

The sixth APPD LEAD Cohort (see list below) was selected from among a highly qualified group of applicants. This sixth Cohort, an energetic and focused group of educational leaders, will graduate from the program during the Plenary Session on Thursday morning. Each Cohort member’s APPD LEAD Education Project is listed below their name and institution.

Sofia Aliaga, MD, MPH
The University of North Carolina at Chapel Hill
Assessment of Procedural Competence in Neonatal and Pediatric Medicine Trainees

Claudia Boucher-Berry, MD
University of Illinois at Chicago
Pediatric Resident Knowledge regarding Risk Factors for Gang Initiation

Bindiya Bagga, MD
University of Tennessee Health Sciences Center
Studying the Progression of Residents’ Cultural Attitudes During Standard Pediatric Residency

Natalie Burman, DO, MA
Naval Medical Center San Diego
Metacognitive Morning Report

Jennifer Barker, MD
University of Colorado Anschutz Medical Campus, Children’s Hospital Colorado
Development of Assessment Tool for the Evaluation of Short Stature

Jennifer Duncan, MD
Washington University School of Medicine
Pediatric Fellowship Career Development Needs Assessment

Sabrina Ben-Zion, MD
Akron Children's Hospital
How to Improve Instructional Quality in Pediatric Residency Continuity Clinic by Engaging Community Preceptors: A Pilot Study

Kristen Glass, MD
Penn State Health Children’s Hospital/ Penn State College of Medicine
Evaluation of a Global Feedback Tool to Assess NICU Fellows’ Teaching and Leadership Skills on Rounds
Jamika Hallman-Cooper, MD
Emory University
Determining the Learning Styles of Pediatric Neurology Residents to Guide Curricula Development

Sarah Hilgenberg, MD
Lucile Packard Children’s Hospital Stanford
Pediatric Resident Perceptions of the Importance and Timing of Communication Curriculum Topics During Training

Hao Hua Hsu, MD
University of Nebraska Medical Center
Burnout in Pediatric Residents: When is Burnout Most Likely to Occur During an Inpatient Service Month

M. Jawad Javed, MD
University of Illinois College of Medicine – Peoria
Better Residents or a Better Curriculum: A Correlative Analysis on the Implementation of a Multiphasic Board Review Curriculum in a Pediatric Residency Program

Stewart Mackie, MD
University of Massachusetts – Baystate Health
Bringing Back the Chalk Talk: A Novel Academic Half-Day Curriculum Utilizing the Mini-Chalk Talk to Enhance Resident Learning

Catherine D. Michelson, MD, MMSc
Boston University/Boston Combined Residency Program
Examining Motivators for Faculty Engagement with Teaching and Education Efforts

Ross Newman, DO
Children’s Mercy Hospital
Pediatric Residents Self-Assessment of ACGME Milestones Compared to Faculty and Peer Evaluation

Candace Smith-King, MD
Helen DeVos Children’s Hospital/ Spectrum Health/
Michigan State University College of Human Medicine
Cultural Humility Through Candid Conversations: A Quality Initiative

Mark Vining, MD
University of Massachusetts Medical School
Toward Building a Better Faculty Assessment: Faculty Perception of the Utility of Current Evaluations

Mary Beth Wroblewski, MD
The University of Toledo
Can I Trust You? Are Residents Writing Safe Prescriptions?

APPD LEARN
(LONGITUDINAL EDUCATIONAL ASSESSMENT RESEARCH NETWORK)

APPD LEARN is APPD’s research network, open to all member programs, with over 145 currently participating. During the past year, APPD LEARN has helped initiate new studies on the impact of academic half-days on board scores (Borman-Shoap, PI) and 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 new 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!

Alan Schwartz, PhD, APPD LEARN Director
Beth King, APPD LEARN Program Manager

APPD LEARN has its own web site at http://learn.appd.org
APPD Meeting Schedule

Tuesday, March 20

7:30am-12:15pm  APPD LEAD Meeting (LEAD Cohort Only)
M101

8:00am-12:00pm  APPD Board Meeting
M202

8:00am - 5:30pm  Forum for Chief Residents (breakfast and lunch will be included)
Imperial Salon B

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

Faculty: Erin Giudice, MD, Program Director, University of Maryland, Sophia Goslings, MD, Associate Program Director, University of South Alabama, Allison McBride, MD, Program Director, Wake Forest Baptist Medical Center, Alan Meltzer, MD, Program Director, Atlantic Health System, Ross Myers, MD, Associate Program Director, UH Rainbow Babies & Children’s Hospital, Maria Ramundo, MD, Program Director, Akron Children’s Hospital, Glenn Rosenbluth, MD, Associate Program Director, University of California, San Francisco

Chief Residents: Lezlie Andersen, MD, Mayo Clinic, Brittany Boswell, MD, Stanford University, Lorraine Canham, MD, University of Maryland Children’s Hospital, Crista Cerrone, MD, University of Connecticut, Alison Chiang, MD, MPH, Stanford University, Vincent DiMaggio, MD, University of Chicago, Michael Dolinger, MD, MBA, Cohen Children’s Medical Center, Margaret Ellis, MD, Wake Forest Baptist Medical Center, Mykael Garcia, MD, St. Christopher’s Hospital for Children, Sarah Germani, DO, University of Connecticut, Sarah Gustafson, MD, University of California, Los Angeles, Haley Johnson, MD, Wake Forest Baptist Medical Center, Alexandra Kilinsky, DO, Cohen Children’s Medical Center, Steven Loscalzo, MD, St. Christopher’s Hospital for Children, Jonah Mandell, DO, University of Connecticut, Justine Mrosak, MD, University of Connecticut, Jordan Newman, MD, Medical University of South Carolina, Michael Perry, MD, Nationwide Children’s Hospital, Anna Plichta, MD, Cohen Children’s Medical Center, Luke Radel, MD, Mayo Clinic, Brian Reilly, MD, Akron Children’s Hospital, Molly Silver, MD, University of Maryland Children’s Hospital, Julie Tsay, MD, Nationwide Children’s Hospital, Amanda Uber, DO, Stanford University, Jasmine Umana, MD, University of Chicago, Comer Children’s Hospital, Daphne Vander Roest, MD, University of Chicago, Megan Williamson, MD, St. Christopher’s Hospital for Children, Sarah Yale, MD, Medical University of South Carolina

7:30 – 8:00  Breakfast & Poster Set-Up
8:00 – 8:15  Welcome and Introductions
Blair Dickinson, MD, MS & Jay Homme, MD
8:15 – 8:45  The Chief Handoff
Jay Homme, MD
8:45 – 9:00  Move to breakout sessions
9:00 – 11:15  Breakout Sessions

Rising Chief Resident Track
9:00 – 10:30  Not Your Average Morning Report
Brittany Boswell, MD, Alison Chiang, MD, MPH, Michael Dolinger, MD, Mykael Garcia, MD, Alexandra Kilinsky, DO, Steven Loscalzo, MD, Anna Plichta, MD, Amanda Uber, DO, Megan Williamson, MD, Blair Dickinson, MD, MS
10:30 – 10:45  Break
10:45 – 11:15  Implementing Change in Your Program
Vincent DiMaggio, MD, Sarah Gustafson, MD, Jonah Mandell, DO, Justine Mrosak, MD, Michael Perry, MD, Julie Tsay, MD, Jasmine Umana, MD, Sophia Goslings, MD, Edwin Zalneraitis, MD
GRADUATING CHIEF RESIDENT TRACK

9:00 – 10:00  
Debriefing the Chief Year
Jay Homme, MD, Ross Myers, MD, Glenn Rosenbluth, MD

10:00 – 10:15  
Break

10:15 – 11:15  
Professional Development Planning and Mentoring
Brian Reilly, MD, Erin Giudice, MD, Jay Homme, MD, Maria Ramundo, MD

11:15 – 11:30  
Return from breakouts

11:30 – 12:15  
Chief Resident Crisis Management
Margaret Ellis, MD, Sarah Gustafson, MD, Haley Johnson, MD, Jordan Newman, MD, Daphne Vander Roest, MD, Sarah Yale, MD, Allison McBride, MD

12:15 – 1:30  
Lunch with “Show Your Best” Platform Presentations

“Medical Education through Diversity (MED) Talks: A Conversation between Patients and the Providers Who Care for Them”
Eric Chow, MD, MS, MPH, Chief Resident, Brown University/Hasbro Children’s Hospital

“Pediatric Fellowship Interview Scheduling in the New Era of a Universal Fall Match”
Anna Plichta, MD, Michael Dolinger, MD, MBA, and Alexandra Kilinsky, DO, Cohen Children’s Medical Center

“Fostering the Advocacy Spirit within Pediatric Residents through a Point-Based System”
Cecilia Monteilh, MD and Sylwia Jasinski, MD, Chief Residents, NYU Winthrop Hospital

Abbreviated Platform Presentations

“Phone Calls: When What To Do Isn’t Always A-Parent”
Matthew T. Clark, MD and Jaycelyn R. Holland, MD, Chief Residents, Vanderbilt University Medical Center

“What happens to my event report? A Quality Improvement (QI) Education Initiative”
Daphne Vander Roest, MD, Chief Resident, University of Chicago

“Implementation of the Professional Development Coaching Program”
Laura Cannon, MD, Pediatric Chief Resident, and Alyssa Tilly, MD, Medicine-Pediatrics Chief Resident, University of North Carolina Hospitals

1:30 – 3:45  
Speed Chiefing
Leslie Andersen, MD, Lorraine Canham, MD, Crista Cerrone, MD, Sarah Germani, DO, Luke Radel, MD, Molly Silber, MD, Ross Myers, MD

3:45 – 4:45  
Meeting of the Minds & Poster Viewing
Blair Dickinson, MD, MS, Sophia Goslings, MD

- Bedside skills initiative: helping second years step into their senior role and integrate into the care team (Christina Wu, MD, Kate Cicozi, MD, Rashi Bamzai, MD, and Katrina Cork, MD, University of Rochester Medical Center)
- Bridging the Gap: A Needs Assessment of Patient and Pediatric Resident Physician Perspectives on Family Needs and Resources (Brittany Boswell, MD, Alison Chiang, MD, and Amanda Uber, DO, Stanford University)
- ‘Chief Chats’: Clinical Reasoning Conferences Conducted Remotely Through An Online Chat Platform (Gayatri Madduri, MD/MT, and Elizabeth Links, MD, University of California – San Francisco)
- Classroom Response Systems: A Method to Enhance the Education During Residency (Carlos Castillo, MD, Alvaro Donaire, MD, and Dulce Gonzalez, MD, Lincoln Medical Center)
- Coaching Faculty Using Faculty Milestones (Sarah Burke, MD, Helen DeVos Children’s Hospital/Michigan State University/Spectrum Health)
- Creating a Culture of Support: Initiating a Brief Reflective Timeout Protocol for Pediatric Residents at Children’s Hospital of Pittsburgh of UPMC (Laura J. West, MD, Children’s Hospital of Pittsburgh of UPMC)
- Effective Debriefing: Empowering Trainees to Process Distressing Events (Morgen Govindan, MD, University of Michigan)
- Efficiency and Learning in Family-Centered Rounding: A Mixed Methods Study (Liny John, MD, MSE, Children’s Hospital of Pittsburgh of UPMC)
- Facilitating Health Maintenance Visits During Pediatric Residency Training (Laura J. West, MD, Children’s Hospital of Pittsburgh of UPMC)
- Feedback QI (Michael Perry, MD, Nationwide Children’s Hospital)
- Implementation of an evidence based curriculum into required resident didactics (Crista Cerrone, MD, University of Connecticut)
- Increasing Resident Engagement Through Interactive Learning at Morning Reports (Katherine A. Jordan, MD, Laura A. Cannon, MD, and Mark W. Chandler, MD, University of North Carolina)
- Podcasts as a Tool to Improve Access to Medical Education (Liny John, MD, MSE, Andrew Prigge, MD, and Matthew Valente, MD, Children’s Hospital of Pittsburgh of UPMC)
- Remediation Plans (Michelle Knoll, MD, Andria Tatam, MD, and Lindsay Eilers, MD, Eastern Virginia Medical School/Children’s Hospital of the King’s Daughters)
• Resident as Teacher: A Realistic Curriculum for Busy Inpatient Teams (Sarah Yale, MD, Morgan Khawaja, MD, Jordan Newman, MD, and Cara Slagle, MD, Medical University of South Carolina)
• Resuscitation Simulation: An Interprofessional Approach (Hunter Daigle, MD, Children’s Hospital of Philadelphia)
• ‘Sim One, Do One, Teach One:’ Using an In Situ Simulation Experience to Enhance Resident Engagement in the Pediatric Emergency Department (Jaycelyn Holland, MD, Monroe Carell Jr. Children’s Hospital at Vanderbilt)
• Through the Looking Glass: Using Simulation to Teach the Fostering of Reflection (Kirsty Hillier, MD, Janaki Paskaradevan, MD, J. Kevin Wilkes, MD, Emily Copeland, MD, Baylor College of Medicine – Houston)
• Utilizing the Google Platform to Improve Organization and Communication in a Pediatric Residency Program (Mariam Gabriel, MD and Mary Kate Mannix, DO, University at Buffalo)
• Wellness House Cup Competition (Janice Gee, MD, Lisa Rasmussen, MD, University of California – Davis)
• Wellness initiative: increasing awareness of support (Kate Cicozi, MD, Rashi Bamzai, MD, Katrina Cork, MD, and Christina Wu, MD, University of Rochester Medical Center)
• X+Y Scheduling in Pediatric Residencies (Katie Semkiu, MD and Mike Mullen, MD, Advocate Children’s Hospital – Park Ridge)

4:45 – 5:00 Top 10 Great Things About Chief Year
Ross Myers, MD

5:00 – 5:30 Wrap-Up, Evaluations & Poster Take Down
Blair Dickinson, MD, MS & Jay Homme, MD

10:00am-5:30pm Coordinators’ Session

Marquis B
10:00am-10:15am Welcome
10:15am-11:45am Workshop 1
GOT WELLNESS? HOW MULTIPLE PROGRAMS APPROACH COORDINATOR WELLNESS IN THE WORKPLACE
Jill Edwards, MBA, C-TAGME, Children’s Mercy Hospital, Kansas City, MO, Michele Bialkowski, University of Colorado, Aurora, CO, Teresa Hudson, C-TAGME, St. Louis University School of Medicine, St. Louis, MO, Stephanie McCartney, BS, C-TAGME, Penn State Milton S. Hershey Medical Center, Hershey, PA
Wellness has become a hot topic in medical education for trainees to ensure they have the tools and ability to care for their own personal needs in addition to the needs of their patients. With these new requirements, the demands on the program coordinator increase, but in many cases resources to ensure care of coordinators are limited. As coordinators, our job is to care for and assist the trainees, faculty, and directors within our program, but we are not as great at taking care of ourselves. This workshop is designed to challenge participants to look at their personal wellness and what systems and resources are available within their institution. In addition, participants will discover the value of mentorship and how to optimize mentoring relationships to grow as an individual and better assist their program.
11:45am-12:00pm Group photo
12:00pm-12:30pm Pick up Lunches
12:30pm-2:00pm Key Stakeholders Session
Updates from the American Academy of Pediatrics (AAP), Electronic Residency Application Service (ERAS), and the ACGME Coordinator Advisory Group. The session will also include an opportunity for Q&A with each of the key stakeholders. Questions will be solicited in advance of the session.
12:30pm-1:00pm American Academy of Pediatrics (AAP) - Charlette Blackful, Manager E-Learning Content and Amanda Hernandez, Dues Sponsored Membership Specialist
1:00pm-1:30pm ERAS - Amy Mathis, Senior Director
1:30pm-2:00pm ACGME Coordinator Advisory Group - Renda Chubb, BSW, C-TAGME
2:00pm-3:30pm Workshop 2
MAKING THE TEAM WORK: PD/PA RESPONSIBILITIES AND BUILDING YOUR PARTNERSHIP
Scott Olson, Heather McPhillips, MD, MPH, Kashena Konecki, Laureen Herrmann, Drake Kendermore, JD, University of Washington, Seattle, WA
Effective and efficient working relationships between residency and fellowship Program Directors and Coordinators are essential to the smooth running of a program. Common pitfalls to these relationships include confusion about responsibilities and roles, differing expectations, inadequate (or excessive) communication, a climate of distrust, and differing work styles or personalities. In addition to creating a stressful work environment, poor working relationships can adversely affect recruitment efforts, daily operations, and vital
projects geared at improving GH education in the top five areas of need identified by the audience. Community leaders will engage all interested members in initiating an action plan and time-frame for innovative scholarly and sharing strategies to overcome specific challenges you face at your own institution. Furthermore, the APPD GH Learning for implementing or improving GH education, you will have the opportunity to work with a facilitated group at developing definition and evaluation of a GH track in residency, participants will work together in facilitated groups to craft standardized GH programs. Using the results of the Delphi process conducted by the APPD GH Learning Community leaders to develop a peer-reviewed guide detailing the why, what, and how of implementing GH education within pediatric residency and fellowship tools. In this interactive session, participants will become familiar with the Pediatric Program Director’s Guide to Global Health – a challenges are still faced in integrating GH into the residency curricula, generating scholarly output, and developing evaluation many residency and fellowship programs have developed various degrees of GH educational offerings for their trainees, prepare our trainees to provide culturally-effective care to patients of all ethnicities and backgrounds, to recognize and advocate about social justice and diversity and inclusion; we must advance an organizational culture – within our training programs, our departments and our national organizations – founded on justice and inclusion. Lastly we will discuss concrete ways to engage trainees in lessons about social justice. Ultimately we cannot simply teach about social justice and diversity and inclusion; we must advance an organizational culture – within our training programs, our departments and our national organizations – founded on justice and inclusion.

PC2: Make Your Efforts Count Twice: Transforming Your Leadership into Scholarship

Marquis A
PDs and APDs engage in a range of teaching activities and projects that may be ripe with opportunities to develop scholarship in medical education. Yet, taking a scholarly approach may be challenging because of a lack of time and understanding of how to transform these activities into effective scholarship. This pre-conference workshop, sponsored by the APPD Research and Scholarship Learning Community, is designed to be practical and relevant for educators who want to develop their knowledge and skills in the fundamentals of scholarship. This workshop will be highly interactive and utilize a variety of formats such as small and large group activities, peer and expert facilitated mentoring, and guided reflection. The workshop will highlight valuable resources and tips such as building collaborative relationships, identifying a mentor, and developing a plan for dissemination. Participants will leave this workshop with a list of helpful resources and an individual action plan for their own scholarship project.

PC3: Pediatric Global Health Education: Standardization, Implementation, and Innovation

Marquis C
Christiana Russ MD, DTMH, Boston Children’s Hospital, Tania Condurache MD, MSc, University of Louisville School of Medicine, Sabrina Butteris MD, MPH, University of Wisconsin Madison, Michael Pitt MD, University of Minnesota, Heather Crouse MD, Texas Children’s Hospital, Heather Lukolyo MD, MHS, Baylor College of Medicine, Jennifer Watts MD, MPH, Children’s Mercy, Kansas City, Joanne Mendoza MD, Emory University, Adelaide Barnes MD, Children’s Hospital Philadelphia, and Nicole St. Clair MD, University of Wisconsin- Madison.
The need to incorporate global health (GH) education into pediatric residency and fellowships cannot be overstated: we must prepare our trainees to provide culturally-effective care to patients of all ethnicities and backgrounds, to recognize and advocate against health inequities, and to partner with colleagues in developing countries to help improve child health worldwide. While many residency and fellowship programs have developed various degrees of GH educational offerings for their trainees, challenges are still faced in integrating GH into the residency curricula, generating scholarly output, and developing evaluation tools. In this interactive session, participants will become familiar with the Pediatric Program Director’s Guide to Global Health – a peer-reviewed guide detailing the why, what, and how of implementing GH education within pediatric residency and fellowship programs. Using the results of the Delphi process conducted by the APPD GH Learning Community leaders to develop a definition and evaluation of a GH track in residency, participants will work together in facilitated groups to craft standardized GH evaluation tools. Whether you are a program director, program coordinator, chief resident, or GH educator, seeking guidance for implementing or improving GH education, you will have the opportunity to work with a facilitated group at developing and sharing strategies to overcome specific challenges you face at your own institution. Furthermore, the APPD GH Learning community leaders will engage all interested members in initiating an action plan and time-frame for innovative scholarly projects geared at improving GH education in the top five areas of need identified by the audience.
PC4: Professional Development 101: Networking and Mentorship  
**M103-M104**  
Facilitators: Kimberly Gifford, MD, Erin Giudice, MD, Megan Aylor, MD, Teri Turner, MD, MPH, MEd, Maria Ramundo, MD, Michelle Barnes, MD, Adam Wolfe, MD, PhD, Allison McBride, MD, Meredith Bone, MD, John Mahan, MD, Cliff Yu, MD  
As educators we spend most of our time supporting our learners. This session will give you a chance to focus on your own professional development. Whether you have recently joined APPD, assumed a new educational role, or are interested in developing your own skills in networking and mentorship, this session is for you! The first part of the session focuses on growing as a leader through mentorship. You will identify your own mentorship needs, work within small groups to share opportunities to meet those needs, and finally discuss expectations for mentors and mentees. The next part of the session focuses on building a network to solve problems, create opportunities, and develop collaborations. After presenters describe opportunities for networking within APPD, you will write a professional elevator speech and create a plan to apply networking principles during the APPD meeting. You will also self-select a case of interest to you and work within a small group to apply networking principles to a current issue. The final part of the session focuses on developing your skills as a mentor. You will identify your own strengths as a mentor and practice mentorship skills to help mentees refine their thoughts, define their needs, and identify resources, expertise, and opportunities. Throughout the session there will be several breaks with activities to emphasize the importance of wellness and pacing yourself to be successful in your career. You will leave the session with motivation, skills, and a professional development plan to help advance your career.

**Wednesday, March 21**

7:15-8:00am Wellness Yoga  
**L508**  
Join your colleagues for a 30-minute yoga session guided by one of our colleagues. Whether you have never tried yoga or you practice regularly, this session will get your day off on the right foot. Class size is limited to 25 – first come, first served. Those who signed up ahead of time and have been notified of acceptance will be admitted.

7:15-8:00am Wellness Zumba  
**L506-507**  
Join your colleagues for a Zumba session guided by an APPD member and instructor. Participants should definitely be in workout clothes and be prepared to sweat, but no prior experience is necessary. Class size is limited to 25 -first come, first served. Those who signed up ahead of time and have been notified of acceptance will be admitted. Please arrive no later than 7:15 so the session can start by 7:30 AM. Towels will be provided by the hotel to be used as mats.

7:30am-8:00am Wellness Walk through Centennial Park  
Join your colleagues for a 30-minute walk through Centennial Olympic Park (just 4 blocks from the hotel!) prior to the start of the day’s sessions. All conference attendees are welcome to join the group. We will meet in the hotel lobby by the elevators, and we will depart at 7:30.

8:00am-9:00am Continental Breakfast  
**Marquis Ballroom Foyer**

9:00am-10:00am Plenary Session  
**Marquis A-C**  
9:00-9:10 Welcome - Franklin Trimm, MD, APPD President  
9:15-9:20 Presentation of Robert S. Holm, MD Leadership Award - Dena Hofkosh, MD, MEd, APPD Immediate Past President  
9:20-9:25 Introduction of Presidential Address - Javier Gonzalez del Rey, MD, APPD President-Elect  
9:25-9:45 Presidential Address - Franklin Trimm, MD, APPD President  
9:50-9:55 Orientation to the day - Andrea Asnes, MD, 2018 Program Chair
10:15am-12:15pm  Grassroots Forum for Associate Program Directors
Marquis A-C
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: Nicola Orlov, MD (University of Chicago Medicine), Dan Sklansky, MD (University of Wisconsin School of Medicine and Public Health), Ben Miller, MD (University of Pittsburgh School of Medicine), and Monique Naifeh, MD, MPH (Oklahoma University School of Medicine)

Grassroots Forum for Coordinators (breakout PC/FC)
Imperial Salon B
Amy Gaug, C-TAGME, The University of Minnesota and Cassandra Shorter, BS, Baylor College of Medicine/ Children’s Hospital of San Antonio
This session will address various topics of interest to the APPD Coordinator Membership. Topics will include, but are not limited to: Coordinator integration into APPD Learning Communities, Leadership Skills Development, Technology Development, Program Communication Skills and Development, and Coordinator Research Opportunities and Development. This session will be facilitated by members of the Coordinators’ Executive Committee, however, the focus will be for all in attendance to collaborate and discuss not only current topics of interest, but how to create opportunities for the Coordinators’ Executive Committee and the Coordinator section membership to work together to address these topics in an ongoing and meaningful way.

Grassroots Forum for Fellowship Program Directors
Imperial Salon A
This moderated open forum is designed specifically for subspecialty fellowship directors and coordinators to discuss a variety of current trends and important updates in fellowship education. We anticipate your active participation. Registrants may be surveyed prior to meeting to identify potential topics of interest. Leaders: APPD Fellowship Directors’ Executive Committee / Pnina Weiss, MD Angela Myers, MD, MPH, Kathleen McGann, MD, Kathy Mason, MD, Jennifer Kesselheim, MD, MEd, MBE, and Christine Barron, MD.

Grassroots Forum for Program Directors
Marquis D
The Grassroots Forum for Program Directors will focus on timely topics of interest to Program Directors. This years’ facilitators will be Jennifer DiPace (New York Presbyterian Hospital/Cornell Campus) and Vasu Bhavaraju, MD (Phoenix Children’s Hospital/Phoenix Children’s Hospital/ Maricopa Medical Center).

12:15pm-1:45pm  Networking Lunch (on your own)

12:30pm-1:30pm  Council of Regional Chairs Lunch Meeting
L502

  Council of Learning Community Chairs Lunch Meeting
M102

1:45pm-3:15pm  Enhanced Learning Session I (choice of 11)

1. “I DON’T WANT SOMEONE LIKE YOU TAKING CARE OF MY CHILD.” STRATEGIES TO ADDRESS DISCRIMINATION BY PATIENTS AND FAMILIES
Emily E. Whitgob, MD, MEd, Rebecca Blankenburg, MD, MPH, Stanford University, Palo Alto, CA, Brian McGileen, MD, Penn State Milton S. Hershey Medical Center, Hershey, PA, Carmin Powell, MD, Lahia Yemane, MD, Alyssa Bogetz, MSW, Stanford University, Palo Alto, CA

M106-M107
Physicians and trainees are increasingly being confronted with discrimination from their patients and patients’ families. Medical trainees can feel alienated; clinical educators may feel powerless. Physicians and trainees receive little guidance for how to respond to discriminatory requests from patients and families. This highly interactive workshop will help prepare physicians and trainees for these encounters. At a time when prejudice is at the forefront of many conversations, the crucial need to have these critical conversations and prepare for discrimination is more urgent than ever. Attendees will reflect upon discrimination by patients and families they have experienced, whether it was directed toward themselves or their trainees. Facilitated small group breakouts will analyze several scenarios and brainstorm successful approaches toward discrimination.
The entire group will then return together to discuss the approaches they created as well as any reactions that arose during the exercise. Group leaders will briefly present strategies that they have developed through their research and that they use at their home institutions to respond to the problem of discrimination by patients and families. Finally, participants will develop a plan to implement the approaches and strategies introduced in the workshop into their own work as clinicians and educators.

2. DEVELOPING EMOTIONAL INTELLIGENCE IN YOUR TRAINEES
Linessa M. Zuniga, MD, Baylor College of Medicine (Houston), Houston, TX, Kim B. Hoang, MD, Stanford University, San Francisco, CA, Alisa A. Acosta, MD, Baylor College of Medicine (Houston), Houston, TX

Marquis D
This workshop will highlight the importance of emotional intelligence (EI) for trainees in caring for patients and other professional situations and provide a framework to teach learners how to develop their EI skills. Emotional intelligence is the ability to manage your own emotions and the emotions of others. There are four domains (self-awareness, self-management, social awareness, and relationship management) with 12 competencies of emotional intelligence that provide the framework for the development of skills to improve one’s EI. Higher EI has been reported to positively contribute to the patient-physician relationship, increased empathy, and teamwork and communication skills, which are many of the domains, competencies, and sub-competencies found with the ACGME Pediatric Milestone project. The workshop will begin with an understanding of one’s own EI through a self-reflective exercise and review of key EI domains and competencies. We will then discuss common scenarios that trainees may face in which EI awareness would benefit the situation (i.e., frustrated family, team interactions, and professionalism issues). We will then focus the workshop on how program leaders can support their trainees in the development of their EI skills. We will share best practices and debate strategies for success. The workshop will utilize a variety of learning methods such as debriefing, pair-share exercises, and small group activities. The workshop will conclude with a large group discussion that aims to engage attendees to share their experiences and ideas and how they will incorporate what they have just learned into their own practice and institution.

3. APPLYING COGNITIVE LEARNING THEORIES TO “MAKE LEARNING STICK” IN THE CLINICAL TEACHING SETTING
Lisa A. DelSignore, MD, Tufts Medical Center, Ariel S. Winn, MD, Lori Newman, MEd, Jennifer C. Kesselheim, MD, MEd, MBE, Diane E. Stafford, MD, Carolyn Marcus, MD, Laura Chiel, MD, Eli Freiman, MD, Children’s Hospital/Boston Medical Center, Boston, MA

Imperial Salon A
Learning for mastery requires work. Yet throughout the medical education system we have been taught to adopt passive learning strategies (i.e. re-reading, highlighting, cramming). While these strategies provide a quick fix and allow us to advance to the next step by passing an exam, for example, the knowledge gains are short-lived and rarely retained over time.

In the book, Make it Stick: The Science of Successful Learning, the authors provocatively turn this notion of passive learning upside-down and present concrete, revolutionary, real-world examples of how applying cognitive learning science can help achieve more productive and sustained learning. Most of these active, cognitive learning strategies feel slow and learners have the perception of not achieving immediate knowledge gains, making them less enticing to adopt, but solid evidence demonstrates how higher order and sustained learning can arise from routinely using these strategies. Successful learning retention encourages students to accept delayed learning gratification given that they will more adeptly recall newly acquired knowledge and skills over time. In this workshop, participants will learn about the theory behind active learning and practice using specific cognitive learning strategies. Participants will also discuss how to embed these cognitive learning strategies into their current clinical teaching practice to enhance learning for mastery.

4. THANKS FOR THE FEEDBACK: A TOOLKIT FOR LEARNING HOW TO RECEIVE FEEDBACK TO DRIVE PROFESSIONAL GROWTH
Jennifer G. Duncan, MD, Washington University/B-JH/SLCH Consortium, St. Louis, MO, Hilary Haftel, MD, MHPE, University of Michigan, Ann Arbor, MI, Catherine D. Michelson, MD, MMSc, Children’s Hospital/Boston Medical Center, Boston, MA, Linda A. Waggoner-Fountain, MD, MEd, University of Virginia, Charlottesville, VA

M101
Background: We swim in an ocean of feedback, and many previous workshops have focused on training providers on how to effectively and efficiently deliver meaningful feedback. In this workshop, we will flip the focus to explore methods for creating a culture to prepare trainees to expect and act on feedback. Often learners state that they want feedback, but in reality are uncomfortable receiving feedback. During this workshop, we will explore techniques to better prepare learners to receive and act upon feedback in order to improve their personal development. Methods: In this highly interactive workshop, participants will work together in small groups to discuss previous experience receiving useful and productive feedback. Next, participants will discuss situations where receipt of feedback was less useful and compare the differences between these two situations. A brief didactic session about receiving effective feedback will be delivered. A trigger video will be shared followed by large group discussion. Participants will then work in trios using role simulation of challenging feedback situations. Next, participants will be instructed in the concept of a personal feedback audit and complete their own audit. Finally, participants will begin to reflect and plan strategies to bring these concepts back to their own learners.
5. MANO A MANO: HOT TOPICS IN MEDICAL EDUCATION
Rebecca Wallihan, MD, Nationwide Children’s Hospital/Ohio State University, Columbus, OH, Emily Borman-Shoap, MD, University of Minnesota, Minneapolis, MN, Nidhi Unaka, MD, MEd, Cincinnati Children’s Hospital Medical Center/University of Cincinnati College of Medicine, Cincinnati, OH, Javier Gonzalez del Rey, MD, MEd, Cincinnati Children’s Hospital Medical Center/University of Cincinnati College of Medicine, Cincinnati, OH, John Mahan, MD, Nationwide Children’s Hospital/Ohio State University, Columbus, OH, Heather McPhillips, MD, MPH, University of Washington, Seattle, WA, Teri Turner, MD, MPH, MEd, Baylor College of Medicine (Houston), Houston, TX, Alan Chin, MD, UCLA Medical Center, Los Angeles, CA

Wednesday, March 21

504-L505

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, address follow-up questions from the moderator, and then respond to audience questions. The debate is then ended by closing remarks by each debater. Audience response will be used to poll attendees on their stance prior to and at the conclusion of each topic.

6. USING FELLOW WELL-BEING PROGRAMS TO CREATE INSTITUTIONAL CLIMATE CHANGE
Hayley Gans, MD, Stanford University, Stanford, CA, Meredith Bone, MD, Ann & Robert H. Lurie Children’s Hospital of Chicago, Chicago, IL, Kathleen McGann, MD, Duke University Hospital, Durham, NC, Jennifer Kesselheim, MD, MEd, Children’s Hospital/Boston Medical Center, Boston, MA, Angela Myers, MD, MPH, Children’s Mercy Hospital, Kansas City, MO

606-L607

Since the recognition of physician burnout studies document a prevalence >50% in physicians, with limited data on fellow burnout demonstrating rates ~ 68%. The ACGME deemed fellow well-being as critical and a responsibility of programs. Efforts focusing on improving well-being require change in organizations, as well as support for individuals. This workshop will highlight multifaceted approaches to bringing climate change to institutions by targeting both institutional and individual components of well-being through programs focused on fellows. In this interactive learning session using collaborative activities such as facilitated small groups, and large group discussions, participants will identify the key drivers of burnout and explore the resources that can be leveraged for well-being initiatives. Participants will learn about the structure, initiatives, successes, and challenges associated with Fellow Well-being Programs in varied institutional environments. This will provide strategies to develop initiatives for a single program or for fellows in a department. Participants will work in small groups to develop plans for creating and implementing their own Fellow Well-being Program. These action plans will be shared to elicit suggestions from the collective group. Presenters will introduce outcomes that can be used to study components of these programs. Participants will leave the workshop understanding that a well-being program can change the learning climate. They will acquire specific tools to create and implement a Fellow Well-being Program as well as understand opportunities to support scholarship. This workshop is applicable to all learners and educators who are interested in improving the learning climate and well-being of trainees at the fellowship level.

7. SPEED DATING WITH THE SIMULATIONISTS: AN INTERACTIVE SESSION TO PROMOTE NETWORKING AND COLLABORATION IN THE FIELD OF SIMULATION EDUCATION
Ariel Frey-Vogel, MD, MAT, Massachusetts General Hospital, Boston, MA, Amanda Rogers, Medical College of Wisconsin Affiliated Hospitals, Milwaukee, WI

604-L605

Simulation is an exploding topic in medical education, offering opportunities for teaching, evaluating, and remediating trainees in a safe and modifiable environment. This growing field includes a variety of modalities including standardized patients, high and low fidelity manikins, task trainers, online modules, and virtual reality experiences, to name a few. To someone exploring the use of simulation for trainees, the world of simulation can be overwhelming. The goal of this session is to demystify the use of simulation in medical training such that the beginner or intermediate simulationist can learn about how to develop a career in simulation, meet experts in the field, have their specific questions answered, and network with peers with overlapping interests for potential future collaboration.

The session will start with an expert panel of pediatric simulationists drawn from the Healthcare Simulation Learning Community who will describe their paths in simulation and answer participant questions about developing a career in simulation. The experts will then divide up by different elements of simulation (such as: choosing simulation equipment, case development, debriefing techniques, and evaluation tools) with one element per table. Participants will rotate in small groups through the tables of their choice, allowing for individualized questions and in-depth discussions. Finally, participants will choose one type of simulation of most interest to them (such as: procedural training, interprofessional education, and clinical reasoning). Participants will divide into tables by the type of simulation of most interest to them and share ideas with other participants with similar interests in small groups facilitated by the experts to determine potential areas for future collaboration.

Participants will leave the session with a summary of key topics discussed during the panel, key resources on each of the elements of simulation discussed as well as each of the types of simulation discussed, and the contact information of their co-participants who share similar interests in simulation.

Wednesday, March 21
8. TOOLS TO ADDRESS THE BLINDSPOTS AND DEVELOP A SELF-STUDY PROCESS CUSTOMIZED TO THE PROGRAM

Abdulla K. Ghor, MD, Denise Lesniak, MA, C-TAGME, Karolyn Tibayan, MEd, Case Western Reserve University (MetroHealth), Cleveland, OH

L401-L403

Preparing for Self-Study is novel to most programs and considered daunting by many stakeholders. Program directors and core faculty are very busy and therefore require a clear direction. After pooling the information from educational sessions on self-study from ACGME, we created a structured model to assist the busy stakeholders for a meaningful self-study process, which had to be completely modified multiple times based on experience of small, medium and large programs in a large teaching institution. The lessons learnt have been incorporated into a “structured but flexible self-study model that every program regardless of the discipline can adapt”. Experience from 13 self studies also indicated the need to adapt the annual program evaluation process to meet future needs of self-study. This session will alleviate fear and walk participants through the whole process step by step in a well-structured format developed from practice. It is designed to recognize self-study as a process to spring programs to the next level of excellence in future. The session includes comprehensive presentations prior to every practice step, and interactive expert facilitated discussion in a learner centered format to enhance skills. Participants will receive a concrete, yet customizable and user friendly format for the Self-Study process. They will plot their program on hypothetical milestones to help them identify their blind spots to advance forward to the next level of excellence. The 18 month map from start to completion with explanation of activities to prepare the self-study summary and achievement summary documents will be practiced in interactive groups. It is designed keeping in mind the limitation in time and resources faced by most programs and to maximize positive results leading to the goal of continuous improvement. Participants will practice preparing their planning committee, AIM statement, developing areas of self-study, performing a SWOT analysis, strategies to engage stake holders, prepare a mock self-study summary and list plans to prepare achievement summary, resulting in experiencing a complete self-study journey. An entire set of tools that eliminates re-inventing the wheel, will be provided to all programs to customize to their needs.

9. MAINTAINING RESILIENCE AND WELLNESS ACROSS THE EDUCATIONAL CONTINUUM: STUDENT TO RESIDENT TO FACULTY

Albina S. Gogo, MD, University of California (Davis) Health System, Sacramento, CA, Ann Burke, MD, Wright State University, Dayton, OH, Amanda Osta, MD, University of Illinois College of Medicine at Chicago, Chicago, IL, Susan Bostwick, MD, New York Presbyterian Hospital (Cornell Campus), New York, NY, Annamaria Church, MD, Loma Linda University Health Education Consortium, Bowling Green, OH

M103-M105

Burnout is an important issue at all levels of the medical education experience from medical student to resident to faculty and practitioner. Although medical students enter medical school with better mental health indicators than age-matched college graduates entering other fields, within two years the medical student rates of depression, fatigue and burnout exceed those of age-matched college graduates. Fatigue, depression and burnout peak during residency with one study finding that 74% of pediatric residents experience burnout. A recent study by Shanafelt found that the rate of burnout amongst pediatricians has increased to almost 50% (generalists and specialists). As educators, we need to be able to identify strategies that will help us maintain our wellness and resilience so that we can not only teach our residents about strategies available, but also serve as role models. In this flipped classroom workshop we will discuss the definition, causes, and strategies to prevent and treat burnout. Prior to the workshop we will suggest participants read relevant articles, including the AAP’s Resilience in the Face of Grief and Loss curriculum, Part D. We will discuss various topics in small groups and then share that discussed in the large group. Reading beforehand is highly recommended but not essential to participation in the workshop, since everyone has knowledge and experiences to offer and experts in the field will be present to facilitate discussions.

10. EARN MOC PART 4 CREDIT WHILE IMPROVING YOUR GLOBAL HEALTH EDUCATION PROGRAM

Sabrina M. Butteris, MD, University of Wisconsin, Madison, WI, Michael B. Pitt, MD, University of Minnesota, Minneapolis, MN, Maneesh Batra, MD, MPH, University of Washington, Seattle, WA, Nicole St Clair, MD, University of Wisconsin, Madison, WI, Adelaide Barnes, MD, Children’s Hospital of Philadelphia, Philadelphia, PA, Joanne Mendoza, MD, University of Virginia, Charlottesville, VA

L405-L406

In 90 minutes, leaders from the American Board of Pediatrics Global Health Task Force (ABP GHTF) and Association of Pediatric Program Directors Global Health Learning Community will work with you to develop quality improvement projects that will not only improve your educational program but also contribute to a national effort to improve global health training programs. The ABP GHTF is developing a library of small group quality improvement (SQIQA) templates aimed at improving global health programs. This library will be available for anyone interested in improving their global health program and will facilitate participants obtaining MOC Part 4 credit for their improvement efforts. Session participants will not only develop their own projects, they will be able to have their projects included in the GHTF template library, affording them the opportunity for immediate scholarly output, program improvement, and a clear path towards obtaining MOC Part 4 credit.

During this interactive session, participants will develop a SMART aim statement, define project measures, identify changes, develop a key driver diagram, and complete a small group quality improvement template. This unique session aims to not only benefit the participants through transfer of knowledge and skills, but to also provide them with immediate scholarly output (contributing to a national project), benefit their programs & trainees (subjects of improvement efforts), and to develop content that will help other programs, including those without sufficient resources to develop this type of project in isolation.
L508
Program Coordinators are always seeking out professional development opportunities and many would like to know how to get involved in scholarship, particularly being able to present their knowledge and expertise at regional and national conferences. However, many are uncertain how to begin the process and the steps that are involved in developing a workshop abstract. The session will be highly interactive, discussing some of the common challenges individuals encounter when brainstorming and drafting workshop ideas, and strategies for overcoming those challenges. We will also explore the qualities of effective workshops and how to incorporate them into the workshop design. We encourage all attendees to bring with them a workshop idea on which they would like to focus. In the end, workshop participants will leave with a resource toolkit and working draft outline for their workshop idea.

M101
Goals: To enhance awareness and understanding of the concept of shared decision-making (SDM), encourage SDM training of pediatric residents and fellows, and ultimately promote application of SDM in clinical practice. Background: When several diagnostic work-up or treatment options are possible, a 23shared decision-making  approach can be utilized. In pediatrics, shared decision-making (SDM) is a clinical communication strategy that involves presenting the best available clinical evidence, and ensuring that the clinician and parents are engaged in the process of making medical decisions about the care of the child. Communication skills and patient-/family-centered approaches to making medical decisions have been highlighted in assessments of competency and independent clinical practice, as in the ACGME Pediatrics Milestones and ABP Entrustable Professional Activities. A Cochrane review (2014) determined that effective SDM training approaches that target healthcare professionals generally include: educational meetings, distribution of educational materials, on-line tutorials, simulated patient experiences, and audit/feedback concerning SDM skills. In this interactive workshop, we will describe and demonstrate several SDM training approaches that can be used with pediatric residents and fellows. We will begin with a brief introduction to SDM, with small group discussions of participant knowledge of barriers to teaching SDM. Then, participants will experience and have the opportunity to practice several SDM training strategies including didactic presentations, on-line clinical case-based curriculum, observation of a simulated clinical encounter with real-time SDM behavior coding, and direct observation of SDM on family-centered rounds. Finally, participants will be provided with a parting packet that includes decision support tools (e.g. decision aid, option grid) to bring back to their home institutions, and the chance to brainstorm how to utilize these SDM training strategies and tools in their clinical practice.

L504-L505
The ACGME has tasked pediatric residency programs to provide a structured curriculum in medical ethics; however despite requirements to train and evaluate residents in ethics, there have been significant barriers to teaching and ensuring competency. Traditionally, efforts to train residents in ethics have focused on lectures or small groups, online modules, and bedside discussions during clinical rounds, but efficacy of these modalities is largely unknown. While Team-based learning (TBL)” in medical education has been shown to be an effective strategy to teach students both clinical and basic sciences, peer-reviewed studies evaluating the effectiveness of TBL in bioethics education have been scant. Our hypothesis is that an adaptively structured TBL format can effectively provide core content, and elicit active discussion in bioethics to pediatric residents. From 2015-2017, we created and facilitated nine TBL sessions on core ethics topics. To evaluate the effectiveness of this curriculum, pediatric residents first completed a baseline ethics knowledge assessment, and then a post-test after 9 sessions. They also completed qualitative evaluations of each session. Baseline pretest scores suggest that didactic and clinical training in ethics may not be sufficient for competency in navigating difficult ethical situations. Post-test data evaluation is currently underway. Qualitative evaluations from residents were very positive, as was the depth and engagement of the sessions. In this interactive workshop, we will present our novel and successful way of creating ethics TBLs by having participants learn the basics of a TBL ethics exercise, help each other to start creating their own, and participating in one themselves. Participants will first identify and analyze barriers to teaching ethics to trainees. Next, attendees will learn the basics of TBL by participating in a TBL. The final portion of the TBL is the application exercise, where participants will create their own ethics mini-TBL. Finally, we will briefly introduce our institution’s data for a successful resident TBL-based ethics curriculum.
14. STRENGTHENING FAMILY-PHYSICIAN COMMUNICATION: STRATEGIES TO IMPROVE RESIDENT EMPATHY IN THEIR INTERACTIONS WITH FAMILIES
Michelle M. Barnes, MD, University of Illinois College of Medicine at Chicago, Linda Gilkerson, PhD, Rachel Justice, MS, Erikson Institute, Chicago, IL, Amanda D. Osta, MD, University of Illinois College of Medicine at Chicago, Alisa Seo-Lee, MD, Rosibell Arcia-Diaz, MD, John H. Stroger Jr. Hospital of Cook County, Stacy Laurent, DO, Jasmine Saavedra, DO, and Miriam Komisar, MD, University of Illinois College of Medicine at Chicago, Chicago, IL
L506-L507
Effective communication is a core skill in the practice of medicine and can strengthen patient-physician relationships, improve patient health status, and improve patient satisfaction. Competencies within the Interpersonal and Communication Skills and Professionalism domains of the Pediatric Milestones Project include emotional intelligence and empathy as key elements of resident competence as a pediatrician. However, training activities to improve these skills for pediatric residents are limited. In response, we developed a curriculum to improve pediatric residents’ empathy and communication with parents and to increase family satisfaction with residents’ communication in the clinical setting. Preliminary data from our study demonstrated an improvement in residents’ self-reported empathy and mindfulness after receiving the training and using the skills learned through the curriculum in practice. In this interactive learning session, participants will explore the FAN (Facilitating Attuned iNteractions) Family Communication Tool and its five core processes: mindful self-regulation, empathic inquiry, collaborative exploration, capacity building, and integration. Participants will learn about attunement as the basis for empathic communication with families. They will work in pairs to practice utilizing the core processes in various communication scenarios. They will develop strategies to keep themselves calm when faced with stressful patient encounters. Finally, participants will brainstorm how to integrate empathic communication training into their training curriculum. This study was supported by an APPD Special Projects Grant.

15. POVERTY SIMULATION: A NOVEL APPLICATION FOR PEDIATRIC CULTURAL COMPETENCY TRAINING
Marie A. Clark, MD, Brian Na, MD, Shiyu Bai, MD, Keith Ponitz, MD, Ross Myers, MD, Jerri Rose, MD, Case Western Reserve University/University Hospital Case Medical Center/Rainbow Babies, Cleveland, OH
Marquis A-C
Poverty impacts child health across the globe, and it is crucial that trainees develop a sensitivity and awareness to challenges faced by families living in poverty. We will explore the use of simulation to expose trainees to social and cultural experiences that may be unfamiliar, through the specific example of a Poverty Simulation. Simulation has traditionally been used in medical education to teach procedural and communication skills, but there is little experience with simulation as a tool to expand trainees’ understanding of their patients’ social and cultural experiences. We will begin with exposure to the Poverty Simulation itself, an experience originally created by the Missouri Community Action Coalition which has been widely used by community agencies across the country to explore the challenges of living life with a limited income. We will then detail our experience with implementing the simulation for trainees, pediatric faculty and hospital administrators, providing insight as to how other programs may develop their own simulations. Next, we will utilize small group discussions to generate other potential strategies for utilizing simulation to teach cultural competency. Emphasis will be placed on possible benefits (faculty development and relationship-building with institution and community leaders), as well as barriers and challenges to the use of simulation. Finally, we will discuss methods and provide specific examples for evaluating a socio-cultural simulation. We will present our experience both with specific data from our research evaluation of the Poverty Simulation and with examples of how the use of the simulation has elucidated our evaluations of trainees. Participants will receive sample evaluation materials, and the large group will discuss how to address barriers to implementing evaluations of the simulation and trainees and how to address them.

16. WHERE DID YOU LEARN THAT? APPRAISAL AND CURATION OF FREE ONLINE ASYNCHRONOUS EDUCATIONAL RESOURCES FOR RESIDENTS
Brad Sobolewski, MD, MEd, Cincinnati Children’s Hospital Medical Center/University of Cincinnati College of Medicine, Cincinnati, OH
L401-L403
Increasingly residents are turning to asynchronous online materials to support their educational needs. In fact, Emergency Medicine residencies allow their trainees to devote a portion of their educational time to online learning. In the era of work hours regulations it is critical that residency programs nurture opportunities for residents to learn outside of the traditional classroom. In this Enhanced Learning Session attendees will learn about the scope of online resources in medical education that have arisen alongside traditional journals and online textbooks. Specifically the #FOAMed movement will be used to illustrate how a like minded community of clinicians passionate about education created and nurtured a successful worldwide educational initiative that spans countless blogs, podcasts, conferences and more. Special attention will be paid to educational theory that supports asynchronous online curricula including self directed learning and intrinsic motivation. Attendees will also learn how to curate and recommend resources for their residents. They will be exposed to and be able to practice methods of critical appraisal and evaluation for blog posts, videos and podcasts that have been developed by leaders in online education. Finally, strategies to assist faculty and residents in on-the-spot assessment and review of online materials that are discussed in real-time during clinical rotations will be highlighted.
What if you were able to do all the work you do as a program director AND - Get help meeting program requirements - Get scholarly credit that will help you with promotion - Identify new and better methods for pediatric training and assessment - Network with program directors across the country - Have fun working with great people? This session is designed for APPD members who want to better understand opportunities for research and scholarship through APPD’s Longitudinal Educational Assessment Research Network (APPD LEARN). We’ll review the core components and functions of APPD LEARN (network, repository, guidance, and survey infrastructure) and give examples of types of studies that have been or could be supported by APPD LEARN. We’ll discuss various ways that APPD members can lead or participate in APPD LEARN studies, and some frequently-used models for organizing network-based research. As a group, we’ll discuss questions about APPD LEARN and suggestions for how to maximize its utility to APPD members. We’ll also discuss complementary scholarship opportunities through the APPD Research and Scholarship Task Force (RSTF) and the Subspecialty Pediatrics Investigator Network (SPIN).

18. BUILDING BRIDGES: DEVELOPING A CORE CURRICULUM FOR PEDIATRIC SUB-SPECIALTY FELLOWSHIPS
Hayley Gans, MD, Stanford University, Stanford, CA, Bonnie Halperrn-Pelsher, PhD, Stanford University, Palo Alto, CA, Bruce Herman, MD, University of Utah, Salt Lake City, UT, Ann Klasner, MD, MPH, University of Alabama Medical Center, Birmingham, AL, Kathleen McGann, MD, Duke University Hospital, Durham, NC, Angela Myers, MD, MPH, Children’s Mercy Hospital, Kansas City, MO, Katherine Mason, MD, Brown University, Providence, RI, Pnina Weiss, MD, Yale-New Haven Medical Center, New Haven, CT

19. IMPROVING OUR TEACHING HABITS: TECHNIQUES FOR EDUCATION IN THE CLINICAL SETTING
Diane E. Stafford, MD, Lori Newman, MEd, Children’s Hospital/Boston Medical Center, Boston, MA

Imperial Salon B

Much of the education provided to residents and fellows is obtained in the context of patient care. However, due to the necessity to focus on the immediate needs of the patient and provision of timely care, the focus on education can be easily lost. As educators in the clinical setting, we must develop the skills for timely and effective teaching, focusing on essential concepts brought out by cases on the wards and in the outpatient clinic, but also acknowledging the limitations of education in these settings. While a variety of models for teaching in the clinical setting, the concept of “microburst teaching” can be effectively utilized in both the inpatient and outpatient setting when time for teaching is limited. Using videos of attending physicians teaching in the context of inpatient rounds and outpatient clinic, participants in this workshop will observe the teaching interaction and then discuss what aspects of the interaction were productive. Workshop leaders will outline several models of microburst teaching in clinical education including the One Minute Preceptor and then discuss how these might apply to various teaching settings. Participants will learn about models for efficient and effective teaching in both the inpatient and outpatient setting and will also strategize how to apply these methods to their current clinical teaching practice to enhance learning for trainees.

20. COLLABORATION WITH GME MENTAL HEALTH PROVIDERS - LESSONS LEARNED IN OPT-OUT COUNSELING FOR PEDIATRIC RESIDENTS. A PANEL DISCUSSION FROM MULTIPLE PERSPECTIVES TO GO FROM CRISIS TO EARLY INTERVENTION.
Appolinia E. Stephenson, MD, PharmD, Sarah Puffer, MD, Jerry Rushton, MD, MPH, Jessica Fultz, MSW, LCSW, Indiana University School of Medicine, Indianapolis, IN

M106-M107

In summer 2017, 99% of our pediatric residents completed a burnout survey administered by the Resilience Study Consortium, with results suggesting significant burnout experienced by our categorical and combined pediatric residents. Comparing
our program results to the national data, our residents showed similar levels of emotional exhaustion, depersonalization, and perceived physical and mental health. As a result, the Pediatric Chief Residents worked with GME Mental Health Services to create opt-out counseling sessions. While free counseling services were available to our residents previously, services were not widely utilized by residents in our program. Anecdotal barriers included difficulty coordinating time for appointments secondary to clinical duties, mental health services appointment availability only during daytime hours, and stigma relating to mental health and potential impacts on one’s reputation. The goals of opt out counseling were to offer residents protected time to attend counseling sessions, for residents to learn about mental health resources available to them, and to reduce stigma regarding counseling utilization. This effort was piloted in the PGY2 resident class this fall, with 30-minute opt-out counseling sessions scheduled for all 43 PGY2 categorical pediatric and combined pediatric residents. This resulted in 28 attending (65%), 7 opting out, 8 no-showing, and 8 scheduling follow-up appointments (29% of those attending). A anonymous pre-survey addressing stigma was completed by 23 residents and a correlated anonymous post-survey is scheduled. Results will be obtained prior to the March meeting to share. This enhanced learning format will include multiple perspectives (chief resident, program director, current pediatrics resident, GME mental health counselor) to create a successful counseling model.

The presentation will build on our experience and encourage participant discussion of some challenging scenarios and cases. Finally, we will use the power of the participants to learn from each other and discuss how to implement GME counseling initiatives or other potential local solutions.

21. I’M REALLY ENJOYING THESE REMEDIATION MEETINGS, WHEN CAN WE MEET AGAIN? PUTTING A POSITIVE SPIN ON REMEDIATION.

Harry L. Hoar, MD, Laura Koenigs, MD, Stewart Mackie, MD, Baystate Children’s Hospital, Springfield, MA, Rachel Boykan, MD, Stony Brook Medicine/University Hospital, Stony Brook, NY

M103-M105

“I’m really enjoying these remediation meetings, when can we meet again?” Putting a Positive Spin On Remediation. The remediation process is typically unpleasant for the struggling resident and faculty alike. Residents on a remediation plan are frequently disengaged in the process, suffer from a lack of confidence in their own abilities, and have difficulty maintaining personal wellness. Similarly, program directors may avoid initiating remediation plans, suffer from a lack of confidence in being able to successfully mediate the resident, and have difficulty maintaining their own wellness during the remediation process. In this session, we will explore methods to put a positive spin on the remediation process grounded in the principles of positive psychology coaching. This approach can help struggling residents and programs develop a strengths-based approach to remediation that may improve both the remediating residents and program’s level of engagement, perceived self-efficacy, emotional wellness, and outcomes during the remediation process. Principles of Carol Dweck’s work on Mindset will be utilized to identify and promote the growth (rather than the fixed) mindset, which is integral to success in a resident’s remediation. In a highly interactive session, participants will share their remediation struggles and successes. Participants will practice having an initial remediation meeting with a resident that focuses on identifying their strengths rather than dwelling on their shortcomings by using the positive psychology coaching framework. Relevant case examples of remediation successes and failures from the presenter’s institutions will be shared and the participants will be encouraged to contribute their own relevant examples for consideration. Questions that participants should be able to answer at the conclusion of the session include: How will you help the resident identify their strengths? How will you involve the resident in designing the remediation plan? How will the remediation plan help foster a growth mindset for the resident and faculty? Participants will leave with a framework to design their own strength-based remediation plans for struggling residents and resources for developing their coaching skills.

22. IT’S A BIRD! IT’S A PLANE! IT’S A... SUPER COORDINATOR?! THE ART OF MANAGING MULTIPLE PROGRAMS

Marianne Custer, BS, C-TAGME, Amanda Ross, BS, Lindsay Haythorn, BS, University of Connecticut, Hartford, CT

Imperial Salon A

The role of the multi-program coordinator can be especially challenging for many reasons: varying program requirements, additional committee meetings, continuous and conflicting recruitment seasons, multiple program directors… So who can possibly do it all and be it all you ask? Super Coordinators of course! This interactive session will provide Super Coordinators with the superpower to efficiently manage multiple residency and/or fellowship programs. Okay& maybe not with superpowers, but Super Coordinators will certainly learn how to combat common challenges by effectively assessing the needs of their programs, identifying opportunities for standardization, and implementing efficient processes to monitor and track program requirements with the tools and techniques in this session. Super coordinators will also learn how to utilize a DMS (daily management system) board and facilitate weekly huddles for improved program coordination. A portfolio of tools will be offered to assist in the assessment, streamlining and tracking of program processes for Super Coordinators.
Thursday, March 22

7:15am-8:00am  Wellness Yoga - **SESSION FULL**
   **L508**
   Join your colleagues for a 30-minute yoga session guided by Anthony Cooley from Children’s Hospital of Atlanta. Whether you have never tried yoga or you practice regularly, this session will get your day off on the right foot. Class size is limited to the first 25 to sign up. Please arrive no later than 7:15 so the session may start by 7:30am.

7:15am-8:00am  Wellness Zumba
   **L506-507**
   Join your colleagues for a Zumba session guided by an APPD member and instructor. Participants should definitely be in workout clothes and be prepared to sweat, but no prior experience is necessary. Class size is limited to 25 -first come, first served. Those who signed up ahead of time and have been notified of acceptance will be admitted.

7:30-8:00am  Wellness Walk
   Join your colleagues for a 30-minute walk through Centennial Olympic Park (just 4 blocks from the hotel!) prior to the start of the day’s sessions. All conference attendees are welcome to join the group. We will meet in the hotel lobby by the elevators, and we will depart at 7:30.

8:00am - 9:00am  Continental Breakfast
   **Marquis Ballroom Foyer**

   Community-Based Continuity Clinic – Open Discussion
   **L405-L406**
   Open forum for discussion by those who have residents in community-based clinics, including sharing ideas about how to engage preceptors, how to make sure residents are being taught evidence-based medicine, how to evaluate effectiveness of teaching, etc.

9:00am-10:00am  Plenary Session
   **Marquis A-C**
   9:00-9:05  Welcome - Franklin Trimm, MD, APPD President
   9:05-9:10  Presentation of Carol Berkowitz Award for Advocacy and Leadership in Pediatric Medical Education - Dena Hofkosh, MD, MEd, APPD Immediate Past President
   9:10-9:20  APPD LEAD (Leadership in Educational Academic Development) Graduation - Su-Ting Li, MD, APPD LEAD Chair
   9:20-9:50  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
   9:50-9:55  Orientation to the day - Andrea Asnes, MD, 2018 Program Chair
10:10am-11:55am Table to Able Session

**Marquis A-C and Marquis D**
*(please refer to signage for specific table topic locations)*

This year we are introducing a new Table to Able session. The theme of this session is Best Practices. The format of the session will consist of tables covering a variety of topics (see list below), with one topic and a specific question related to that topic at each table. There will be an expert Table Leader who will address the question and topic and facilitate discussion. Each table session will be 25 minutes in length with the opportunity to participate in three table topics during the session.

- Academic Advancement
- Addressing Burnout
- Board Preparation
- Building Your Team
- Continuity Clinic
- Core Curriculum: Procedural and Night Education
- Developing Cultural Humility and Structural Competency
- Getting to know APPD: Structure and Key Resources (APPD LEARN and APPD LEAD)
- Global Health
- Individualized Curriculum
- Mentorship
- Milestones
- New Project Ideas / “Cool Research Idea” Think Tank
- Patient Safety
- Promoting Resilience
- Recruitment and the Match Frenzy
- Scholarship
- Self-Study Visit
- Succession Planning
- Wellness

12:00pm-1:15pm Regional Lunch Meetings

- **Mid-America:** West PA, OH, WV, KY, IN, MI
- **Mid-Atlantic:** Southern NJ, East PA, DE, MD, Washington DC
- **Midwest:** IL, WI, MN, IA, MO, KS, NE, OK, SD
- **New England:** ME, NH, MA, CT, VT, RI
- **New York:** NY, Northern NJ
- **Southeast:** VA, NC, SC, GA, FL, AL, MS, LA, AR, TN
- **Southwest:** TX
- **Western:** CA, NV, OR, WA, AK, CO, NM, UT, AZ, HI

1:30pm-3:00pm Learning Community Meetings (choose one)

**Assessment Learning Community**

The Assessment Learning Community is a group of program directors, associate program directors, coordinators, and other educational leaders seeking to improve assessment practices for trainees, faculty and programs. We welcome newcomers and returning members alike. During our Learning Communities session at APPD Spring 2018, we will break into our four main working groups to continue current projects and brainstorm new/additional directions. The four main working groups include: Assessment of Learners focusing on Learner Communication, Assessment of Learners focusing on Peer Assessment, Assessment of Faculty, and Evaluation of Programs. These groups are working to meet our Learning Community’s three main goals for 2017-2019: 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 & Mental Health Learning Community**

The new Behavioral and Mental Health Learning Community is excited to hold its inaugural session at the 2018 APPD Annual Spring Meeting in Atlanta! We are planning an interactive session where participants and attendees will become familiar with the needs assessment and background supporting the creation of this community. This session will include a panel discussion and presentation by the members of the writing group who developed the EPA #9 - “Assess and manage patients with common behavior/mental health problems”. In addition, program directors involved in the EPA study currently evaluating EPA #9 will provide insight on the successes and challenges with assessment of resident competency in behavioral and mental health. Attendees will then work in facilitated small groups focused on identifying the evolving needs of Behavioral and Mental Health training and priorities for assessment in graduate medical education. Please join us!

**Community Health & Advocacy Training Learning Community**

As a new Learning Community, the Community Health & Advocacy LC will hold its first session in Atlanta, and we are eager to get started! During this interactive session, participants will learn about the background of this new LC and why it was created. The session will include a panel of leaders in community pediatrics education from around the country who will discuss various challenges they have faced as educators and how they overcame them. After a facilitated panel discussion, participants will individually conduct a brief needs assessment of their own community pediatrics and advocacy curricula, and they will utilize a pair/share format to discuss in small groups. 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 a collection of resources to enhance their community pediatrics curricula.
Curriculum Learning Community
The Curriculum Learning Community recognizes we are in an incredibly innovative and evolutionary period of graduate medical education and is in line with the APPD’s vision for change and growth. For the next year we plan to focus on several specific goals with three overarching themes: engaging our membership as much as possible, building of a needs assessment, and collaboration. During our session at the APPD annual meeting, we will briefly review our past accomplishments and then set to work on our future directions. A majority of the time will be spent in actively revising our vision, developing and prioritizing goals for the Learning Community and the membership at large, and launching our group onto a successful and rewarding path. We encourage all those with an interest in curricula (i.e., development, research, revision, innovation, collaboration), regardless of level of experience, to join us.

Educational Technology Learning Community
The APPD Educational Technology Learning Community will host an interactive table talk session, describing best practices and showcasing the latest technology used by program leadership. Participants will rotate from table to table as hosts demonstrate various tech or programs they have implemented or found useful in program administration or medical education. 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 & Professional Development Learning Community
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 point.
- 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 Learning Community
The Healthcare Simulation Learning Community welcomes you to join us in a discussion of the use of simulation in pediatric education. We will begin by discussing two projects we have been working on since the last national APPD meeting. The first is the development of two workshops for this conference and the second is developing a survey for the APPD community to determine what programs are currently doing in simulation and how we can provide simulation resources and mentorship for the APPD community at large. We will discuss the current state of our survey and brainstorm ways we can move from this needs assessment to the next step of planning an intervention to meet the needs of the APPD community. Following the discussion of these two current projects, we will have people present their work in simulation to both offer ideas to and get feedback from members of the learning community. We hope you will join us in learning about what others are doing in simulation, networking with colleagues involved in simulation education, and helping us to plan our next series of projects for the coming year!

LGBTQA+ Learning Community
The LGBTQA+ Learning Community will hold its annual spring meeting in Atlanta, and we are excited to meet those of you who are new and reconnect with old friends! We plan to discuss with the group the nomenclature change and what that means for us, as well as discussing relevant topics in medical education, including on the national level. In addition, we will report out on updates on our three subgroups: curriculum, recruitment, and advocacy. 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 Learning Community
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 our annual meeting during which we will welcome our global health education scholarship recipients (this year joining us from Laos and Ghana), share abstract presentations about global health education, and discuss ways to get involved in the group’s efforts.

Research & Scholarship Learning Community
Come join us for the APPD Research & Scholarship Learning Community session! At this session, we will review accomplishments of our learning community over the past year, including surveys reviewed, workshops submitted, and scholarship from members of the group. Next, we will brainstorm as a large group how our learning community 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. These working groups typically focus on topics such as workshop submissions for future meetings and policies and processes to support scholarship. Members often collaborate with each other on great projects throughout the year following this session. We welcome all APPD members, regardless of whether you are a novice or expert at educational research scholarship.

Under-Represented Minorities in Graduate Medical Education Learning Community

Originally proposed as a Pediatric Education Group, the URM Learning Community was first designed as a response to the dearth of Under-represented Minorities in Academic Pediatrics. The group soon became a home for like-minded individuals interested in fortifying the pipeline of URMM trainees in Pediatrics, but also interested in creating an inclusive environment for URMM learners and for tackling issues like bias and social justice in academic medicine. Our LC has been divided into three (3) sub-committees, each with their assigned objectives, to better address the overarching goals of the LC: (a) Curriculum Development (b) Recruitment (c) Retention and Support. During the APPD Spring Meeting each subcommittee will be reporting on their progress to the larger LC, as well as meeting as sub-committees to discuss goals, structure and leadership for the new academic year. Additionally the larger LC will hear from the APPD Vision 2020 Diversity and Inclusion project team and how their work has impacted the strategic plan for APPD. Lastly the LC membership will be charged with selecting new leadership - Aisha Barber stepped down as co-lead in the summer of 2017 and Patricia Poitevien will be stepping down as of spring 2018.

3:15pm-4:45pm  Coordinators’ Mentoring Session
Imperial Salon A
In continuation of our mentoring program, this meeting will be an opportunity for coordinators to network and receive on-the-spot mentoring, in a group setting, from peers who work in the same type of program structure. This session will be led by the APPD Coordinators’ Mentoring Workgroup.

Forum for Directors of Small Programs and Affiliate Chairs
L401-L403
Small programs have been traditionally defined as having 10 or less residents per year. Programs of this size have inherent benefits and also challenges that face program directors as they educate and manage trainees in these environments. So what unique characteristics make applicants choose us over the larger programs? The small program session this year will feature 4 short presentations from a variety of small programs from different parts of the country and focus on ways these programs have capitalized on their strengths. Interactive groups with open discussion will assist each attendee in recruiting those applicants that are the best fit residents for your program. Facilitators: Brian Youth, MD, Maine Medical Center; Keith Mather, MD, University of Oklahoma College of Medicine - Tulsa; Joe Zenel, MD, Sanford School of Medicine, University of South Dakota; and Rebecca Chasnovitz, MD, Kaiser Permanente Medical Group (Northern California).

Facilitated Networking Session
(see room assignments below next to topics)
Please enjoy the company of wonderful APPD colleagues at the inaugural Facilitated Networking Session. Join faculty experts and junior colleagues alike to share experiences on topics specific to their role as educators and program leaders. Open to all APPD attendees. Topics include:
- Professional Development Planning (Getting promoted based on education related work, optimizing mentoring experiences, developing faculty and institutional leaders) - M103-M105
- Leadership Development (Balancing decisiveness and inclusivity, managing difficult leaders, programs/resources for leadership development) - Imperial Salon B
- Work/Life Balance & Time Management (Supporting others while also taking care of self and family, politely setting boundaries, saying “no”, managing workload) - Marquis D
- Program administration (Effective program organization, time management, collaborating with leaders, managing administrative team) - M106-M107

4:45pm-6:15pm  Poster Session – Educational Scholarship and QI Projects
Marquis A-C
(Please see pages 41-93 for poster abstracts)
Friday, March 23

7:00am - 8:00am  Continental Breakfast
    Marquis Ballroom Foyer

8:00am-9:00am  Plenary Session
    Marquis A-C
    8:00-8:05  Welcome - Franklin Trimm, MD, APPD President
    8:05-8:10  Special Project Awards - Rebecca Blankenburg, MD, Chair of Council of Learning Community Chairs
    8:10-8:15  Presentation of Walter W. Tunnessen, Jr. MD Award for the Advancement of Pediatric Resident Education - Dena Hofkosh, MD, MEd, APPD Immediate Past President
    8:15-8:45  Update from the American Board of Pediatrics (ABP) with Q&A - Suzanne K. Woods, MD, Executive Vice President, American Board of Pediatrics
    8:45-8:55  APPD LEARN/PMAC Update (Longitudinal Educational Assessment Research Network / Pediatrics Milestones Assessment Collaborative) - Alan Schwartz, PhD, APPD LEARN Director
    8:55-9:00  Orientation to the day - Andrea Asnes, MD, 2018 Program Chair

9:00am-10:15am  Platform Presentations from Top Educational Scholarship/QI Abstracts and Presentation of Research Awards
    Marquis A-C
    9:00-9:05  Presentation of Research Awards – Presented by Andrea Asnes, MD, APPD Program Chair
    APPD QI Project Award: Mackenzie S. Frost MD, University of Texas Southwestern Medical School, Dallas, TX – Platform Presentation # 2 (details on page 30)
    APPD Research Award: Jennifer Kesselheim, MD, EdM, Children’s Hospital/Boston Medical Center, Boston, MA – Platform Presentation #4 (details on page 31)
    APPD Trainee Research Award: Lisa N. Rasmussen, MD, University of California (Davis) Health System, Sacramento, CA – Poster # 21 (details on page 49)
    9:05-10:15  Platform Presentations from Top Educational Scholarship/QI Abstracts

1. IMPACT OF A PEDIATRIC VALUE CURRICULUM ON RESIDENT KNOWLEDGE, ATTITUDES AND BEHAVIOR
   Lisa E. Herrmann MD MEd, Michael Tchou MD, Allison Parsons, Cincinnati Children’s Hospital Medical Center/University of Cincinnati College of Medicine, Cincinnati, OH, Naveen Muthu MD, Rebecca Tenney-Sorreo MD MSeD, Evan Fieldston MD MBA MSHP, Brad Lindell MD, Adam Dziorny MD PhD, Tara Bamat MD, Children’s Hospital of Philadelphia, Philadelphia, PA, Maya Dewan MD MPH, Cincinnati Children’s Hospital Medical Center/University of Cincinnati College of Medicine, Cincinnati, OH
   Background: Rising healthcare costs and concerns regarding overuse have increased the focus on high-value care (HVC) education; currently only 10% of pediatric residency programs have HVC curricula. A multi-site HVC curriculum was instituted during the 2016-2017 academic year. Objective: To evaluate the effect of a HVC curriculum on pediatric trainee knowledge, attitudes and behaviors Methods: We performed mixed methods evaluation of a pediatric HVC curriculum at two hospitals during the 2016-2017 academic year. The basic curriculum provided to all pediatric residents consists of 4 standardized didactics and 12 interactive HVC morning reports. Residents on hospital medicine rotations participated in HVC improvement projects using quality improvement methodology. An anonymous, voluntary REDCap survey, adapted from a previously published survey, was distributed to all residents pre and post-curriculum to evaluate trainees perceived knowledge of healthcare costs, charges, reimbursement and value. Survey results were compared via paired t-tests. Qualitative analysis of post-curriculum focus
groups was also completed. Results: 291 residents were exposed to the basic HVC curriculum. 50 residents were exposed to both the basic curriculum and HVC improvement project. 80 residents (27.5%) completed both the pre and post-survey. Self-reported knowledge of healthcare costs, charges, reimbursement, and value demonstrated significant improvement at both institutions (p<.05 for all areas). (Figure) Attitudes around value showed mixed results. Thematic analysis of focus group transcripts identified two themes: curriculum impact on HVC and how HVC affects individual practice. HVC improvement projects resulted in more appropriate continuous pulse oximetry orders for bronchiolitis and timelier transition of IV to enteral antibiotics. Conclusion: The implementation of a HVC pediatric curriculum incorporating didactics and interactive case discussions is feasible and results show improved knowledge about HVC. HVC improvement projects augmented curricular knowledge gains, translating into behavior change.

★ Winner - APPD Quality Improvement (QI) Project Award ★

2. A QUALITY IMPROVEMENT PROJECT TO IMPROVE TIMELINESS OF SUBMISSION OF FELLOW EVALUATIONS BY NEONATOLOGY FACULTY
Mackenzie S. Frost MD, Allie Austin, Andi Scarborough, Luc Brion MD, University of Texas Southwestern Medical School, Dallas, TX

Background Evaluation of pediatric trainees by faculty is an important and required part of any training program. Timeliness is also imperative as it is an Accreditation Council for Graduate Medical Education (ACGME) requirement that at least 90% of evaluations are received on time. Our neonatal-perinatal fellowship program has a total of 12 fellows who are evaluated by 42 faculty members. We recognized that our fellowship training program was not compliant with ACGME requirements as the majority of the faculty evaluations of our neonatal fellows were being submitted late. Aim Statement Our SMART aim statement was to increase the proportion of evaluations of University of Texas Southwestern neonatology fellows completed on time by faculty to 90% by the end of the academic year. Interventions Background data for on time evaluation submission was collected over 11 rotation blocks. The fellowship program directors and coordinators created process maps and designed interventions. Three Plan-Do-Study-Act (PDSA) cycles were completed. Cycle 1 interventions included individual email and ad hoc phone calls reminders to faculty. Cycle 2 introduced a standardized timeline of 4 reminders before the evaluation due date with the last reminder being given directly by the program director. Cycle 3 added text pages in addition to emails starting with the first reminder. Data analysis was performed with Statistical Process Control. Measures Process Measures are compliance with the standardized reminder process, and number and type of reminders required. Outcome Measures are the percentage of evaluations completed on time. Results We had 87% compliance with the standardized reminder process during the last academic year. The percentage of evaluations completed on time increased from a baseline of 25% to 49% after PDSA cycle #1, 77% after PDSA cycle #2, and to 91% after PDSA cycle #3. Each cycle demonstrated special cause variation.

Conclusions and Next Steps A standardized text and email reminder system for evaluation completion was successful in achieving compliance with ACGME requirements for on time evaluation submission by faculty. Next steps include deadline for completion included in first email/text, automated email from evaluation system, and condensed reminder schedule to minimize burden on program staff.

3. FUNDING SOURCES AND FINANCIAL INSECURITY IN PEDIATRIC FELLOWSHIP PROGRAMS
Pnina Weiss MD, Yale-New Haven Medical Center, New Haven, CT; Angela L. Myers MD, MPH, Children’s Mercy Hospital, Kansas City, MO, Kathleen A. McGann MD, Duke University Hospital, Durham, NC, Katherine E. Mason MD, Brown University, Providence, RI, Jennifer C. Kesselheim MD, Med, Children’s Hospital/Boston Medical Center, Boston, MA, Geoffrey M. Fleming MD, Vanderbilt University, Nashville, TN, Christine Barron MD, Brown University, Providence, RI, Ann Klasner MD, MPH, University of Alabama Medical Center, Birmingham, AL, Melvin B. Heyman MD, University of California (San Francisco), San Francisco, CA, Doria L. Weiss, University of Michigan, Ann Arbor, MI, Elizabeth Mauer MS, Linda M. Gerber PhD, Erika L. Abramson MD, New York Presbyterian Hospital (Cornell Campus), New York, NY

Background: Shortages of pediatric subspecialists exist in many fields accompanied by insufficient recruitment of new fellows. The current system of funding graduate medical education is inadequate. No prior studies have described the funding sources of pediatric fellowships or the effects of funding constraints, including financial insecurity. Design/Methods: We conducted a national survey of pediatric fellowship program directors (FPD) between November 1, 2016 and February 9, 2017. Information about program characteristics and funding sources for salaries and educational expenses was collected. FPD were asked to rate their security regarding funding for academic year 2019 and later (AY2019+) on a sliding ordinal scale (very insecure to very secure; 0-4). Multivariable logistic regression was used to examine the association between insecurity and program characteristics and sources of funding for fellow salaries. Results: Data were obtained from 519 FPD, representing 14 different pediatric subspecialties, with a 65% overall response rate. The major sources of funding for fellows salary and educational expenses were hospital or Graduate Medical Education (GME)/Children's Hospital GME and division, respectively. Funding limitations restricted program size and access to educational resources in 23% and 36% of programs, respectively. Nineteen percent of FPD perceived their program as insecure in AY2019+. Programs were more likely to be
Insecure if the source of trainee salary was the division (OR 1.80 [95% CI 1.11-2.89], p=0.016) or extramural funding (OR 1.86 [95% CI 1.16-3.0], p=0.01). Programs with 7 or more fellows (OR 0.44 [95% CI 0.24-0.77], p=0.01) or programs receiving hospital or Children’s Hospital GME/GME funding in years 2 or 3 (OR 0.54 [95% CI 0.32-0.89], p=0.02) were less likely to be rated as insecure. Conclusions: Funding constraints in fellowship programs have limited recruitment and access to educational resources and led to financial insecurity. More stable funding of fellowship programs is critical to maintaining an adequate pediatric subspecialty workforce.

Winner - APPD 2018 Research Award

4. SPEAKING UP ABOUT TRADITIONAL AND PROFESSIONALISM-RELATED PATIENT SAFETY THREATS: A SURVEY OF PEDIATRIC TRAINEES
Jennifer Kesselheim MD, EdM, Children’s Hospital/Boston Medical Center, Boston, MA, Sigall Bell MD, Harvard Medical School, Boston, MA, Will Martinez MD, Vanderbilt University, Nashville, TN, Lisa Lehmann MD, Children’s Hospital/Boston Medical Center, Boston, MA, Julia Shelburne MD, University of Texas Health Science Center at Houston, Houston, TX, Jason Etchegary PhD, University of Texas Health Science Center at Houston, Santa Monica, CA, Eric Thomas MD, MPH, University of Texas Health Science Center at Houston, Houston, TX

Background: Safe and professional patient care depends on a culture in which health professionals speak up regardless of authority gradient. Objective: To measure pediatric trainees’ experiences, attitudes and factors associated with speaking up about traditional versus professionalism-related safety threats. Methods: An anonymous, cross-sectional survey was administered to 512 pediatric residents and fellows at two large US children’s hospitals in 2015. The survey queried attitudes about, barriers and facilitators for, and self-reported experience with speaking up. In addition, two safety vignettes (traditional vignette and professionalism vignette) assessed the likelihood of speaking up, anticipated assertiveness, and perceived potential for patient harm. Results: Of 223 participants (response rate 44%); 68% were female and PGY level was evenly distributed. Respondents more commonly observed unprofessional behavior (57%, 127/223) than traditional safety threats (34%, 75/223); p<0.001, but reported speaking up about unprofessional behavior less commonly (48%, 27/56 vs 79%, 44/56; p<0.001). Fear of conflict (45%, 100/223, for safety vs. 67%, 150/223, for professionalism; p<0.001) and concerns over getting someone else in trouble (46%, 102/223, for safety vs. 39%, 88/223, for professionalism; p<0.001) were the most commonly endorsed barriers to speaking up. Respondents more commonly indicated a high likelihood of speaking up in the traditional than the professionalism vignette (64%, 143/223, vs. 10%, 22/223; p<0.001) and this difference persisted even among respondents who perceived high potential patient harm in both scenarios (69%, 96/144 vs. 20%, 16/81; p<0.001). Respondents with a high likelihood of speaking up anticipated using assertive language more commonly in the traditional vignette than in the professionalism vignette (89%, 17/19, vs. 47%, 9/19; p=0.02). Conclusions: Responding pediatric trainees commonly observed unprofessional behavior yet were less likely to speak up about it, and less likely to use assertive language when doing so, compared with traditional safety threats even when they perceived high potential patient harm. These data highlight unmet needs for the culture of safety in pediatric practice.

5. BURNOUT IN PEDIATRIC RESIDENTS: FINDINGS FROM A NATIONAL LONGITUDINAL SURVEY
Maneesh Batra MD, MPH, University of Washington, Seattle, WA, John D. Mahan MD, Nationwide Children’s Hospital/Ohio State University, Columbus, OH, Charles Schubert MD, Cincinnati Children’s Hospital Medical Center/University of Cincinnati College of Medicine, Cincinnati, OH, Paris Wilson MD, MED, UPMC Medical Education, Pittsburgh, PA, Betty B. Staples MD, Duke University Hospital, Durham, NC, Janet R. Serwint MD, Johns Hopkins University, Baltimore, MD, Hilary McCafferty, University of Arizona, Tucson, AZ, Alan J. Schwartz PhD, University of Illinois College of Medicine at Chicago, Chicago, IL, Kathi Kemper MD, MPH, Nationwide Children’s Hospital/Ottawa State University, Columbus, OH

Background: Resident burnout is common and associated with poor health and sub-optimal patient care. Previous studies have involved small and/or cross-sectional samples and gaps remain in understanding predictive factors. Objective: Determine the prevalence of burnout among pediatric and med-peds residents in a national sample over 2 years, and characterize potential personal & programmatic risk/protective factors. Design/Methods: The Pediatric Residency Burnout-Resilience Consortium, a nationally representative sample of 46 programs, conducted an annual anonymous survey of residents in April-June of 2016 and
ELECTIVES

23. INTRODUCING SUGAR PACK! PRE-DEPARTURE ACTIVITIES CURRICULAR KIT FOR GLOBAL HEALTH ELECTIVES

Nicole St Clair, MD, University of Wisconsin, Madison, WI, Denise Bothe, MD, Case Western Reserve University/University Hospital Case Medical Center/Rainbow Babies, Cleveland, OH, Sabrina Butteris, MD, University of Wisconsin, Madison, WI, Carmen Cobb, MD, Medical College of Wisconsin Affiliated Hospitals, Milwaukee, WI, Emilia Connolly, DO, MPH, Cincinnati Children’s Hospital Medical Center/University of Cincinnati College of Medicine, Cincinnati, OH, Elizabeth Groothuis, MD, MPH, Ann & Robert H. Lurie Children’s Hospital of Chicago, Chicago, IL, Stephanie Lauden, MD, CTropMed, Nationwide Children’s Hospital/Ohio State University, Columbus, OH, Amy Rule, MD, MPH, Chuck Schubert, MD, Cincinnati Children’s Hospital Medical Center/University of Cincinnati College of Medicine, Cincinnati, OH, Sarah Webber, MD, University of Wisconsin, Madison, WI, Michael Pitt, MD, University of Minnesota, on behalf of the Midwest Consortium of Global Child Health Educators, Minneapolis, MN

LS08

Are you struggling to create a curriculum that addresses all aspects of global health (GH) elective preparation? Struggle no more! The SUGAR Team (Simulation Use for Global Away Rotations, sugarprep.org) is proud to introduce the latest innovation from the Midwest Consortium of Global Child Health Educators: SUGAR PACK® (Pre-Departure Activities Curricular Kit)

6. IMPROVING TRANSITION TO OUTPATIENT CARE FOR HOSPITALIZED CHILDREN

Meaghan S. Wido MD, Kristan E. Madison MD, Natalie Burman DO, MA, Naval Medical Center San Diego, San Diego, CA

Background Transitions of care from inpatient to outpatient settings are critical to prevent readmission and optimize continuation of care by primary care providers (PCP). For patients admitted to our pediatric ward, there was no uniform approach to notification of PCP of discharges. Additionally, there was no system to ensure continuity of care for outpatient follow-up needs.

Aim Statement Our aim is to improve discharge email notification to the follow-up providers and PCPs for pediatric patients admitted to 75% by May 31, 2018. Interventions Through our resident continuity clinic curriculum, the residents engaged stakeholders in both settings to create an interprofessional team consisting of nurses, providers, nurse managers, information technology specialists and clerk staff. This team created a structured system of daily list of discharges, confirmation of PCP, team nurse listserv, and electronic record modifications. Hospital course and follow-up data was transmitted to the medical homeport team via encrypted emails to the team nurse, follow-up provider and/or PCP. Measures Our primary outcome measure was the percentage of patients for which emails were sent to providers. Progress was tracked monthly. Multiple PDSA cycles were performed to iteratively improve the process and transition from a manual to a more automated process. Results We increased the number of discharge emails for patients following-up at our hospital-based clinic from initially untracked prior to January 2017 to 63% in November 2017. We implemented an administrative process that transitioned from the residents to the clerk staff in February, improving consistency of provider notifications. We reviewed our progress quarterly and made revisions with the resident team and other stakeholders to execute future PDSA cycles.

Conclusions and Next Steps We improved the process of transitions of care between inpatient and outpatient providers but have yet to achieve our aim. These changes were well received by the homeport team with feedback on increased efficiency in clinic, improved communication about follow-up testing and more PCP involvement. PCPs have requested notification of discharges when close follow-up is not scheduled. Our next step is to involve stakeholders for the clinics that are not hospital-based.
for global health elective preparation training. The purpose of SUGAR PACK is to provide educators with a comprehensive facilitator training package, paired with an easily adaptable curriculum, to effectively prepare trainees for GH electives in low-resource settings. SUGAR PACK is free, online, easy to implement, and highlights the following pre-departure topics: clinical competency with resource limitations; health, safety and wellness; ethics and culture; education and professional development; and debriefing. By adding to the existing preparation resources on sugarprep.org (including simulations and procedural training), educators now have a “total package” for preparation training materials, with the ability to tailor the package to individual needs. The workshop will make the case for the importance of a comprehensive preparation process, and guide participants through the process of preparation training by introducing innovative SUGAR PACK tools in small groups. The learning session will be fun, interactive, and intended to make educators feel comfortable implementing the package locally, even with no prior GH expertise. Participants will leave the session equipped to employ SUGAR PACK at their institutions, and will be empowered to adapt SUGAR PACK as necessary to meet their trainee and institutional needs. Session leaders are members of the Midwest Consortium of Global Child Health Educators, each with extensive background in preparing trainees for global experiences in low-resource settings. *SUGAR PACK will go live online just prior to the APPD 2018 meeting at sugarprep.org

24. ENTRUSTABILITY: CAN YOU MEASURE IT? INCORPORATING A CASE-BASED PEDIATRIC CLINICAL JUDGMENT EXERCISE TO ASSESS ENTRUSTABILITY OF INTERNs IN CRITICAL CLINICAL DECISION-MAKING
Kelsie L. Avants, DO, Pavan K. Srivastava, MD, Margarita A. Mankus, MD, Amanda D. Osta, MD, Michelle M. Barnes, MD, Stacy Laurent, DO, Claudia Boucher-Berry, MD, University of Illinois College of Medicine at Chicago, Chicago, IL

Imperial Salon B
As medical training is moving towards the assessment of learners within the framework of Entrustable Professional Activities (EPA’s), training programs have a growing need to develop tools to adequately assess entrustability of learners to perform various functions. The Association of American Medical Colleges (AAMC) developed the Core EPAs for Entering Residency to define the behaviors expected of medical students at the beginning of residency. In order to assess intern readiness to serve in the inpatient setting, we created a pediatric-specific unfolding case based on many of the functions described in EPA 10, “Recognize a patient requiring urgent or emergent care and initiate evaluation and management”. We utilized AAMC’s EPA framework, as opposed to the EPA framework developed by the American Board of Pediatrics (ABP), given that our focus was on learner transition to residency rather than to independent practice as a pediatrician. This exercise was designed to assess readiness to serve in the inpatient setting and as a formative exercise for interns. This case and assessment rubric have been successfully utilized with medical students and interns at our institution. During this workshop, participants will use small and large group formats to learn about one way of assessing entrustability, practice scoring the clinical judgment exercise, compare interexaminer reliability, and brainstorm ways to implement the tool in their programs. At the conclusion of the workshop, participants will leave with the necessary knowledge and tools to implement a clinical judgment exercise for assessment of learner entrustability to recognize a pediatric patient requiring urgent care and intervention.

25. SIMEDIATION: THE USE OF SIMULATION IN REMEDIATION TO DIAGNOSE, COACH, AND ASSESS STRUGGLING LEARNERS
Amanda Rogers, MD, Medical College of Wisconsin Affiliated Hospitals, Milwaukee, WI, Ariel Frey-Vogel, MD, Massachusetts General Hospital, Boston, MA, Dipti Mirchandani-Shah, MD, Hofstra Northwell School of Medicine at Cohen Children’s Medical Center, New Hyde Park, NY, Kimberly Collins, MD, Johns Hopkins All Children’s Hospital, St Petersburg, FL, Renuka Mehta, MBBS, Medical College of Georgia, Augusta, GA, Danielle Reed, MD, Children’s Mercy Hospital, Kansas City, MO, Rebecca Blankenburg, MD, Sarah Hilgenberg, MD, Stanford University, Palo Alto, CA, Caroline Rassbach, MD, Stanford University, Stanford, CA, Karen Mangold, MD, McGaw Medical Center of Northwestern University, Chicago, IL, Liahia Yemane, MD, Stanford University, Palo Alto, CA, Nancy Toifl, MD, MEd, University of Alabama Medical Center, Birmingham, AL, Shannon Scott-Vernaglia, MD, Massachusetts General Hospital, Boston, MA, Abigail Schuh, MD, Michael Weisgerber, MD, Medical College of Wisconsin Affiliated Hospitals, Milwaukee, WI

M103-M105
Remediation of struggling learners is a common yet challenging component of medical education. Barriers to success include insufficient opportunities to directly observe learners to fully understand their deficits, lack of safe and reliable situations for learners to practice necessary skills, and a paucity of high quality feedback to reassess progression following remediation. The use of SIMediation, or simulation in remediation, provides a unique opportunity to overcome these barriers by creating a predictable, safe, and modifiable environment that can be used to enhance the remediation process.

This interactive workshop will provide participants the knowledge, skills, and tools needed to use SIMediation in the diagnosis, coaching, and assessment of struggling learners. We will begin by having workshop participants share challenges encountered during remediation and brainstorm how simulation can be used to enhance the process. Facilitators will then outline ways simulation can be used in remediation. Next, facilitators will review key steps in developing effective simulation-based exercises and tips to avoiding common pitfalls. Workshop participants will then synthesize and apply what they have learned. Participants will self-select small groups focused on either 1. diagnosis of the learner’s deficiencies, 2. practice and skill development in the areas of the deficiencies, or 3. assessment at the end of remediation to determine readiness to conclude remediation. Each small group will select a common struggling learner (clinical reasoning, communication, etc) and, with the guidance of small group facilitators, will apply the concepts presented to create an outline of a simulation-based exercise that could be used as part of a remediation plan. Finally, facilitators will share examples of how they are currently using simulation in remediation. Participants will leave with an outline of each of the simulation-based exercises created by the small groups and access to a toolbox of additional cases, tools, and other resources they can use to integrate SIMediation into their own program.
26. BE A GRAPHIC ARTIST FOR A DAY: HOW TO DESIGN AND PRESENT POSTERS THAT GRAB ATTENTION

Gregory H. Gorman, MD MHS, National Capital Consortium, Bethesda, MD, Andreas Asnes, MD, Yale-New Haven Medical Center, New Haven, CT; Su-Ting Li, MD MPH, University of California (Davis) Health System, Sacramento, CA, Erika L. Abramson, MD, MSc, New York Presbyterian Hospital (Columbia Campus), New York, NY, Karen S. Vogt, MD, National Capital Consortium, Bethesda, MD

M101

Poster sessions can be a jungle, especially for the young investigator. After all of the hard research effort that culminates in an accepted research abstract, physicians then need to rely on skills of visual and oral presentation that are usually the realm of the marketing, graphic arts, and business fields. This workshop will give participants the basic skills of how to design and present a scientific poster to maximize its impact. Attendees will apply what they have learned to critique and improve real posters. Session leaders have expertise in designing, editing, and presenting scientific posters and include a graphic artist for an interdisciplinary look at a frequently neglected scholarly skill.

27. TEACHING RESIDENTS TO MITIGATE PREJUDICE (TRMP): USE OF AN EXPERIENTIAL COMMUNICATIONS COURSE WITH ROLE PLAY TO PREPARE RESIDENTS TO ADDRESS PREJUDICE IN THE WORKPLACE

Sylvia S. Choi, MD, Stephanie Dewar, MD, Evelyn C. Reis, MD, UPMC Medical Education, Pittsburgh, PA, Regina Toto, MD, Children’s Hospital of Philadelphia, Philadelphia, PA

L506-L507

The ACGME is committed to the principle that discrimination and harassment is unacceptable and must not be tolerated and that the environment for trainees will discourage discrimination and harassment by colleagues, supervisors, teachers, peers, other staff members, and patients. The AAP supports measures to improve culturally effective health care through training at all levels and increase diversity amongst pediatric providers. Neither organization address how providers can be trained to respond to discrimination from patients as the workforce becomes more heterogeneous. Clinicians may encounter discriminatory comments directed at themselves or others in the workplace and feel ill-equipped to respond. This creates conflict and can negatively impact patient care and resident well being. We have developed a communication course for pediatric residents focused on practicing skills to address expressions of prejudice during Family Centered Rounds. This course uses clinical scenarios and simulated parents for experiential learning. The residents can choose to practice responding to intolerant views directed at themselves or a teammate, using the hospital’s Code of Conduct or focusing on shared decision making. The process of learning is experiential and uses guided self-reflection, discussion among peers, and feedback from the simulator and faculty. Following participation in this course, residents felt better prepared to respond to discriminatory comments on rounds. During this interactive workshop we will demonstrate the Primary Teaching Method of guided facilitation and self-reflection, training of faculty facilitators, creating a safe learning environment for role play, and the specifics on essential resources will be reviewed. We will share the specific scenarios for the role plays. Participants will be given the opportunity to practice these scenarios using role plays so they can receive real time feedback from the course directors. Lastly, we will discuss how to create similar courses at other institutions.

28. HOW TO ENSURE SUCCESS IN YOUR COMMUNITY-BASED PEDIATRIC RESIDENCY (WITH OR WITHOUT AN ACADEMIC AFFILIATION)

Jerome G. Chen, MD, MHS, University of Florida (Orlando), ORLANDO, FL, Alison E. Niebanck, MD, Memorial Health-University Medical Center/Mercer University School of Medicine (Savannah), Savannah, GA, Adam D. Wolfe, MD, Baylor College of Medicine (San Antonio), San Antonio, TX, Chevon M. Brooks, MD, Morehouse School of Medicine, Atlanta, GA

M106-M107

Out of 197 pediatric residencies in the US, 85 (43%) are either university-affiliated and community-based, or solely community-based. Community institutions are generally smaller, are located in suburban and rural areas, are closely aligned with the community, and focus on patient care in a primarily clinical environment. Leaders of community-based pediatric residencies face different challenges than leaders of academic, university-based programs, including 1) Recruitment and development of faculty members 2) Interactions with employed versus contracted faculty members 3) Interactions with leadership, such as department chairs 4) Recruitment of residents 5) Curriculum development 6) Relationships with local medical schools 7) Promoting scholarly activity. We propose a novel Enhanced Learning Session to discuss these challenges in a 90-minute, highly interactive workshop format. The target audience will be PDs, APDs, and Chief Residents from community-based pediatric residencies. Since this is a new session that will gather like-minded people who may not have been together before and since the topic is broad, we will send a pre-meeting needs assessment survey to pre-registrants to solicit specific questions and distribute introductory reading in a flipped classroom format. We also will distribute material generated during the session and follow-up with participants after the meeting.

29. STRUCTURING FACULTY DEVELOPMENT USING A BLUEPRINT

Miriam E. Bar-on, MD, Oriaku Kas-Osoka, MD, MEd, University of Nevada School of Medicine (Las Vegas), Las Vegas, NV

Imperial Salon A

Faculty development is a key component of the ACGME program requirements in pediatrics (II.B.7). Having a blueprint facilitates timing and implementation of activities to meet both program and faculty needs. Further, correlating the blueprint to the cyclical GME calendar can better integrate topics as they are needed which addresses adult learning principles. In this highly interactive workshop, topics will be identified, categorized by target audience and assigned to the relevant part of the calendar or season. After a brief introduction to curriculum design and strategic planning, participants will assess their own faculty development needs taking into account resources as well as potential obstacles and document them on a matrix. The
large group will discuss a variety of modalities and venues to present their faculty development activities. Then selecting one participant’s faculty development needs, pairs of individuals or small groups will add content, modes of delivery and settings to the matrix. A flow diagram of the GME seasons will be distributed and the final small group activity will be to match the activities with the calendar to have an integrated package. Handouts,工具kits and matrices will be provided for participants to continue their work for their home institution. Before leaving, attendees will be asked to develop a timeline for designing and implementing their blueprints for their program.

30. HOW TO MAKE A DIFFERENCE: A NOVEL APPROACH TO TEACHING WHAT EVERY PEDIATRICIAN NEEDS TO KNOW ABOUT LEGISLATIVE ADVOCACY
Benjamin Hoffman, MD, Alison Empey, MD, Megan Aylor, MD, Beau Gilmore, MD, Monica Luttrell, MD, Oregon Health and Science University, Portland, OR
L401-L403
“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 are equipped with the knowledge and skill at all levels of advocacy, from individual, to community and policy levels. While many programs have developed curricula and programs to teach legislative advocacy skills, there remains tremendous variability in teaching methods, learning objectives and assessment of competence. 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, aligning them with published standards (CPTI CHAMP Mapping Tool). We will then introduce our legislative advocacy curriculum, which fully activates residents to demonstrate the core skills necessary for legislative advocacy while fitting within our noon conference schedule. We will then use a nationally recognized, peer-reviewed 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! We will also share a Google Site for participants to access resources referenced in the workshop, and to share further work.

31. CALLING THE CONSULTANT! THE EDUCATIONAL OPPORTUNITY OF THE SUBSPECIALTY CONSULTATION
Ross Myers, MD, Jessica Goldstein, MD, Ingrid Anderson, MD, Keith Ponitz, MD, Case Western Reserve University/University Hospital Case Medical Center/Rainbow Babies, Cleveland, OH, Katherine Mason, MD, Brown University, Providence, RI
L405-L406
Subspecialty consultations are common occurrences in medical centers, allowing opportunity for enhanced patient care through collaboration between subspecialists and hospitalists. The consultation also provides a unique platform for an educational exchange for all learners on both sides of the consult. Prior curriculum examining the educational aspects of the consultative interaction have been heavily focused on the subspecialty trainee. However, the full impact of this interaction can be experienced by all learners from both sides participating in both sides of the consultation. The purpose of this workshop is to provide a practical strategy to implementing a robust educational infrastructure to subspecialty consultation to benefit trainees at all levels on both sides of the consultative experience. After a brief introduction exploring the opportunities and challenges of this unique teaching moment, attendees will be engaged in a SWOT analysis of the consultation. Attendees will form small groups based on their primary type of learner: resident or fellow. Each group will then identify the opportunities and barriers to the resident/fellow consultative interaction serving as an optimal educational tool from their learner’s perspective. The groups will then switch their mindset to the perspective of the other learners and complete a similar exercise. Each group will then develop strategies for enhancing the educational aspects of this exchange which will be shared in a large group discussion. During this portion of the workshop, additional resources and approaches will be provided to augment those discussed in the small group to provide attendees with the tools needed. Methods to evaluate both residents and fellows on the consultative interaction will also be discussed. Attendees will leave this workshop with an educational approach to the consultation encounter that would be applicable to their home institution for trainees, hospitalists, and subspecialists.

32. CULTIVATING SELF-EMPOWERMENT TO ASSESS AND IMPROVE CAREER GOALS AND ENVIRONMENT.
Kristen Copeland, BA and Pamela Carpenter, MEd, C-TAGME, University of Utah, Salt Lake City, UT
Marquis D
Empowerment is the process in which an individual recognizes a connection between their goals and the individual’s perception of how best to achieve them. This allows a relationship between an individual’s efforts and life outcomes to develop. This workshop will explore statistics relating to the success of minority groups and administrators in reaching for and achieving raises, job satisfaction, and salaries. Based on the current research, the audience will discuss the definition of empowerment and how that can be used to assess and execute the need for possible job title change or salary increase. The workshop will focus on what the individual can do to be proactive in their process of promotion, professional development, and career satisfaction and will consist of didactic discussions, interactive breakout sessions, and an opportunity for a panel Q&A.
STRENGTHEN YOUR ERAS SKILLS!

35. GETTING THE MOST OUT OF ERAS FOR YOUR BEST RECRUITMENT SEASON EVER: A HANDS ON SESSION TO STRENGTHEN YOUR ERAS SKILLS!
Mackenzie S. Frost, MD, Deanna E. Bailey, BA, Cat Bailey, BA, University of Texas Southwestern Medical School, Dallas, TX

Imperial Salon B

Do you feel like you’re using ERAS to its full potential? Successful recruitment is crucial to pediatric training programs, but requires a significant amount of time and manpower. Making recruitment processes efficient and streamlined is key to recruitment success. Every training program uses ERAS during recruitment. However, many programs are unaware of the ways that ERAS can make recruitment more efficient and effective. This hands-on learning session will demonstrate these capabilities of ERAS, and participants will learn how to utilize them to improve recruitment. Participants must bring a laptop computer with internet capability and must have ERAS access in order to fully participate in this session. A team consisting of an associate program director and program coordinators will facilitate this session. After a brief introduction, facilitators will demonstrate how to create custom filters to use for screening applicants, and participants will create their own filters within their own ERAS accounts online. Next, participants will create a calendar using the ERAS self-scheduler that applicants can demonstrate how to create custom filters to use for screening applicants, and participants will create their own filters within

34. DEATH BY A THOUSAND PAPER CUTS: MICROAGGRESSIONS AND THEIR EFFECTS ON THE LEARNING CLIMATE
Michael J. Maurer, MD, Rachel L. Goldstein, MD, Luisa F. Valenzuela Riveros, MD, Alyssa Honda, MD, Michelle R. Brooks, C-TAGME, Hayley A. Gans, MD, Fernando S. Mendoza, MD, MPH, Stanford University, Palo Alto, CA, Yana Vaks, MD, Kaiser Permanente Medical Group (Northern California), Santa Clara, CA, Lahia Yemane, MD, Stanford University, Palo Alto, CA

M103-M105

Most healthcare providers have observed, committed, and experienced microaggressions (MA) at some point in their careers. The challenge is that MA are more insidious than overt discrimination and originate from unconscious biases. Microaggressions have major negative implications on the learning climate, individual provider well-being and patient care. In isolation, these incidents may be viewed as harmless, but cumulatively can have lasting effects. A growing body of literature exposing the negative effects of MA on the learning climate compels educators and institutions to educate trainees and faculty in how to recognize, process, respond to and prevent MA. In this session, participants will have the opportunity to learn about MA and their impact on the learning climate through interactive activities. Participants will begin with a reflection and small group discussion to explore their current understanding of MA, followed by a brief didactic on definitions and literature on this topic. With this knowledge, participants will begin experiential learning in a variety of role-play settings with debriefs after each scenario. Following these activities, small groups will work to create action plans to take back to their institutions on ways to improve their own learning climate. Participants will leave with an awareness of MA and their negative effects on the learning environment. They will acquire skills needed to recognize, process, respond to and prevent MA, as well as action plans to take back to their institutions to improve the learning climate.

33. EMPOWERING 21ST CENTURY LEARNERS TO OWN THEIR EDUCATION: TOOLS AND STRATEGIES FOR PROMOTING LEARNER DEVELOPMENT
Kimberly Giford, Dartmouth-Hitchcock Medical Center, Lebanon, NH, Daniel J. Schumacher, MD, MEd, Cincinnati Children’s Hospital Medical Center/University of Cincinnati College of Medicine, Cincinnati, OH, Patricia J. Hicks, MD, MHPE, Children’s Hospital of Philadelphia, Philadelphia, PA, Ann Burke, MD, Wright State University, Dayton, OH, John Mahan, MD, Suzanne Reed, MD, Nationwide Children's Hospital/Ohio State University, Columbus, OH, Lynn Thoreson, DO, University of Texas at Austin Dell Medical School Pediatric Program, Austin, TX, Laura Zastoupil, MD, University of Colorado, Aurora, CO

Marquis D

Many recent faculty development efforts focus on engaging learners in their education. The next step is not only to engage learners in their education but also to empower them to own their education. To do this, we must complement faculty development with learner development of lifelong learning skills, including: assessing, planning, and monitoring learning. The developmental progression of lifelong learning enables learners to take increased responsibility for their education, lessening faculty teaching demands while expanding the roles of mentor and coach. As learners engage in educational experiences to learn context-specific skills, they can simultaneously develop their lifelong learning skills. Educators can promote this learner development with tools and strategies to empower learners to manage their educational experiences through mentorship, coaching, and design of educational experiences. This session will begin with a roadmap describing the learner developmental stages. Facilitators will frame lifelong learning skills in three categories: assessment as a catalyst for learning, planning learning experiences, and monitoring learning by developing reflection, mindfulness, and other wellness practices. Participants will select a category of interest and join a small group discussion to generate a list of tools and strategies to promote the chosen lifelong learning skills and approaches to integrating them into existing learning experiences. The small group work will be shared with the large group with time for questions, additional ideas, and discussion of how to empower learners to own their education. Following the session, all participants will receive a toolkit that includes a summary of the ideas co-generated during the session as well as additional references and resources compiled by the facilitators.
use to schedule their interview day themselves. Participants will then learn how to create CSV exports, and will generate their own report during the session. Finally, participants will review the ranking and reporting tabs, and will practice utilizing them. The session will end with time for additional questions regarding ERAS functionality and additional practice of their new ERAS skills. Participants will practice all of these skills within their own ERAS account online, thus making future use of their newly created filters easy. Participants will also leave the session with handouts detailing step-by-step instructions for each functionality reviewed.

36. THERE’S LIFE AFTER THIS? EXPLORING CAREER PATHWAYS IN MEDICAL EDUCATION

Hilary M. Haftel, MD, MHPE, University of Michigan, Ann Arbor, MI, Debra Boyer, MD, MHPE, Children’s Hospital/Boston Medical Center, Boston, MA, Geoffrey Fleming, MD, Vanderbilt University, Nashville, TN, Dena Hofkosh, MD, MeD, UPMC Medical Education, Pittsburgh, PA, Katherine Mason, MD, Brown University, Providence, RI, Kathleen McGann, MD, Duke University Hospital, Durham, NC, Richard Mink, MD, MACM, UCLA Medical Center, Torrance, CA, Pnina Weiss, MD, Yale-New Haven Medical Center, New Haven, CT

Imperial Salon A

Career paths in medical education have changed significantly over the last few decades. Rather than being positions considered additive to one’s career aspirations, medical education is now a career path of its own. While many successful Program Directors and Clerkship Directors flourish in these positions for their entire careers, others may look for leadership opportunities beyond these roles, yet be uncertain what options are available and how to go about pursuing them. This interactive workshop will provide an introduction to the many career options available in medical education beyond program and clerkship directorship with frank and open discussion with medical educators who have pursued them. Attendees will undergo a visioning exercise using the INSPIRE1 model to help articulate what their long-term goals may be in medical education by developing their own mission and vision of the future based on their personal values. Attendees and workshop leaders will develop a list of resources and opportunities to help prepare participants to advance in their career and leadership roles. Lastly, attendees will develop a short-term and longer-term plan to define their pathway from here to there.


37. K(NO)W HISTORY K(NO)W SELF: RACISM IN MEDICINE SEMINAR

Camila M. Mateo, MD, Kate Antanovich, EdM, Christine Cheston, MD, Catherine Michelson, MD, MMSc, Children’s Hospital/Boston Medical Center, Boston, MA

M106-M107

With a national dialogue increasingly focused on the violent manifestations of racism and continued racial health inequity across all healthcare quality metrics, there is an ethical imperative to look inward as medical educators to improve our pedagogy on race and racism. Improving medical education on this topic is a necessary part of any plan to address the quality chasm that persists for minority populations. Despite this, there are few examples of anti-racism curricula within pediatric training programs. Given that America is largely racially segregated, cross-racial conversations about race and racism are unlikely unless they are intentional. This, coupled with a biomedical curriculum that often lacks protected spaces to discuss race and racism within a social context, can create a gap in baseline understanding of race, racism, and its effects on our patients and our practice. This seminar seeks to fill this gap by creating a shared foundational understanding of racism in medicine through the lens of our shared identity, responsibility, and historical legacy as providers with the ultimate goal of empowering participants to identify ways to dismantle institutional racism present in our everyday lives. This session will combine antiracism didactics, small group, and large group discussions into an interactive learning experience. Through the inclusion of several tenants of public health critical race praxis (race as a social construct, the use of storytelling to demarginalize minority voices, disciplinary self-critique) participants should leave the session with (1) a shared knowledge and vocabulary regarding race and racism, (2) an understanding of the historical legacy of racism within the medical institution, and (3) a critical lens from which to interrogate institutional racism in medicine at their current training levels in the exam room, the classroom, through research, and as future leaders.

38. NOT SO FAST! DO-IT-YOURSELF ULTRASOUND TRAINING FOR PEDIATRIC RESIDENCY PROGRAMS

Shannon Flood, MD, Ryan Good, MD, Andrew Krack, MD, Lauren Anderson, MD, Amanda Toney, MD, Jon Orsborn, MD, University of Colorado, Aurora, CO

L-401-L403

Point-of-care ultrasound, POCUS, is ultrasound performed by the provider at the patient’s bedside to answer a specific clinical question, and is now incorporated into numerous medical specialties for a variety of applications. Emergency Medicine residency programs have incorporated POCUS into their training for many years, and in 2015 the American Academy of Pediatrics released a policy statement recommending that PEM fellowship programs should provide POCUS training. However, no guidelines exist for training pediatric residents in POCUS and few pediatric specific POCUS training tools exist.

The goal of this workshop is to provide the rationale for POCUS training for pediatricians and a recipe for how to develop an individualized POCUS training program tailored to each program and institution. This workshop is NOT intended to train participants on how to perform POCUS, but rather is focused on teaching what is required to build an ultrasound training program and the wide range of potential applications that could be valuable for pediatricians. This workshop is aimed at residency program directors, chief residents and rotation directors interested in incorporating POCUS into their curriculum.

We will have six ultrasound machines available for hands-on practice and plan to limit workshop attendance to 24 participants to ensure a 4:1 participant to machine ratio in order to give participants sufficient time with the equipment. We plan to
introduce participants to several different types of ultrasound machines in small group sessions to provide exposure to a wide range of ultrasound machine types. Additionally, we plan to demonstrate a variety of ultrasound models, both low-cost homemade and commercially available, that can be used for POCUS training. Finally, we will discuss in small groups potential applications and barriers to incorporating POCUS training into individual pediatric residency programs and then report out to the large group. Participants of the workshop will acquire the knowledge and skills to implement an ultrasound training program catered to their own pediatric residency curriculum using the tools provided in the workshop as well as shared learning from other participants.

39. PEDIATRIC GLOBAL MORNING REPORT: AN OPEN, ONLINE EDUCATIONAL RESOURCE FOR AND BY RESIDENCY PROGRAMS
Marc I. Rabner, MD, MPH, Seiji Hayashi, MD, MPH, The Human Diagnosis Project, Washington, DC

Case conferences are an effective tool for training residents on a breadth of knowledge quickly and efficiently. However, due to work-hour restrictions, day-night schedules, multiple clinical sites, etc. these are increasingly difficult to organize and have full resident participation. Today's options for disseminating these teaching conference materials are limited to powerpoint presentations or screenshots of whiteboards, neither of which engage the learner in active learning. The Human Diagnosis Project is an open, online system that enables sharing of the best clinical cases across residency programs. A key innovation is that clinicians can post cases in 5-6 minutes, and once posted, can be solved as a brief case simulation by trainees anywhere at anytime. Through Pediatric Global Morning Report (GMR), the best of the pediatric clinical cases posted to the system are collected and distributed through daily clinical case simulations to trainees across the U.S. These teaching cases promote active engagement in the learning process and help trainees hone their clinical decision making skills. Enrolling in GMR is as simple as completing a brief profile online (<1 min). Residency programs can integrate GMR into their curriculum by: 1. Identifying a physician champion for their program (e.g., PD, APD, Chief Residents), 2. Posting at least one case conference case to the system monthly, 3. Providing contact information for their residents so they can be auto-enrolled in the program. To date, there have been over 1,000 case simulations posted. The average active participant solves 2.8 cases per week and surveys show that 84% of residents prefer the educational format of GMR's brief case simulations to multiple-choice questions. Through Pediatric GMR, trainees can learn from a variety of the most interesting pediatric cases in the country even if they are unable to attend case conference. GMR allows learners to be actively engaged in their learning and sharpen their clinical decision making skills with case based simulation. In this session, we will discuss the educational potential of GMR for Pediatrics. There will be time for teams of attendees to create their own and solve GMR cases.

40. MAKING IT STICK: HOW TO HARNESS THE POWER OF SPACED LEARNING & RETRIEVAL PRACTICE TO ENHANCE MEDICAL EDUCATION
Rebecca Wallihan, MD, Nationwide Children's Hospital/Ohio State University, Columbus, OH, Teri Turner, MD, MPH, MEd, D'Juanna White-Satcher, MD, Baylor College of Medicine (Houston), Houston, TX, Sara Multerer, MD, University of Louisville, Louisville, KY

Traditional methods of teaching often focus on repeated study for learning information, with quizzes or tests used only as summative assessment. Additionally, many curricula employ blocks of learning concentrated on a single topic, rather than spaced, or interleaved, learning. However, literature suggests both spaced repetition and test-enhanced learning can improve learner motivation and content retention. In medical education, the spacing and testing effects have been used to improve both knowledge retention and skill performance for medical students, residents, and faculty. In this highly interactive workshop, participants will discover the science behind spaced and test-enhanced learning and work in small groups to identify methods to implement these principles into their training programs, faculty development, and daily teaching. Participants will also work to move these techniques beyond medical knowledge and formulate strategies for their use in improving communication skills, procedural competence, and patient care.

41. EMPOWERING TRAINEES TO CARE FOR PATIENTS AND FAMILIES WITH LIMITED ENGLISH PROFICIENCY
Jessica D. Jones, MD, Kerryllyn Rice, MD, Coralee Del Valle Mojica, MD, MPH, Victor Cueto, MD, Meghan Stawitcke, Sara L. Salem, EdM, Elizabeth Talley, MD, Rebecca Blankenburg, MD, MPH, Stanford University, Stanford, CA

Patients and families with limited English proficiency (LEP) are at increased risk for poor quality of care due to communication barriers. The use of professional medical interpretation (PMI) is an indispensable component of clinical encounters involving patients and families with LEP, yet underutilization and misuse of PMI by trainees and other healthcare providers is very common. In this interactive workshop, participants will discuss common barriers that prevent trainees from adhering to best practices when using PMI. Using engaging activities and brief didactics, we will demonstrate strategies to promote appropriate use of PMI that can be incorporated into curricula at home institutions. In role-plays, participants will have the opportunity to practice in situ teaching of trainees in common clinical scenarios requiring the use of PMI. Small group discussions after each scenario will promote candid discussion of common challenges and ways to overcome them in real-time. After participating in this workshop, participants will have gained new skills to improve trainee education surrounding communication with LEP patients and families and will be empowered to help their home institution improve care for this at-risk population.
Poster Session Details

THURSDAY, MARCH 22, 4:45PM-6:15PM
Marquis A-C

PLEASE NOTE THAT POSTERS WILL BE ON DISPLAY BEGINNING AT 4:00pm

Posters will be separated in the following topic areas in the Poster Session:
- Bias/Diversity: Posters 1-2
- Social Determinates of Health/Poverty/Advocacy: Posters 3-4
- Global Health: Posters 5-8
- Clinical Skills/Simulation: Posters 9-15
- Entrustment/EPA/Milestones: Posters 16-25
- CCC/Program: Posters 26-38
- Feedback/Evaluation: Posters 39-42
- Teaching/Curriculum: Posters 43-73
- Wellness/Resilience: Posters 74-93
- Safety/QI: Posters 94-115

Congratulations to the following APPD 2018 Research Award winners:

APPD QI Project Award: Mackenzie S. Frost MD, University of Texas Southwestern Medical School, Dallas, TX – Platform Presentation #2 (see page 31)
APPD Research Award: Jennifer Kesselheim, MD, EdM, Children's Hospital/Boston Medical Center, Boston, MA – Platform Presentation #4 (see page 32)
APPD Trainee Research Award: Lisa N. Rasmussen, MD, University of California (Davis) Health System, Sacramento, CA – Poster #21 (see page 49)

BIAS/DIVERSITY

1. DIVERSITY IN RECRUITMENT: PROVIDING STRUCTURE TO MEANINGFUL DISCUSSION
Sarah M. Gustafson, MD, Tatiana Gellein, MD, Neema Pithia, MD, Alisha Ranadive, MD, UCLA Medical Center, Los Angeles, CA

Background: Diversity events are avenues to promote diverse recruitment of applicants for residency. Thoughtful discussions about diversity and diversity-related topics at these events can be difficult to achieve in short periods of time inclusive of introducing applicants to residents and residency leadership. To inspire genuine and thoughtful conversations, UCLA aimed to provide improved conversational structure to its annual diversity dinner recruitment series hosted at faculty homes.

Methods: Resident feedback on previous year’s diversity dinner series was solicited in a focus group via email and in-person discussion. Identified areas for improvement included a lack of structured conversation, an assumption that they are evaluated at the dinner, and applicants feeling “put on the spot” in a large group. To improve on these areas, each Fall 2017 dinner had a theme selected by the residents, for example, Race in Medicine and Discrimination in Medical Training. Formats included viewing TED talks on the topic or reading an article with the author present, followed by small group discussion. Interdepartmental collaboration involved diversity stakeholders inclusive of medical student committees and residents from other departments. An announcement was made during each dinner that there was no evaluation and honest discussion was encouraged. More detailed evaluations regarding content and discussions were emailed to all faculty, residents, applicants, and medical students who attended. Results: Preliminary feedback described increased in-depth discussion and genuine participation from stakeholders, applicants and trainees. A resident stated, “It was life-affirming for me to hear people talk about race and racism in real terms—like it’s a real problem.” Conclusions: Meaningful discussions resulted from the structured topics, reassurance about a safe space, and increasing the diversity of stakeholders present. In spite of sensitive topics, meaningful conversations can take place during recruitment with focused programming, stakeholders, and focused attention to providing a safe environment for rich discussion.

2. DEVELOPMENT OF AN INNOVATIVE DIVERSITY AND INCLUSION (D&I) EDUCATIONAL PROGRAM
Alice N. Hackett, MD, Jane E. Kramer, MD, Sherald R. Leonard, MD, Margaret A. Scotellaro, MD, Bridget L. Voigt, MD, Jean M. Silvestri, MD, Anna Spagnoli, MD, Susan Chubinskaya, PhD, Rush University Medical Center, Chicago, IL

BACKGROUND: To provide high quality care, health systems must establish an atmosphere of respect for diverse cultural experiences, beliefs, and values. Building a healthcare team that reflects the culture of the community they serve is key to achieving this goal. OBJECTIVES: To improve the culturally sensitive care of our patients, the Department of Pediatrics at Rush University Medical Center established a D&I Task Force. This team developed a multi-faceted curriculum for faculty, residents, and staff with the goal that participants better appreciate their own biases and improve their cross-cultural
sensitivity. Ultimately, we hope to improve the climate in our department around these issues, enabling us to recruit a more diverse workforce. METHODS: The curriculum includes three surveys: implicit bias, inter-cultural competency, and pre- and post-assessments of the department’s cultural climate. A mandatory half day retreat is held with guest speakers discussing equity, inclusion, and cross-cultural sensitivity. Thereafter, monthly interactive workshops are held on related topics (race, gender, disability, and sex discrimination, implicit bias, healthcare disparities, etc.). Attendance is monitored and CME credits are provided. Faculty who interview residency applicants participate in a role play session to raise cultural awareness and recognize bias. The program will be assessed annually via the climate survey to establish improvement and identify next steps. RESULTS: The pre-program climate survey identified instances of bias experienced by departmental stakeholders. A post-retreat survey revealed a high level of satisfaction among participants. Each participant received an individual assessment of their culture survey. The post-program survey will be administered at the end of the academic year and repeated annually. Results will be shared with the department. CONCLUSIONS: Rush Pediatrics D&I Educational Program is a novel, multi-faceted curriculum that addresses bias and improves cultural sensitivity within a Department of Pediatrics. This is a model that can be adapted to other academic institutions.

SOCIAL DETERMINANTS OF HEALTH/POVERTY/ADVOCACY

3. AN ONLINE EDUCATIONAL MODULE TO ADDRESS ADVERSE CHILDHOOD EXPERIENCES AND TRAUMA-INFORMED CARE FOR THE PEDIATRICIAN

Anna Schmitz, MD, Kelly Hodges, MD, Susan Light, MD, Lynn Sheets, MD, Medical College of Wisconsin Affiliated Hospitals, Milwaukee, WI

Background: The epidemic of adverse childhood experiences (ACEs) and toxic stress has many known health consequences to children and families, and extensive literature exists linking ACEs to increased morbidity and mortality. Pediatricians are in pivotal positions to help families understand ACEs and their impact, and to practice trauma informed care (TIC). Despite the significance of ACEs and TIC, structured education was not available to pediatric residents within our program. Residents baseline understanding, comfort, and perceived importance of these topics is currently unknown. Objective: Our primary objective was to identify pediatric residents baseline understanding, comfort, and perceived importance of ACEs and TIC. Our secondary objective was to develop an online educational module designed to improve understanding of and comfort with ACEs and TIC. Design/Methods: Surveys were administered to residents using a 5 point Likert Scale (1: low, 3: neutral, 5: high) to assess knowledge and confidence in ACEs and TIC. These results are shown in Figure 1 as the median response score (n=28). Module developers attended an ACEs training and reviewed published research. A self-directed, interactive module was designed, edited by stakeholders, and offered to pediatric residents as part of the Child Advocacy rotation. Results: Baseline survey results demonstrate that residents do not feel confident in discussing ACEs, TIC or resiliency (median = 2/5) with patients and families. Although residents feel it is very important to discuss ACEs, toxic stress and resiliency with families (median = 5/5, very important), they report rarely discussing these topics with families in clinic (median = 1/5 or 2/5, no visits or rare visits). Conclusions: Development of an educational module established consistent ACEs and TIC education for pediatric residents within our program. The baseline survey results highlight the need and importance for education on this subject among residents. Further information is needed to determine if the educational module is an effective means to deliver this information. Post module surveys are being sent 1 to 3 months after module completion and will be compared to pre-module results. If proven effective, the module can be adapted to other residency and healthcare provider training programs, to enhance knowledge, awareness and confidence in ACEs and TIC.

4. IMPACT OF SOCIAL DETERMINANTS OF HEALTH CURRICULUM ON RESIDENT EMPATHY

Jennifer B. Peralta, MD, Danielle F. Smith, MD, Carol Duh-Leong, MD, Anne Durstenfeld, MD, Rhonda G. Acholonu, MD, Montefiore Medical Center/Albert Einstein College of Medicine, Bronx, NY

Background: Understanding social determinants of health (SDH) is an essential component of pediatric health care delivery, yet remains an underemphasized competency in residency education. SDH have been shown to be a risk factor for poor outcomes in almost every pediatric disease. We believe competency in SDH furthers physicians understanding of the structural environments in which patients live while simultaneously allowing for the delivery of individualized, effective and empathetic care. Objectives: To evaluate baseline empathy levels of pediatric residents and examine the extent to which a curriculum on SDH increases empathy and increases residents’ comfort with exploring patients’ SDH. Design/Methods: We developed an empathy-based learning curriculum which practices approaching patient interactions by reflecting on one’s own background and relating them to the experiences of patients. The goal is to utilize interactive and reflective exercises to strengthen the empathy muscle thereby facilitating better relationships with patients. The curriculum includes 6 1-hour sessions covering implicit bias, education and career opportunities, food insecurity, home and built environment, violence...
5. IMPLEMENTATION OF A VOLUNTARY AND RESIDENT-RUN GLOBAL HEALTH SIMULATION FOR PEDIATRIC RESIDENTS USING THE SIMULATION USE FOR GLOBAL AWAY ROTATIONS CURRICULUM

Fiona A. Pirrocco, DO, Ian Goodman, MD, University of Massachusetts, Springfield, MA

Background: Use of the Simulation Use for Global Away Rotations (SUGAR) curriculum has been shown to improve global health preparedness for residents. Often this is led by global health attending faculty however a resident-run curriculum offers several potential benefits including resident-centered learning and an opportunity for residents with interest in global health to gain confidence in a leadership role. Residents are also likely to provide feedback to each other differently than they would to attending faculty. Objective: To assess feasibility, benefits, and limitations of a voluntary, resident-run global health simulation. Methods: We implemented resident-run simulations using the SUGAR curriculum to pediatric residents on a voluntary basis. We have conducted multiple sessions over the last three years (N1, N2, and N3) with collection of feedback after each session. After each session, 30 minutes were reserved for in-person feedback and debriefing. A follow-up email was sent to each participant for additional feedback. Conclusions: N1 feedback included recommendations for more technical skill didactics. N2 feedback also expressed interest in learning technical skills and medical didactics with less time focused on emotional preparedness. N3 feedback included recommendations to conduct simulations during the day while on elective rotations for ease of scheduling and to allow residents to fully focus on the cases. Over three years, several interested residents have also been given opportunities to fully lead simulations using resident feedback from prior sessions. Conclusions: A resident-run SUGAR curriculum is not inferior to an attending-run model and helps to train residents with global health interest in leadership roles as well as adapt cases based on resident feedback.

6. QUALITATIVE ANALYSIS OF POST-TRAVEL REFLECTION ESSAYS FROM AN INTERNATIONAL HEALTH ELECTIVE IN TANZANIA

Laura Eder, MD, Margaret Westwater, MD, McGaw Medical Center of Northwestern University, Chicago, IL

Background: Pediatric resident interest in global health is increasing and studies have shown educational benefits of international health electives (IHEs). Reflection essays are useful tools in evaluating IHEs. Lurie Children’s residency offers a teaching-focused IHE in Mwanza, Tanzania. The rotation includes pre-travel preparation and post-travel debriefing with a required, open-ended reflection essay. Objectives: Qualitatively analyze reflection essays of participants in the Tanzania IHE in order to examine the experiential themes and to find areas for improvement in the preparatory program, in-country experience, and post-travel debriefing. Methods: After de-identification, 42 essays from 2011-2016 were analyzed. The essays were independently reviewed by two researchers and a combined list of 45 themes was generated. Each essay was labeled as overall positive, negative, or neutral. A secure qualitative analysis program (Dedoose) was used to code passages after which theme counts were generated. A third party reviewer was available for any discrepancies in coding or theme identification. Results: The most common theme identified was limited resources (81% of the essays). Other common negative experiences included death (69%), medical culture differences (64%), and frustration (62%). Common positive themes were feelings of gratitude (62%), dedication of the host staff and trainees (41%), and positive cultural experiences (33%). Themes related to educational experiences included the IHE being a valuable teaching experience (60%), learning about new disease processes (48%), and influence on future career (41%). Overall, 79% of the essays were coded as the resident having a positive experience. Conclusions: The Tanzania IHE is a positive experience for Lurie residents, offering a valuable teaching experience and the opportunity to learn about unfamiliar disease processes. There are opportunities for improvement in pre-travel preparation and debriefing during and after travel, with particular focus on experiences with limited resources, patient deaths, and feelings of frustration.

7. INFLUENCE OF GLOBAL HEALTH OPPORTUNITIES ON RESIDENCY PROGRAM SELECTION AND FUTURE CAREER PLANS

Caitlin Kaeppler, MD, Kristen Winsor, Kelsey Porada, Medical College of Wisconsin Affiliated Hospitals, Milwaukee, WI

Background: Global Health (GH) education and experiences are becoming more important among medical students and residents. However, not all residencies offer GH opportunities. Even fewer institutions have a formal GH curriculum. While the obvious benefit of GH education is to prepare one to practice internationally, studies show that international electives increase a learner’s communication skills, cultural humility, understanding of public health, and resource utilization. Therefore, skills obtained through these experiences may be applied to low-resource settings locally. 4th-year medical students applying for residency have not been surveyed on their interest, exposure, or future plans related to GH and its bearing on their residency program choice. METHODS: All 207 4th-year medical students at the Medical College of Wisconsin were surveyed. Data was
collected and analyzed through Qualtrics. RESULTS: 60 students responded (29%). 72% of students applying to Pediatrics or Medicine/Pediatrics rated GH experiences during residency as moderately important or higher. 28% of all students rated GH experiences as very important and 25% reported that they would only consider residencies with GH opportunities. 45% of students rated the presence of a formal GH curriculum in residency as at least moderately important. 42% of students who rated GH experiences in residency as moderately or very important plan to practice the majority of their career in the U.S.

8. GLOBAL HEALTH TRACK PASSPORT: AN INNOVATIVE MODEL FOR SELF-PACED, MULTI-CHOICE LEARNING FOR LONGITUDINAL CURRICULA

Risha Moskalewicsz, MD, Cindy Howard, MD, MPH, Tina Slusher, MD, Sophia Gladding, PhD, Emily Danich, BA, Ifelayo Ojo, MBBS, MPH, Michael B. Pitt, MD, University of Minnesota, Minneapolis, MN

Background: Implementing comprehensive global health (GH) training for numerous residents with varying schedules, interests, and skillsets is challenging. Objective: Convert our existing GH Track curriculum into an individualized, self-paced, trackable, competency-based program that takes into consideration different learning-style preferences. Methods: GH faculty and residents reviewed our existing track curriculum (published 2011) to identify gaps in content based on updated GH competency recommendations. We then created a GH Track Passport (Fig. 1) as a living e-document which includes 5 units, and provides access to 104 educational offerings. Learners can choose among several options to attain each objective including attending in-person lectures, watching embedded online modules, scheduling a discussion with select faculty, attending in-person simulations, or engaging in an assigned reading or writing exercise. By using the embedded Log It links, quarterly progress reports can be generated and shared with learners and their GH mentors. Conclusion: The GH Track Passport is an innovative (open-access) approach to individualizing a competency-based program within a busy residency program by giving learners an opportunity to choose among multiple educational opportunities.

First Two Pages of Global Health Passport – Full Document Available at tinyurl.com/GHPassport
assessed over time. Further investigation into sustained confidence in performing these procedures, increased confidence levels performing procedures and increased total number of procedures performed half way through administering immunizations was 9.42 vs 6.71. Conclusion: In formalizing a procedure week, pediatric residents demonstrated Mean confidence level performing urinary catheterizations was 7.85 vs 2.85, performing venipuncture was 6.57 vs 3.29, and IV placement was 5.42 for interns who completed the procedure week vs 2.00 for interns who had not completed the week. Logs were updated. Interns who completed the procedure week logged an average of 33.4 total combined procedures categorized as emergent, urgent or office-based for subgroup analysis. RESULTS: The return rate was 61.3%. Overall, there was little concordance between procedures pediatricians perform and opinions about their importance. Pediatricians said they almost never perform 11 of 13 ACGME/RRC procedures, yet rated all as moderately important. Pediatricians felt adequately prepared for all 13 procedures. Hospitalists and ambulatory care physicians practicing at the study institution were less likely (p<.01) to perform urgent and office-based procedures. Physicians located closest to the study institution performed fewer emergent, urgent and office-based procedures (p<.01). CONCLUSIONS: Our findings demonstrate a lack of concordance between procedures performed in the general pediatricians practice and those recommended by accrediting bodies. Further research and discussion is needed prior to the next procedural guideline revisions. REFERENCES 1. Accreditation Council for Graduate Medical Education. “ACGME Program Requirements for Graduate Medical Education in Pediatrics.” 2013. Available from: https://www.acgme.org/Portals/0/PFAssets/ProgramRequirements/320_pediatrics_2016.pdf. Accessed: 11/3/2016 2. Ben-Isaac E, Keefer M, Thompson M, Wang VJ. Assessing the utility of procedural training for pediatrics residents in general pediatric practice. J Grad Med Educ. 2013; 5(1); 88-92. 3. Oliver Jr. TK, Butzin DW, Guerin RO, Brownlee RC. Technical skills required in general pediatric practice. Pediatrics. 1991; 88: 670-673. 4. Dillman DA. Mail and internet surveys: The tailored design method (2nd Ed.). Hoboken, NJ; John Wiley & Sons, Inc. 2007.

10. POSTER WITHDRAWN

11. INTERN PROCEDURE WEEK INCREASES EXPERIENCE AND CONFIDENCE
Leslie S. Andersen, MD, David P. Radel, MD, Jason H. Homme, MD, Paul J. Galardy, MD, Mayo Clinic College of Medicine (Rochester), Rochester, MN
Background: In our recent ACGME surveys, graduating pediatric residents expressed limited preparedness to perform procedures such as venipuncture, IV placement, bladder catheterization, and immunization administration. Objective: Formalize bedside procedure training into the residency curriculum to increase total number of procedures performed by residents and improve confidence level in performing these procedures in practice. Methods: A week-long procedure experience was added to the intern float month and includes training and clinical practice in venipuncture, IV placement, bladder catheterization, and immunization administration. Training completion is documented on a pocket-sized procedure card. Residents electronically log procedures performed during residency. Confidence level in performing procedures was assessed through a survey. Results: At the time of review, 7 of 14 interns had completed the procedure week and all procedure logs were updated. Interns who completed the procedure week logged an average of 33.4 total combined procedures compared to an average of 2.3 total for interns who had not completed the procedure week and 2.4 total for second years at the same point in their training. A survey assessing confidence level performing procedures on a scale of 1 (not at all confident) to 10 (confident performing independently) was completed by all 14 interns. Mean confidence level performing IV placement was 5.42 for interns who completed the procedure week vs 2.00 for interns who had not completed the week. Mean confidence level performing urinary catheterizations was 7.85 vs 2.85, performing venipuncture was 6.57 vs 3.29, and administering immunizations was 9.42 vs 6.71. Conclusion: In formalizing a procedure week, pediatric residents demonstrated increased confidence levels performing procedures and increased total number of procedures performed half way through intern year when compared to other trainees. Further investigation into sustained confidence in performing these procedures, ongoing increase in total procedures performed, and improved procedural skills preparedness on ACGME survey data will be assessed over time.
Wednesday, March 20 – Friday, March 22
Atlanta, GA
www.APPD.org

12. DEVELOPMENT OF THE AUTONOMOUS SENIOR RESIDENT: A CHIEF RESIDENT-LED COACHING INITIATIVE
Jacquelyn Campbell, MD, Rachel Cafferty, MD, James Gray, MB, BCh, BAO, Erin Gutowski, DO, MPH, Erin King, MD, University of Minnesota, Minneapolis, MN, Maren Olson, MD, MPH, University of Minnesota, Saint Paul, MN

Background: With restricted duty hours and increasing faculty presence, pediatric residents struggle to obtain adequate autonomy to graduate as independent, confident pediatricians. A survey assessing perspectives on autonomy from graduates of the University of Minnesota pediatric residency program in 2017 revealed a perception of insufficient autonomy with only 31% of graduates reporting discussion of expectations for autonomy and leadership with their attendings. Objective: Develop and implement strategies for promoting senior resident autonomy during inpatient pediatric rotations through education and coaching with chief residents on site. Methods: Chief residents at two academic children’s hospitals incorporated brief coaching sessions for senior residents during orientation at the beginning of each rotation. Senior residents were encouraged to: (1) discuss expectations of team leadership with their attending, (2) position themselves on rounds to encourage junior trainees to present to them, and (3) speak first in rounds when communicating with families. Chief residents observed rounds to provide direct feedback to residents. Residents completed a survey at rotation end regarding which techniques they used and whether they discussed expectations. Results: Since the implementation of chief resident-led coaching, 33 senior residents have rotated through the two hospitals, of which, 88% completed post-intervention surveys. 52% of residents reported that they consistently set expectations with their attending physician and 41% cited improved autonomy as a result of this. 34% of senior residents perceived increased autonomy when oral presentations were directed at them. Conclusions: With chief resident coaching, more senior residents are discussing expectations with their attendings at the start of their inpatient rotations. As a result of these conversations and small behavioral modifications, resident perceptions of autonomy have increased. Increasing empowerment and autonomy of senior residents improves meaningfulness and competency leading to confident, independent pediatricians.

13. PEDIATRIC RESIDENT SELF-CONFIDENCE, NOT PAST EXPERIENCE, IS CORRELATED WITH THEIR ABILITY TO PERFORM BAG-MASK VENTILATION AND ENDOTRACHEAL INTUBATION
Joseph Resch, MD, Abby Smolcich, MD, Amanda Rogers, MD, Robert Treat, Medical College of Wisconsin Affiliated Hospitals, Milwaukee, WI

Background: The Accreditation Council for Graduate Medical Education (ACGME) Pediatric Residency Program Requirements state that pediatric residents must demonstrate competence in bag-mask ventilation (BMV) and neonatal endotracheal intubation. Many programs use the number of procedures residents log to determine when residents are deemed able to perform procedures independently. Many studies about resident procedure skills focus on ways to improve resident self-confidence in their ability to perform those skills. Less information is known about the correlation between residents prior experience performing procedures, their self-confidence in their procedural skills, and their actual procedural competence. An understanding of these correlations may help in interpreting the importance of logging numbers as well as reported self-confidence. Design/Methods: Residents were asked to quantify the number of times they had performed BMV and neonatal intubation and rate their self-confidence in their ability to perform these procedures on a 5-point Likert scale. They were then observed performing these procedures through the use of a standardized simulation scenario and task trainers. Their procedural competence was measured with a validated airway management checklist by a trained observer. The Pearson correlation coefficient between prior experience, self-confidence, and procedural competence was calculated. Results: 24 first-year pediatric residents completed the assessment. A correlation was seen between self-reported confidence and procedural competence (r=0.663, p<0.05). No correlation was seen between prior experience and procedural competence. Conclusion: Resident self-confidence in their BMV and neonatal intubation skills may be more indicative of their procedural competence than their prior experience performing these skills.

14. THE USE OF DIRECT OBSERVATION AND AN INDIVIDUALIZED SIMULATION WORKSHOP IS ASSOCIATED WITH IMPROVED RESIDENT CONFIDENCE IN BAG MASK VENTILATION AND INTUBATION SKILLS
Abby Smolcich, MD, Joseph Resch, MD, Amanda Rogers, MD, Robert Treat, Medical College of Wisconsin Affiliated Hospitals, Milwaukee, WI

Background: The Accreditation Council for Graduate Medical Education pediatric residency program requirements state that residents must demonstrate competence in bag-mask ventilation (BMV) and neonatal endotracheal intubation. Graduate survey results indicate that our graduates do not feel prepared to perform these skills. Limited information is known about resident competence which may be due to insufficient opportunities to directly observe their skills. Design/Methods: First-year pediatric residents were assessed performing BMV and neonatal intubation on task trainers using a validated checklist by a trained observer. Common themes related to strengths/deficits were noted and used to develop a simulation workshop. During the workshop, resident performance was evaluated using the checklist followed by a one-on-one hands-on educational session which identified knowledge gaps. Pre-post workshop confidence in procedure skills were calculated from an average of six five-point Likert scale items (5=strongly agree). Dependent t tests and Cohen’s d effect sizes were used to assess pre-post confidence between paired samples. Inter-item reliability determined with Cronbach alpha. Results: Thirty-seven residents completed the reliable (alpha=.86) assessment. Strengths identified included airway assessment and basic steps ofBMV. Deficits included equipment use and troubleshooting complications. Nine residents completed the subsequent individualized workshop. A significant (d=1.5, p<.001) increase in pre (mean (sd)=16.6 (3.8)) to post (24.4 (2.2)) confidence scores was reported. Conclusions: A one-on-one simulation workshop regarding BMV and neonatal intubation developed from direct observation of resident performance was associated with improved confidence in procedure skills. Next steps include a repeat assessment in the spring to determine if improved confidence is sustained and if it is associated with improved procedural competence.
15. GIVE IT A SHOT: PARTICIPATION IN JUST-IN-TIME IMMUNIZATION WORKSHOP FOLLOWED BY PEER INFLUENZA VACCINATION IS ASSOCIATED WITH IMPROVED RESIDENT CONFIDENCE IN IMMUNIZATION SKILLS

Amanda Rogers, Michael Weisgerber, Medical College of Wisconsin Affiliated Hospitals, Milwaukee, WI
The Accreditation Council for Graduate Medical Education (ACGME) Pediatric Residency Program Requirements state that residents must demonstrate competence in immunization administration. Despite a required simulation immunization workshop, graduate survey results indicate that our residents do not feel prepared to perform this procedure. Residents identify a lack of opportunities to vaccinate in a non-simulation supervised environment as a contributor to their lack of confidence. The Center for Disease Control recommends, and hospital policy requires, that all residents receive the influenza vaccine unless contraindicated. This can be logistically challenging due to schedule restrictions. A just-in-time (JIT) immunization workshop followed by peer influenza vaccination could provide an opportunity for residents to receive their vaccination at work and gain experience vaccinating in a supervised environment. To assess the impact of a JIT immunization workshop preceding peer influenza vaccination on resident confidence in their immunization skills. We developed a voluntary session including a review of immunization administration and JIT simulated practice followed by supervised peer vaccination. All residents were surveyed one month post session rating their confidence administering immunizations on a 5-point Likert scale. Mann Whitney U test was used to compare residents who participated to those who did not. One third of residents participated in the session (N=30). On one month follow up, residents who participated were more likely to report feeling confident in their immunization skills than those who did not (p=0.02). A JIT immunization workshop followed by peer influenza vaccination provides an opportunity for residents to receive their required immunization at work and is associated with improved resident confidence in their procedural skills. Next steps include assessing if session implementation is associated with changes in ACGME graduate survey results and number of immunizations residents log.

16. ENTRUSTABLE PROFESSIONAL ACTIVITIES (EPAS): MAPPING PERFORMANCE TO MILESTONES

Bethany Auble, MD, MEd, Kris Saudek, MD, Danita Hahn, MD, Amanda Rogers, MD, Abigail Schuh, MD, Robert Treat, PhD, Michael Weisgerber, MD, MS, Medical College of Wisconsin Affiliated Hospitals, Milwaukee, WI
Background: Entrustable Professional Activities (EPAs) are elements that can be used to assess the scope of practice, knowledge, skills, and attitudes. The American Board of Pediatrics (ABP) has identified 13 specific EPAs and mapped these to several sub-comptencies (SC) thought to be contained within an EPA. The ABP mapped EPA3 (care of the well newborn) to the SCs: PC3, PC5, MK2, ICS1, PP7 and EPA4 (management of acutely ill patient) to PC1, PC5, PC6, PC7, MK2, ICS1, ICS6. While this makes theoretical sense, this association has not been formally studied. Objective: We aim to evaluate the relationship between two EPAs and specific SCs. Methods: We conducted a one-year cohort study of evaluations which included both EPA3 and EPA4 and ABP-mapped SCs. A 5-point scale with 0.5 increments was used both for EPAs and SC milestone levels (1-5). Pearson correlations were used to describe the relationship between mapped SC and EPAs. Cross-tabulation was used to analyze the frequency a given EPA rating back-mapped to a specific SC milestone level. Multivariate linear regression was used to analyze the most impactful SC on EPAs. Results: From July 2016 to June 2017, every intern was evaluated during a newborn nursery rotation (n=30) and 6 inpatient blocks (n=155). Correlations between the individual SCs and EPA3 were r=0.399 to 0.709 (p<0.001) and with EPA4 were r=-0.347 to 0.644 (p<0.001). Cross-tabulations showed when EPA3 was rated a 3.0, 78-85% of mapped SC were rated milestone levels 3 (+/- 0.5) and when EPA4 rated a 3, 78-91% of mapped SC were rated milestone level 3 (+/-0.5). Regression analysis revealed that PC6 (accurate examinations) and PROF3 (ethical behavior) were the best predictors of EPA 4 (R²=0.591, p<0.001) while PC2 (prioritizing responsibilities), PBLII (performing learning actions) and PC3 (hand-offs) were the best predictors of EPA3 (R²=0.676, p<0.001). Conclusions: We verified SCs mapped by the ABP with EPA3 and 4 are moderately correlated and a given EPA rating back maps to a milestone. The best predictors of EPA3 were exam skills and professionalism, and the best predictors of EPA 4 were prioritizing responsibilities, hand-offs, and performing learning activities.

17. PREDICTORS OF PEDIATRIC RESIDENT PERFORMANCE IN THE AGE OF MILESTONES-BASED COMPETENCY ASSESSMENT

Alan S. Chin, MD, James H. Lee, MD, UCLA Medical Center, Los Angeles, CA
BACKGROUND: Multiple studies have looked at predictors of residency performance, across specialties, with mixed results. However, these studies were all published prior to the use of milestones-based competency assessment. Using a post-positivism theoretical framework, we investigated whether the introduction of milestone-based competency assessment, which allows for increased specificity in evaluation of resident performance, can improve the ability to correlate predictors from the resident match process to specific residency competencies and performance. METHODS: We examined the relationship between Pediatric residency match criteria from ERAS applications and the interview process and PGY1 milestone-based competency assessment. We used an opportunistic sample of all intern classes from 2014-17 for categorical pediatric residents at UCLA. We utilized objective information, such as clerkship grades, MSPE overall ranking, USMLE scores, interview score, internal rank order list, etc. We assessed the association of these predictors with Clinical Competency Committee (CCC) milestones levels for the ACGME 6 competency areas at the end of the PGY1 year. Correlation coefficients and p-values were calculated comparing recruitment predictors to PGY1 average milestones levels in the 6 ACGME competency areas for each resident. RESULTS: Results showed that there is statistically significant correlation between recruitment interview scores and all 6 ACGME competencies, with correlation coefficients ranging from 0.19 to 0.41. MSPE rank percentage, when available,
also showed statistically significant correlation with Patient Care, Interpersonal Communication Skills, Systems-Based Practice, Problem-Based Learning, and Professionalism, with correlation coefficients ranging from 0.26-0.33. Other predictors also had statistically significant correlation with various ACGME competency areas, but none across as many competency areas as interview scores and MSPE rankings.

18. CONFOUNDING EFFECT OF TRAINING YEAR ON MILESTONES-BASED ASSESSMENTS
Daniel J. Sklansky, MD, Melissa A. Cercone, MD, John G. Frohna, MD, Kathleen A. DeSantes, MD, Megan F. Neuman, MD, University of Wisconsin, Madison, WI

Background: Many residency programs use milestones-based assessments to inform clinical competency committee (CCC) decisions. No studies have examined whether assessments are affected by resident training year. Association of higher milestones competency scores with higher training year could be confounded by unconscious anchoring bias from training year status. Objective: To determine if resident sub-competency scores increase more rapidly in the 6 month period between CCC sessions that corresponds to promotion from first to second year status (between-year) compared to the 6 month periods contained within the first and second training years (within-year). Methods: Two residency classes were studied over three academic years at our mid-sized residency program. Prior to semi-annual CCC sessions, end of rotation milestones-based sub-competency assessments were aggregated into a summary score for each resident. For resident classes beginning in 2014 and 2015, we calculated “improvement scores” by measuring the difference in aggregate scores between fall and spring of training year 1 (first within-year), spring of training year 1 and fall of training year 2 (between-year), and fall and spring of training year 2 (second within-year). Residents who left the program or changed classes were excluded. Mean improvement scores were compared using a T test assuming unequal variances. Results: A total of 4,363 individual sub-competency assessments were made by faculty for 25 pediatric residents. First and second within-year improvement scores were similar, at 0.264 and 0.176 (p=0.23), respectively. The mean between-year improvement score of 0.385 was significantly greater than the mean within-year improvement score of 0.220 (P=0.05), showing nearly double the rate of score improvement. Conclusion: Milestones-based assessment may be influenced by resident training year, as demonstrated by accelerated milestones score increases during the time period spanning training year promotion. Further studies should evaluate efforts to minimize the potential non-competency anchored effect of training year status on milestones score assignment.

19. PEDIATRIC FELLOWS ARE NOT EXPECTED TO ACHIEVE “ENTRUSTMENT” AT GRADUATION FROM FELLOWSHIP
Richard Mink, MD, MACM, Los Angeles County-Harbor UCLA Medical Center, Torrance, CA, Carol Carraccio, MD, MA, American Board of Pediatrics, Chapel Hill, NC, Bruce Herman, MD, University of Utah, Salt Lake City, UT, Jeanne Baffa, MD, Sidney Kimmel Medical College at Thomas Jefferson University/duPont Hospital for Children, Wilmington, DE, Jill Fussell, MD, University of Arkansas for Medical Sciences, Little Rock, AR, Jennifer Kesselheim, MD, EdM, Dana-Farber / Boston Children’s Cancer and Blood Disorders, Boston, MA, Kathleen McGann, MD, Duke University Hospital, Durham, NC, Angela Myers, MD, MPH, Children’s Mercy Hospital, Kansas City, MO, Cary Sauer, MD, MSc, Emory University, Atlanta, GA, Diane Stafford, MD, Boston Children’s Hospital, Boston, MA, Pnina Weiss, MD, Yale-New Haven Medical Center, New Haven, CT, Alan Schwartz, PhD, University of Illinois College of Medicine at Chicago, Chicago, IL

BACKGROUND: Entrustable Professional Activities (EPAs) define the tasks expected of pediatric subspecialists in independent
practice. There are 7 EPAs common to all pediatric subspecialties, and at graduation, fellows may not have achieved the level in which no supervision is required. In addition, there may be different expectations among the subspecialties for the minimum level of supervision for graduating fellows, as well as the level required for independent practice. OBJECTIVES: For each of the 7 common subspecialty EPAs, to compare the expected minimum level for graduation with the level of entrustment and to determine if the difference between the two levels is similar among the subspecialties. METHODS: The Subspecialty Pediatrics Investigator Network surveyed all fellowship program directors (FPD) of the 14 ACGME accredited fellowships for which the ABP offers certification. Respondents were asked to indicate the minimum level of supervision expected for a graduating fellow and the level at which a practicing subspecialist should be able to perform the EPA leading to a safe and effective outcome using a previously validated 5-point level of supervision scale. The goal for participation was 75% of FPDs in each subspecialty. RESULTS: The response rate was 82% (660/820) with all subspecialties but one (at 67%) meeting the prescribed goal. In all EPAs except one (apply public health principles and improvement methodology), the level reported by FPDs for independent practice was greater than the expected level at the time of graduation. In addition, the magnitude of the difference between the two levels did not differ among the subspecialties for any EPA. CONCLUSIONS: FPDs in the subspecialties do not expect graduating fellows to meet levels required for independent practice for 6 of the 7 common pediatric subspecialty EPAs. This suggests that an appropriate infrastructure needs to be provided for junior faculty until they can achieve the level required for independent practice. Further study is needed to determine if fellow workplace performance is consistent with these FPD expectations.

20. EXPECTED FELLOW MINIMUM LEVEL OF SUPERVISION AT GRADUATION FOR THE COMMON PEDIATRIC SUBSPECIALTY ENTRUSTABLE PROFESSIONAL ACTIVITIES

Richard Mink, MD, MACM, Los Angeles County Harbor UCLA Medical Center, Torrance, CA, Alan Schwartz, PhD, University of Illinois College of Medicine at Chicago, Chicago, IL, Bruce Herman, MD, University of Utah, Salt Lake City, UT, David Turner, MD, Duke University Hospital, Durham, NC, Diane Stafford, MD, Boston Children's Hospital, Boston, MA, Cary Sauer, MD, MSc, Emory University, Atlanta, GA, Angela Myers, MD, MPH, Children's Mercy Hospital, Kansas City, MO, Jennifer Kesselheim, MD, EdM, Dana-Farber/Boston Children's Cancer and Blood Disorders, Boston, MA, Deborah Hus, MD, MEd, Baylor College of Medicine (Houston), Houston, TX, Pamela High, MD, Brown University, Providence, RI, Patricia Chess, MD, University of Rochester, Rochester, NY, Jeanne Baffa, MD, Sidney Kimmel Medical College at Thomas Jefferson University/dupont Hospital for Children, Wilmington, DE, Carol Carraccio, MD, MA, American Board of Pediatrics, Chapel Hill, NC

BACKGROUND: The Subspecialty Pediatrics Investigator Network previously created level of supervision (LOS) scales for each of the 7 common pediatric subspecialty Entrustable Professional Activities (EPAs). Still unknown are the minimum LOS required for graduation from fellowship and the importance of each EPA in the graduation decision. OBJECTIVES: For each of the 7 EPAs, to determine the opinion of fellowship program directors (FPD) about the minimum LOS a fellow must achieve to complete fellowship and whether a fellow would be allowed to graduate if this level is not met. METHODS: Through APPD LEARN, a survey was sent to all FPDs of ACGME accredited fellowships with ABP certification. The survey asked FPDs to identify the minimum LOS required for graduation and the importance of reaching this level in the graduation decision. The participation goal was 75% of FPDs in each subspecialty. The 10th percentile was set as the minimum level. RESULTS: The response rate was 82% (660/820) with all subspecialties except one (at 67%) meeting the goal. The expected lowest LOS at graduation differed (<0.05) across the EPAs. For the EPAs describing providing for/obtaining consultation and facilitating handovers, the minimum LOS was indirect supervision with discussion of information for selected simple and complex cases. For the other 5 EPAs, direct supervision and coaching was necessary. Whether a fellow would be allowed to graduate if the minimum LOS was not met also differed across EPAs (<0.05). 84% and 86% of FPDs indicated a fellow would not be allowed to graduate if the level for the consultation and handovers EPAs (respectively) was not met compared with 37% for the quality improvement and 31% for the leading the profession EPAs. CONCLUSIONS: Expectations differ for the minimum LOS required for graduating fellows across the common subspecialty EPAs. The relative importance of the EPAs in making the graduation decision also differ. Further study is needed to determine if fellows are meeting these expected levels and to understand the differences in importance.

★★ Winner - APPD 2018 Trainee Research Award ★★

21. EVALUATION OF PEDIATRIC RESIDENT COMPETENCY: MILESTONES COMPARED TO LEVEL OF SUPERVISION

Lisa N. Rasmussen, MD, Daniel J. Tancredi, PhD, Su-Ting T. Li, MD, MPH, University of California (Davis) Health System, Sacramento, CA

Background: The adoption of the Entrustable Professional Activities (EPA) framework suggests using level of supervision as the primary evaluation scale. It is currently unknown whether level of supervision or milestone ratings are better at differentiating levels of learners. Methods: Retrospective cohort study using resident evaluation data collected from July 1, 2011 to June 30, 2013 using a 6-point scale based on level of supervision required (1=substantial supervision needed; 2=moderate supervision needed; 3=occasional supervision needed; 4=minimal supervision needed; 5=no supervision needed; 6=ready to supervise others) and from July 1, 2013 through June 30, 2015 using 5-point milestone scales. Scores were normalized to 0 to 1 scale to permit comparisons between level of supervision and milestone scores, using inverse-variance weighted mixed-effects linear regression models for each of 8 similarly worded competencies. Regression parameters were expressed as annual rates of change in normalized scores in order to determine which rating system provides a clearer representation of post-graduate learner progression. The greater the mean evaluation rate of change (e.g. from PGY1 to PGY2), the stronger the ability to differentiate learner levels. Results: Data was abstracted on 68 residents and 140 person-years. Annual rates of change were...
higher for level of supervision ratings (0.12-0.17, 95% CI 0.12-0.18) compared to milestone ratings (0.10-0.13, 95% CI 0.08-0.14) with a statistically significant difference in slopes ranging from 0.02 to 0.05 indicating that the level of supervision ratings permit clearer differentiation of level among residents by post-graduate year. Conclusions: The greater slopes in resident progression for level of supervision rating than for milestones suggest that the level of supervision scoring provides a more clear measurement of resident progress. Level of supervision scoring similar to what is suggested in the EPAs may allow programs greater ability to differentiate between learner performance and identify struggling learners.

### Table: Annual Rates of Change Higher for Level of Supervision Ratings

<table>
<thead>
<tr>
<th>Competency</th>
<th>Annual Change in Mean Level of Supervision</th>
<th>Annual Change in Mean Milestone</th>
<th>Differences in Slope (95% CI)</th>
</tr>
</thead>
<tbody>
<tr>
<td>PCI: Gather Information</td>
<td>0.15 (0.14, 0.16)</td>
<td>0.13 (0.11, 0.14)</td>
<td>0.02 (0.01, 0.04)</td>
</tr>
<tr>
<td>PC4: Diagnostic/therapeutic decisions</td>
<td>0.16 (0.15, 0.18)</td>
<td>0.11 (0.10, 0.13)</td>
<td>0.05 (0.03, 0.07)</td>
</tr>
<tr>
<td>MK1: EBM</td>
<td>0.17 (0.15, 0.18)</td>
<td>0.12 (0.10, 0.13)</td>
<td>0.05 (0.03, 0.07)</td>
</tr>
<tr>
<td>PBL1: Identify limits</td>
<td>0.14 (0.12, 0.15)</td>
<td>0.11 (0.10, 0.13)</td>
<td>0.02 (0.004, 0.04)</td>
</tr>
<tr>
<td>PBL4: Incorporate feedback</td>
<td>0.14 (0.13, 0.15)</td>
<td>0.10 (0.09, 0.12)</td>
<td>0.04 (0.02, 0.06)</td>
</tr>
<tr>
<td>PROF1: Humanism</td>
<td>0.12 (0.11, 0.14)</td>
<td>0.10 (0.08, 0.11)</td>
<td>0.03 (0.01, 0.05)</td>
</tr>
<tr>
<td>SBP1: Coordinate care</td>
<td>0.15 (0.14, 0.16)</td>
<td>0.10 (0.08, 0.11)</td>
<td>0.05 (0.03, 0.07)</td>
</tr>
<tr>
<td>SBP3: Teamwork</td>
<td>0.14 (0.13, 0.15)</td>
<td>0.10 (0.08, 0.11)</td>
<td>0.05 (0.03, 0.06)</td>
</tr>
</tbody>
</table>

22. PEDIATRIC RESIDENT PREPARATION FOR COMMUNITY PEDIATRIC HOSPITAL MEDICINE

*Ann H. Allen, MD, University of Wisconsin, Madison, WI, Michelle Hofmann, MD, MPH, University of Utah, Salt Lake City, UT*

**Background:** Pediatric hospital medicine in community hospitals (PHM-CH) continues to expand and many pediatricians practicing in those hospitals are not PHM fellowship trained. Best strategies for preparing pediatric residents for PHM-CH careers are unknown but needed to design Accreditation Council for Graduate Medical Education (ACGME) procedural competencies, PHM core competencies, and clinical rotations to transfer relevant skills. **Objective:** To characterize educational experiences and needs of hospitalists practicing PHM-CH. **Methods:** Cross-sectional national survey of community hospitalists in 2017. Participants were from the American Academy of Pediatrics Section of Hospital Medicine community hospitalist listerv. Survey assessed demographics of community pediatric hospitalists. Using 5-point Likert scales respondents rated importance of ACGME-required educational units, procedural competencies, and PHM Core Competencies on preparation for PHM-CH. Survey results were analyzed using descriptive statistics. Results: 109 responses (25% response rate) were received. In community hospitals, 4% of pediatric hospitalists were PHM fellowship trained. Most clinical time was spent in the Newborn Nursery, Pediatric ward with/without trainees, and Emergency Department. ACGME-required procedural competencies rated as extremely important by two-thirds of respondents were bag mask ventilation, lumbar puncture, neonatal and non-neonatal endotracheal intubation, Neonatal Resuscitation Program, and Pediatric Advanced Life Support (PALS). PHM Core Competencies rated as extremely important by two-thirds of respondents were fluids and electrolytes, lumbar puncture, oxygen delivery/airway management, pain management, PALS, and radiographic interpretation. 99% reported that time in a community hospital should be required for residents seeking a career in PHM-CH. The most important Pediatric subspecialty rotations were Infectious Disease, Pulmonology, Cardiology, Neurology, Otolaryngology, Anesthesia, Radiology, and Surgery. The most important non-clinical PHM Core competencies included patient safety, leading a healthcare team, quality improvement, business practices, and transitions of care. **Conclusion:** These data inform program directors, faculty, and residents about competencies and rotations that might support successful careers in PHM-CH. Future efforts should focus on curriculum standardization to better prepare pediatric residents for PHM-CH.

23. PRELIMINARY EVALUATION OF AN INTERN CLINICAL ORIENTATION BASED ON THE AAMC CORE EPAS

*Meredith L. Carter, MD, Shirin Jafari-Namin, DO, Inova Fairfax Medical Campus/Inova Children’s Hospital, Falls Church, VA*

**BACKGROUND:** New resident physicians demonstrate a wide variation in readiness to perform the skills which are required at the beginning of residency. Most residency programs include an intern orientation, but the content and amount of time focused on clinical skills is variable. In response to concerns regarding the competency of new medical school graduates, the Association of American Medical Colleges (AAMC) has identified 13 core entrustable professional activities (EPAs) for entering residency. A focused needs assessment performed at Inova Children’s Hospital prioritized 5 of these EPAs for intern clinical orientation curriculum development: (EPA 2) Prioritize a differential diagnosis following a clinical encounter, (EPA 3) Recommend and interpret common diagnostic and screening tests, (EPA 4) Enter and discuss orders and prescriptions, (EPA 8) Give or receive a patient handover to transition care responsibility, and (EPA 10) Recognize a patient requiring urgent
or emergent care and initiate evaluation & management. Based on this needs assessment, the intern clinical orientation was re-designed for 2017. **OBJECTIVE:** Evaluate an intern clinical orientation curriculum based on the AAMC EPAs 2, 3, 4, 8, and 10. **METHODS:** The study used a single group pretest-posttest design of the 13 interns entering the Inova Pediatric Residency Program in 2017. Interns rated their level of confidence (5 point Likert scale) in 7 clinical tasks corresponding to 5 EPAs before and after a 30-hour clinical orientation. The outcomes were the absolute change in interns’ confidence levels for each task. Outcomes were analyzed using a Wilcoxon-Pratt signed rank test. **RESULTS:** Interns demonstrated a significant increase in their confidence levels for 6 of the 7 tasks (Z = -3.03--3.27, p < 0.005, r = 0.59-0.64) corresponding to 4 of the EPAs (3, 4, 8, and 10) following the clinical orientation (Table). No significant improvement was demonstrated in the task corresponding to EPA 2, which demonstrated a median change from 3 to 3.5 (Z = -1.89, p = 0.12, r = 0.37). **CONCLUSION:** An orientation prior to the start of intern clinical duties was effective in increasing intern confidence in 4 EPAs. Additional studies are required to evaluate this orientation curriculum with objective measures.

### 24. FACULTY MILESTONES FOR THE EDUCATOR’S CONTINUUM
**Savanna L. Carson, MS, Cambria Garell, MD, Jessica Lloyd, MD, Kate Perkins, MD, PhD, Deborah Lehman, MD, UCLA Medical Center, Los Angeles, CA**

**Background:** Adoption of ACGME Milestones for learner assessment has familiarized learners and faculty with the use of concrete behavioral descriptors to assess the trajectory of professional development. Just as these frameworks of observable behaviors have enhanced feedback and self-assessment for residents, faculty assessment also deserves increased specificity for educator development. Assessment of clinical teaching is important for the development of competence of clinician educators and is used for faculty promotion decisions. **Methods:** To address the need to provide specific faculty feedback, a pediatric departmental faculty milestone evaluation tool was developed. The descriptors were based on ABP milestones for teaching, supervision, leadership, feedback, professionalism, and systems-based practice, and modified to reflect observable developmental steps along an educator’s continuum, from novice to expert. The descriptors were designed to be evaluable by trainees at various levels (residents and fellows) and to better reflect competencies of clinician-educators. The tool was developed by medical education faculty and staff in consultation with trainees and other faculty members. The new 7 question milestone-based evaluation tool, utilized a 5-point descriptive milestone scale, as compared to the previous academic year’s faculty evaluation, which consisted of 14 questions, scored on a 5-point Likert scale (1, unsatisfactory to 5, outstanding). **Results:** 773 evaluations were administered in Fall 2017. The new evaluation tool resulted in a wider utilization of the 5-point scale when compared with the old evaluation tool. Top range scores (i.e., score of 5) were reduced by 12% when the milestone tool was used for evaluation (39% Top category of milestone score, 5229 data points) as compared to the older Likert scale form (52%, 5scores, 20239 data points). **Conclusion:** Compared to a more traditional and less descriptive Likert scale evaluation tool, the use of a milestone based evaluation tool provided a wider range of assessments, reduced standard deviations between evaluations, and potentially increased the validity of faculty evaluations.

### 25. LOW FIDELITY, HIGH VALIDITY OSCKE ASSESSMENT IN THE HIGH FIDELITY ERA
**Melissa Buryk, MD, MPH, Rhett Barrett, DO, Naval Medical Center (Portsmouth), Portsmouth, VA**

**Background:** Our Pediatric Residency has been conducting an annual Objective Structured Clinical Knowledge Examination (OSCKE). While anecdotally it appears that OSCKE scores provide a predictive index for board pass rates and as a formative tool to fill knowledge gaps, this theory has not been formally analyzed. **Objective:** To determine if OSCKE scores correlate with ABP scores similarly to ITE scores. To determine if knowledge from the OSCKE is retained 3 months following exam completion. **Methods:** The OSCKE is an 11 station examination with each station representing a core clinical subspeciality or general pediatric topic. Each station is worth a total of 15 points with a total possible scores of 165 points. Residents have 10
minutes per station with 2 minutes to transition and 2 rest stations. At the end of the exam residents are debriefed, in a group setting, regarding the objectives of each case. A short quiz with 2 questions per station was administered 3 months following examination. Data will be summarized using means/standard deviation for scores per class per year. Construct validity will be ensured by comparing class means within each year using ANOVA. In training examination scores will be compared with board examination scores using Pearson correlation for each class and each year. OSCKE scores and in training exam scores will be correlated with American Board of Pediatrics Score using Pearson correlation and logistic regression modeling. Post-OSCKE knowledge testing will be summarized by means/SD. Results: OSCKE scores demonstrated increasing class means by both within years and within class from year to year. PGY-3 OSCKE scores demonstrated higher Pearson correlation with ABP scores for past graduates than PGY-3 ITE scores. Post quiz demonstrated increased specific knowledge acquisition on compared with OSCKE for individual residents. Discussion: By combining the in-training exam with the OSCKE we hope to be able to both better identify learners in danger of failing the board exam who may be in need of additional remediation. The OSCKE has also proven to lead to medical knowledge retention.

26. ASKING THE RIGHT PEOPLE THE RIGHT QUESTIONS: THE USE OF APPRECIATIVE INQUIRY TO INFORM PROGRAM EVALUATION IN GRADUATE MEDICAL EDUCATION

Jennifer A. Rama, MD, MEd, Carla Falco, MD, Baylor College of Medicine (Houston), Houston, TX, Dorene Balmer, PhD, Children’s Hospital of Philadelphia, Philadelphia, PA

Background: Graduate medical programs must conduct an annual program evaluation as per the Accreditation Council of Graduate Medical Education (ACGME) common program requirements. Although general guidelines for program evaluation exist, innovative yet practical approaches to program evaluation are seldom reported. Appreciative Inquiry (AI) offers such an approach by focusing on successful moments, effective processes, and program strengths while also allowing for identification of problems by reframing deficiency-focused language into desires or possibilities. Objective: To describe a novel application of AI and demonstrate how it led to meaningful improvements in a GME program. Methods: An interview guide was developed to align AI concepts. Two faculty members conducted semi-structured interviews with a convenience sample of 11 recent alumni of a small fellowship program at Texas Children’s Hospital. The interviews were audio-taped, transcribed and reviewed. Data were categorized into one of AI’s four phases: 1.) Inquire, 2.) Imagine, 3.) Innovate, 4.) Implement. The fellowship committee reviewed the data and brainstormed ways to improve the fellowship program. Results: Alumni frequently talked about supportive learning relationships with faculty. Their desire for change tended to focus on improving specific topics or skills (e.g. end of life talks). Alumni also desired more preparation for faculty outpatient demands, particularly as it relates to seeing higher volumes of non-acute patients. AI-informed program evaluation data were shared with faculty to reinforce the positive impact of their relationships on learning. Relevant stakeholders (e.g. palliative care) were recruited to implement curricular changes, and a community clinic rotation was added to expose fellows to higher volumes of patients with bread and butter diagnoses. Conclusions: AI is an innovative and practical approach to program evaluation that allows for the identification of actionable desires for change.

AI Phase | Purpose | Interview questions
---|---|---
Inquire | Identify what works well | Thinking back on your experiences during fellowship, tell me about a peak experience, a time you felt most proud or committed to your role as a fellow.
Imagine | Discuss possibilities and create a shared vision | What were the circumstances that made this experience possible for you? (e.g. end of life). What is important to you that makes that experience so memorable?

27. COMPARING COMBINED WEIGHTED ORDERED RANK LISTS TO TRADITIONAL EVALUATION METHODS FOR CREATION OF RANK LISTS FOR NEONATAL FELLOWSHIP APPLICANTS

Mackenzie S. Frost, MD, Andi Scarborough, BS, MBA, Allie Austin, Luc Brion, MD, University of Texas Southwestern Medical School, Dallas, TX

Background - Traditional ranking by comparing average scores assigned to applicants can be significantly impacted by which faculty interview and how those faculty assign scores. Kiger & Annibale proposed creating rank lists by merging ordered rank lists using the sums of pair-wise comparisons. Our program wanted to create an efficient comparison algorithm and to weight sums by the number of comparisons, thereby limiting bias that could result from variability in number of interviews per applicant. Designs/Methods - Each applicant was interviewed by four core faculty plus additional faculty members. Faculty assessed fellow applicants after interviews two ways: assigning scores (ranging from 1-10) using our traditional evaluations and by creating an ordered rank list of the applicants they had interviewed. Two overall rank lists were created, one using the average scores from interview evaluations and one from the ordered rank lists. The combined ordered rank list was created using Excel to sum pair-wise comparisons created for each interviewers ordered rank list and to weight these sums by the number of comparisons for each applicant. Including macros in the algorithm accelerated the process to < 1 minute. We then compared the rank list created by our traditional method versus the combined ordered rank list using SPSS. Results - 100% of interviewer's submitted ordered rank lists and scores for each applicant interviewed. 64% of applicants on our traditional rank list tied numerically with at least one other applicant. 30% of ordered rank lists had at least one mismatch when compared to the applicant's average scores. The combined ordered rank list for all faculty compared to the traditional rank list showed a R2
of 0.85, a Cronbach alpha of 0.96 and an intraclass correlation coefficient (ICC) of 0.92 (Fig 1). The combined ordered rank list for the core group compared to the traditional rank list showed a R2 of 0.95, a Cronbach alpha of 0.99 and an ICC of 0.97 (Fig 2). Conclusions - Adding macros to the algorithm yielded an efficient process for building a combined ordered rank list with separate ranks for each applicant. In contrast, the traditional rank list had tie scores for over half of the applicants. Ranking by both methods showed excellent correlation with increased reliability for the core group of faculty.

28. VALIDITY OF POOLED FACULTY EVALUATIONS IN A NEONATAL-PERINATAL FELLOWSHIP PROGRAM
Mackenzie S. Frost, MD, Luc Brion, MD, University of Texas Southwestern Medical School, Dallas, TX

Background: At University of Texas Southwestern (UTSW), faculty receive their evaluations from trainees only after 6 evaluations have been completed. The pooling of evaluations helps protect trainee anonymity, but faculty who are on service infrequently could go for years without receiving any evaluations while they wait for 6 to accrue. This is a significant issue because it limits feedback needed for faculty to improve performance and limits sufficient documentation for promotion.

Methods: The annual group evaluation was created including all the items included on rotation evaluations with additional questions on mentorship (based on validated tool by Fleming) and foundation in neonatal knowledge. The chief fellow would lead a group meeting of all fellows to complete annual evaluations for each faculty member. Three academic years of evaluation data were reviewed. The group evaluation was compared to our traditional individual rotation evaluation with Blant-Altman plots, Spearman Rho, and intraclass correlation coefficient (ICC). Results: The Blant-Altman plot of the two evaluations showed no significant difference. The Blant-Altman plot of the shared section of the two evaluations showed no significant difference. The shared sections of the two evaluations were correlated with a Spearman Rho of 0.59 (n=56). Mentors had significantly higher group evaluation scores than those with a single annual evaluation. After adjusting for those variables, the Spearman Rho increased to 0.69. There was no correlation between the rank of the latest rotation evaluation and the corresponding average of all rotation evaluations (Spearman Rho 0.20, p=0.19, n=41). In the subset of faculty with at least 3 rotation evaluations in a single year, the Spearman Rho was 0.37 (P=0.044, n = 30). The ICC between the shared items in the group evaluation and the average rotation evaluation within an academic year as 0.56 (p< 0.001). In contrast, the ICC between the latest rotation evaluation and the average rotation evaluation was 0.2 (p=0.10). This data was submitted to the Accreditation Council for Graduate Medical Education (ACGME), and the evaluation form was approved for use in our program. Conclusion: The group annual evaluation has good correlation and reliability when compared to our rotation evaluations. Using this ACGME approved evaluation tool allows more faculty to receive evaluations each year.
Background: Pediatric residency programs have many conferences and activities to meet the educational needs of their residents. The development of a specific experience to share the best practices in education amongst programs would be beneficial to pediatric training programs and residents. Objective: Implement and evaluate an exchange program where pediatric chief residents visit another residency program to experience a sample of the educational offerings of another institution. Methods: Chief residents from seven pediatric residency programs in the Mid-America Region of the Association of Pediatric Program Directors visited another institution in the region for a day during the 2016-2017 academic year. Chief residents participated in various activities directed to their individual interests including educational conferences, meetings with program directors, and discussions with faculty. Two surveys were administered to all participating chief residents. The first was sent approximately one month after the visit to assess the experience with the primary outcome being if any changes to educational conferences or curriculum were made or plan to be made at their home program based upon what they observed at the other. The second survey confirmed if any planned changes were enacted and also asked chiefs to reflect on what they gained from the exchange experience. Results: Ten pediatric chief residents participated in this program. Nine participants responded to the initial survey with 7 responding to the follow-up survey. All indicated they felt it was a worthwhile experience. Chief residents from two of the seven programs reported that they have made changes in their own program's educational offerings based on the visit to the other program. These enhancements include a new interactive morning conference structure, an intubation readiness checklist, and increased PICU nursing presence at mock codes. Conclusions: This exchange program was well received by the pediatric chief residents who participated and has led to change in educational offerings at some participating residency programs.

30. SUBSPECIALTY PROGRAM COMPLIANCE AND FELLOW EXPERIENCE WITH THE DELAYED PEDIATRIC FELLOWSHIP START DATE
Richard Mink, MD, MACM, Los Angeles County-Harbor UCLA Medical Center, Torrance, CA, Elaine Muchmore, University of California (San Diego), San Diego, CA, David Wininger, MD, The Ohio State University, Columbus, OH, Adam Turner, MPH, PMP, Laurel Leslie, MD, MPH, Gail McGuinness, MD, American Board of Pediatrics, Chapel Hill, NC, Dena Hofkosh, MD, MPH, UPMC Medical Education, Pittsburgh, PA

BACKGROUND: Residents are under contract to work until June 30, yet fellowships typically begin July 1, creating great difficulty for those who must relocate to another city. In 2014, the Council of Pediatric Subspecialties recommended that starting with the July 2017 appointment year, fellowships delay their start date (SD) and begin no earlier than July 7. OBJECTIVES: To determine if pediatric fellowship programs required their incoming fellows to report after July 1 and to gauge fellow experience in programs in which the SD was or was not delayed. Methods: In collaboration with the ABP, surveys were sent to pediatric fellowship program directors (FPD) and first-year pediatric fellows in the fall of 2017 asking whether their fellowship SD was after July 1, 2017 and about other concerns. To determine program compliance, data from the surveys were pooled. RESULTS: Response rates for the fellow (265/698) and FPD (458/803) surveys were 38% and 57%, respectively. Data from FPDs without any incoming fellows (n=51) or fellows not starting fellowship within 1 month after finishing residency (n=47) were excluded. Overall, 300/464 (64.7%) programs from 119 different institutions required their fellows to report after July 1. The most common reasons cited by FPDs for not delaying included institutional factors, concern for lack of health insurance and concern for an income gap. Of the 125 fellows for whom the SD was delayed, only 2(1.6%) indicated that a gap in income had a great impact and only 46.5%(59) had health insurance, with 28%(35/125) unaware of COBRA. 92% of fellows who reported on or before July 1 indicated they would have preferred a delayed SD. CONCLUSIONS: In the 1st year of implementation, most pediatric fellowships delayed their SD to after July 1. Fellows do not report difficulty with an income gap but < 50% had health insurance, with many unfamiliar with COBRA. 92% of fellows who reported on or before July 1 indicated they would have preferred a delayed SD. Fellows in programs in which the SD was not delayed strongly preferred that their fellowship had complied with the recommendations. FPDs need education about the desires of fellows and trainees need to be informed about COBRA.

31. RESIDENT CLINIC CONTINUITY
Perry Krumenacher, MD, Megan Neuman, MD, John Frohna, MD, Jens C. Eickhoff, PhD, University of Wisconsin, Madison, WI

Background: Continuity of care is one of the most important components of medical education. The lack of continuity has been linked to decreased patient satisfaction and poor resident well-being. Method: To address this issue, a single Pediatric Residency program implemented a longitudinal continuity curriculum to enhance the resident experience and improve patient care outcomes. Objectives: To determine if there was an improvement in patient visit volume and continuity, and to determine if resident perceptions of continuity improved. Results: There was an increase in patient visit volume from 2015 to 2016, with a significant increase in the number of consecutive visits seen by residents. Continuity was significantly greater in 2016 compared to 2015. Resident satisfaction surveys showed an improvement in perceptions of continuity. Conclusion: The longitudinal continuity curriculum was successful in improving patient visit volume and continuity, as well as resident perceptions of continuity.
Each FI was categorized into one of nine identified themes, which were then grouped further into overarching themes. The reviewers discussed to reach consensus. Results: 1,737 total FIs were documented over 30 years, ranging from 34 FIs (1993) to 612 FIs (2012). Each FI was ultimately tracked as Resolved, Ongoing or Unresolved. Through document analysis, we examined trends and themes in resident feedback to the RP over time.

Methods: Annual FI lists from 1986-2016 were reviewed. Each FI was coded by two independent reviewers. Themes were identified until no new themes emerged. If discrepancies in coding arose, the 2 reviewers discussed to reach consensus. Results: 1,737 total FIs were documented over 30 years, ranging from 34 FIs (1993) to 612 FIs (2012). Each FI was categorized into one of nine identified themes, which were then grouped further into overarching themes.

Background: Annually, our pediatric residency program (RP) asks residents to compile ideas to improve their training experience. This list of feedback items (FIs) is presented to RP leadership and is the basis for action items in the next year. FIs are ultimately tracked as Resolved, Ongoing or Unresolved. Through document analysis, we examined trends and themes in resident feedback to the RP over time. Methods: Annual FI lists from 1986-2016 were reviewed. Each FI was coded by two independent reviewers. Themes were identified until no new themes emerged. If discrepancies in coding arose, the 2 reviewers discussed to reach consensus. Results: 1,737 total FIs were documented over 30 years, ranging from 34 FIs (1993) to 612 FIs (2012). Each FI was categorized into one of nine identified themes, which were then grouped further into overarching themes.
categories including Education (e.g. improve cardiology rotation), Wellness (e.g. start resident big sibling program) and Patient Care Tasks (e.g. hire more case managers). By comparing percent of total FIs of each theme per year, trends over time were analyzed (Figure 1). While the percent of Education FIs was stable over 30 years, the percent of Wellness FIs decreased (47.6% of FIs in 1986; 15.9% in 2016). Patient Care Task FIs increased over time (2.4% of FIs in 1986; 36.2% in 2016). Regarding Unresolved FIs only, the percent of Education and Patient Care Task FIs slightly increased over time, while the percent of Wellness FIs declined (83.3% of Unresolved FIs were Wellness in 1986; 0% were Wellness in 2016). Conclusions: Pediatric resident feedback to the RP has changed over time. Increased Patient Care Task FIs may reflect increased focus on patient safety/patient experience or greater administrative patient care tasks. Decreased Wellness FIs over time and the decline in Unresolved Wellness FIs may reflect increased RP responsiveness to wellness secondary to awareness of physician wellness/burnout. Further investigation is required to understand observed trends and underlying causes, and will aid in anticipating/addressing changing resident training needs going forward.

35. PEDIATRIC FELLOWSHIP INTERVIEW SCHEDULING IN THE NEW ERA OF A UNIVERSAL FALL MATCH
Anna Plichta, MD, Michael Dolinger, MD, MBA, Alexandra Kilinsky, DO, Hofstra Northwell School of Medicine at Cohen Children’s Medical Center, New Hyde Park, NY

Background: The interview period for Pediatric Fellowships, which used to occur over a 2-yr period, is now concentrated in the fall of the PGY3 yr. All programs except for heme-onc and cardio participated in the fall 2017 match, and they too will join the process in 2018. While a fall match allows residents more time to prepare, the concurrent interview seasons create scheduling challenges for residencies. Programs have developed a myriad of ways to manage this challenge. Most limit a resident’s number of interviews or require use of paid time off (PTO). This puts a significant stress on resident wellness. Our goal was to establish a method to track and organize interviews, maintain wellness, elicit feedback, and improve the process for future recruitment seasons. Methods: Residents scheduled 2 wks of vacation when they anticipated the most interviews, and no additional PTO was required. To facilitate scheduling, they logged fellowship interview dates, in real time, using a Google form. A spreadsheet was used to help arrange necessary coverage. Residents were encouraged to schedule unlimited interviews on electives. Upon completion of interviews, residents completed a survey about the process, challenges to scheduling, and advice for future applicants.

An interview time line was created for each subspecialty fellowship. Results: At our institution, 17 of 32 PGY3s and 3 PGY4 chiefs participated in the fall 2017 match. They applied to 10 subspecialties. All 20 residents successfully matched. A total of 230 interviews were logged: 28 cancelled, 202 attended. Interview dates ranged from 7/28-11/17. The results of the individual subspecialty interview dates varied greatly (Fig 1). Only 6.5% of interviews occurred during previously scheduled vacation time. All residents had a favorable/neutral view of the logging process. Conclusion: We developed a user-friendly method to track and schedule interviews to minimize PTO and maintain wellness. Pilot interview recruitment date curves were created for many fellowships. This information can be used by programs in the future to guide optimal vacation and elective scheduling.
36. TEAMWORK MAKES THE DREAM WORK: HOW A GROUP OF COORDINATORS MADE MENTORING POSSIBLE
Jill Edwards, MBA, C-TAGME, Children’s Mercy Hospital, Kansas City, MO, Katherine Adams, C-TAGME, Lehigh Valley Health Network/University of South Florida College of Medicine, Allentown, PA, Michele R. Bialkowski, University of Colorado, Aurora, CO, Anita Smith, C-TAGME, Penn State Milton S. Hershey Medical Center, Hershey, PA, Teresa Hudson, C-TAGME, St. Louis University School of Medicine, St. Louis, MO, Stephanie McCartney, C-TAGME, Penn State Milton S. Hershey Medical Center, Hershey, PA, Emily Mitchell, MA, University of Colorado, Aurora, CO, Alice Del Rosario, BS, UCLA Medical Center, Los Angeles, CA, Jacqueline Riley, BS, Emory University, Atlanta, GA

BACKGROUND: APPD coordinator group mentoring has continually evolved with the goal of connecting a diverse group of coordinators to provide mentorship and support. One mentoring group, the IncredAbles, has found success in implementing a basic structure and consistent form of communication. The current method is: 1) A monthly 30-minute phone meeting is scheduled 2) Members submit topics of discussion for the agenda 3) Members call in and discuss agenda items. Additional questions discussed if time allows 4) Additional information or resources requested are sent via email along with minutes. The overall time to organize and report back to the members is 30 minutes monthly. OBJECTIVE: The primary objective of the data is to show the benefits of group mentoring and the measurable outcomes produced from a structure that allows for sharing best practices, assisting others with implementing new processes, and overall encouragement and support. METHODS: Several methods were used. First, 16 members were surveyed on their experiences as a member. Members were asked qualitative questions on perceived benefits of the group such as support, time saving measures, and help with projects and tasks. Second, specific examples were requested as to how the IncredAbles assists members in their programs and what they appreciate most. Third, two independent researchers thematically analyzed the 2016 and 2017 meeting minutes, and four common themes were chosen: information sharing, process improvement, encouragement, and scholarly activity. Then, six members were assigned five sets of minutes each to analyze independently and designate discussed topics with one of the four themes. Nine members then discussed the outcomes. Data was compiled by a member who had not been part of the analysis process.

RESULTS: Per the survey results, 66.67% noted that “support from peers” was the most helpful piece of the IncredAbles’ model. From the collection tools, one unique aspect reported was the ability to talk with pediatric coordinators, which differed from other medical education groups that usually consist of multiple specialties. In the thematic analysis of the meeting minutes, the following data was collected: 62 instances of information sharing, 28 of process improvement, 16 of encouragement, and 3 of scholarly activity. It was also noted that in instances of information sharing, there was usually another theme discussed in conjunction. CONCLUSION: The IncredAbles have been able to maintain membership and achieve success through consistent structure, collaboration and coordinator-driven content. Having pediatric coordinators with a variety of programs and types represented (residency vs. fellowship) expands the scope while remaining applicable. The group has been able to implement a process that allows for information sharing with measurable outcomes such as innovation within their individual programs as well as scholarly activity while encouraging peers. Due to the collective effort and input of all of the members, we believe the IncredAbles’ model can be used as a framework for success.

37. UTILIZING SPECIALTY IN TRAINING EXAMINATIONS AND ANNUAL PROGRAM REVIEW TO IMPROVE PROGRAM CURRICULUM
Ashley L. Siems, MD, Michael Bell, MD, Children’s National Medical Center, Washington, DC

BACKGROUND: The ABP offers Subspecialty In-Training Examinations (SITE) annually to provide a global assessment of one’s current knowledge in a subspecialty, and allows fellows, to some extent, predict their performance on subsequent certifying examination. Concurrently, an annual evaluation of the program is undertaken to assess the effectiveness of the existing curricula of courses provided to trainees during the year. While this information is readily available in most training programs, development of future curricula utilizing this information for the entire program has not been robustly studied. We developed a methodology using the results of the SITE and annual review as a needs assessment for curriculum development. Methods: The 2017 Pediatric Critical Care Medicine SITE score summary was used to identify subject matter where a majority (>80%) of the critical care fellows answered questions incorrectly; These were then cross referenced with curricula which occur monthly as to where they would be best suited. The curricula were also evaluated using the Annual Program Review. As one of the lowest scoring curricula and one with the highest proportion of targeted topics, the simulation curriculum was completely redesigned using the SITE exam areas of weakness. Individual simulation sessions were evaluated prior to and after curriculum re-design. Evaluation: 34 topics were identified. The average score for curricula was 6.2 ± 1.5 (range of 3.3 to 8.6). After the re-design, mean scores increased from 7.8 ± 1.2 from 6.2 ± 0.8 (n = 15 per year). Fellows indicated improvement in understanding of topics with an average rating on a five point scale improving from 3.8 ± 0.6 to 4.2 ± 0.4. Additionally, the fellows perceived the presenter to be better prepared and more organized. Conclusions: This curriculum design highlights that SITE scores and Annual Program Evaluations which are mandatory ACGME activities can be utilized to identify program wide areas of weakness and utilized in curriculum design.

38. MOTIVATIONS FOR VOLUNTEER ACADEMIC FACULTY INVOLVEMENT IN PROGRAMMATIC ADMINISTRATIVE TASKS
Jon P. McGreevy, MD, MSPH, Vasudha Bhavaraju, MD, Kiley Vander Wyst, MPH, Brigham C. Willis, MD, M Ed, Phoenix Children’s Hospital, Phoenix, AZ

BACKGROUND: Academic programs often rely on faculty without specific educational titles to volunteer their time for the integral tasks of training programs (i.e. mentorship, evaluation, remediation). There is currently no literature investigating why faculty choose to take on these extra roles. This study seeks to identify factors that motivate faculty to participate in non-teaching and non-research academic tasks and barriers to continued involvement as a means to engage more faculty into similar roles.
Methods: Using a Modified e-Delphi Survey Methodology, educational champions and core faculty, who do not receive protected time or other compensation for educational activities, were queried on their motivations and barriers for their efforts. Results: Three rounds of survey have been completed with response rates of 65% (35/54), 50% (27/54) and 48% (26/54). Faculty identified 7 themes to participate in these programmatic needs as: improve patient outcomes, keep up to date with changes in medicine, faculty find these activities fun, inspire others, provide a challenge in their career, pay forward what they received in training, and a sense of duty as a physician. Ultimately, the strongest motivators were the ability to inspire others followed by a sense of duty as a physician (ranked #1 or #2 by 47% and 42% of faculty respectively). Barriers to involvement were few and focused on 3 themes: Lack of protected time (100%), clinical demands of patient volume (89%) and lack of recognition for their work or effort (81%). Conclusions: The success of training programs depends on general faculty to take on program tasks, but it is unclear why some faculty choose to do so. In this study, motivators tended to be internal to the character traits of these faculty without a single mention of external motivation. Barriers to involvement are external to the character of the faculty. This study shows that while some barriers cannot be controlled by program leaders (i.e. clinical demands), there may be simple solutions to advocate for the extra efforts of our volunteer faculty through recognition and reward.

FEEDBACK/EVALUATION

39. RESIDENT PEER COACHING: A NOVEL LEARNING TOOL AND METHOD FOR FORMATIVE EVALUATION
Mallory B. Smith, MD, Matei S. Petrescu, MD, Sarah F. Denniston, MD, Baylor College of Medicine (San Antonio), San Antonio, TX

BACKGROUND: Peer coaching is a tool used in faculty development for continued training and evaluation. However, there have been limited reported uses of peer coaching in resident education. OBJECTIVE: Assess the utility of resident peer coaching and attitudes of residents towards peer coaching. METHODS: We reviewed the literature on peer coaching and translated a faculty peer coaching tool to the resident level. A pre-survey was used to assess baseline attitudes about peer feedback. Subsequently, residents participated in a peer coaching workshop and were introduced to a rubric designed to assess supervisory skills in the inpatient setting. These skills are represented in 9 ACGME pediatric sub-competencies: PC2, PC3, PC4, PC5, SBP1, SBP3, PROF1, PROF5, and ICS1. Residents voluntarily participated in peer coaching over 5 months. Following each session, the resident pair submitted an anonymous rubric and feedback documentation. Following completion of the peer coaching, residents completed a post-survey. RESULTS: Ten upper level residents took the pre-survey, 8 turned in rubrics and feedback documentation, and 9 completed the post-survey. All residents perceived peer feedback to be valuable on the pre-survey. Residents gave feedback to each other in areas of rounding efficiency, engaging learners, creating autonomy, teaching on rounds, and patient safety. On the post-survey, 67% reported that peer coaching was valuable and would recommend it to a colleague. Additionally, 33% felt more confident in their supervisory skills, and 85% changed their supervision techniques after participation. CONCLUSIONS: We found that residents did find peer coaching to be a valuable tool for learning and adjusted their practice after peer coaching. However, some residents reported they learn better in other settings. The data suggests peer coaching is a viable tool to incorporate into resident education. The use of this tool in formative feedback and how peer coaching might assist in resident progression along ACGME milestones warrants further study. We believe resident peer coaching is a valuable novel tool to enhance resident education.

40. DELIVERING FEEDBACK TO RESIDENTS USING A DOCUMENTATION ASSESSMENT TOOL
Danita R. Hahn, MD, Julie M. Kolinski, MD, Heather L. Toth, MD, Michael C. Weisgerber, MD, MS, Caitlin Pilon, BA, Amalia Wegner, MD, Medical College of Wisconsin Affiliated Hospitals, Milwaukee, WI

Introduction: Feedback is a crucial element of resident education, and Pediatric Hospital Medicine (PHM) faculty strive to provide feedback amidst multiple barriers. The use of a standardized tool to provide feedback on inpatient resident progress notes can simply the process for faculty while providing a framework for feedback about documentation. Methods: Education on the use of the standardized tool, the Physician Documentation Quality Instrument 9-item version (PDQI9), was provided. The PDQI9 evaluates the following attributes of documentation on a 1 (not at all) to 5 (all the time) Likert scale: up-to-date, thorough, useful, organized, comprehensible, succinct, synthesized, and internally consistent. Each PHM faculty member was asked to evaluate one progress note per resident per week using the PDQI9 and provide feedback. Survey data was obtained regarding PHM faculty opinion of the time spent on this process, as well as perceived improvement in resident and faculty progress note quality. Clinical teaching evaluations of PHM faculty by pediatric residents were also assessed. Results: Faculty were surveyed from February to December 2016 resulting in 45 responses (75% return rate). Survey data indicated that 62% of faculty gave feedback, with 73% spending 10 minutes or less. 50% of faculty perceived that resident notes improved and 73% felt that their own documentation improved. Faculty evaluation scores for providing timely and constructive feedback improved from 1.81 pre-intervention to 1.58 post-intervention (p value <0.008 using ANOVA) on a Likert Scale of 1 (Major Strength) to 5 (Major Weakness). Conclusions: Using the PDQI9, the majority of PHM faculty delivered feedback to residents in 10 minutes or less, and there was perceived improvement in the quality of both resident and faculty progress notes. Additionally, there were improvements in resident evaluation scores of faculty regarding the provision of feedback. References: Stetson, P. et al. 2012. Assessing Electronic Note Quality Using the Physician Documentation Quality Instrument (PDQI-9). Applied Clinical Informatics. 3(2): 164-174

ADVOCATING FOR VOLUNTEER FACULTY THROUGH RECOGNITION AND REWARD
41. LEAVING NEW INNOVATIONS BEHIND: CREATING A MOBILE-ACCESSIBLE ROTATION, FACULTY AND FELLOW EVALUATION
Kate Antanovich, EdM, Catherine Michelson, MD, Children’s Hospital/Boston Medical Center, Boston, MA

Background: Various approaches have been utilized to gather resident feedback to address residency issues as well as get data on faculty performance. Our program has historically administered rotation and faculty evaluations as two separate surveys via New Innovations. Residents reported their dissatisfaction with the content and usability of the existing evaluations, evidenced by the low completion rates. Objective: In the 2017-2018 academic year, our large pediatric residency program removed faculty and rotation evaluations from New Innovations and created a single Qualtrics survey to gather data on rotations, faculty and fellows. Our primary objective was to create a user-friendly, mobile-accessible evaluation to gather more meaningful qualitative and comparative quantitative data on resident experience. The second objective was to increase the evaluation response rate. Methods: From July 2017, the new evaluation was distributed prior to the end of the rotation with reminders afterwards. It consisted of 8 multiple choice and free text questions aimed at collecting data focused on the areas of continued concern for the program. Residents were surveyed in January 2018 to measure satisfaction with the new evaluation and solicit comments for improvement. Results: 62 residents (41% of all trainees) completed the survey. 93% of respondents were satisfied with the evaluation’s user-friendliness and 87% with the length. Response rate improved from 38% to 56%. The average time to fill out the evaluation was 8 minutes and there was a substantial but anecdotal increase in quantity of qualitative feedback that we are currently analyzing. Survey results were shared with fellowship directors and for the first time incorporated into their CCC meetings. Comparative data on individual faculty and rotation will be shared with Division Chiefs in June 2018. Conclusions: Creating a short, mobile-friendly evaluation led to an increase in residents’ satisfaction and response rate as well as the ability to share comparative data with fellowship and rotation directors for fellow and faculty performance evaluation.

42. DATA-DRIVEN PRACTICE HABITS FOR PEDIATRIC TRAINEES: GETTING A RETURN ON OUR DATA ENTRY INVESTMENT
Emily M. Powers, MD, Nitu Kashyap, MD, Pnina Weiss, MD, Yale-New Haven Medical Center, New Haven, CT

Background: Residents and fellows are required to receive data on quality metrics and benchmarks related to their patient populations. Despite near universal use of electronic health records (EHRs) and other software for monitoring trainee activities, the promise of meaningful feedback derived from these systems has yet to be fully realized. In the 2016-2017 ACGME resident surveys, only 70% of trainees reported being provided data about practice habits. Objective: To provide meaningful feedback on practice habits to pediatric fellows by developing subspecialty-specific data-driven dashboards Methods: Focus groups with pediatric fellows and fellowship and residency program directors identified areas of desired feedback metrics including procedure counts, documentation metrics, rapid response rates, mock RVUs, and delivery attendance. Using novel data queries, queries from existing attending physician metrics, and iterative design, data was extracted from the EHR (Epic Systems) and passed into data visualization software generating dashboards with graphical representations and was then automatically and regularly sent to fellows via email. Results: Dashboards were developed for 8 of the 11 fellowship programs. A major challenge was the difficulty in reliably associating trainees with individual patient visits and cases given varied documentation practices. This was addressed via careful analysis of fellow workflow and synthesis of multiple methods of association pulling from visit provider, note author, and shift schedules. Five fellowships had continuity clinics and reports were designed, based on faculty models, that included metrics on chart completion time, no-show rate, patient volume, and in-basket metrics. Novel dashboards were developed for PICU and NICU fellowships including metrics on procedures, rapid responses, delivery attendance and specifics. Individualized dashboards are in the planning stages for the remaining fellowships and for the residency program. Effectiveness of these dashboards in giving meaningful feedback will be assessed by focus group and survey. Conclusions: Novel dashboards have been developed using the EHR to provide data-based feedback on practice habits to pediatric fellows. Challenges such as case association can be overcome by careful analysis of workflow and multi-layer identification processes as well as standardization of workflow. A similar process of feedback could be adopted in other residency and fellowship programs.
43. CREATION OF A CANCER SURVIVORSHIP CURRICULUM FOR PEDIATRIC RESIDENT PHYSICIANS

Lindsay F. Schwartz, MD, Clarence Braddock, MD, MPH, UCLA Medical Center, Los Angeles, CA, Roy L. Kao, MD, UCLA Medical Center, Long Beach, CA, Myung-Shin Sim, MS, DrPH, UCLA Medical Center, Los Angeles, CA, Jacqueline N. Casillas, MD, MSHS, UCLA Medical Center, Long Beach, CA

Background: Due to advances in treatment, 83% of childhood cancer patients now survive into adulthood. As such, trainees should expect to treat this unique population regardless of intended career path. Unfortunately, there is a paucity of graduate medical education dedicated to cancer survivorship. Prior to this study, the pediatric residency program at the University of California, Los Angeles (UCLA) did not provide formal cancer survivorship instruction. Objective: The purpose of this study was to implement and evaluate a formal curriculum for UCLA pediatric residents that addressed important topics related to the care of childhood cancer survivors. Methods: A small group, case-based curriculum was created and integrated within existing educational structures at UCLA. A retrospective pre-posttest method was utilized to evaluate the curriculum due to its demonstrated efficacy as a measurement tool of program development. Residents received an evaluation following program completion. They were asked to indicate their level of agreement with statements concerning their knowledge, skills, and attitudes towards cancer survivorship topics both before and after their curricular session. Responses were examined using paired t-tests and one-sided binomial tests. Results: Thirty-seven participants completed the curriculum evaluation for a response rate of 84.1%. Each assessment item showed a significant increase from prior to post-curriculum; p<0.05. At least 20% of residents showed improvement in each survey item, and several items showed upwards of 30% improvement post-curriculum; p<0.05. Residents believed this curriculum enhanced their overall pediatric knowledge base (M=3.27; SD=0.65) and would recommend it to residents at other pediatric residency programs; M=3.30; SD=0.70. Conclusions: This curriculum represents one method to deliver training on cancer survivorship issues. Future directions include adaptation of this curriculum to educate additional pediatric providers, such as medical students, nurses, and faculty, as well as providers in other medical specialties.

44. PEDIATRICS IN PRESS - A RESIDENT DRIVEN INNOVATIVE MODEL OF EDUCATION

Krishna Kishore Umapathi, MD, Sruthi Menon, MD, Kimberly Hung, MD, Abdulla Ghori, MD, Case Western Reserve University (MetroHealth), Cleveland, OH

Background: Residency programs have used traditional methods of didactics to educate residents for long. With monotony creeping into these standard ways of teaching, various educational bodies are encouraging innovations in education. A flipped classroom approach with residents presenting interactive short topics in a microteaching format in a limited time, is well suited to the millennial learner and increases retention of knowledge. Objectives: a) To help the time-limited resident keep abreast of latest developments such as changes in guidelines, advances in therapeutic/diagnostic modalities and technological innovations. b) To help develop lateral thinking of residents by discussing topics such as an uncommon manifestation of a common condition, a common manifestation of an uncommon condition, a silent presentation of a critical condition and visual diagnoses. c) To promote the resident as a teacher and encourage development of a personal style of teaching. Methods: Three volunteers out of 24 residents in a residency program were mentored by an experienced faculty. Collectively the group reviewed the latest journals of relevance in the discipline and selected topics pertinent to the goals of the educational initiative. Five/six topics are presented within 30 minutes on a monthly basis by the volunteer residents. Results: Six months after implementation, residents were surveyed to evaluate effectiveness and to obtain feedback. Responses suggest that most of our goals and objectives were met and that micro teaching was preferred over hour long didactics on a single topic. Most residents found the sessions useful for clinical practice and requested increased frequency of sessions and are volunteering to be a part of this initiative. Hence the program is trying to add more in the curriculum. Conclusion: Pediatrics in Press (PIP) is an innovative teaching model that aims to develop a unique way of teaching future educators. It promotes microteaching and quick sharing of latest developments in the field among busy residents. It can be applied easily across all disciplines and will make an excellent complement to regular educational methodologies.

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<td>Better compared to morning report</td>
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<td>Better compared to afternoon didactics</td>
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<td>1</td>
<td>2</td>
<td>8</td>
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<td>Frequency of PIP preferred</td>
<td>12 weeks</td>
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45. WHAT IS THE INDIVIDUALIZED CURRICULUM?
Kimberly A. Gifford, MD, Dartmouth-Hitchcock Medical Center, Lebanon, NH, Daniel J. Schumacher, MD, MEd, Cincinnati Children’s Hospital Medical Center/University of Cincinnati College of Medicine, Cincinnati, OH, Suzanne Reed, MD, Nationwide Children’s Hospital/Ohio State University, Columbus, OH, Ann Burke, MD, Wright State University, Dayton, OH, Laura Zastoupil, MD, University of Colorado, Aurora, CO, Lynn Thoreson, DO, University of Texas at Austin Dell Medical School Pediatric Program, Austin, TX, John Mahan, MD, Nationwide Children’s Hospital/Ohio State University, Columbus, OH, Tai Lockspeiser, MD, University of Colorado, Aurora, CO

Background: The heterogeneity in individualized curricula across residencies makes sharing and studying IC challenging. We aimed to define overarching programmatic goals for IC and potential learner outcomes. Methods: Using an online questionnaire, program leaders described their program’s IC, overarching goals, and both current and potential learner outcomes. IC descriptions were examined to identify implicit programmatic IC goals. Two investigators coded the responses using qualitative content analysis, grouped the codes using thematic analysis, and discussed discrepancies. Focus groups of participants were conducted for member checking and elaboration of concepts. Results: The 34 respondents represented programs of all sizes, regions, and degrees of self-reported IC importance to their program. The analysis reached saturation of ideas with no new goals or outcomes for the last 6 response analyzed. Only three programs had explicit IC goals and four programs assessed resident IC outcomes. When categorizing explicit and implicit goals into themes, the descriptions aligned with the three domains of self-determination theory (SDT) (relatedness, competence, and autonomy). Thus, the data were reviewed again through the lens of SDT. The subsequent focus groups endorsed the SDT framework, refined the goals, conceptualized potential outcomes, and made two new observations: (1) individualized education extends beyond the six months of IC, and (2) some goals were common across all programs, while others applied only to subsets of programs or learners. The table summarizes the resulting model for the goals of individualized education in pediatrics. Types of potential IC outcomes included: process metrics, work products, and competence assessments by residents and faculty. Conclusions: This framework for goals and outcomes of individualized education can be used as a common language to promote more rigorous and collaborative study of IC across programs. Individual programs may also use it to help structure IC improvements. The next steps are to align assessment of outcomes across programs and examine approaches to IC implementation using those shared outcomes.

<table>
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<tr>
<th>Overarching goals for Individualized Education</th>
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<tr>
<td><strong>Domain</strong></td>
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<tr>
<td>Relatedness</td>
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46. EVALUATING LEARNER PREFERENCE OF SCHEDULE TYPE FOR BEST ENGAGEMENT OF PEDIATRIC RESIDENTS DURING CRITICAL CARE ROTATION IN A SMALL RESIDENCY PROGRAM: RESULTS OF A MIXED-METHODS ANALYSIS
Jody N. Huber, MD, University of South Dakota, Sioux Falls, SD

Background: A call schedule and shift schedule are frequently debated at this institution, where a call schedule is utilized. Recent studies suggest that a shift schedule reduces work hours and improves sleep, raising the question which schedule provides a better education. Objective: Determine if a call or shift schedule provides superior knowledge and professionalism, while limiting fatigue for pediatric residents during the pediatric intensive care unit (PICU) rotation in a small residency program. Methods: This is a mixed-methods study design. Participants were randomized to either a call or shift schedule during the PICU rotation with default call schedule for non-participants. Participants were evaluated by pre- and post- knowledge testing; surveys offered to participants and staff assessed attentiveness, bedside care and professionalism. Fatigue was evaluated by the Eppworth Sleepiness Scale. Statistical analysis utilized a t-test of unequal variances. Two focus groups were conducted with non-participants and participants. Graduated participants and non-participants were surveyed via anonymous email responses. Findings/Results: Study enrollment is ongoing over a two year period. Thus far, seven residents have been randomized to the call schedule and eight to the shift schedule. A total of eighteen residents were surveyed/participated in a focus group. No major differences could be detected between each group in regards to knowledge, professionalism or fatigue. Overall themes from focus groups and surveys are summarized in Table 1. Advantages and disadvantages to both schedules were noted. Participants recognized a learner preference for schedule type and suggested offering both schedules to residents. Conclusions: No difference was found between the call or shift schedule in regards to knowledge, professionalism and fatigue. Participants expressed learner preferences for one schedule over the other. Many recommended the shift schedule during PGY-2 year and call schedule during PGY-3 year.
47. DISCUSSING DEATH: A CURRICULUM TO EMPOWER RESIDENTS
Katherine J. Schultz, MD, Jessica Turnbull, MD, Travis Crook, MD, Rosemary Hunter, MD, Vanderbilt University, Nashville, TN

One of the challenges physicians face is to deliver end of life (EOL) news, and yet surveys of pediatric residents show not only minimal training in EOL discussions, but also little natural improvement in skills over time. Parents also note frustration, with up to 75% reporting a negative experience, citing resident inexperience and discomfort as contributing factors. This study aims to introduce a formal, sustainable pediatric resident curriculum regarding EOL discussions. It is hypothesized that the type of modality used in instruction will affect resident comfort having EOL discussions, and that facilitated discussion will be the most effective modality. A needs assessment survey was sent to attendings and fellows in different pediatric subspecialties. PGY-2 residents were randomized to either Intervention Group 1 or 2 (IG1, IG2). PGY-3 residents served as the control group (CG). All participants completed a demographics survey, a previously validated pre- and post-intervention survey, and a reflection essay. IG1 and IG2 participants watched a pre-recorded video introducing the SPIKES model. IG1 participants then participated in a simulated patient scenario, while IG2 participants participated in a facilitated small group session. Quantitative results will be completed in March 2018. Qualitative evaluation of the essays demonstrated the following themes: a lack of prior experience, resident discomfort dealing with death, appreciation of the curriculum, and how the experience will impact their future practice. When assessed through a qualitative lens, all participants indicated that the subject is poorly taught and desired more formal education. Both IG1 and IG2 participants relayed discomfort with their scenarios, though those in IG1 expressed greater anxiety with the scenario formality. IG2 residents seemed to reflect more on what the scenario taught them. Based on preliminary qualitative results, it is anticipated that the pending qualitative results will support the hypothesis that the best modality for teaching how to have EOL discussions is via facilitated group discussion.

SPIKES model
• Setting
• Perception
• Involvement
• Knowledge
• Empathy/Emotion
• Setting/Strategy/Self Reflection
Due to the high and rising costs of healthcare in the United States, there is increasing focus within graduate medical education around teaching trainees about cost and value within healthcare. However, there is little guidance on how programs should implement a curriculum focused on high value, cost-conscious care (HVCCC). We surveyed pediatric chief residents across the country between April-June 2017 using the Association of Pediatric Program Directors (APPD) chief resident listserve. Our survey addressed two primary questions: 1) How, if at all, are pediatric residency programs teaching HVCCC concepts to residents? 2) Are pediatric chief residents satisfied with their HVCCC training? We received responses from 131 of 495 pediatric chief residents (28%). This group was of similar demographic breakdown to the national cohort of pediatric chief residents with regard to academic versus community affiliation and regional location (p = 0.08, 0.47). The majority of chief residents (87%) reported receiving no formal training in HVCCC during residency despite most (89%) believing formal HVCCC training should be included in residency. The majority of chief residents (53.8%) were not comfortable practicing HVCCC. Factors associated with satisfaction with HVCCC training included access to cost data (p = 0.047), use of an electronic medical record (p = 0.04) and receiving any form of formal HVCCC training. The most frequently identified major barriers to the practice of HVCCC were lack of administrative support (67%), lack of training (59%) and fear of missing a diagnosis (57%). Our findings, although limited by small sample size, indicate that the majority of pediatric chief residents did not receive formal training in HVCCC during residency and feel unequipped to practice HVCCC. Our study highlights the importance of incorporating formal training in HVCCC into pediatric residencies. Ultimately, educating residents in HVCCC can hopefully lead to high quality care while reducing unnecessary cost that continues to plague the US healthcare system.

### 49. EDUCATION TRACK: BEYOND THE RESIDENTS AS TEACHERS CURRICULUM

Eyal Ben-Isaac, MD, Adriana Hernandez, MD, Michelle Thompson, MD, Children’s Hospital of Los Angeles, Los Angeles, CA

Introduction: Many residents are interested in acquiring the skills to become better teachers. Most training programs currently employ a Residents as Teachers curriculum to develop these skills. Here we describe our program’s Education Track, for residents interested in teaching and pursuing an academic career. Methods: Through participation in the track, residents develop skills for effective bedside and classroom teaching, leadership and life-long learning skills, and also have the opportunity to design, implement and disseminate an educational innovation or curriculum. To accomplish this, the track offers additional teaching opportunities to participants, longitudinal feedback from track mentors, didactic sessions, reflective exercises, and guidance in completing an educational research project. The Kirkpatrick model is used for evaluation of the track. Informal feedback and data from surveys and focus groups measure participant satisfaction. Participant learning is evaluated through direct observation of teaching assignments, participants’ evaluations by their own learners and successful completion of the required project. Behavior change and impact will be measured through longitudinal tracking of participants’ careers and future contributions in medical education. Results: To date 6 residents have graduated the track and 13 are currently participating. All 6 graduates have presented their projects regionally and/or nationally, and 1 has been published in MedEd Portal. Four of the 6 graduates are actively pursuing academic careers. Participants have acknowledged the track’s role in developing their confidence, teaching skills, public speaking abilities, and ability to provide feedback. Participants’ feedback has led to changes in the track’s didactic curricula and plans for designated instruction in survey design. Selected trainee projects have been incorporated into the residency program’s curricula. Discussion: Implementation of an education track for interested residents allows these trainees to develop important skills for future careers as clinician-educators and may lead to expansion of residency program curricula.

### 50. HOW TO INCREASE RESIDENT PARTICIPATION IN CONTINUITY CLINIC DIDACTICS

Kristen E. Samaddar, Katy Mullens, Jennifer Farabaugh, Phoenix Children’s Hospital, Phoenix, AZ

Background: Implementing a longitudinal didactic curriculum during busy continuity clinics can be difficult and is compounded further by having clinic sites at 3 institutions. Teaching based on patient care is vital but can miss key topics. Several curriculum delivery approaches were trialed over two academic years to determine the best way to inspire active participation. Methods: Three teaching approaches were compared in terms of participation, administrative effort, and qualitative comments from residents. These methods were delivery of curriculum via Facebook, email, and the hospital based learning management system (LMS). Results: The Facebook discussion board reached 35 to 60 residents/week (30-80% of the program) but participation decreased over time. Approximately ¼ were active in posting comments; the remainder only viewed the content. A handful of residents enjoyed the format, but many desired to separate personal and professional lives. Delivery of content via weekly emails reached all residents but participation was not directly measurable. A survey after 6 months showed 42% read content weekly but only 8% participated in a discussion. Several liked the ability to archive material but most desired more timely feedback with answers. When continuity directors used the LMS to send weekly questions, they paired questions thematically with monthly program didactics. The ability to preload materials significantly decreased administrative efforts compared to prior methods. The format inspired 84% of residents to participate more actively and allowed for immediate feedback as answers appeared once submitted. Residents commented that they appreciated the immediate feedback and the ability to work at their own pace. Conclusions: While no method for teaching and delivering curriculum overcomes all barriers, participation can be maximized by listening to the priorities learners. In our program, learners valued an online format that was exclusively for professional use, a consistent theme for didactics, and the ability to work autonomously while receiving immediate question/answer feedback.
Poster Abstracts

51. NOVEL MENTAL HEALTH CURRICULUM IN A PEDIATRIC CONTINUITY CLINIC IMPROVES MENTAL HEALTH SCREENING AND DIAGNOSIS
Skyler McLaurin-Jiang, MD, Laurie W. Albertini, MD, Gail M. Cohen, MD MS, Callie L. Brown, MD MPH, Palmer Edwards, MD, Wake Forest University School of Medicine, Winston Salem, NC

Background: As mental health (MH) conditions are present in 20% of children, and there is a shortage of pediatric MH providers, there is increased focus on training pediatric residents to diagnose and manage common MH conditions. Little is known about the effect of MH curricula on resident practice. Methods: A child and adolescent psychiatrist (CAP) was integrated into our continuity clinic 6 hours per week to consult and to teach a curriculum of 8 lectures on common MH diagnoses. We retrospectively reviewed diagnostic and management decisions made the year prior to (year 0) and after (year 1) implementation. Inclusion criteria: children 6 to 18 years old, documentation of a positive Pediatric Symptom Checklist and/or documentation of MH diagnoses (depression, anxiety, oppositional defiant disorder, conduct disorder, psychosomatic disorder, or eating disorder) or a related chief complaint. We excluded patients with diagnoses of ADHD alone. We performed chi-squared and t-tests to compare visit characteristics between years and logistic regression to determine correlates of MH diagnosis and management, adjusting for age, gender, race/ethnicity, and visit type. Results: 113 visits met criteria in year 0 and 251 in year 1. There were no baseline differences in age, gender, race, or insurance type by year. In multivariate analysis, pediatric residents were more likely to use MH screening tools (OR 5.20, 95% CI 1.98-13.73) and to make a MH diagnosis (OR 1.90, 1.02-3.53) in year 1 compared to year 0. There were no differences in prescribing psychotropic medications (OR 0.84, 0.35-2.01), follow up visits (OR 0.87, 0.53-1.43), or MH referrals (OR 0.69, 0.42-1.12) between years. Conclusions: Following the institution of a CAP-led MH curriculum, there was a 5-fold increase in use of MH screening tools and 2-fold increase in MH diagnoses. These findings suggest that a dedicated MH curriculum can impact the ability of pediatric residents to screen for and diagnose MH conditions. Further research is needed to study curricula that impact the management decisions of pediatric residents.

52. PEDIATRIC RESIDENT EXPERIENCES AT MORNING REPORT
Joshua T. Williams, MD, University of Colorado, Denver, CO, Laura Zastoupil, MD, Melisa Tanverdi, MD, Leonard B. Seltz, MD, University of Colorado, Aurora, CO

Background: Morning report (MR) is a fixture in many residency programs, yet its impact on pediatric resident learning and factors affecting resident attendance and participation are unclear. Objective: To explore pediatric residents MR experiences, preferences, and perceived learning. Methods: We performed a qualitative study of pediatric residents at the University of Colorado (2016-2017). MR occurs weekdays 7:30-8:00 AM. We conducted focus groups with a semi-structured interview guide and analyzed transcripts via constant comparative methods according to grounded theory methodology, reaching thematic saturation. We developed codes iteratively, resolved disagreements by consensus, and identified major themes. Results: Twenty-six residents (10 PGY-1, 5 PGY-2, 11 PGY-3) participated in five focus groups. Most attended MR 2-3 times per week. Analyses revealed four themes: (1) Factors Affecting Attendance: Service obligations impeded on-time attendance and caused frequent interruptions. Fatigue after service months and gap time before elective rotations hindered attendance. (2) Resident Learning & Curriculum Development: Resident learning was hit or miss. Interactive discussions of relevant topics and attending/fellow input promoted learning. Residents desired a structured curriculum, explicit learning objectives, and varied teaching methods (e.g. chalk talks). (3) Conference Climate & Engagement: Resident engagement was variable. Some residents perceived attending physicians’ presence as intimidating. Lecture hall style seating, late arrival, and fear of appearing unintelligent inhibited participation. (4) Resident Presenter & Chief Resident Roles and Challenges: Presenters were challenged by case selection and preparation, time management, and engagement of all learner levels. Increased chief resident involvement, beyond transcribing discussions, was desired to mitigate challenges. Conclusions: Residents perceived MR as valuable when interactive discussions facilitated learning in a safe environment. Work is needed to improve attendance, optimize the learning climate, create a curriculum with novel teaching strategies, and develop resident presenter skills.

53. SCHOLARLY ACTIVITY TRAINING DURING RESIDENCY: HOW WELL ALIGNED ARE PROGRAM DIRECTORS AND RESIDENTS?
Erika L. Abramson, MD, MS, New York Presbyterian Hospital (Cornell Campus), New York, NY, Michelle D. Stevenson, MD, MSc, University of Louisville, Louisville, KY, Monique Naifeh, MD, MPH, University of Oklahoma Health Sciences Center, Oklahoma City, OK, Elizabeth Mauer, MS, Linda Gerber, PhD, New York Presbyterian Hospital (Cornell Campus), New York, NY, Su-Ting Li, MD, MPH, University of California (Davis) Health System, Sacramento, CA

Background: Participation in scholarly activity (SA) is an ACGME requirement. However, there is little guidance for programs on how best to meet these requirements. Our previous work with program directors (PDs) and residents suggests the SA curriculum can impact the ability of pediatric residents to screen for and manage MH conditions. Little is known about the effect of SA curricula on resident practice. Methods: We conducted cross-sectional surveys of second and third year pediatric residents and PDs at 22 diverse programs through APPD LEARN. We used purposive sampling to ensure diverse program size, region, and academic/community affiliation. Surveys assessed resident demographics, program characteristics, beliefs about SA training, barriers, and satisfaction. Results: 464 of 771 residents (60.2%) and 22/22 PDs (100%) responded. 20/22 PDs (91%) agreed or strongly agreed that all residents should participate in a scholarly project. In those programs, the average proportion of residents who similarly agreed or strongly agreed was 83%. However, only 9/22 PDs (41%) said they were extremely or very satisfied with the quality of their program’s SA training. In those programs, the average proportion of residents who were extremely or very satisfied was 38%. Lack of time to conduct SA was viewed as more of a major barrier by residents than their PDs, regardless of whether the PDs viewed lack of time as a major, minor, or not a barrier. 7/22 PDs (32%)...
disagreed that all residents should have protected time to conduct SA. However, the average proportion of residents in those programs who disagreed was only 7%. PDs and their residents were more aligned with regard to the barrier posed by lack of training to conduct SA and lack of a research curriculum. Interestingly, lack of faculty mentorship was perceived as more of a barrier by PDs than their residents. 9/22 PDs (41%) said lack of faculty mentorship was a major barrier. Yet in those programs, the average proportion of residents who said lack of faculty mentorship was a major barrier was only 15%. Conclusions: Discordance exists between PD and resident views of the SA training experience, particularly with regard to lack of time to conduct SA. Better alignment of PD and resident views is important to ensure a positive training experience for residents.

54. WHAT MAKES THE PERFECT INPATIENT CONSULTATION? A QUALITATIVE ANALYSIS OF RESIDENT AND FELLOW PERSPECTIVES
Sara Pavitt, MD, Alyssa Bogetz, MSW, Rebecca Blankenburg, MD, MPH, Stanford University, Palo Alto, CA
Background: Inpatient consults represent an important opportunity for resident and fellow learning and have the potential to affect patient safety. With new communication modalities being used to teach and deliver consult recommendations, identifying strategies to optimize these interactions is imperative to improve medical education and patient safety. Methods: IRB-approved, qualitative grounded-theory study using semi-structured focus groups of pediatric residents and fellows at Stanford from October 2016-September 2017. Questions were developed by expert consensus to address study objectives. Focus groups were audio-recorded and transcribed verbatim. Two investigators independently coded the transcripts and reconciled codes to develop categories and themes using constant comparison. The third author reviewed codes, categories and themes for validation. To further ensure trustworthiness, participants reviewed and commented on the themes accuracy. Results: 27 residents and 16 fellows participated in 7 focus groups (3 resident, 4 fellow). Four themes emerged: 1) Many forms of communication are used to deliver initial inpatient consult recommendations (in-person, phone, text message, EMR notes); 2) Residents and fellows prefer in-person communication for inpatient consults, as it leads to better teaching, learning, and improves patient safety; 3) Multiple strategies can optimize consults regardless of communication modality such as setting upfront consult communication expectations, using a standardized consult template, sharing initial recommendations with the whole team, using a combination of communication modalities, and fostering relationships; 4) The method by which residents ask the initial consult affects the entire interaction. If done well, it increases fellow engagement, which leads to more fellow teaching, better resident understanding, and improves patient care (Figure 1). Conclusions: Residents and fellows believe that initial consults that are structured and conducted in-person improve teaching, learning, and patient care. Several strategies exist to optimize this process.

55. USE OF THE AMERICAN ACADEMY OF PEDIATRICS (AAP) BIOETHICS CURRICULUM IN PEDIATRICS RESIDENCY TRAINING: RESULTS OF A NATIONAL SURVEY
Lauren E. Veit, MD, Children’s Hospital/Boston Medical Center, Boston, MA, Janice L. Liebhart, MS, Not Affiliated with Program/Institution listed above, Itasca, IL, Jennifer C. Kesselheim, MD, MEd, Children’s Hospital/Boston Medical Center, Boston, MA
Background: The Accreditation Council for Graduate Medical Education (ACGME) requires that pediatrics residents demonstrate an adherence to ethical principles. In 2011, the AAP Section on Bioethics published a free, downloadable, case-based modular curriculum for residency programs, but data assessing uptake and perceptions of this curriculum are lacking. Methods: We conducted a national survey of pediatric program directors (PDs), which was distributed through the Association of Pediatric Program Directors listserv. Results: Only 32% of respondents (N=54, 27%) were aware of the AAP curriculum, and only 22% had used it. Respondents overwhelmingly reported that offering maintenance of certification part II for PDs and faculty implementing the curriculum might promote utilization (85%). Of PDs who used the AAP curriculum, 46% thought it was effective on its own and 36% believed it should be supplemented with other teaching materials. 27% reported having no resident ethics curriculum, and 81% responded “no” or “not sure” when asked if the effectiveness of ethics education in their program had been evaluated in the last 3 years. Lack of time/other priorities was the most commonly cited obstacle to ethics education (73%). Interestingly, 94% of respondents agreed or strongly agreed that ethics education is an important part of residency training, but only 61% agreed or strongly agreed that programs should use a formal ethics curriculum. Discussion/Conclusions: The AAP bioethics curriculum may be underutilized by pediatric residency programs. Most responding PDs were not aware that this curriculum is available, suggesting that increased outreach or professional incentives could increase use. However, while an overwhelming majority of PDs agreed that ethics education is an important part of residency training, many fewer endorsed implementation of a formal ethics curriculum and a minority had recently evaluated ethics education in their program. Further study is needed to better understand this disparity and support programs in fulfilling ACGME requirements.
56. PEDIATRIC PAIN MANAGEMENT: TOOLS FOR RESIDENT EDUCATION
Rebecca MacDonell-Yilmaz, MD, MPH, Angela Anderson, MD, Brown University, Providence, RI

Background: Pediatricians need skills in pain management but many residents find current training inadequate. Educational tools are needed to bridge this gap. Objectives: We developed and evaluated 2 case-based tools for teaching pediatric residents pain management using opioids. Efficacy was measured by multiple-choice questions and subjects’ self-reported comfort level with opioid prescribing. Methods: Pediatrics residents at Hasbro Children’s Hospital in 2016-2017 (N=79) and 2016 graduates (N=23) were eligible. The study was approved by the Lifespan IRB. Residents and graduates participated over one year using SurveyMonkey® web-based software. Baseline survey included training year, exposure to pain/palliative care teaching, comfort with opioids, and concerns/barriers to prescribing followed by 10 case-based multiple-choice questions addressing dosing, conversion, reduction for incomplete cross-tolerance, and risk of toxicity. Residents were assigned to 1 of 2 self-administered teaching tools: an interactive presentation or an article on pediatric pain management. Residents reviewed the tool and completed a post-intervention survey on the same 10 cases but with different medication dosages. Participants completed a final survey using the same cases but different dosages. Results: Baseline survey was completed by 64 participants; 17 completed the intervention and 17 completed the final survey. Subjective comfort with dosing and converting opioids increased post-intervention. Mean scores on objective questions increased; PGY1 and PGY3 residents had a statistically significant increase (p<0.001). Of the 20 who completed >2 surveys, 12 reported increased comfort and 13 had objective improvement. Results were similar between tools. Concerns reported at baseline, including risk of addiction and limited experience with opioids, persisted at later time points. Conclusions: Current pediatrics residency curricula inadequately address pain management. Use of self-administered tools increased residents’ comfort and objective knowledge. Further efforts to improve and disseminate tools are needed to train all pediatricians in these critical skills.

57. CREATION, IMPLEMENTATION, AND EVALUATION OF A CURRICULUM IN SCHOLARLY DEVELOPMENT
Ross E. Myers, MD, Keith Pontz, MD, Case Western Reserve University/University Hospital Case Medical Center/ Rainbow Babies, Cleveland, OH, Meghan Treitz, MD, University of Colorado, Aurora, CO, Katherine Mason, MD, Brown University, Providence, RI

Background: The importance of research and research training for residents has been recognized by both the AAP and ACGME. A needs assessment showed that most senior residents in our program were not comfortable with research methodology skills. Few residents participated in scholarly work leading to dissemination of findings outside the institution. Objective: Design, implement, and evaluate a research curriculum for pediatric residents with a primary goal of increasing the scholarly output of residents. Methods: An enhanced curriculum on scholarly activities was developed and implemented in a large pediatric residency program. Seminars included topics ranging from Educator Portfolios to Study Design, IRB Logistics, and Scholarship Dissemination. Retrospective pre-post surveys were obtained after each conference to determine its effectiveness. Comments were also collected via the survey about improving and enhancing the curriculum. Quantitative data were analyzed by average change score. Qualitative data were reviewed and summarized descriptively. Scholarly output, as measured by peer-reviewed presentations and manuscript publications, was analyzed using chi squared comparing one year prior and one year after implementation of the new curriculum. Results: 38 out of 83 pediatric and med/peds residents participated in this curriculum. Scholarly output increased from 6.25% to 15.7% of all residents in the program after implementation of the new curriculum (p<0.01). An increase in resident comfort level was demonstrated in 5 out of 6 areas of research methodology with average score increases from 0.86 to 1.33 on a 4-point Likert scale. Quantitative data revealed areas for improvement in the curriculum and generated ideas for additional sessions. Conclusions: Providing a robust research curriculum for pediatric residents led to a statistically significant increase in scholarly product dissemination outside the institution and improved resident comfort with topics and skills of research methodology. Iterative feedback is being used to inform ongoing revision and improvement of the curriculum.

58. A HUMANITIES CURRICULUM IN A PEDIATRIC TRAINING PROGRAM
Susan Gottlieb, MD, Leona Jaglom, PhD, Ilya Bialik, MD, Steven Gelman, MD, Yvonne Ferreira, MD, Revathy Sundaram, MD, Madhu Gudavalli, MD, Ali Nadroo, MD, Jolanta Kulpa, MD, Pramod Narula, MD, New York Methodist Hospital, Brooklyn, NY

Background: Exposure to the humanities can stimulate empathy and reflection. In an effort to cultivate these traits in our trainees, we developed a humanities program with a focus on literature and the visual arts. Objective: To document the residents’ responses to the program. Design/methods: For the past two years, the humanities curriculum was embedded in a small group learning experience (PODs- Pediatric Opportunities for Development in Small Groups) already in place. All of the residents (N=27) participate in PODs. There are 6-8 residents, heterogeneous with respect to year of training, in each group. Group membership is assigned for the year. PODs groups, facilitated by senior faculty, meet for 90 minutes of protected time twice a month. Reading materials and other assignments are emailed to the residents in advance. Assessment modalities include weekly minutes, questionnaires, reflective writing, and focus groups. Four of the sessions annually are devoted to the humanities. The literature portion consisted of two sessions. In the first session, each group discussed a poem, a piece of short fiction or a first person narrative written by a physician, parent or patient. For the second literature session, each resident wrote an original piece related to training and shared it with the group. Writing formats included haikus and 56 word stories. The arts component also had two sessions. The first entailed a group visual analysis of a painting depicting a pediatric subject. The second session involved a visit to the Brooklyn Museum where the residents chose a work that reflected their clinical experience and presented it to their group. Results: 88% of residents agreed that the humanities topics were a valuable addition to the program. They awarded the humanities program a 4 (out of 5) learning score. In the focus groups, residents
59. AN INDIVIDUALIZED CAREER EXPLORATION ROTATION: CAN WE IMPACT CAREER DECISION EARLY IN TRAINING?

Heather B. Howell, MD, Francisco Hernandez, MBA, BA, Hannah Famiglietti, MD, Patricia Poitevien, MD, New York University School of Medicine, New York, NY

Background: The time during training that pediatric residents make a decision about career path is varied. Approximately half of residents plan to pursue fellowship; a percentage that is fairly stable across the 3 years of training. Individual priorities such as work-life balance, educational debt and career structure (i.e. time spent on direct patient care, research, education or administration) impact the decision. Exposure to possible career options early in training may help decision making.

Objective: To determine interns perception of the usefulness of a 2 week individualized career exploration (CE) rotation.

Methods: In July 2016 we implemented a 2 week CE rotation for interns that was individually designed to expose them to an area within pediatric medicine of their choosing that they are considering for their career. The experience was specifically tailored to emphasize aspects they may not typically be exposed to during an elective, such as faculty scholarship, career path and life-style. Interns were surveyed before and after their CE rotation. We used descriptive statistics to analyze interns perceptions of preparedness to make a decision about post-residency career path. Results: 24 interns completed pre and post CE rotation surveys. On the pre-rotation survey, when asked how prepared they felt to make a decision about their post-residency career 13% were neutral and 54% felt un-prepared. We found no association between timing of CE rotation during intern year and level of confidence to make a career decision. 79% felt positive that a CE rotation would help with making a career decision. On the post-rotation survey 83% of interns felt better prepared to make a career decision and 100% of interns felt the CE rotation was worthwhile. When asked which of the assigned rotation activities where most useful 42% of interns chose faculty shadowing, 32% chose conducting a faculty mini-interview, and 25% chose the self-reflection exercise.

Conclusion: A CE rotation during intern year can increase perceptions of preparedness to make a decision about post-residency career path.

60. EVALUATING CURRICULAR MODULES IN THE CARE OF CHILDREN WITH MEDICAL COMPLEXITY: A MIXED-METHODS RANDOMIZED CONTROLLED TRIAL

Kathleen Huth, MD MMS, Children’s Hospital/Boston Medical Center, Boston, MA, Tobey Audcent, MD, Children’s Hospital of Eastern Ontario, Ottawa, ON, Sara Long-Gagne, MD MSc, Université de Montréal, Montréal, Anne Marie Sbrocchi, MD, McGill University, Montréal, Montreal, QC, Natalie Weiser, MA, Doug Miller, Danielle Arje, University of Toronto, Toronto, Toronto, ON, Nathalie Major, MD, Kheirie Issa, MD, Children’s Hospital of Eastern Ontario, Ottawa, ON, Eyal Cohen, MD MSc, Julia Orkin, MD MSc, University of Toronto, Toronto, Toronto, ON

Background: Pediatric residents report discomfort in caring for children with medical complexity (CMC), with variable training across programs. Little is known about the impact of dedicated CMC training on resident clinical performance and self-efficacy. Objectives: 1) To evaluate the effectiveness of a structured CMC curriculum in improving simulated clinical performance in complex care compared to usual training; 2) To explore pediatric residents perceived self-efficacy in caring for CMC. Design/Methods: Pediatric residents from 2 residency programs were randomly assigned to participate in educational modules on either: (a) clinical assessment, care planning and technological dependency or (b) non-complex care topics. The two groups were compared on a national OSCE complex care station on medical expertise in tracheostomy care. Semi-structured qualitative interviews were conducted post-intervention and transcripts analyzed using conventional content analysis. Results: Of 101 eligible residents, 94 residents were randomized (Figure 1). Residents who attended all modules and the OSCE [intervention (n=20) and control (n=24)] were included in the final analysis. Residents were PGY1 (41%), PGY2 (30%) and PGY3 (30%). Few (11%) reported being quite/extremely comfortable caring for CMC at baseline. There was no significant difference in mean OSCE score between intervention and control groups (19.2±3.4 vs. 18.2±3.4; p=0.316). Qualitative analysis revealed three emerging themes: 1) Building a system of care: collaborative and interdisciplinary approach to care, 2) Navigating uncertainty: recognizing knowledge gaps and limitations; 3) Professional identity formulation: developing skills through exposure and experience. Conclusion: Complex care modules delivered in a classroom setting did not lead to improved simulated performance in a medical expert-focused OSCE station despite increased resident-reported self-efficacy in approaching care of CMC and developing roles and relationships within a care team. These findings highlight the need for integrative and longitudinal clinical learning opportunities in complex care.

Figure 1: Flow diagram of resident participation in CMC curriculum (intervention) versus usual training (control)
61. LONE RANGER OR PIT CREW? EVALUATING THE IMPACT OF A TEAM-BASED CARE CURRICULUM FOR PEDIATRIC RESIDENTS

Dawn S. Tuell, MD, Gayatri Jaishankar, MD, Ivy Click, EdD, Beth Fox, MD, Jodi Polaha, PhD, East Tennessee State University, Johnson City, TN

Introduction: Efforts to improve health care in the US are focusing on the Quadruple Aim which targets enhanced patient experiences, population health management, control of costs and improved provider satisfaction. Traditional academic centers have fallen behind in preparing pediatricians to practice in this new milieu; pediatric residents consistently report feeling least competent in systems-based practice. To better prepare residents to enter the work force, we introduced a team based care curriculum for pediatric residents in the 2016-2017 academic year. Methods: Participants in the new curriculum included all 21 residents in our academic based residency program. An inter-professional team developed a curriculum consisting of six core modules: team care, team communication, quality improvement, health care roles, champion teams and advanced communications. Prior to participation, residents completed a pre-test of knowledge and the validated Attitudes Toward Health Care Teams scale. The same instruments were administered after completion of the modules. Results: All 21 pediatric residents completed the pre and post-tests. Resident knowledge significantly improved from a pre-test score of 63% to a post test score of 70% (p< 0.05). The Quality Improvement and Team Roles subtests showed significant improvement (p<0.05). On the Attitudes Towards Health Care Teams scale, the residents had a favorable attitude toward team value and team efficiency; these did not significantly change from pre to post-test. Pediatric residents’ attitudes toward physicians shared role in the team improved significantly (p<0.01). They reported enhanced attitudes regarding two key constructs: 1) shared team leadership and responsibility and 2) limits on physician control of team function. Conclusions: While pediatric residents in general had a favorable view of team-based care, participation in a team-based care curriculum positively affected their views of the physician’s role on a team. Understanding shared labor within a team, may help residents to achieve the fourth Quadruple Aim of satisfaction in healthcare by all providers.

62. EFFECTS OF A DAILY INTERACTIVE QUIZ ON PEDIATRIC RESIDENT CASE CONFERENCE CONTENT

Michael B. Spewak, MD, Carolyn L. Price, MD, Laura K. Eder, MD, Sharon M. Unti, MD, McGaw Medical Center of Northwestern University, Chicago, IL

Background: Resident case conferences are staples of graduate medical education and expose residents to a variety of additional clinical and decision-making scenarios. However, discussions skew towards less common topics. Additionally, the clinical demands on residents can delay conference start time and decrease the time available for teaching. Objective: Increase the quantity of conference topics overall and better incorporate general pediatrics content into resident case conferences. Methods: Starting in June 2017, a daily quiz question was projected in the room for the first 5-10 minutes of case conferences while awaiting a resident quorum. Answers were recorded anonymously using a free web-based tool. The number and topics of cases presented over the first 6 months of the 2016-2017 and 2017-2018 academic years were compared by unpaired t-tests, Chi-squared tests, and Fisher exact tests to assess the impact of these quizzes on conference content. Descriptive statistics of pediatric resident, fellow, and faculty self-reported survey data were performed. Results: These quizzes increased the mean number of cases per conference by 31.7% (mean 2.68 in 2016, 3.53 in 2017; p=0.001), increased the total number of topics discussed by 29.3% (from 451 to 583) and increased the general pediatrics content from 18.7% of topics in 2016 to 29.5% in 2017 (p=0.001) without statistically decreasing the total number of non-quiz cases performed. Most residents reported quiz-related increases in the educational value of conferences (21/24; 87.5%) and their own medical and general pediatrics knowledge (both 22/24; 91.7%). Most residents (23/24; 95.8%) recommended continuing the quizzes next academic year. Fellow and faculty responses mirrored these findings. Conclusions: Implementation of a daily quiz at the start of resident case conferences increased the quantity of conference topics and the proportion of general pediatrics cases. This curriculum was valued by participants and represents a simple, effective, and exportable tool to address several common educational barriers in case conferences.

63. IMPLEMENTATION OF A NOVEL CURRICULUM AND CONCEPTUAL FRAMEWORK FOR PEDIATRICIAN-SCIENTIST DEVELOPMENT

Audrea M. Burns, PhD, Satid Thammasitboon, MD, MHPE, Teri L. Turner, MD, MPH, MEd, Mark A. Ward, MD, Jordan S. Orange, MD, PhD, Baylor College of Medicine (Houston), Houston, TX

BACKGROUND: In an effort to strengthen the physician-scientist pipeline, Baylor College of Medicine (BCM) and Texas Children’s Hospital (TCH) implemented the Pediatrician-Scientist Training & Development Program (PSTDP). Embedded in the mission of the PSTDP is development of research-oriented scholars who cultivate excellent clinical and research training through the tenets of mentorship, didactic training, and interdisciplinary reflective experiences. The BCM PSTDP has developed a programmatic structure that is founded upon an established conceptual framework of Professional Identity Formation (PIF) based on findings from Rosenblum et al. We report early outcomes along with curriculum implementation grounded in PIF. OBJECTIVE: The PSTDP curriculum fosters pediatrician-scientist development through the merger model for PIF in which the two separate domains of a clinician and scientist are synergistically integrated to promote career sustainability in academia. PSTDP residents begin transforming by creating and refining “provisional selves” through interdisciplinary programmatic experiences. Experiences are road mapped in the year-specific curriculum which includes a clinical case report writing workshop (year 1), a pilot grants program and model study section (year 2) and pediatrician-scientist identify formation reflection writing (year 3). RESULTS: As the program is now midway through the third year, short term goals have been achieved of increasing the number of MD/PhD residents that apply and matriculate into the BCM residency by four-fold along with 78% of the first PSTDP class matching into TCH for subspecialty training. CONCLUSION: The BCM PSTDP offers a unique program of pediatrician-scientist development through combining immersive career development through a tailored three-year curriculum in the context of PIF. 1. Rosenblum, N. Professional Identity Formation and the Clinician-Scientist: A Paradigm for a Clinical Career Combining Two Distinct Disciplines. Acad Med 91, 1612-1617 (2016).
64. DIAGNOSTIC TESTING FOR (NON-)DUMMIES: APPLYING ADULT LEARNING THEORY TO TEACH STATISTICS-BASED INTERPRETATION OF CLINICAL TEST RESULTS

Adin Nelson, MD, Rutgers New Jersey Medical School, New York, NY

BACKGROUND: Sensitivity, specificity, and predictive values - the basic statistics behind using and interpreting clinical tests - are taught in all medical schools, yet studies have shown that a majority of physicians cannot correctly define and apply these concepts. This is easily seen from a common clinical scenario: a patient presents with fever and sore throat but no tonsillar enlargement or erythema; they have a positive rapid Strep test, and they receive antibiotics without consideration of whether the test result is true.

OBJECTIVE: Use the principles of Adult Learning Theory (ALT) to design a workshop reviewing the statistics behind diagnostic testing and applying those concepts through Bayes’ Theorem. DESIGN: Following the ALT principles of 1) making the material relevant, 2) recognizing and building on prior knowledge, and 3) using interactive activities to allow learners to discover key principles for themselves, we designed a workshop built around analyzing and applying a fictitious lab test. Using a fictitious test instead of a real clinical test avoided confounding from any prior knowledge about the test. The workshop included reviewing basic definitions, applying the test in different situations to show how the predictive values vary, and then practicing using Bayes’ Theorem to interpret test results.

EVALUATION: The workshop was taught to 28 general pediatrics residents in Newark, NJ. Before the workshop, the residents took an anonymous multiple-choice test on definitions and application of biostatistical concepts. After the workshop, the test was repeated, and the pre-test and post-test scores were compared. RESULTS: Average scores rose from 4.1/8 (51%) on the pre-test to 6.5/8 (81%) on the post-test. A two-tailed t-test showed p < 0.001 for that difference, and post-hoc power analysis showed a power of 99% to detect the observed difference at this sample size. CONCLUSIONS: This workshop based on ALT principles and built around a fictitious test was highly effective in reviewing basic biostatistics and teaching Bayes’ Theorem.

65. JACKPOT: USE OF A LOTTERY INCENTIVE SYSTEM IS ASSOCIATED WITH SUSTAINED GAINS IN RESIDENT ACADEMIC PRODUCTIVITY

Emily Borman-Shoap, MD, Lei Zhang, MS, Michael B. Pitt, MD, University of Minnesota, Minneapolis, MN

Background: Residency programs are required to promote engagement in scholarship and report this data annually. Positive Peer-Pressed Productivity (P-QUAD) is a novel dual-incentive model that combines increased transparency through awareness of peers’ engagement in scholarship with a weighted cash lottery where tickets are earned at various degrees of academic success (i.e. 1 point/ticket for an abstract submission, 2 for a poster acceptance, 6 for manuscript acceptance, etc.). We had successfully piloted this program with hospitalist faculty, but its role within residency was unknown. Objective: Determine if a novel weighted-lottery system contributes to sustained increases in academic productivity within a residency program and supports gathering information for mandated reporting. Methods: We implemented P-QUAD within our pediatric residency program on July 1, 2015 and collected data through June 30, 2017. Residents first reported their scholarship submissions/acceptances for the year prior, establishing the program baseline. During the two-year pilot, residents logged their academic submissions and acceptances on a web interface (pquad.org) where they could view their real-time scores and the work of their peers. At the end of each academic year, we compared P-QUAD points for each category compared these numbers to baseline.

Results: Engagement in scholarship across the program as measured by the total P-QUAD score for each year increased 53% from baseline (504 vs 329 points/year) [Figure - left]. Mean submissions and acceptances per resident who reported their scholarship increased across all categories ranging from a 19% increase in abstract submissions to a 275% increase in accepted manuscripts per resident [Figure - right]. Conclusion: Our residency program has seen sustained gains in academic productivity at both the program-wide and participating resident levels in the two years since implementing P-QUAD. Additionally, we have been able to maintain a real-time database of resident scholarship which supports ACGME reporting.
66. NEEDS ASSESSMENT AND EARLY EXPERIENCE WITH AN OUTPATIENT COMPLEX CARE ELECTIVE

Karl Eckberg, MD, Emily Borman-Shoap, MD, University of Minnesota, Minneapolis, MN

Background: Caring for children with complex healthcare needs is an increasingly important skill for general pediatric practice, but there is wide variability in education and comfort level among pediatricians. The American Board of Pediatrics highlighted this skill by including “EPA 6: Providing a Medical Home for Children with Complex Healthcare Needs” as one of the Entrustable Professional Activities (EPA) for general pediatric practice. Based on this EPA, we created a needs assessment survey to identify gaps in resident knowledge and skills. Our results informed the creation of a 4-week elective experience for residents, which uses community resources, medical supply companies, and clinical experiences in complex care clinics, as well as independent learning such as the AAP modules on medical home. Methods: In 2017, we created and delivered a needs assessment survey to all of our pediatric and medicine-pediatric residents. We then crafted goals and objectives for the elective and a curriculum based on content specifications for EPA 6 as well as areas identified as knowledge gaps by residents. Results: 61 residents (58% of all residents) completed the needs assessment survey. 33% of respondents plan on a career in primary care. Residents reported having less adequate experience and decreased comfort level in caring for children with complex health care needs in the outpatient setting compared to inpatient settings (Figure 1). Residents identified managing medical devices, coordinating care in the outpatient setting, and providing health maintenance for children with complex healthcare needs as their top three desired areas to learn more about. Early feedback about the elective has been that hands-on experience with medical devices and time spent working in a clinic specializing complex care were highly valued components of the experience. Discussion: Our needs assessment suggests a need for enhanced training in care of children with complex healthcare needs in the outpatient setting. We present an EPA-informed, community-connected approach to designing and implementing an outpatient complex care elective.

67. RECOGNIZING A CYCLE OF DEPENDENCE THAT IMPEDES RESIDENTS’ ABILITY TO LEARN NEUROLOGY: A QUALITATIVE STUDY EXPLORING PEDIATRIC RESIDENTS’ PERSPECTIVES.

Thuy Nguyen, MD, Stanford University, Stanford, CA, Sara Pavitt, MD, Courtney Wusthoff, MD, Stanford University, Palo Alto, CA, Caroline Rassbach, MD, Stanford University, Stanford, CA

Background: Patients experience long wait times after referral to a child neurologist due to a national shortage of these providers. Given this wait, pediatricians must be prepared to address the initial evaluation and management of neurological problems. Methods: IRB-exempt, qualitative study using semi-structured focus groups of pediatric residents at Stanford during November 2017. Questions were developed by expert consensus to address study objectives. Focus groups were audio-recorded and transcribed verbatim. Two investigators independently coded the transcripts and reconciled codes to develop categories and themes using constant comparison associated with grounded theory. The fourth author reviewed codes, categories and themes for validation. Results: 18 pediatric residents participated in 3 focus groups. Four themes emerged: 1) Residents desire more training to initially assess and manage patients with neurological conditions; 2) Residents of all levels feel unprepared and uncomfortable with assessing and managing patients with neurological conditions; 3) The complexity of patients with neurological problems and residents’ lack of confidence in their own neurology skills contribute to over-dependence on neurologists. This leads to deterioration of residents' skills, devaluation of their clinical role, and uncertainty about their ability to manage patients with neurological conditions (figure 1); and 4) Residents are motivated to overcome their dependence on neurologists and offer the following strategies to optimize their learning: teaching from all levels of motivated supervisors, strengthening relationships/communication with the neurology team, and curriculum that includes multiple modalities of teaching. Conclusions. Pediatric residents are motivated to acquire more skills to initially assess and manage patients with neurological conditions. They recognize key factors that contribute to a cycle of dependence that impedes their learning and offer strategies to overcome these barriers.
69. IMPROVING THE RESIDENT RESEARCH EXPERIENCE THROUGH THE IMPLEMENTATION OF A RESIDENT SCHOLARLY OVERSIGHT COMMITTEE
Jon F. McGreevy, MD, MSPH, Kiley Vander Wyst, MPH, Brigham C. Willis, MD, M Ed, Vasudha Bhavaraju, MD, Phoenix Children's Hospital, Phoenix, AZ

Background: An increasing number of residents in our program have chosen to perform research, but have had variable support to complete their projects due to less experienced mentors, time constraints, limited resources, and lack of accountability. The concept of a Scholarly Oversight Committee (SOC) is traditionally used in pediatric fellowship programs to address similar barriers and uphold a high level of research output. We created a similar forum in our program to optimize the resident research experience. Objective: Improve the quality, completion, and dissemination of resident scholarly activities within a large pediatric residency program through a Residency SOC (RSOC). Methods: All residents actively involved in research at any stage are required to present, with an early emphasis on those who are fellowship-bound. Residents are provided with a slide template to highlight their work and allow time for Q&A. Each hour-long session has 3-4 presentations. The RSOC panel is comprised of educational leaders, research mentors, and interested research faculty who provide feedback and guidance for next steps. Residents receive a written summary of their RSOC comments and present 3-4 times as their project progresses throughout residency. Results: Since May 2016, 16 residents have presented at 5 RSOC sessions. Projects include 2 case reports, 6 quality improvement projects, and 8 research projects, and ranged in stages from pre-IRB-submission, data collection phase, analysis to manuscript review. Two research and one QI project are novel resident-initiated ideas. One project has already been presented nationally. Conclusions: Implementation of a RSOC provides the opportunity to intervene early in resident research, track projects, navigate hurdles, and ensure success and completion of scholarly work in a supportive environment. We plan to compare scholarly output by type, completion and dissemination before and after initiating the RSOC to measure its effectiveness.

70. NEW PARENT ELECTIVES IN U.S. PEDIATRIC RESIDENCY PROGRAMS: A QUALITATIVE ANALYSIS
Elena Griffin, BS, Benjamin Hoffman, MD, Oregon Health and Science University, Portland, OR

Background: In 2015 62% of pediatricians were women, and approximately 80% of women give birth to their first child during residency training. During the required 36 months of pediatric residency training, a maximum of one month of leave may be taken per year, which includes sick, vacation, and parental leave. In response to the needs of residents, both male and female, a number of residency programs developed electives that allow residents time at home following the birth of their child while also completing their training within the time constraints set by certifying bodies. Objective: To perform an in-depth, qualitative analysis of New Parent elective curricula at pediatric residency programs. Design/Methods: We obtained a convenience sample of New Parent elective curricula through a post to the general discussion board of the Association of Pediatric Program Directors. A qualitative analysis was performed examining several categories, including duration, general structure of elective, required activities (e.g. reading and writing components), summative product(s), and evaluation method. Results: Of the 207 ACGME accredited pediatric residency programs, 54% of program directors completed the survey. 38% responded that they offer an elective for residents who become parents during their training, of which 33% (14) submitted their curricula and assessment tools for analysis. Results: Qualitative analysis revealed tremendous variability in all aspects of New Parent electives (Tables 1 and 2). 71% (10) of electives had a component of required reading composed of parenting books and/or academic journal articles. 64% (9) had a writing component, with 78% (7) of these involving some form of reflective writing. The majority of electives (79%, 11) required a summative product, with this most often being a presentation to peers. 50% (7) of respondents reported using their program's standardized evaluation form for assessment, while 36% (5) reported using a rotation-specific evaluation. In approximately 2/3 (64%) of electives, residents were required to meet with a faculty mentor during and/or after the elective. Conclusions: While the majority of pediatricians are women and approximately...
half will give birth to their first child during residency training, only 38% of pediatric residency programs offer New Parent electives. For those programs that offer electives, there is marked variability in all aspects of curricula and assessment. There is need for both increased availability and a more standardized approach to curriculum development.

71. PEDIATRIC RESIDENCY TRANSGENDER EDUCATION INITIATIVE
Elizabeth S. Sandberg, MD, Steven Weinberg, MD, Zachary Smith, MD, Emily Vander Schaaf, MD, Sue Tolleson-Rinehart, PhD, University of North Carolina Hospitals, Chapel Hill, NC

Background: Pediatricians are often the first healthcare providers informed of a transgender youth’s gender-related questions or concerns. Prior to June 2017, our institution’s pediatric residency did not have a formalized curriculum regarding the health care needs of transgender youth. Our objective was to assess pediatric residents’ familiarity and comfort with the health care needs of transgender patients and assess knowledge about medical management of transgender youth. Design/Methods: We distributed a baseline survey to assess residents’ familiarity and comfort with the medical care of transgender patients. This was composed of the BASE All Staff Assessment Survey from The Fenway Institute in addition to 8 original case-based questions. We distributed the survey via email to be completed voluntarily and anonymously. This survey would serve to demonstrate the need for a quality improvement project aimed at improving pediatric resident comfort and knowledge regarding transgender health. Results: 62 residents completed the survey (93% response rate). Of the respondents, 50% agreed/somewhat agreed they were familiar with the unique health issues affecting transgender people, 24% felt prepared to meet the needs of transgender patients. 40% often/sometimes talked to patients about their gender identity, whereas 16% never talk to their patients about gender identity. 40% of respondents were not comfortable talking to patients about this topic. Case-based knowledge questions revealed that residents were knowledgeable in some topics but not in others. Over 90% of respondents correctly answered questions regarding the gender-affirmative approach to care of gender-expansive children, the frequency of persistence of gender dysphoria in childhood, and basics about puberty and primary care of transgender patients. In contrast, only 57% of respondents correctly identified the appropriate use of GnRH agonist based on a patient’s pubertal development. Only 10% of respondents correctly identified increased body/facial hair as potential permanent effects of testosterone. Conclusion: Prior to a quality improvement project to improve comfort and knowledge, 4 in 10 pediatric trainees at our institution reported being uncomfortable providing services to transgender youth. Residents would benefit from a curriculum on medical care unique to this potentially vulnerable population. Despite a lack of comfort with this topic, the survey indicates that residents have some baseline knowledge about the medical care for these patients, but more education is needed. The curriculum should aim to increase comfort talking about gender identity with patients, ability to recognize health issues unique to this population, and knowledge of appropriate medical management.
72. INCREASING RESIDENT ENGAGEMENT THROUGH INTERACTIVE LEARNING AT MORNING REPORTS
Katherine A. Jordan, MD, Laura Cannon, MD, Mark W. Chandler, MD, Kenya McNeal-Trice, MD, University of North Carolina Hospitals, Chapel Hill, NC

Background: Morning report is a commonly used venue to utilize clinical cases for teaching core pediatric topics. Given the competing demands of residency training, as the academic year progresses, active resident participation in morning report can be difficult to sustain. We hypothesized that interactive, competitive and team-based activities would increase resident engagement and participation in our morning conferences series. Objective: Introduce interactive teaching modalities to improve resident engagement, participation, learning and satisfaction at morning report conferences. Methods: We developed interactive learning activities to integrate into the traditional format of our morning reports. Following a resident’s presentation of a clinical case, the chief resident would lead a learning activity. Among others, these included “Pick 5”, a detective style approach to diagnosis; “Matching” an image and fact matching activity highlighting high yield board review topics; and “Charades Race”, a fast-paced race to identify pictures and buzz words. All activities were designed to be competitive with teams of mixed learner levels participating. Activities were followed by a brief didactic session with learning points from the case. A web-based survey was used to evaluate the efficacy this curriculum. Results: Residents overall reacted very positively to the activities, with favorable evaluations at both three and six months interval. At six months, in comparison to traditional morning report format, 88% of residents surveyed report they participate more with the new activities; 85% report more engagement; 77% reported higher knowledge acquisition; and 77% report more satisfaction. Conclusions: Team-based and competitive learning activities easily integrated into a traditional morning report format. These activities emphasized active learning and created opportunities for residents to teach in the small groups. Residents report improved satisfaction, engagement, participation and learning. These activities could be adapted for use at other residency programs that have clinical case based conferences.

73. LONGITUDINAL COMMUNITY ASSETS CURRICULUM FOR PEDIATRIC RESIDENTS
Catherine Park, MD, Joshua Bakke, MD, Jason Yau, MD, Bindiya Bagga, MD, University of Tennessee, Memphis, TN

Background: Previously, our residents’ community pediatrics exposure was limited to a month-long rotation in the third year. However, the residents reported dissatisfaction with the content and timing of this experience. This, coupled with AAP’s emphasis on child poverty as well as our high local rates, led us to believe that a longitudinal community pediatrics experience might be more valuable. Objective: To design and implement a longitudinal curriculum aiming to improve the residents’ knowledge on poverty and community resources. Methods: A needs assessment survey revealed that the majority (94%) strongly agreed/agreed that a longitudinal curriculum would be beneficial. Therefore, one was developed and incorporated into the weekly residents’ continuity clinic beginning August 2016. The 3 most impoverished zip codes were identified with the idea of focusing on 1 a year so that residents could be exposed to all 3 during residency. Different social determinants of health topics were addressed monthly (transportation, education, gangs, mental health, food insecurity, etc.). The residents completed a self-paced electronic curriculum composed of Prezi presentations and supplemented with handouts, interviews with key community members, group discussions, and identification of community assets. The resources were provided to the residents so that they could be shared with their patients. Results: Our novel curriculum led to an increase in the residents’ awareness of social determinants of health and an increased confidence in caring for impoverished patients. Pre surveys showed that 18/33 residents felt very/somewhat knowledgeable about the community resources for the under-resourced while post surveys showed that 35/38 residents felt very/somewhat knowledgeable about the resources. Post surveys also indicated that 36/38 residents felt that this longitudinal curriculum added value to their residency and future practice. Conclusions: The implementation of an electronic longitudinal curriculum has led to improved understanding of our community needs and, in turn, an increase in residents’ interest, involvement, and impact in the community.

74. SOOTHING THE BURN: A COMPREHENSIVE WELLNESS PROGRAM FOR PEDIATRIC RESIDENTS
Anna Schmitz, MD, Sonia Mehta, MD, Catherine Ferguson, MD, Kaitlin McKenna, MD, Jessica DeValk, MD, Michael Weisgerber, MD, Medical College of Wisconsin Affiliated Hospitals, Milwaukee, WI

Background: Residency programs are charged by the ACGME with ensuring resident wellness while monitoring for and mitigating the effects of resident burnout and fatigue. To date, reports of effective strategies on how to do this are lacking. Objective: To design and implement a longitudinal curriculum aiming to improve resident wellness and burnout monitoring started in August 2017. Among 91 residents, 79 participated in 1 or more wellness activities, 60 completed 1 or more W ratings and 46 completed the aMBI. The median W rating was 71%, and by category: 54% good, 27% fair, and 20% poor. Reported burnout by sub domain was: 45% EE, 38% DP, 23% PA and 17% overall burnout.
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75. A PROGRAM’S EXPERIENCE WITH HEALER’S ART: FOSTERING COMPASSIONATE HEALING AND HUMAN CONNECTION
Miri Lader, MD, Ann E. Burke, MD, Adrienne Stolfi, MSPH, Evangeline Andarsio, MD, Claire Hanson, MD, Craig Boreman, MD, Wright State University, Dayton, OH

Background: Resident well-being is a crucial issue in Graduate Medical Education (GME). Many programs are seeking educational strategies and experiences that will foster resilience and well-being. Healer’s Art (HA) is a program from the Remen Institute for the Study of Health and Illness (RISHI). It is used to provide professional formation for medical students who aspire to bring their passions into their work by practicing a medicine of service, human connection and compassionate healing. Our residency is the first pediatric program to utilize this course in GME. Objective: Determine interns’ perceptions of the usefulness of participation in HA to their practice of medicine. Methods: Interns participated in 5 3-hour HA workshops during orientation and the first month of internship. Faculty trained in HA facilitated the experience. Sessions explored “nurturing your wholeness”, “sharing grief and honoring loss”, “mystery and awe”, and “service as a way of life”. Course evaluations validated in medical students were completed by the interns. Evaluations included ratings of the course and faculty (from 1=Poor to 5=Excellent), and statements about course impact (from 1=Strongly Disagree to 5=Strongly Agree). We used mean (SD) to summarize responses, and conducted thematic analysis of written comments. Results: Fourteen of 16 (88%) interns who participated completed evaluations. Quality of course faculty was rated highly overall at 4.6 (0.6). Interns felt the course provided important content not available elsewhere in their training (4.3 [0.6]). As a result of the course they felt more committed to patient centered care (4.0 [0.9]), were more certain they belong in the profession (4.1 [0.7]), and felt more supportive of peers and colleagues (4.5 [0.7]). Themes included learning about one’s emotions and recognizing that everyone struggles with similar feelings. The biggest challenges were time and returning to patient care after emotion-filled sessions.

Conclusions: HA in a residency program has perceived value to interns in the broad areas of compassion, patient centeredness and connectedness.

76. SUICIDE RISK ASSESSMENT AND MANAGEMENT TRAINING PRACTICES IN PEDIATRIC RESIDENCY PROGRAMS: A NATIONWIDE NEEDS ASSESSMENT SURVEY
Lucy E. Schoen, MD, Alyssa L. Bogetz, MSW, Stanford University, Rebecca A. Bernert, PhD, Palo Alto, CA

Background: Suicide is a serious public health concern and the second leading cause of death among adolescents. Although pediatric providers are a critical point of contact for suicide risk screening, triage, and intervention, little is known about the content or perceived adequacy of suicide risk assessment and management training practices in pediatric residency programs. Objective: Among pediatric program directors (PDs) and chief residents (CRs), to (1) characterize training practices in pediatric residency programs nationwide, and (2) evaluate areas of training need to guide curriculum development. Methods: An IRB-approved, cross-sectional, anonymous survey of all pediatric residency PDs and CRs was distributed online through the Association of Pediatric Program Directors listservs from May to June 2017. The 24-item survey was developed through expert consensus to assess training practices and perceived needs in suicide risk assessment and management training. We calculated descriptive statistics for all variables. Results: A total of 95/204 PDs and 210/494 CRs completed the survey. Although 82% of respondents believed suicide risk assessment and management training was very or extremely important, only 18% of PDs and 10% of CRs reported adequate preparation relative to training need. Forty-five percent of PDs and 66% of CRs endorsed formal training (PD median=3 hours [IQR 1-4.5 hours], CR median=1.5 hours [IQR 0-3 hours]), which was provided across...
diverse rotations and not always mandatory. Only 20% of PDs and 10% of CRs reported use of a clinical practice guideline or policy document to guide clinical practice. PDs and CRs agreed on top-ranked educational priorities including interviewing adolescents about risk, identifying suicide risk factors, and locating relevant community resources; perceived barriers included limited time for training, lack of training resources, and need for additional expert faculty to guide training. Conclusions: PDs and CRs endorsed a need for improved guidance in suicide risk assessment and management education, which may benefit from programmatic curricular changes to enhance medical education and guide suicide prevention efforts.

77. IMPLEMENTATION OF A PEDIATRIC WELLNESS CURRICULUM AND ITS IMPACT ON RESIDENT BURNOUT AND THEIR PERCEPTION OF WORK-LIFE BALANCE
Johanan Vargas, MD, Jessica Berrios, C-TAGME, Erika Regalado, MD, Bronx-Lebanon Hospital Center, Bronx, NY

Background: Physician burnout occurs in nearly 40% of pediatric residents resulting in well-being deficits affecting their future. Research suggests establishment of a wellness curriculum during residency may contribute in decreasing burnout throughout training. Objective: Determine the prevalence of burnout in pediatric residents working in a community hospital and evaluate the impact of a newly introduced curriculum on the degree of resident burnout and work-life balance. Methods: A resident wellness curriculum was created based on the AMA 6 areas of well-being (Table 1). The goal is to improve the wellness and resiliency of pediatric residents. Curriculum objectives include 1) support and promote resident wellness through presentations, activities and events, 2) review and improve curriculum components based on resident feedback, and 3) establish a resident wellness policy. A committee was formed to oversee activities, implement changes to the curriculum, and incorporate preferences. Pre and post curriculum surveys included Mini Z burnout questions, PHQ-2 and free text for suggestions. Residents were surveyed after 1 and 1.5 year of curriculum implementation. Results: Out of 43 participants, 25 completed the survey at 1 year and 24 at 1.5 years post implementation. Residents who agreed or strongly agreed with job satisfaction increased from 95.2% to 100%. The perception of workload control improved from 41.7% satisfactory to 68% good or optimal rating. Perception of stress due to residency requirements decreased by 12.6% from 1 year to 1.5 years post-implementation. When asked to what degree the new curriculum contributed to overall wellness and work-life balance, 52% believed contribution was some and 28% believed it contributed greatly. Conclusion: After resident wellness curriculum implementation there has been improvement in burnout and the perception of work-life balance. Curriculum modifications will be based on bi-annual survey in future research will focus on curriculum effectiveness by observing changes in stress, depression, burnout and work-life balance.

Table 1: Resident Wellness Curriculum Outline

<table>
<thead>
<tr>
<th>Elements of Wellness</th>
<th>Activities/Events</th>
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<tbody>
<tr>
<td>Nutrition</td>
<td><em>Nutrition education</em></td>
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<tr>
<td></td>
<td><em>Snacks/ water for residents on call</em></td>
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<td></td>
<td><em>Cooking classes</em></td>
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<td></td>
<td><em>Peru to the world culinary expo</em></td>
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<td>Fitness</td>
<td><em>Yoga/Meditation</em></td>
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<td></td>
<td><em>Zumba</em></td>
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<td></td>
<td><em>Discounted gym access</em></td>
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<td></td>
<td><em>monthly massages</em></td>
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<tr>
<td>Emotional Health</td>
<td><em>Online module: sleep deprivation</em></td>
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<td></td>
<td><em>Group and individual meetings with social worker</em></td>
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<td></td>
<td><em>paint night</em></td>
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<td></td>
<td><em>Operation Christmas Child (charity)</em></td>
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<tr>
<td></td>
<td><em>Grill exchange</em></td>
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<td></td>
<td><em>Spring and Fall outing</em></td>
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<tr>
<td>Preventative Care</td>
<td><em>Online module: physician health</em></td>
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<td></td>
<td><em>encourage annual checkups</em></td>
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<td></td>
<td><em>personal days off for medical purposes</em></td>
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<tr>
<td>Financial Health</td>
<td><em>Personal finance</em></td>
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<tr>
<td></td>
<td><em>Life insurance/disability</em></td>
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<tr>
<td></td>
<td><em>Online module: learn to personal finance</em></td>
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<tr>
<td>Mindset/Behavior</td>
<td><em>Conflict resolution</em></td>
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<tr>
<td>Adaptability</td>
<td><em>Online module: resident initiation</em></td>
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<tr>
<td></td>
<td><em>Online module: working effectively with an interprofessional team</em></td>
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<td></td>
<td><em>Online module: thriving through residency</em></td>
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<td></td>
<td><em>Meditation exercises</em></td>
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<td></td>
<td><em>ongoing wellness surveillance</em></td>
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<td></td>
<td><em>attending resident social events</em></td>
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<td></td>
<td><em>PGY2 retreat: focus on leadership/team building</em></td>
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<td></td>
<td><em>PGY3 retreat: focus on training reflection</em></td>
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</table>

78. DEVELOPING PERSONAL AND PROFESSIONAL RESIDENT WELLNESS THROUGH RESIDENT LED ACTIVITIES AND DISCUSSIONS
Shannon E. Barker, DO, Chad Vercio, MD, Loma Linda University Health Education Consortium, Moreno Valley, CA

Background: The discussion of resident burnout, depression, and suicide has become more prominent amongst programs across the country as well as the ACGME. Residency is an intense period of our lives where we spend more time at work and less time with our families, compounded with the difficult patient encounters we experience. Unfortunately, this results in increased rates of resident burnout, depression, and suicide. Due to the nature of residency and the education residency provides, we cannot change the hours or patients residents see and must foster wellness within the work environment. Methods: Our goal has been to establish a program in which residents would discuss activities they find bring themselves wellness but also be educated on how to develop meaning or purpose in their work. We hosted monthly wellness sessions where a resident would bring an activity that helps them be well. Activities have included yoga, meditation, crosswords, and baking. Following would be a topic discussion led by residency faculty with mostly resident participation. Topics have included prioritizing duties, work/life integration, and dealing with angry caregivers. Immediate feedback was assessed via anonymous surveys after the session. Results: We have had overwhelmingly positive feedback from the residents. They have participated in activities that have helped them know each other better and shared tools on simple things they do to enjoy their time at work and home. The discussions have also been robust and allowed residents to ask how each other or faculty deal with challenging situations both professionally and personally. Conclusion: We were able to establish a regular, sustainable, and low cost wellness session that has kept residents engaged and has allowed them to have a safe space to explore topics that may hinder wellness throughout their training and future careers.
Burnout is recognized as a pervasive problem in residency. One possible approach to avoid burnout is to debrief after critical incidents in patient care. This study is an assessment of residents’ burnout and experience with debriefing in a mid-size pediatric residency program prior to the implementation of the leading a debrief module from the American Academy of Pediatrics Resiliency Curriculum. The Maslach Burnout Inventory was administered to pediatric trainees at the end of the academic year. Concurrently, it was administered to the incoming interns during orientation. The Maslach is scored in three domains: emotional exhaustion, depersonalization, and personal accomplishment. An average score on a 6-point scale in each domain was generated for each individual. All participants also were surveyed about their experience and comfort with debriefing. 20 trainees (33% response rate) and 23 orientees (100% response rate) completed the surveys. A significant difference in burnout was found between orientees and trainees, with scores for emotional exhaustion (EE) of 1.7 vs. 3.3, depersonalization (DP) of 1.2 vs. 2.7, and sense of personal accomplishment (PA) of 5.1 vs. 4.4, respectively. A trend towards higher levels of emotional exhaustion and depersonalization were noted in junior residents vs. interns and senior residents, although not statistically significant. 37% of participants reported sometimes or most times debriefing after critical incidents, with the remaining 63% reporting rarely or never debriefing. Individuals who had more frequently participated in debriefings had significantly higher levels of burnout (EE: 3.9 Most Times vs. 2.1 Rarely, DP: 3.5 Most Times vs. 1.5 Rarely). The pediatric trainees in this study experienced a high degree of burnout, increased from a pre-residency baseline. Surprisingly, burnout symptoms of emotional exhaustion and depersonalization were actually higher in individuals who more frequently participated in debriefing. Further clarification of the relationship of debriefing to burnout symptoms in pediatric residents should be undertaken to ensure that educational efforts in teaching debriefing are beneficial.
81. THE INTIMIDATION FACTOR: WORKPLACE INTIMIDATION AND ITS EFFECTS ON WELLNESS, MORALE, AND PATIENT CARE
Rebecca Hernandez, MD, MPH, Karli McCoy, MD, Amanda Chavez, MD, Samantha Wertz, BSN, RN, Elizabeth Payne, MAEd, C-TAGME, LSSBB, University of Texas Health Science Center School of Medicine at San Antonio, San Antonio, TX
Bullying and intimidation are common in the workplace and often normalized in the culture of medicine. In previous surveys conducted, up to 98% of respondents reported experiencing or witnessing behavior problems between medical professionals. Bullying may be experienced on a personal, work, or even physical level. Such behaviors affect patient care and employee wellness leading to an increase in preventable medical errors as well as increased rates of employee burnout, depression, and suicide. Our team completed a literature review prior to beginning the project to set a baseline on what types of intimidation are most prevalent in the workplace. Next, we surveyed a group of nurses and physicians at various levels of training and experience to obtain quantitative data based on a Likert scale. We conducted interviews for more in-depth qualitative information. This mixed methodology allowed us to gather data about the incidence of bullying among some of our colleagues, but also qualitative data and more information about individual experiences. The information was placed into an interactive 1-hour Grand Rounds format given to our department as well as other training programs that reached out as interest grew around our programs Anti-Bullying campaign. One hundred percent of survey and interview respondents experienced some form of intimidation including yelling, teasing, and even physical intimidation. Superiors were the most commonly cited source, but peers, patients, and patients families also contributed significantly to incidences of intimidation. Intimidation increases the rate of stress, anxiety, burn-out, and depression among both physicians and nurses leading to decreased enjoyment in work, worsening mental health issues, and relationship difficulties. This atmosphere results in hesitation to report medical errors and limited communication among colleagues. The culture of medicine has normalized intimidation for many years, and therefore the many forms of intimidation often go unrecognized. Learning to recognize all forms of intimidation is the first step in prevention and elimination of these behaviors in medicine. Open communication is key to preventing negative behaviors as well as improving employee wellness and patient safety. Through interdisciplinary collaboration, we can change the culture of medicine and improve wellness as well as patient safety.

82. THE PEDIATRIC BUDDY PROGRAM: COHORT 3 WELLNESS FOCUS
Beth Payne, MAEd, C-TAGME, LSSBB, Haneme Idrizi, MD, Michelle Arandes, MD, University of Texas Health Science Center School of Medicine at San Antonio, San Antonio, TX
The Pediatric Buddy Program was developed in 2014 between the Department of Pediatrics at UT Health San Antonio and their primary clinical learning partner. This program pairs pediatric nurses and interns with an overarching goal of encouraging a cooperative clinical work environment through mutually valued system improvement projects. Cohort 3 teams developed projects concentrating on WELLNESS in medicine, given the current national trends related to burnout, depression and overall physician well-being. The focus of each project is through the lens of the healthcare team well-being and how it impacts patient care and safety. Team composition varies yearly to accommodate changing nurse enrollment, however the curricular structure of the buddy program has remained consistent: Team formation during an interactive CLER-centered orientation, protected quarterly didactics, development of a collaborative QI/SB project, completion of pre-and post-program surveys and completion of reflective journaling. The pre-and post-knowledge and exposure data, along with twelve months worth of reflective journaling is being analyzed to evaluate the positive impact on collaborative attitudes. Participants demonstrated attainment of system improvement knowledge by completing and submitting for review of their scholarly projects. There were four total team projects: stress and burnout management, communication styles and techniques, bullying in the workplace and time management and organizational skills. By jointly working on projects that relate to personal needs, Cohort 3 aimed to address healthcare team well-being and cooperation as a positive culture change. By offering education such as the Pediatric Buddy Program that values the importance of an interprofessional approach in medicine, a positive shift in overall resident education can occur. The completed projects serve as the programs first set of formal curriculum on wellness topics. Two of the projects have continued to grow into larger more robust pathways to wellness such as a formal resident driven Wellness Committee and a multi-specialty Anti-Bully campaigns led by our Pediatric trainees.

83. MINDFUL MOMENTS: IMPROVING RESIDENT WELLNESS THROUGH A TEXT-MESSAGE BASED CURRICULUM
Anita Desai, MD, Allison Rubin, MD, Stanford University, Palo Alto, CA
Background: Physician burnout is an increasingly recognized problem, and studies estimate that up to 65% of pediatric residents experience burnout. Methods: In April - Nov 2017, we implemented an IRB-approved text-message based wellness curriculum in a pediatrics residency program that targeted 5 areas: nutrition, self-care, relaxation, interpersonal relationships, and motivation. Residents received text messages 2 times weekly during the study. 3 validated scales: 10-item Perceived Stress Scale (PSS), 15-item Mindful Attention Awareness Scale (MAAS), and 9-item Abbreviated Maslach Burnout Inventory (AMBI) were measured at start, midway, and at conclusion of the curriculum. Data was analyzed using paired t-tests and qualitative data was analyzed by content analysis. Results: 40/64 (62.5%) of invited residents opted-in to receive text messages, and 19/40 (47.5%) completed at least one follow up survey. 64% of residents reported completing 75-100% of activities at 4 month follow up and 73% of residents reported completing 50-75% of activities at 8 month follow up. We observed significant improvement in PSS at 4 months (p=0.023), but not 8 months (p=0.306). No significant change was noted in MAAS or AMBI scores at 4 or 8 months follow up. Qualitative analysis showed that residents appreciated the accessibility and ease of the text messages and felt that reminders for individual wellness foster discussion, creating a culture of wellness. Up to 93% of residents believe text messages are a good way to deliver a wellness curriculum to residents, and 85% of residents would recommend a similar
curriculum to other programs. Conclusion: This innovative pilot-study demonstrates that a text-message based curriculum was well received, positively impacts resident wellness and may decrease resident perceived stress. Future directions should focus on approaches to engage more residents long-term and creating an online repository of wellness curricula for future use.

84. EFFECTIVE DEBRIEFING: EMPOWERING TRAINEES TO PROCESS DISTRESSING EVENTS
Morgyn Govindan, MD, Patricia Keefer, MD, Julie Sturza, MPH, Nasuh Malas, MD, MPH, University of Michigan, Ann Arbor, MI

Introduction: Physicians commonly experience adverse patient events as part of their training and practice. These events can negatively affect provider emotional health and the care they provide, potentially leading to professional stress and burnout. Several studies have shown that debriefing after difficult experiences positively impacts provider wellness. While distress crosses experience levels, junior providers report the greatest need for support after adverse events. Methods: We developed a two-hour debriefing workshop where senior residents learn the components of an effective debriefing session and practice these skills in a small-group setting. Participants completed surveys pre- and post-intervention regarding their attitudes, knowledge and confidence in leading debriefing sessions. Univariate statistics were used to describe responses to the pre- and post-intervention surveys. Paired t-tests were used to assess for significant changes in responses from the pre- to post-intervention period. Results: Twenty 2nd year pediatric and medicine-pediatric residents participated in the pilot study. Participants reported a mean of 2.2 distressing events in the preceding month (SD 2.4). Only 10% of participants reported debriefing within one week of an event. No residents reported having formal training in debriefing, and only 10% had ever led a debriefing session. Following the workshop, there were statistically significant improvements in multiple domains, including comfort in leading debriefing sessions and likelihood of recognizing personal distress (Table 1). Discussion: This pilot study demonstrates that a two-hour debriefing workshop for senior residents can result in greater knowledge of debriefing, greater confidence in leading debriefing and better recognition of personal distress. It may serve as one model to enhance training and education regarding debriefing in residency training programs.

<table>
<thead>
<tr>
<th>Survey Question</th>
<th>Pre, mean (SD)</th>
<th>Post, mean (SD)</th>
<th>p-value for paired t-test</th>
</tr>
</thead>
<tbody>
<tr>
<td>How comfortable do you feel requesting a debriefing session after a distressing event?</td>
<td>2.6 (0.9)</td>
<td>3.4 (0.6)</td>
<td>0.002</td>
</tr>
<tr>
<td>How comfortable do you feel leading a debriefing session after a distressing event?</td>
<td>1.8 (0.8)</td>
<td>3.3 (0.6)</td>
<td>&lt;0.0001</td>
</tr>
<tr>
<td>How likely are you to lead a debriefing session after a distressing event?</td>
<td>2.1 (0.9)</td>
<td>3.4 (0.7)</td>
<td>&lt;0.0001</td>
</tr>
<tr>
<td>How likely are you to notice symptoms of distress in yourself?</td>
<td>3.4 (0.9)</td>
<td>3.8 (0.9)</td>
<td>0.02</td>
</tr>
</tbody>
</table>

85. PERSISTENT BURNOUT AND MINDFULNESS IN PEDIATRIC INTERNSHIP
Colin M. Sox, MD, MS, Christine Cheston, MD, Catherine Michelson, MD, MMSc, Yarden S. Fraiman, MD, Children’s Hospital/Boston Medical Center, Boston, MA

Background: Burnout negatively affects physician well-being and is common during residency training. Objectives: To determine the prevalence of burnout at the beginning, middle and end of pediatric internship, and to assess factors associated with burnout. Methods: We conducted a longitudinal cohort study of burnout and mindfulness during the first year in which a large pediatric residency program implemented a novel 6-month mindfulness curriculum for interns. We invited all interns to complete the Maslach Burnout Inventory, Jefferson Empathy Scale, and Five-Facet Mindfulness Questionnaire at orientation, 6 months and 12 months. We conducted chi-square and t-tests, as well as multivariate logistic regressions. Results: All eligible interns participated in the survey at baseline (n=50, 100% response), 42 at 6 months (84%), and 38 at 12 months (70%). Mean age was 28 years, and 30% were male. Of the 16 interns who were burned-out at baseline (36%), 9 were no longer burned-out after the curriculum ended 6 months later. Of the 33 interns who completed all three surveys (66%), 7 were burned-out at the beginning, middle and end of internship, while 7 were not burned-out at any point during the year. At baseline, interns’ mean mindfulness score was 124.4 (SD 15.0; range 95 to 153); males had significantly lower mindfulness scores (117) than females (128; p-value = 0.02). Interns not burned-out at baseline had significantly higher baseline mindfulness scores (128) than interns burned-out at baseline (118; p = 0.02). Similarly, interns who were not burned-out on any of the 3 surveys had significantly higher mindfulness scores (134.4) than those who were burned-out at least once during internship (121.2; p = 0.007). Controlling for age, gender, and baseline empathy, interns with higher baseline mindfulness had a significantly lower odds of starting internship burned-out (OR: 0.06; 95% CI: 0.12–0.004). Conclusion: Burnout is common during pediatric intern orientation, often persisting throughout internship. Mindfulness was independently associated with both burnout during intern orientation and persistent burnout during internship.

86. RESILIENCE: RESIDENT LED INITIATIVE TO EMPOWER A CHANGE IN CULTURE AND PROMOTE RESILIENCE IN ACCORDANCE WITH THE ACGME LEARNING ENVIRONMENT GUIDELINES
Alexandra Kilinsky, DO, Michael Dolinger, MD, MBA, Anna Plichta, MD, Hofstra Northwell School of Medicine at Cohen Children’s Medical Center, New Hyde Park, NY

Introduction: The ACGME’s CLER Program states that residency programs should measure and educate residents about burnout yearly. Simply measuring burnout is akin to measuring the symptoms of a disease without treating the underlying cause. In turn, we focused on establishing resident wellness with the development of specific resiliency strategies and tools through a unique resident-led wellness curriculum using the CLER program as a guide. We then developed novel assessment tools to measure the effectiveness of the program. Methods: Our curriculum was designed by a faculty-mentored resident
wellness committee. Interventions addressed the AMA’s 6 key aspects of personal well-being: nutrition; fitness; emotional health; preventative care; financial health; and mindset, behavior and adaptability. Interventions were paired with specific outcome measures. Maslach Burnout Inventories were distributed pre-curriculum, and at 3-month intervals. Surveys at the completion of activities assessed the effectiveness of the session. Results: A 2017 pre-curriculum survey of our 100 pediatric residents revealed that 41% of PGY3s admitted to feeling burnt out from my work and feeling more callous since I took this job. 3 months into the curriculum, 48% of PGY1s, 23.5% of PGY2s and 83.3% of PGY3s believe that residency interfered with their personal wellness. Before our fitness workshop, only 20% of the residents belonged to a gym; after the class, an additional 60% joined a local gym. After attending a series of financial lectures, 50% of those who did not previously contribute to their retirement funds now plan to do so. 80% of residents said they now plan to eat healthier while only 15% reported eating healthy prior to a nutrition session. Using our resiliency assessment, 90% of residents said they learned something valuable from a negative patient experience. Discussion: Early results of our resident-led initiatives demonstrate that interventions targeted at specific aspects of well-being yield tangible improvement in resident wellness behaviors.

87. WE DON’T ALL SCREAM FOR ICE CREAM: CREATION OF AN INTEGRATED LONGITUDINAL WELL-BEING CURRICULUM

Jessica L. Meikle, MD, Weston Powell, MD PhD, Lauren Poull, MD, Tiana Won, MD, Heather A. McPhillips, MD MPH, Maneesh Batra, MD MPH, University of Washington, Seattle, WA

BACKGROUND: Increased recognition of physician burnout has prompted wellness initiatives at many residency programs. Our residents formed a wellness committee during the implementation of a ‘79 wellness week’, but this annual effort has been met with criticism that physician burnout is a deeper issue than can adequately be addressed in a single week or only with gestures of appreciation, such as free ice cream. OBJECTIVE: Our primary objective was to develop a longitudinal approach to well-being, integrated into daily resident life. METHODS: Our GME team has implemented a thirty minute well-being check-in developed by residents at the beginning of each rotation. Sessions are facilitated by a resident and a chief, with breakfast provided. Residents are encouraged to share strategies for professional and personal resilience. A list of suggested strategies is distributed at each session and one is highlighted for each rotation. Additionally, this 79 strategy of the month is included in a weekly residency newsletter. Residents are encouraged to commit to discrete goals for the month and share them for collective accountability.

RESULTS: Since October 2016, 14 sessions have occurred. Excellent attendance and early qualitative survey data suggests positive reception with areas for improvement. Residents have valued the team-based nature, adaptability, and individualization of the approach. Survey results revealed that prior to the start of the sessions, 50% of residents engaged in wellness activities less than 2 times per week. Following the first cycle of sessions, residents had set personal goals such as exercising, healthier eating, intentional relationship time, and mindfulness practices; however, few had set work- or hospital-based goals. The sessions have been adapted to focus more on work-related wellness. CONCLUSIONS: Addressing physician well-being at the programmatic level is multifaceted, but our monthly well-being sessions represent a means to promote well-being into the daily workflow that is acceptable to residents and may foster a culture of cultivating resilience in preparation for careers after residency.

88. ACCEPTANCE AND PERCEIVED BENEFITS OF CONFERENCE-BASED STORYTELLING SESSION ON PEDIATRIC RESIDENT WELLNESS

Daria Murosko, MD MPH, Children’s Hospital/Boston Medical Center, Zeena Audi, MD, Yuan He, MD MPH, Children’s Hospital/Boston Medical Center, Jonathan Gall, MD, Daniel Zheng, MD MHS, Tyler Rainer, MD, Avital Ludomirsky, MD MPP, Sarah Wingertor, MD, Children’s Hospital/Boston Medical Center, Boston, MA

INTRODUCTION: The principles of “narrative medicine”, including self-reflection, storytelling and creative self-expression, have been shown to increase emotional awareness and preserve empathy in medical trainees. However, the burden of clinical duties and educational experiences can be prohibitive to resident participation in a storytelling curriculum. We piloted an hour-long, narrative session during protected educational conference time. OBJECTIVE: Determine residents’ acceptance and perception of benefits of a conference-based storytelling session. METHODS: The conference-based storytelling session was delivered to residents from one large, urban pediatric residency program. It consisted of 3 segments: a plenary session during which a resident volunteer shared a personal story, a prompted reflection with written response, and a small-group guided discussion. Residents completed a survey that assessed their experience in the session and its impact on their personal wellness. We used descriptive statistics to analyze perceived impact on wellness and, using grounded theory, conducted a thematic analysis of written comments. RESULTS: 37 pediatric residents (26 were interns) completed the survey. 100% of respondents reported the session was helpful for their personal wellness, and all stated they would participate in this type of experience again. Comments focused on both on the physician-physician colleague relationship (16/26; 62%) and physician-self relationship (8/26; 31%). Participants perceived this session enhanced understanding and closeness among residents, and many stated that this session made them feel less alone. Participants also commented that this session encouraged self-
80. RESIDENT USE OF THE ELECTRONIC MEDICAL RECORD (EMR) OUTSIDE OF WORK
Lorraine E. Canham, MD, Molly H. Silber, MD, Leah S. Millstein, MD, Jason W. Custer, MD, Susan Feigelman, MD, Ronald San Juan, MD, Erin L. Giudice, MD, University of Maryland, Baltimore, MD

Background: EMRs allow providers continual access to patient information inside and outside of work hours. In an already demanding field, the ability to utilize this clinical data at any time has potential to compromise a tenuous work-life balance.

Residency has been shown to be a particularly vulnerable time with up to 75% of residents reporting burnout by the end of training. Proposed contributors include long work hours, high stress levels, sleep deprivation, and lack of leisure time, all of which may be exacerbated by an inability to “unplug”. Objective: To characterize resident use of EMR outside of work and assess its effects on wellness. Methods: A total of 48 pediatric residents (70% response rate) from a single institution completed a 21-item survey. Results: All respondents endorsed EMR use outside of work with the majority accessing 1-2 times/day (N=37, 77%) for 30 min or less (N=27, 56%). The most common reasons for access varied and included checking a team census (N=47, 98%), writing notes (N=38, 79%), and reviewing lab results (N=31, 65%). Of respondents, 39% felt others expected them to access EMR remotely, including faculty (N=15) and co-residents (N=9). Most reported that access is necessary to their job (N=39, 81%). Use extended to checking EMR while driving (N=8, 19%) and on vacation/time off (N=31, 65%). Overall, 42% felt that EMR affected work-life balance with 34% endorsing some effect on personal relationships. Of the thirty-one residents who self-reported feelings of burnout, 17% felt that remote access to EMR contributed. Conclusions: This study represents an initial look at resident use of EMR outside of work and its impact on wellness. Residents universally endorse remote EMR access. More than a third report an effect on work-life balance with a compelling number endorsing that EMR access contributes to burnout. Red flags include EMR access while driving, access during vacation, and effect on relationships. Future directions include better quantification of time spent using EMR remotely and comparison of access and burnout using a validated assessment tool.

90. ONE PROGRAM’S JOURNEY INTO THE WIZARDING WORLD OF WELLNESS
Cameron D. Nereim, MD, Rebecca M. Plant, MD, Sharon Dabrow, MD, University of South Florida Morsani, Tampa, FL

Background: Within the medical community, the mounting toll of physician burnout is no longer a secret. Burnout rates among US medical students, residents and practicing physicians now exceed 50%. Though early attempts at developing individual and organizational strategies to promote physician wellness and resiliency have yielded promising results, there is still a pressing need for innovative methods to combat burnout.

Objective: To create a residency-based framework for the incentivization of productive and protective behaviors of resident wellness. We describe how we designed this framework to facilitate interactions among resident “siblings” as part of our program’s previously established “Big-Little Sibling” mentorship program. Design/Methods: We devised a theme-based “Wellness House Cup” competition whereby residents from our pediatric and medicine/pediatric programs were “sorted” into 1 of the 4 “Hogwarts Houses” from the popular “Harry Potter” universe. We developed 50 wellness-related activities, giving each a “wellness point” (WP) value (1 to 50), proportional to their potential impact on wellness (e.g., “share a meal with colleagues” - 15 WPs, “see your doctor” - 50 WPs). Using a point-multiplier system, we incentivized “big-little sibling” interactions. To claim WPs, residents submitted pictures of their activities to the chief residents who tracked WP totals. Gift cards were awarded quarterly to the top WP scoring individual and house members. Results: The majority of residents engaged in the “Wellness House Cup” as active WP scorers. After 35 days of competition, 89% of residents were active WP scorers, which increased to 98% by the 60 days. After 184 days, 100% of residents were active WP scorers. After 3 months our 56 residents had a total of 13,108 WPs (average of 234 WPs per resident). Conclusion: Through the creation of an innovative “Wellness House Cup” competition, we were able to effectively engage our entire residency within a short period of time, while promoting wellness-related activities. We hope to present resident-survey data describing measures of physician burnout.

91. CARE TEAM ASSISTANT PROGRAM: PROMOTING RESIDENT WELLNESS AND EFFICIENCY
Michelle-Marie Peña, MD, Ryosuke Takei, MD, Anna Sweeney, Zoey Atabek, George Dalember, MD, Nicole Washington, MD, Jeanine Ronan, MD, Children’s Hospital of Philadelphia, Philadelphia, PA

Background: The burden of administrative tasks has been linked to depersonalization of residents, a major component of physician burnout.1,2 The Care Team Assistant (CTA) program was created to provide administrative support to inpatient resident teams and to help promote wellness while optimizing care. Objective: To determine the CTA program’s impact on resident administrative task burden and job satisfaction. We also examine the CTA program’s effect on timely discharges. Methods: We conducted 2 surveys of inpatient pediatric residents to assess their perception of the CTAs’ administrative support. In secondary analysis, the percentage of general pediatrics patients discharged by noon on 1 inpatient team before and after the utilization of CTAs was also compared. Results: Twenty-six residents responded to the first survey in April 2017 (47% of residents on inpatient teams with a CTA). Of these residents, 92% strongly agreed or agreed that the percentage of
92. THE BENEFITS OF A CONSISTENT APPROACH AMONG PROGRAM DIRECTORS IN ADDRESSING RESIDENT BURNOUT
Eva K. Schwartz, MD, Ben Miller, MD, Stephanie B. Dewar, MD, UPMC Medical Education, Pittsburgh, PA
BACKGROUND: Identifying and addressing burnout in residents is an important step toward preventing self-harm and promoting wellness within a residency community. Our residency program has used the Maslach Burnout Inventory (MBI) during semi-annual Program Director (PD) Meetings since 2014 to screen for trainee burnout. In 2016 a focus group of residents revealed that some had negative experiences during this discussion of the MBI score during a PD Meeting.
OBJECTIVE: We aimed to improve the residents’ perceptions of a discussion about burnout during PD Meetings by implementing a consistent approach to the discussion and potential interventions. METHODS: Baseline information was collected via surveys to residents and PDs following Fall 2016 PD Meetings. In February 2017, all PDs gathered with a behavioral health specialist to create a consistent approach to conversations about burnout and develop a list of appropriate interventions. A second survey was conducted following PD Meetings in Spring 2017. RESULTS: In the pre-intervention survey, only 38% of residents who had a concerning burnout score said they were always discussed during previous meetings. After the most recent meeting, 84% of residents with a concerning score reported that they were discussed (p < 0.05). Residents negative perceptions of the conversation decreased, with only 8% of residents feeling worse following the discussion with a PD compared to 17% previously. Perception of self-efficacy among PDs generally improved, with those feeling very effective increasing from 11% to 40%. PDs were slightly better equipped to offer helpful solutions as well, as the percentage of residents unable to identify any helpful interventions regarding burnout dropped from 31% to 22%. CONCLUSION: Providing training to PDs regarding discussion of burnout with trainees greatly increased the likelihood that a concerning score was discussed. There were also slight improvements noted in satisfaction among residents, with less residents reporting negative experiences and fewer residents unable to identify helpful wellness interventions.

93. EXPLORING GRIT AND RESILIENCE IN FIRST YEAR PEDIATRIC (P1) RESIDENTS
Rebecca Wallihan, MD, John Mahan, MD, Suzanne Reed, MD, Claire Stewart, MD, Mary Kay Kuzma, MD, Alex Rakowsky, MD, Nationwide Children’s Hospital/Ohio State University, Columbus, OH
Background: The first year of residency is a challenging time, with new roles, responsibilities, and learning activities. While many focus on prior academic achievements of incoming residents, we hypothesized that personal characteristics such as grit and resilience would explain some of the ability of first year residents to master this new role. Grit is defined as the blend of passion and persistence that enables individuals to continue on in difficult circumstances, while resilience represents the ability to bounce back from adversity stronger as a result of the trial. Objective: To define measures of grit and resilience in P1 residents and explore their relation to performance. Methods: P1 residents completed standard measures of grit (Duckworth) and resilience (Smith’s Brief Resilience Scale [BRS]) prior to beginning training. Scores from these self-assessments were compared to ACGME pediatric milestone assessments during the first 6 months of training. Descriptive statistics were applied and correlations explored via standard statistical methods. Results: Data were available for 37 (79%) residents. Median scores were 3.9/5 (IQR: 3.5-4.1) for grit and 3.7/5 (IQR: 3.3-4) for BRS, both comparable to non-medical reference groups. There were no differences in grit or BRS by age or gender and no association between grit and BRS. There were no significant associations between grit or BRS and milestone assessments of patient care, medical knowledge, systems-based practice, practice-based learning and improvement, or professionalism. However, both grit and BRS positively correlated with interpersonal communication skills (grit: r=0.38, p=0.02; BRS: r=0.39, p=0.02). Conclusion: Grit and resilience in P1 residents did not correlate with performance as assessed by ACGME pediatric milestones, with the exception of interpersonal communication. This association is interesting, as good communication requires persistence and ability to relate. Further study will be required to determine if grit and resilience change during training and whether these baseline characteristics predict for future burnout, stress or performance.

SAFETY/QI

94. TEACHING PATIENT SAFETY CONCEPTS TO PEDIATRIC TRAINEES
Ayesha Mirza, MD, Jeffrey Winer, MD, Matthew Garber, MD, Kartikeya Makker, MD, Nizar Maraqa, MD, Rana Alissa, MD, University of Florida College of Medicine-Jacksonville, Jacksonville, FL
Introduction: Health care quality and patient safety remain one of the core areas of focus for the Accredited Council on Graduate Medical Education. Training programs must promote safe inter-professional team based care and educate trainees on patient safety activities, as well as promote awareness of the patient safety systems in the institutions where they work.
In addition to using the traditional approach to teaching patient safety, disclosure of a safety event as well as introduction to the concepts of “Just Culture” and “safely doing less” add a unique perspective to the patient safety training module that we developed for pediatric trainees at our institution. Methods: This 4-hour learning activity was conducted using a formal didactic, followed by two different simulation activities. Each activity was followed by an interactive discussion/debriefing at the conclusion of the simulation case. Pre/post-test surveys were used for learner evaluation. The first case was used to assess learner knowledge of routine basic patient safety steps when evaluating a sick febrile patient. The second case was used to assess learner knowledge and comfort when confronted with disclosure of a patient safety event secondary to medication error to a patient’s family. Results: Participants showed significant improvement on content-based questions from 51.7% to 69.3% correct (p < .001). After Bonferroni correction, only the question on over diagnosis showed significant improvement (p = .001). Participants reported significantly increased confidence in all five of the areas evaluated (p < .001)(Table). Overall, participants evaluated the session highly, averaging between 3.89 and 4.07 for all sections of the workshop on a 5-point Likert scale. Conclusion: Our participants placed high value on the workshop. Specifically, the question on over diagnosis showed significant improvement on the post-test. Formal education on patient safety is crucial and should be an ongoing event. While this training module was specifically developed for pediatric trainees, it can be used for all types of learners comprising the healthcare team.

### Table. Pre- and Post-session Participant Self-reported Confidence

<table>
<thead>
<tr>
<th>Domain</th>
<th>Average Confidence Pre-test</th>
<th>Average Confidence Posttest</th>
<th>p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Communicating patient safety issue with families</td>
<td>2.54</td>
<td>3.31</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Identifying medical overuse/overdiagnosis</td>
<td>2.43</td>
<td>3.24</td>
<td>0.002</td>
</tr>
<tr>
<td>Reporting medical errors appropriately</td>
<td>2.25</td>
<td>3.38</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Identifying interventions to prevent medical errors</td>
<td>2.14</td>
<td>3.28</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Defining culture of safety</td>
<td>2.25</td>
<td>3.45</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Total</td>
<td>2.32</td>
<td>3.94</td>
<td>&lt;0.001</td>
</tr>
</tbody>
</table>

Number Key: 1 = Not at all Confident, 2 = Somewhat Confident, 3 = Confident, 4 = Very Confident, 5 = Completely Confident

95. INCORPORATING 3 GOOD THINGS INTO PEDIATRIC RESIDENT INPATIENT HANDOFFS

Bianca Argueza, MD, Diana Tsen, MD, Margaret McNamara, MD, Glenn Rosenbluth, MD, Daniel West, MD, University of California (San Francisco), San Francisco, CA

Background: Resident physicians experience burnout: emotional exhaustion, depersonalization, and reduced personal achievement. A potential way to reduce burnout is through the 3 Good Things (3GT) positive psychology exercise. Objective: To measure pediatric resident burnout and assess the feasibility, acceptability, and impact of incorporating 3GT into pediatric resident inpatient handoffs. Methods: A survey measuring emotional exhaustion, depersonalization, and personal achievement, was administered to incoming PGY1s (class of 2019) in a pediatric residency program at the beginning and end of their intern year. As a comparison, the same survey was administered to outgoing PGY1s (class of 2018) at the end of their intern year. PGY1 hospitalist teams incorporated an adapted version of 3GT into handoff throughout intern year (13 blocks). They completed a mixed-methods survey assessing participation, feasibility, and acceptability after each block. After block 5, the activity was abbreviated to One Good Thing (1GT) based on feedback, and incentives were introduced to encourage participation. Results: Participation varied widely (0-93%) among different blocks. Participation was higher for 1GT than 3GT (3.5 vs. 0.9 days/week). Practicing 1GT was faster than 3GT (1.8 vs. 2.3 minutes). Most participants felt that handoff (68%) and wellness (62%) were positively impacted, describing an optimistic ending to the day, reflection time, and team bonding as beneficial effects. Most participants (73.5%) wanted the activity to continue. Emotional exhaustion and depersonalization increased throughout intern year for the class of 2019. However, they had lower emotional exhaustion scores than the class of 2018 at the end of their respective intern years. Conclusions: Burnout increases throughout intern year, but 3GT/1GT positively affects wellness and may protect against emotional exhaustion. It is more feasible and acceptable to incorporate 1GT than 3GT into pediatric resident inpatient handoffs.

96. PROGRAM SELF-EVALUATION AND EDUCATIONAL PRACTICE IMPROVEMENT OF SENIOR PEDIATRIC RESIDENTS’ PERCEPTIONS OF PROCEDURAL COMPETENCE

Brittany J. DiFabio, MD, Denise S. McIntyre, MPH, Mike Derrick, MD, Syed A. Rizvi, MD, Olivia A. Butters, MD, Erik W. Black, PhD, Nicole Paradise Black, MD, MEd, University of Florida, Gainesville, FL

Background: Following the 2015-2016 ACGME third-year survey results, we identified 7 procedures where greater than 20% of third-year residents did not perceive themselves prepared to perform the noted procedures without supervision. Residents are informed of key procedures requiring competence prior to graduation, however at this point there was little scaffolding associated with the process. Timely and proper logging of procedures emerged as a secondary key concern. Aim Statement: By June 2017, at least 80% of third-year residents who respond to the ACGME 2016-2017 survey will respond “agree” or “strongly agree” to at least 10 of the 13 ACGME-required procedures and residents will increase the average number of procedures logged per resident per month from 2.6 to 5. Interventions 1. Posters displayed in specific clinical areas listing current procedure totals for each resident and displayed in clinical area (3/2017). Simplified method to log procedures (3/2017). 5. Implemented monthly rotation procedure “report card” on specific rotations (PICU, NICU, ED, Newborn, Acute), listing current procedure totals for each resident and displayed in clinical area (3/2017). Measures 1. Responses from the 2016-2017 ACGME survey to determine perception of procedural competence by third-year residents. 2. Average number of procedures logged per resident per month. Results 1. Responses: 80% of third-year residents. 2. Average number of procedures logged per resident per month from 2.6 to 5. Interventions 1. Posters displayed in specific clinical areas listing current procedure totals for each resident and displayed in clinical area (3/2017). Simplified method to log procedures (3/2017). 5. Implemented monthly rotation procedure “report card” on specific rotations (PICU, NICU, ED, Newborn, Acute), listing current procedure totals for each resident and displayed in clinical area (3/2017). Measures 1. Responses from the 2016-2017 ACGME survey to determine perception of procedural competence by third-year residents. 2. Average number of procedures logged per resident per month.
Residents who responded to the 2016-2017 ACGME survey responded “agree” or “strongly agree” to 6 of the 13 procedures. We saw improvements in the “agree” and “strongly agree” percentages in 9 procedures, with one moving to >80% (neonatal resuscitation) and one improving from 37.4% to 79% (IV). 2. Logging: We increased logging from 2.6 to 2.9 procedures per resident per month. Conclusions and Next Steps: By increasing resident awareness of the procedures required for graduation through various methods, as well as improving ease of logging procedures and a specific simulation for 1 procedure, we saw improvements in reported competence in 9 of 13 procedures and logging. Despite improvement, our initial PDSA cycles did not result in reaching our specific aims and therefore we are continuing to develop and study further interventions.

97. IMPROVING STANDARDIZATION OF PAGING COMMUNICATION USING QUALITY IMPROVEMENT (QI) METHODOLOGY
Rachel Weigert, MD, Medical College of Wisconsin Affiliated Hospitals, Wauwatosa, WI, Anna Schmitz, MD, Paula Soung, MD, Kelsey Porada, MA, Medical College of Wisconsin Affiliated Hospitals, Milwaukee, WI, Michael Weisgerber, MD, Medical College of Wisconsin Affiliated Hospitals, Wauwatosa, WI

Background: Paging is a primary mode of communication in hospitals, though it does not allow for direct response and contents are variable. This project aims to standardize paging practices to improve end user (EU) satisfaction, patient safety, and efficiency of care. Aim Statement: By January 2018, aims are to: 1) increase the percent of pages including six critical elements (CEs): senders first and last name, seven-digit call-back number, patient name, room number and urgency indicator (FYI, Call, Come) to 90%, 2) improve EU satisfaction to 80% rating paging communication as good or excellent and 3) decrease the frequency of patient safety events related to paging. Interventions: We conducted a hospital-wide QI project at our stand-alone academic childrens hospital. EUs determined six CEs required for effective paging communication. Interventions ranged from staff education to multiple alterations of the paging platform to optimize entry of CEs and ultimately with required fields for CEs. Measures: Paging data from 7 attending and resident pagers were analyzed monthly starting December 2015, excluding 2 months without extractable data. Survey data reflected multidisciplinary EUs including nurses, residents and attendings. Outcome measures were inclusion of all six CEs, EU satisfaction rating on a 5-point Likert scale survey and incident safety event reports. Process measures were inclusion of individual CEs. Balancing measures, including use of work-arounds, were tracked. Statistical process control charts were used to track the impact of interventions. Results: Special cause improvement was noted in use of all six CEs and specifically urgency indicator CE with means increasing from 4.4 to 78.0% and 46.1 to 99.5% respectively. EU satisfaction improved from 40 to 88% rating the paging system as good or excellent. Safety events related to paging ranged from 7-13 per year. Work-around usage decreased by 48%. Conclusions and Next Steps: System-wide use of required fields in our paging platform has resulted in significant improvement in inclusion of CEs and EU satisfaction. Safety events related to paging remain unchanged at low frequency. Work-arounds have been curbed by enhancements to improve ease of CE incorporation for EUs. Required fields should be considered at institutions seeking to improve standardization of pages and EU satisfaction.
98. AN INITIATIVE TO INCREASE PEDIATRIC RESIDENT LACERATION REPAIR PROCEDURE LOGS

Tracey L. Wagner, MD, Michael Dunn, MD, Sandra Spencer, MD, Nationwide Children's Hospital/Ohio State University, Columbus, OH

Background The Accreditation Council for Graduate Medical Education (ACGME) governs accredited residency programs for compliance with pediatric resident proficiency in several procedures. Our institution utilizes Suture Technicians; therefore residents may graduate without performing a sufficient number of required laceration repairs to reach proficiency. Aim Statement Increase laceration repairs logged by pediatric residents from a baseline median of 6.75 per month to greater than 30 per month by 7/01/2018 and sustain through 2019. The global goal is to increase competency and confidence in laceration repair. Interventions Initial interventions alerted faculty to the problem and increased the number of dedicated procedure shifts. A third intervention was to create a laceration repair education module for residents. Measures Procedure logs were monitored monthly as the primary outcome measure. Laceration procedure note documentation in the EMR was used as a process measure to determine the percentage of laceration repairs performed in the ED by pediatric residents. Our balancing measure was ED length of stay. Results Baseline data of pediatric residency logs from July 2015 to June 2016 demonstrated a monthly mean of 6.75 simple laceration repairs. Following the interventions, an increase was noted to a new mean of 22.75 laceration repairs logged per month. Unfortunately, when procedure shifts were decreased due to overlap, there was a trend to below the mean. As a processing measure, data was collected from the EMR on laceration repair procedure notes. There was no significant change in ED length of stay for patients with laceration repair after our interventions to increase resident repair rates. Conclusions and Next Steps Our QI interventions increased pediatric resident simple laceration repair procedure logs but not yet to our goal of greater than 30 procedures logged each month. Additional interventions include a post-test for the module. Over the next 2 years, the Graduating Resident Survey will be reviewed to determine if there are any changes in resident confidence in simple laceration repair.

99. ENHANCING BREASTFEEDING RATES USING CROSS-SECTIONAL DATA, SURVEYS, AND A POPULATION-BASED NEED INTERVENTION: A QUALITY IMPROVEMENT PROJECT

Ashley Colberg Sabo, MD, FAAP, Sonali Mehta Patel, MD, FAAP, Advocate Christ Medical Center, Oak Lawn, IL

Background Breastfeeding is recognized as the superior form of infant feeding by both the AAP and WHO. It has been linked to reduction in rates of otitis media, URI, GI illness, obesity and diabetes. Current national and local breastfeeding rates, including rates in our resident clinic, fall below goal according to Healthy People 2020 objectives. A variety of factors are possible causes of this, including lack of knowledge about breastfeeding benefits, lactation technique difficulties, insufficient family and social support, and inadequate physician knowledge and support. Aim Statement The purpose of this project is to implement an outpatient practice change aimed at mitigating barriers to breastfeeding in order to improve rates and thus improve the overall health of our infants. The goal is to increase overall breastfeeding by at least 10% within 1 year. Interventions Data on the use of breast milk vs. formula was obtained from a sampling of 30 patient charts each of newborn and 1 and 6 month olds. A survey asking about preferences and potential barriers to breastfeeding was then distributed to mothers at newborn, 1 and 6 month visits for 1 month. 77% of survey respondents reported that increased instruction from providers was most needed. We began monthly lactation reviews for residents discussing breastfeeding techniques, equipment, and benefits. Measures Charts were reviewed every 3 months after the intervention began, and the rates of breastfeeding were recalculated. A section to record whether breastfeeding support was given during visits was added to the charts in order to evaluate whether provider support is increasing and may be contributing to changes in rates. Results The overall breastfeeding rates increased from 50% to 70% for newborns, 13.3% to 53.3% for 1 month olds and 6.7% to 16.7% for 6 month olds over 9 months. Conclusions and Next Steps Using a needs-based survey, we generated an idea for a practice change to increase breastfeeding rates in our clinic population. Our results suggest that increasing provider education about lactation, so they may in turn confidently recommend and teach parents about breastfeeding, may increase overall breastfeeding rates in a clinic population such as ours. We have modified the intervention over successive PDSA cycles to further enhance rates. For example, we added nursing and medical assistant education, in order to increase the types of providers able to provide education to mothers and to extend applicability of the intervention to a larger variety of practice types.
100. IMPROVING JUNIOR MEDICAL STUDENT (JMS) PEDIATRIC KNOWLEDGE AND SATISFACTION WITH RESIDENT TEACHING USING PREMADE TEACHING RESOURCES
Kris Saudek, MD, Alina Burek, MD, Medical College of Wisconsin Affiliated Hospitals, Milwaukee, WI
Background At our institution third year medical students reported they would like more formal teaching from pediatric residents. Because residents have many clinical responsibilities, finding time for teaching on wards can be challenging. To address this limitation, we created premade teaching materials for residents to use with their students. Aim Statement Over the course of the 2016-2017 academic year we sought to: 1) improve JMS satisfaction with pediatric resident teaching (as measured by student surveys completed at the end of their rotation) by at least 0.5 points (on a 5-point Likert scale), and 2) improve pediatric knowledge score by 10% (as measured by our clinical knowledge test and the pediatric National Board of Medical Examination (NBME)). Interventions Premade powerpoints (ppt) covering general pediatric topics were made available to all pediatric residents on our educational platform to encourage formal teaching. Resident survey indicated the ppt were infrequently used due to lack of awareness of their existence and location. Two interventions were implemented at staggered time points to facilitate use of the ppt: 1) residents were educated about the ppt, and 2) fliers were placed in resident work rooms on wards. Measures Outcome measures included rating of the JMS satisfaction with resident teaching during their pediatric clerkship and average JMS scores on both clinical knowledge test (10 multiple-choice questions based on ppt content) and NBME scores. Process measures included percentage of residents using the ppt pre/post intervention (both self-report and tracking their use on our educational platform). Results Use of premade teaching materials increased post-intervention from 17% to 51%. Student satisfaction scores with teaching after intervention ranged from 4.26 to 4.52 (on a 5-point Likert scale). Average clinical knowledge scores increased by 10% (68% vs 71%). Recent NBME scores are increasing and have been consistently above the national average (Fig). Conclusions and Next Steps Premade teaching material increased the number of formal resident driven teaching sessions on a pediatric clerkship. An increase was noted on both, the clinical knowledge scores and NBME scores. Next steps will be to standardize the format of the ppt and make systematic changes to resident teaching requirement to promote formal teaching on wards.

101. IMPROVING A PEDIATRIC RESIDENCY PROGRAM’S BOARD PASS RATES AND IN-TRAINING EXAM SCORES BY STRICTLY IMPLEMENTING AN ACADEMIC CURRICULUM AND CUSTOMIZED IMPROVEMENT PLAN
Melissa R. Grageda, MD, Ana Mendez, MD, Teresa Lemma, Richmond University Medical Center, Staten Island, NY, Rudrani Belnekar, Richmond University Medical Center, Staten Island, NY, Jiliu Xu, Jane Ponterio, Brian McMahon, Richmond University Medical Center, Staten Island, NY
Background Our pediatric residency training program struggled with low board pass rates last year. Timely assessment of trainees’ medical knowledge was then prioritized, in order to identify and assist individuals in need of focused academic mentorship. Aim Statement We aimed to increase the board and in-training exam (ITE) pass rates of pediatric resident trainees to 80% over a 12-month period. Interventions At the start of the academic year, our academic committee strictly implemented a curriculum comprised of weekly lecture series and regular mandatory assessments (i.e., block exams). During the third quarter, trainees performing below academic expectations were identified and placed on individualized academic improvement plans. Such plan included an initial study habit assessment, weekly review sessions, and customized mock in-training exams. Measures The process measure was the block exam pass rate, and outcome measures were the following year’s standardized (ITE and board) exam pass rates. For this project, we set the passing ITE score at the reported 5-year moving average per level-specific ITE scaled score group. The model for improvement and serial PDSA cycles were utilized to test changes throughout the study. The average increase in standardized exam scores of trainees before and after implementation of the study curriculum and academic plans was compared. Results There was a gradual improvement in the block test pass rates over 12 months. Nine out of eighteen trainees were placed on academic improvement plans. The in-training and board exam pass rates improved the following year (from 39% to 61%, and 17% to 83%, respectively). There was a statistically significant difference in the average increase in standardized exam scores before and after implementing the study curriculum and academic plans (0.3 vs 44.8 point increase, respectively, p<0.0005). Conclusions and Next Steps Strict implementation of an academic curriculum and customized improvement plans was associated with an increase in ITE scores, and improved board pass rates.
102. HIV SCREENING IN AN URBAN ADOLESCENT POPULATION
Paul Broker, MD, Melony Chakrabarty, MD, Jan Piatt, MD, Michelle Huddleston, MD, Jason Santiago, MD, Jennifer Farabaugh, BA, Kristen E. Samaddar, MD, Phoenix Children's Hospital, Phoenix, AZ

Background: The risk for HIV/AIDS is often unrecognized in adolescent populations. In 2015, 22% of new HIV diagnoses were in persons aged 13-24 years (37.2 per 100,000 population), of which, 8% were diagnosed with AIDS. Despite national and international recommendations for routine HIV screening starting at age 15, screening rates remain low. In line with this trend, average HIV screening rates for adolescent patients in our urban General Pediatrics and Adolescent clinic were only 3% from 2015-16. Aim Statement: Our aim is to increase HIV screening rates during preventative and sick visits for patients aged 15 to 24 by December 2017. Secondary aims are to destigmatize HIV screening and increase physician-patient counseling of high-risk behaviors. Interventions: Several PDSA cycles were implemented: education of the multidisciplinary clinic team; creation of a standardized screening workflow; introduction of rapid HIV testing; design and distribution of an educational pamphlet for families; and development of a nursing driven protocol. Measures: Data was obtained and analyzed for percentage of adolescents screened during preventative, sick, and combined visits monthly. Results: Screening results for each time interval are as follows: November 2015-April 2016 (6 months) 3.8% combined, 3.2% preventative only; May-December 2016 (8 months) 7.9% combined, 10.6% preventative only, 7.1% sick only; January-August 2017 (8 months) 10.8% combined, 21.9% preventative only, 4.8% sick only; September 2017 (4 months) 9.8% combined, 23.1% preventative only, 3.1% sick only. Conclusions and Next Steps: HIV screenings in our clinic increased 7-8 fold at preventative care visits. Additional successes include incorporated education pamphlets, interdisciplinary teamwork and engagement of families in the screening process that has been standardized and destigmatized. Additionally, accessing rapid point of care HIV testing was shown beneficial in increasing screening rates. Currently a nursing driven protocol for rapid HIV screening is being implemented with the goal of increasing the success of the screening program even further.

103. A RESIDENT LED QUALITY IMPROVEMENT INITIATIVE TO IMPROVE OFFICE VISIT CYCLE TIME
Stacie C. Kahn, MD, SaiEldeen Alzoobaee, MD, Anthony Yuen, MD, Katherine Armstrong, MD, Ashley Cozzo, MD, Kristin Crosby, MD, Bryce Hoffman, MD, Shazia Lutfieali, MD, Lauren Navallo, MD, Jenna Piccininni, MD, Dara L. Rajeshwar, MD, Hilary Schreiber, MD, Sevini Shabbaz, MD, Erika Abramson, MD, MSc, Snezana Osorio, MD, MS, Efniki Kyvelos, MD, MS, New York Presbyterian Hospital (Cornell Campus), New York, NY

Background: The provision of care in a timely fashion is one of the six aims of health care quality put forth by the Agency of Healthcare Research and Quality (AHRQ), a division of the United States Department of Health and Human Services. The AHRQ states that prolonged waits and delays can be harmful for both those receiving and those giving care. Aim Statement: At the Pediatric Resident Group Practice by June 2017 we aimed to: 1. Decrease Overall Clinic Visit Time by at least 30%. 2. Decrease Procedure Wait Time (blood work and immunizations) by at least 30%. 3. Maintain the average Resident Physician Visit Time (time spent with the patient in the exam room). Interventions: In this observational time series, data were collected monthly from December 2016 to June 2017. The inter-professional team including residents, nurses, technicians and attending physicians performed a series of planned sequential interventions to improve flow in the procedure area and to inform the patients of estimated wait time. Measures: Time data was collected with the use of a patient flow sheet (as the patients moved through the clinic the time of their arrival, registration, triage, physician encounter, procedures, and checkout were recorded). Data were analyzed using statistical process control charts and established Associate for Process Improvement (API) rules for detecting special cause variation were applied. Results: We measured wait times for total of 28 visits. Average Overall Visit Time was 96.3 minutes with average time between the physician visit and
 completion of procedures (Procedure Wait Time) of 26.5 minutes. Procedure Wait Time decreased significantly from 26.5 minutes to 15.2 minutes (43%), while Overall Visit Time decreased significantly from 96.3 minutes to 49.9 minutes (48%). In assessing the balancing measure, the time spent with a physician, it appeared that residents achieved a balance and there was no change in the overall Resident Physician Visit Time of 39.1 minutes. Conclusions and Next Steps Implementation of this quality improvement project identified target areas for improvement in timeliness in the Resident Group Practice. Recognition of these problem areas and multiple interventions resulted in significant decreases in both targeted areas of Procedure Wait Time and Overall Clinic Visit Time. Future interventions will address timeliness during other portions of the clinic visit.

104. CONTINUITY CLINIC REPORTING
Megan F. Neuman, MD, John Frohna, MD, University of Wisconsin, Madison, WI
Background The ACGME requires continuity clinic to provide exposure to the spectrum of normal pediatric development at all ages, as well as to special health care needs and chronic conditions. Historically paper logs provided this information, but research shows them to be fraught with errors. The electronic medical record (EMR) offers a tremendous opportunity for more robust information on residents’ experiences in continuity clinic. In our mid-sized academic pediatric residency, residents have continuity clinics at seven faculty clinics, a community health center, and 4 clinic sites in 3 other health systems. Aim Statement To identify pertinent measures for continuity clinic reports and to have reports on all residents within 1 year. Interventions We formed a work group with stakeholders including the continuity clinic director, preceptors from 3 health systems, and senior residents. We collaborated with partners in the EMR and billing departments. The group established, implemented, assessed, and refined data collection in Plan-Do-Study-Act (PDSA) cycles. Measures Based on literature and program goals, we identified six measures to report: patient age and gender, average visits per session, visit type, diagnoses, and payor mix. Results After the first implementation cycle, we reported on 29 of 45 (64%) of residents, all from faculty clinics. Reports included patient age and gender, as well as average visits per session. We also collected diagnoses seen, but analysis was limited due the ICD9 to ICD10 transition. After the second implementation cycle, we had data on 44 of 45 (97%) of residents; in the third cycle, 100% clinics reported. We added payor mix in the second cycle and the proportion of preventative visits in the third cycle. Conclusions and Next Steps Preceptor involvement was key to success, especially for data sharing between health systems, and involvement was encouraged by availability of MOC Part 4 credit. Because reports are generated automatically from EMR data, ongoing reporting is sustainable. These reports will be used to identify and fill gaps in clinic experiences at resident, clinic site, and program levels. This approach illustrates how other programs can obtain comprehensive continuity clinic data, which may inform their quality improvement efforts.

105. ENHANCED MEANING IN WORK THROUGH EFFICIENT AND EFFECTIVE DISCHARGE SUMMARIES
Christine Skurkis, MD, Christine Pulice, DO, Megan Griffiths, MD, Karen Rubin, MD, Christopher Grindle, MD, Kalpana Shenoy, RN, MSN, Edwin Zalneraitis, MD, University of Connecticut, Hartford, CT
Background Residents and faculty devote excessive time to documentation. Discharge summaries lacked timely completion. Faculty were cited for 772 (10.3%) delinquent summaries (>30 days after discharge) in one year due to resident delays in dictating summaries. Only 27% were completed within 24 hours of discharge. PCPs and families cited frustration due to delays in discharge summaries at follow up. Aim Statement By December of 2016, greater than 50% of discharge summaries will be completed within 24 hours of discharge. We added payor mix in the second cycle and the proportion of preventative visits in the third cycle. Conclusions and Next Steps Preceptor involvement was key to success, especially for data sharing between health systems, and involvement was encouraged by availability of MOC Part 4 credit. Because reports are generated automatically from EMR data, ongoing reporting is sustainable. These reports will be used to identify and fill gaps in clinic experiences at resident, clinic site, and program levels. This approach illustrates how other programs can obtain comprehensive continuity clinic data, which may inform their quality improvement efforts.
final progress note combined was reduced from 20 minutes to 5 minutes on average. Residents, faculty and PCPs reported universal satisfaction starting immediately with full implementation, faculty noted additional professional and personal time, and there were no family complaints. Conclusions and Next Steps We were able to design an efficient and effective discharge summary that improved timely handover to PCPs, reduced delinquencies and increased provider time for meaning in work. Next steps are to further improve discharge timeliness and to revise our EPIC daily progress note to improve timely completion and improve consistency of information shared.

106. OPTIMIZING PEDIATRIC RESIDENT HANDOFFS BY MINIMIZING INTERRUPTIONS
Emy Abraham, MD, Meghan Jacobs, MD, Samara Appelstein, DO, Jennifer Nead, MD, SUNY Upstate Medical University, Syracuse, NY

Background Resident handoffs are essential to communicating clinical information in a concise and precise manner. Despite the implementation of I-PASS at our residency program, frequent interruptions during handoffs often jeopardize patient safety and continuity of care. Aim Statement We sought to decrease the number of interruptions during pediatric resident handoffs by 50% within 2 months. Interventions Two complementary interventions were studied simultaneously during handoffs: an email sent to nurses/residents/attendings reinforcing the policy for protected handoff times with hands-free communication devices (Vocera) placed on “do not disturb” mode and providing baskets for residents to set aside cell phones. Subsequent tests of change adapted the two interventions into a checklist that was integrated into the 8 situational overview aspect of I-PASS, inspired by the similar use of checklists in the aviation industry.

Measures Handoffs were directly observed to identify the frequency of the most prominent types of interruptions as the primary outcome measure. Baseline data revealed interruptions consisted of nurse calls on Voceras, attendings walking in, and resident use of cell phones.

Results Over the course of 2 months with two different resident teams, the run chart pattern strongly supports a decrease in the overall number of interruptions from a baseline median value of 4, and achieving the intended goal of less than 2 interruptions per handoff. Further stratification of data for subset analysis also demonstrates special cause variation with shift in data points for Vocera and cell phone interruptions, both of which involved tests of change requiring an active participation by the residents. This indicates the interventions were attributable for improved changes in the process. Conclusions and Next Steps Implementation of a checklist can lead to a substantial decrease in interruptions during resident handoffs, and can be easily applied by other institutions using I-PASS. Future PDSA cycles involve studying a daily alert or sign posted at start of handoffs, compliance with the checklist as a process measure of implementation, and the length of handoff as a balancing measure.

107. IMPLEMENTATION OF THE NEW BRUE (BRIEF RESOLVED UNEXPLAINED EVENT) GUIDELINES: A QUALITY IMPROVEMENT AND COST-SAVINGS INITIATIVE
Rupin Kumar, MBBS, Diksha Shrestha, MBBS, Sayali Yewale, MBBS, Renuka Verma, MD, Monmouth Medical Center, Long Branch, NJ

Background Significant variation exists in the evaluation and management of patients experiencing a Brief Resolved Unexplained Event (BRUE), previously known as Apparent Life-Threatening Event (ALTE). In May 2016, the AAP published the first Clinical Practice Guidelines (CPG) specific for patients experiencing BRUE. The CPG provide an approach to evaluation based on risk stratification, as well as management recommendations for the lower-risk infants. We suspected based on anecdotal experience that our institution did not adhere to the CPG. This may lead to extensive laboratory studies and radiologic work-up which is unnecessary for low-risk BRUE patients. Aim Statement This study aims to use quality improvement methodology to improve our classification and subsequent management of BRUE through increased adherence to the CPG. With emphasis on low-risk BRUE patients, we aimed to reduce (by 1/12/17): 1. Rate of admission by at least 25% 2. Cost of hospitalization by an average of $2,000 per patient per hospitalization 3. Number of studies involving radiation exposure (X-Rays and CT scans) by 50%, pneumocardiograms by 50% and laboratory investigations (CBC, respiratory viral panel) by 25%. Interventions Interventions included multiple lectures, Grand Round presentations and educational posters to update residents, inpatient and ER providers regarding the appropriate management of patients with low risk BRUE as per the CPG. Non-adherent physicians were identified and follow-up email reminders were sent at the end of each PDSA cycle (3 months). Measures Low-risk BRUE patients who were either discharged from the ER or admitted to the ward were compared...
Cumulatively, the first PDSA cycle increased transfusion consent to a return to baseline occurring in 2 months after the first intervention. Both cycles demonstrated a downward trend over time, with month following cycle 2, the documentation percentage tripled (see figure). After each intervention, inpatient charts were reviewed for measures. After each intervention, inpatient charts were reviewed for consent documentation over a two month period. Results After each intervention, inpatient charts were reviewed for consent documentation over a two month period. Results

Background Residents routinely consent patients for blood transfusions without any formal training on how to discuss or document consent. Kaiser Oakland policy requires consent prior to the first transfusion of each hospitalization. Baseline data demonstrated only 21.4% of inpatient pediatrics patients had documented consent, prompting this resident-led quality improvement project. Aim Statement To screen > 50% of patients for FI at well visits by October 2018 Interventions Provider education and supplying screening tools, incorporating FI screen in the electronic medical record (EMR) Measures Three stages of data were analyzed: 1) baseline practice habits 2) provider education including screening tools and 3) integration of a FI screen in EMR. During the re-design of the EMR template, two validated screening questions (Hager et al, 2010) were embedded in the screening section. 60 well child visits (20 from under 1yr, 1-4yr, and 5-11yr) were randomly selected and reviewed. We measured frequency of screening, positive responses to screening questions, and any pertinent comments about FI in the plan. Results At baseline, FI screening was not documented for any chart reviewed. After education, screening rates increased to 8.3%. Following integration with EMR, screening rates were 70%. FI was identified in 9.5-20% of those screened. The ANOVA single factor test showed significant difference between the three groups. Tukey’s HSD post hoc test showed that there was a significant difference in the number of screens performed between Stage 1 and 3 and between Stage 2 and 3. There was no significant difference in screening between Stage 1 and 2. demonstrating that education alone did not suffice to increase screening. Conclusions and Next Steps An EMR embedded FI screen serves as a reminder and allows for quick, effective documentation. Many patients with FI were identified and given resources. This project seeks to shift current clinical practice by demonstrating that FI screens should be integrated into all preventative care documentation as provider education alone did not suffice to increase screening. Next steps include identifying more resources to provide families, improve follow up to monitor resources utilization, and encourage the use of the screen in other clinical settings.

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110. A RESIDENT-LED QUALITY IMPROVEMENT INITIATIVE TO IMPROVE FOOD INSECURITY SCREENING AND REFERRAL AT THERESA LANG CHILDREN’S CENTER

Angela Chan, MD, New York Presbyterian Hospital (Cornell Campus), New York, NY, Robyn E. Rosenblum, MD, New York Presbyterian Hospital (Cornell Campus), Flushing, NY

Background: Food insecurity, an inadequate access to food, is associated with adverse health outcomes, yet is not routinely addressed in clinical settings. The AAP’s Policy Statement in October 2015 recommends using the USDA’s 2-question validated screening tool at health care maintenance visits, to promote food security for all children. However, at the New York Presbyterian Queens (NYPQ) Resident Clinic, food insecurity rates are largely unknown. Aim Statement: By June 2017, at the NYPH Resident Clinic we aimed to: 1. Increase screening rate of household food insecurity to 50%. 2. Increase referral rate to Women, Infants and Children, Nutrition and Food Service (WIC)/Supplemental Nutrition Program (SNAP) for patients who screen positive to 90%. 3. Maintain infant and toddler autism screening using MCHAT as a balancing measure.

Interventions: Cycle 1: Set up 2 question text macro in EMR and posted flyers in the exam rooms. Cycle 2: Printed referral handouts (WIC/SNAP) and made them readily available. Cycle 3: Group email reminders were sent and in-time feedback was given to the team. Measures: The Model of Improvement was used for this Quality Improvement (QI) project. From December 2016 to June 2017, residents screened patients for food insecurity using USDA’s 2-item screening tool and made appropriate referrals to WIC/SNAP/community resources. Residents performed 3 plan-do-study-act (PDSA) cycles focused on maintaining process improvements. Data were collected via EMR review on resident documentation of screening and referrals. Statistical control charts were utilized to display and analyze the data. Associates in Process Improvement rules were applied to detect special cause variation. Results: Similar to the national food insecurity rate of 21%, our data showed a rate of 21.9%. Residents food insecurity screening rate improved from 0 to an average of 57% over 6 months and 100% were referred. Although screening goals were met, results showed that 64.2% of patients screened were already connected to community resources (WIC, SNAP, or both). An unexpected significant increase in MCHAT screening rate from 57% at baseline, to 88% was observed. Conclusions and Next Steps: In this resident led QI project, the QI team successfully implemented the AAP recommended screening tool and established previously unknown food insecurity rates. Residents improved food insecurity screening rates and achieved outcome goals of 100% referral to WIC and SNAP. MCHAT screening improvement rates likely reflect their awareness of the importance of screening documentation. Future studies will need to address the identified gap between patient reported connection to WIC and SNAP and yet having food insecurity, and also to address the impact of food insecurity on child growth and development.

111. IMPROVING PHYSICIAN TO PHYSICIAN COMMUNICATION OF PICU TRANSFERS TO RNF AT CLEVELAND CLINIC CHILDREN’S

Aiman Altaqi, MD, Sarah Davidson, MD, Jessica Smith, DO, Niyati Bondale, MD, Katie Pestak, DO, Arnaldo L. Zayas-Santiago, MD, Cleveland Clinic Foundation, Cleveland, OH

Background: ACGME developed an initiative aimed at supporting and spreading innovation to transform the clinical learning environments where residents pursue their training. Motivated by this initiative, a survey was conducted and showed that over 90% of Pediatric Residents had received a patient to regular nursing floor (RNF) from Pediatric Intensive Care Unit (PICU) without sign-out, leading to work inefficiency and unsafe patient transfers. Hoping to improve transitions of care, a Quality Improvement Project followed. Aim Statement: After baseline data was obtained, interventions were implemented to increase the number of PICU to RNF transfers with sign-out completed from 70% to over 90%. Interventions: A Pediatric Resident quarterback role was developed to accept and distribute all PICU to RNF transfers. To ensure clear documentation that sign-out had taken place, a PICU transfer note was incorporated into the patient’s electronic record. Education sessions for stakeholders involved followed. Measures: Our primary outcome measure was the percentage of PICU to RNF transfers occurring with sign-out. Results: Prior to our QI project, 70% of PICU to RNF transfers were occurring with sign-out. After interventions were implemented, this number increased up to 100%. Conclusions and Next Steps: After breaking down and reviewing the PICU to RNF transfer process at our Institution, we were able to target areas for improvement. Following QI methodology we were able to increase the percentage of PICU to RNF transfers occurring with sign-out from 70% to 100%. Initial inconsistent results following interventions, were attributed to new process lack of awareness and process fatigue and
subsequent education sessions were needed to ensure goal was achieved. Next step is to look at percentage of readmissions to PICU within first 24 hours after transfer to RNF.

112. PATIENT SAFETY EVENTS - IMPORTANT, BUT NOT REPORTED
Sarah Francis, MD, Kristen Samaddar, MD, Richard Engel, MD, Anna Gary, MD, Jennifer Farabaugh, Lilia Parra-Roide, MD, Phoenix Children’s Hospital, Phoenix, AZ
Background Recognition of preventable medical errors is a well-established public health priority, but more recently gaining attention in residency education. The ACGME CLER patient safety pathway emphasizes the role of residents in identifying, reporting, and understanding the importance of patient safety events. Despite frequent encounters with safety events, residents are historically known to under report. Aim Statement Understand resident perception of patient safety and medical errors, identify barriers to reporting, and increase total reports made by resident by 50%. Interventions An anonymous pre-intervention survey was distributed to residents at Phoenix Children’s Hospital in September 2017. Questions included involvement in safety events, event reporting, barriers to reporting, and overall perception of patient safety. Following the survey, the Medial Director of Patient Safety and Quality led a conference on key safety topics. In January 2018, safety whiteboards were introduced into team workrooms as a visual reminder and to reduce time required by residents to outline safety events. Senior and/or chief residents will review these boards weekly and assist with submitting events online. Measures Effectiveness of interventions will be measured using number of reports made by residents in the hospital online reporting system. Results The pre-intervention survey found that residents, on average, feel reporting safety events is important, rating it 4.5/5. In the month prior to survey, 48% of respondents reported being involved in a safety event, while only 13% reported this event. Identified reasons for not reporting include lack of knowledge of how to report (n=35) and amount of work to report online (n=32). Before interventions, residents on average placed 3-6 reports per month in the online reporting system. Conclusions and Next Steps Residents value patient safety event reporting and recognize its importance to patient care. However, there are many barriers to event reporting, most notably lack of knowledge and degree of difficulty in using the reporting system. We have implemented a basic whiteboard tool to improve speed of documentation. We are eager to collect data on number of patient safety events identified and recorded by residents post-implementation.

113. WELLNESS IN TRAINING INITIATIVE (WITI)
Ansi Hakkim, MD, Albert Shan, MD, Ma Khin Khin Win, MD, Natalia Rimareva, MD, Menogh Glen Valentine, MD, Brooklyn Hospital Center, Cynthia Katz, MD, Icahn School of Medicine at Mount Sinai, NYC, NY
Background Existing studies of resident wellness report overall burnout rates exceeding 50% among residents in training. A survey at baseline conducted in our pediatric residency program determined that 50% of our residents met burnout criteria among which 68% met criteria for severe burnout. Aim Statement To decrease overall burnout rates in pediatric residents at our program utilizing focused interventions over a 9 month period. Interventions Our interventions focused on identifying burnout, improving work environment and providing resources to promote wellness. PDSA 1 addressed existing burnout with didactics,
Background In the 2017-2018 academic year, we began a pilot using Entrustable Professional Activities (EPAs) as a framework for facilitating more frequent and specific feedback in the Emergency Department (ED). We created an on-demand evaluation form and allowed residents to choose which EPA on which to be evaluated. Residents were instructed to get feedback after most scenarios.

Conclusions and Next Steps Our QI project is an attempt to multifaceted resident wellness curriculum to decrease resident burnout and promote wellness. After the implementation of the interventions in a phased manner, the rates of severe burnout dropped significantly from 66% to 16.7%, demonstrating success of the WiT Initiative. The project is ongoing in the pediatric department and has also expanded to involve other residency programs at our institution.

114. IMPROVING CONFIDENCE IN NEONATAL RESUSCITATION SKILLS IN RESIDENTS IN THE NICU AND NEWBORN NURSERY
Angela Lai, MD, Lawrence N. Bennett, MD, Loyola University, Maywood, IL

Background Despite initial certification of delivery room skills via the Neonatal Resuscitation Program (NRP) at the beginning of Pediatric residency and renewal every 3 years, the majority of US resident trainees do not retain NRP knowledge and long term resuscitative skills. “Deliberate practice and focused education” has been shown to help residents retain, improve, and maintain their resuscitation skills over a 1-2 year residency period. Aim Statement In first year residents rotating through neonatal intensive care (NICU) and newborn nursery (NBN) rotations, we aim to increase confidence with delivery room equipment setup and improve scores on resuscitation simulation by 50% in their first year and continue to maintain that skill level throughout training. Interventions Pediatrics and Medicine-Pediatrics residents were followed for 18 months during their NICU and NBN rotations. Cycle 1 standardized resident NRP education with dedicated time and equipment for practice. In cycle 2, review was limited to small groups with individualized immediate feedback and standardized simulation. In cycle 3, simulation was completed in an actual delivery room, emphasis was placed on troubleshooting, and feedback was given in real time. Measures The three outcomes measured were 1) confidence in leading resuscitations in four delivery room scenarios, 2) delivery room equipment setup, and 3) performance on a resuscitation simulation. Results The percentage of residents who were “somewhat confident” (answered > 5 on a 1-9 Likert scale, 1=not comfortable, 9 = very comfortable) increased or were similar in 3 scenarios (40 week meconium, 35 week NSVD, 33 week pre-eclampsia) but decreased slightly (17% to 11% by cycle 3) in the 26 week resuscitation scenario. Median equipment setup scores did not differ considerably across cycles. Median simulation performance scores increased slightly from cycle 1 to cycle 2 (0.45 to 0.87 with maximum score 1) and were maintained in cycle 3 (0.87). Conclusions and Next Steps In summary, while there was no significant improvement of delivery room setup and simulation scores, these skills were maintained and did not decline over time. Confidence in leading resuscitation did trend upward with increased exposure to simulation through the cycles, except for the extremely premature neonate. Increasing time for dedicated practice of neonatal resuscitation skills with simulation increases resident confidence in the delivery room for most scenarios.

115. IMPROVING COMPLETION RATE OF REAL-TIME EPA-BASED FEEDBACK IN THE EMERGENCY DEPARTMENT
Emily Borman-Shoap, Dorothy Curran, MD, Vishal Naik, MD, Timothy Raushcke, MD, Benjamin Ryba-White, MD, University of Minnesota, Minneapolis, MN

Background The goal of this project was to improve completion of EPA-based feedback forms in the ED. Our intervention was an on-demand form and feedback at every shift. Our goal is to implement a series of PDSA cycles to improve completion rates. Aim Statement Increase average number of real-time EPA evaluations completed per resident per rotation by 30% from baseline at the University of Minnesota Masonic Children’s Hospital ED by February 2018. Interventions Our first intervention was to post reminder signs in the ED. We also did surveys at the end of each rotation to identify barriers to getting EPA-based feedback. Measures Data collected includes the number of EPA-based feedback forms completed each rotation, number of different faculty completing the forms, and types of EPAs assessed. Barriers identified in
end of rotation survey are also being tracked. Results 20 residents have been a part of the pilot. The first 3 months served as our baseline; average completion rate was 2.4 EPAs per resident. In the next 3 months, completion rates per resident averaged 1, 2.3, and 0. Individual completion rates range from 0 to 7. A total of 37 episodes of EPA based feedback have been recorded. Ten different faculty members have given feedback using the EPA form. The most commonly chosen EPAs for evaluation were EPA 4--Acute, common diagnoses (50%), followed by EPA 17--procedures (18%). Analysis of barriers to obtaining EPAs showed that top 4 identified by residents were 1) too busy 2) forgot 3) did not know EPAs were expected and 4) attending shift ended prior to completion of evaluation. Conclusions and Next Steps Our baseline data support the idea that EPAs can be a viable method of feedback in the ED. Without reinforcement of the goals of the pilot, we saw a drop off in completion rate as compared to our baseline. We have also noted significant variation among residents. Planned future interventions include: reinforcing goals of the pilot with residents, giving feedback to attendings on who has completed evaluations, faculty development sessions, and posting a dashboard in the ED for residents to track completion.
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All you need to know about the Annual Meeting is now available on the APPD Mobile APP. For downloading information, please see the insert provided at registration.

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

Live-Streaming / Recording Prohibited
The use of live-streaming devices and other recording devices during the APPD Meeting is prohibited.

Mother’s Room
In order to provide privacy and convenience to breastfeeding mothers, a room has been reserved each day from 8am-6pm. Please stop by the registration desk for instructions on how to access the room.

Luggage Storage
As you check out of your hotel rooms on Friday morning, you may store your luggage in L504-L505. Please note that luggage will be left at your own risk, with neither APPD nor the Atlanta Marriott Marquis Hotel assuming any responsibility for your belongings.

CME
CME credit for physicians for the APPD program is included in your registration fee.

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laura@appd.org

Kathy Haynes Johnson, Associate Director
kathy@appd.org

Rosemary Haynes, Association Manager
rosemary@appd.org

Daglyn Carr, Association Administrator
daglyn@appd.org

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- Leadership to make decisions quickly and appropriately
- Ability to lead conference calls to guide group discussion in an organized fashion
- Delegation skills to share responsibilities and provide opportunities for leadership in others
- Prior experience reviewing APPD and/or PAS abstracts
- Familiarity with CME requirements and process
- Willingness to commit 1-2 hours weekly during fall and winter, increasing to 5-6 hours per week for a week during two busy review and notification periods, and perhaps up to 8-10 hours per week for a week or two total during review process for individual Enhanced Learning Sessions (formerly workshops) and Educational Scholarship and QI abstracts, including abstract review and group rank discussions
- Enjoy the process - it's so much fun to see what everybody is doing!!

Interested candidates should submit a brief application to info@appd.org to include
  (1) list of relevant experience
  (2) paragraph describing interest
  (3) priorities for the APPD Annual Spring Meeting

For additional information on duties and responsibilities, please go to www.appd.org/pdf/APPDSpringMtgProgPlanningExecCtte_RolesResp_Rev2018.pdf

The 2018 Program Chair, Andie Asnes, would also welcome your questions about her experiences with this process. Please contact her at andrea.asnes@yale.edu or talk to her during the meeting.

The APPD Board of Directors will review all of the applications and invite the best applicant to serve.

Deadline to apply is May 9.
APPD Global Pediatric Educator Scholarship Recipients

For the second year, the APPD Global Health Learning Community is delighted to welcome two recipients of the APPD Global Pediatric Educator Scholarship. Many pediatric educators from around the globe seek to improve child health by advancing pediatric education in their countries, but often lack access to the educational resources we enjoy through professional associations and conference attendance. Our goal is to recognize pediatric educators who demonstrate early leadership in improving pediatric education in low and middle income countries, and to provide them with additional career development and/or networking opportunities by inviting them to attend the APPD spring conference. We hope that by sharing educational resources and fostering collaboration with these colleagues that we will further the goal of ensuring the health and well being of all children everywhere.

Dr. Sommanikhone Phangmanixay finished medical school in Laos, a small land locked country between Thailand and Cambodia in 1987. After completing her pediatric residency in 2001, sponsored by Health Frontiers, Dr. Sommanikhone was assigned to the provincial hospital in Bokoeo, where she was deputy director for 15 years. This hospital serves an area of 200,000 people. While there, Dr. Sommanikhone focused on developing educational programs for improving maternal and child health within the hospital and in the community. She returned to Vientiane in 2006, as University Faculty and Head of the pediatric department at the central teaching hospital, where she was responsible for teaching medical students and residents.

In 2012, when the Children’s Hospital opened, Dr. Sommanikhone was appointed deputy director in charge of all educational programs. She serves as the countrywide Chairperson of IMCI (Integrated Management of Child Illness) and Vice Chairperson of the Pediatric Association in charge of on-going medical education.

Since becoming Director in 2016, Dr. Sommanikhone’s focus has been to improve the quality of care in the hospital and to address issues pertaining to maternal and child health.

Dr. Alhassan Abdul-Mumin hails from the republic of Ghana in West Africa. He currently works as a senior Pediatrician and senior lecturer at the Tamale Teaching Hospital and University for Development Studies, School of Medicine and Health Sciences, Tamale, Ghana. The hospital is the only teaching hospital in the Northern part of Ghana with a pediatric bed capacity of 120 and 40 neonatal ICU beds serving a population of about 2.4 million.

As the head of department for Pediatrics, he coordinates the daily learning and teaching of medical students rotating through the department. He is also responsible for the training of house officers (interns) and supervises the daily clinical work of other junior doctors in the department. He oversees a mentoring program aimed at recruiting more junior doctors into the pediatric residency program in Ghana in order to increase the strength of faculty in the university. This program has so far yielded 2 specialists, 1 resident in training and 7 junior doctors ready to enter residency in September 2018.

His ultimate long term goal is to establish a full Pediatric residency program in Tamale, Ghana.
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