The Evolution of Residency Training: Adapting and Innovating in a New Era

March 28 - 31, 2012
San Antonio, TX

San Antonio Marriott Rivercenter
101 Bowie Street, San Antonio, TX

*This activity has been approved for AMA PRA Category 1 Credit™*
<table>
<thead>
<tr>
<th><strong>Wednesday, March 28</strong></th>
<th><strong>Thursday, March 29</strong></th>
<th><strong>Friday, March 30</strong></th>
<th><strong>Saturday, March 31</strong></th>
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<td>7:00am</td>
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<tr>
<td>Registration Begins</td>
<td>Breakfast and Platform Presentations -- Best of Research and QI Abstracts</td>
<td>APPD Governance Panel Presentation</td>
<td>Continental Breakfast</td>
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<td>8:00 – 11:00am</td>
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<td>Continental Breakfast</td>
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<tr>
<td>Forum for Directors of Small Programs/Affiliate Chairs</td>
<td>APPD Awards and Annual Reports</td>
<td>8:00 – 10:00am Workshop Session I</td>
<td>Coordinators' Workshop</td>
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<td>8:00am – 1:30pm</td>
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<tr>
<td>Coordinators' TAGME Exam (prior registration necessary)</td>
<td>Task Force Meetings</td>
<td>Coordinators' Workshops</td>
<td>Wrap-Up Session from Grassroots Forums</td>
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<tr>
<td>Forum for Chief Residents</td>
<td>Lunch on Own</td>
<td>Break</td>
<td>Workshop Session III</td>
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<tr>
<td>11:00am – 3:30pm</td>
<td>Mentoring Session (prior registration necessary)</td>
<td>12:45 – 2:15pm</td>
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<tr>
<td>Pre-Conference Workshops (separate registration required)</td>
<td>Council of Regional Chairs Luncheon</td>
<td>Regional Lunch Meetings</td>
<td>Break / Check out of hotel</td>
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<tr>
<td>1:30 – 1:50pm</td>
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<tr>
<td>Coordinators' Orientation</td>
<td>APPD Presidential Address</td>
<td>Poster Session</td>
<td>Workshop Session IV</td>
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<tr>
<td>1:50 – 2:30pm</td>
<td>2:00 pm – 8:10 pm</td>
<td>3:30 – 5:00pm</td>
<td>12:45 – 2:15pm</td>
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<tr>
<td>Coordinators' Mini-Plenary</td>
<td>Special Plenary</td>
<td>Coordinators' Task Force Meetings</td>
<td>Council of Task Force Chairs Luncheon</td>
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<td>2:30 – 5:45pm</td>
<td>Presentation</td>
<td>3:45 – 4:45pm</td>
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<td>Coordinators' Workshops</td>
<td>5:15 – 6:15pm</td>
<td>Task Force Meetings</td>
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<td>3:45 – 5:45pm</td>
<td>Coordinators' Workshop</td>
<td>4:45 – 6:15pm</td>
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<td>Grassroots Forum for Program Directors</td>
<td>6:45pm</td>
<td>Global Health Meeting</td>
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<td>Grassroots Forum for Associate Program Directors</td>
<td>Coordinators' Dinner Social</td>
<td>(separate arrangements)</td>
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<td>Grassroots Forum for Fellowship Directors</td>
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<td>5:45 – 6:45pm</td>
<td>Networking Reception</td>
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Welcome to San Antonio!

Welcome, welcome, welcome! We are extremely glad you’re here. The APPD Annual Spring Meeting programming is chock-full of workshop offerings, pre-conference training, and discussions about important topics affecting each of us. Having this packed agenda is a good problem to have and we couldn’t be happier!

The programming continues to be modified based on feedback from previous years. An emphasis this year is to have the sessions be more interactive, when possible. Further, many of the presentations and “handouts” are posted on the APPD website for your reference. The plenary has been modified (again, based on member feedback) to a shorter, more streamlined session. Most of our collaborating organizations will have a report posted online which describes their activities and agendas.

The APPD has tried to develop mechanisms for getting more members involved. Take advantage of one of these avenues as you discern what you are passionate about: education, curricular development, APPD LEARN, actively working within a task force or region, mentoring, and/or APPD LEAD. Become involved!

It has been a great and humbling honor to serve as the President over the past two years. It is exciting to know I will pass the proverbial “baton” on to Patty Hicks. Her thoughtful leadership style will work wonderfully with such a committed and insightful member base. I look forward to seeing how APPD responds and successfully moves forward with the New Accreditation System. The right APPD leadership is definitely in place!

I would also like to thank the 2012 Meeting Program Committee and, in particular, the Executive Planning Committee: Susan Guralnick (Chair), Marsha Anderson (Co-Chair), Suzette Caudle, and Aditee Narayan. This group has done great work to prepare this annual extravaganza. Thanks also to Coordinators’ Executive Committee Co-Chairs, Jaime Bruse and Avis Grainger, for putting together an excellent program track for the coordinators.

We hope you have a fruitful and enlightening meeting. Try to meet people, share ideas, provide feedback and, please, stop by and say “hello” to me.

Most sincerely,
Ann Burke, MD
APPD President
**Continuing Education Credit**

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

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

### Sessions Available for CME Credit

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<tr>
<th>Session Time</th>
<th>Session Title</th>
<th>Credit Hours</th>
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<tr>
<td><strong>Wednesday, March 28 - 9.0 hours</strong></td>
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<td>8:00am - 11:00am</td>
<td>Forum for Directors of Small Programs/Affiliate Chairs</td>
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<td>11:00am - 3:30pm</td>
<td>Pre-Conference Workshop</td>
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<td>3:45pm - 5:45pm</td>
<td>Grassroots Forums for Program Directors</td>
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<td>Grassroots Forums for Associate Directors</td>
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<td>Workshop Session IV</td>
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**TOTAL CREDIT HOURS: 21.0**
APPD Leadership

President
Ann Burke, MD (2010-2012)
Wright State University

President-Elect
Patricia Hicks, MD (2010-2012)
Children's Hospital of Philadelphia

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

Past-President
Susan Guralnick, MD (2010-2012)
Winthrop University Hospital

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

Board of Directors
Cynthia Ferrell, MD, MSEd (2010-2013)
Oregon Health and Science University

Lynn Garfunkel, MD (2009-2013)
University of Rochester

Javier Gonzalez del Rey, MD, MEd (2010-2013)
Cincinnati Children’s Hospital Medical Center/
University of Cincinnati College of Medicine

Ann Guillot, MD (2011-2014)
University of Vermont

Christopher Kennedy, MD (2011-2014)
University of Missouri at Kansas City

Jerry Rushton, MD, MPH (2008-2012)
Indiana University School of Medicine

Coordinators Executive Committee
Jaime Bruse, C-TAGME, Co-Chair (2009-2012)
University of Utah

Avis Grainger, C-TAGME, Co-Chair (2009-2012)
Carolinas Medical Center

Jean Ashley, MSBC, C-TAGME (2011-2014)
University of Louisville

Patricia Jacobi, (2010-2013)
Washington University/B-JH/SLCH Consortium

Staci Leitner (2011-2014)
Stanford University

Kathryn Miller, C-TAGME (2010-2013)
Johns Hopkins University

Nomination Committee
Susan Guralnick, MD, Chair, Winthrop University Hospital
Richard Shugerman, MD (2010-2012), University of Washington
Monica Sifuentes, MD (2011-2013), Los Angeles County-Harbor UCLA Medical Center

2012 Annual Meeting Program Committee

Executive Planning Committee
Susan Guralnick, MD, Program Chair
Winthrop University Hospital

Marsha Anderson, MD, Program Co-Chair
University of Colorado Denver

Suzette Caudle, MD
Carolinas Medical Center

Aditee Narayan, MD
Duke University

Program Committee Members
James Bale, MD
University of Utah

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

Ann Burke, MD
Wright State University

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

Alex Djuricich, MD
Indiana University School of Medicine

Patricia Hicks, MD
Children’s Hospital of Philadelphia

Karin Hillenbrand, MD
Pitt County Memorial Hospital/East Carolina University

Heather McPhillips, MD
University of Washington

James Moses, MD
Children’s Hospital/Boston Medical Center

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

Franklin Trimm, MD
University of South Alabama

Robert Vinci, MD
Children’s Hospital/Boston Medical Center
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Cynthia Ferrell, MD, MSEd, Chair (2013)
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Holly Hering (2013)
Program Coordinator - Res Trng Prog
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Teri L. Turner, MD, MPH, MEd (2014)
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Western Region
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Peds Residency Program Director
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Kathy Morten (2012)
Ped Residency Program Coordinator
Univ of Colorado/Ped Residency Prgrm
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Join an APPD Task Force!

The APPD Task Forces are seeking new members. Please attend one (or more) of the task force meetings and plan to become an active part of these important groups. Task force meetings will be held on Thursday, March 29 from 10:30 am – 12:00 pm and on Friday, March 30 from 3:45-4:45 pm. All are welcomed!

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

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

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

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

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

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

Curriculum Task Force:
Karin Hillenbrand, MD, Chair
Pitt County Memorial Hospital/East Carolina University
Rebecca Blankenburg, MD, Vice Chair
Stanford University

Evaluation Task Force:
Suzette Caudle, MD, Chair
Carolina Medical Center
Kathleen Bartlett, MD, Vice Chair
Duke University

Faculty and Professional Development Task Force:
Clifton E. Yu, MD, Chair
National Capital Consortium
Nancy Spector, MD, Vice Chair
St. Christopher’s Hospital for Children

Learning Technology Task Force:
Joel Forman, MD, Chair
Mount Sinai School of Medicine
Franklin Trimm, MD, Vice Chair
University of South Alabama

Research and Scholarship Task Force
Linda Waggoner-Fountain, MD, Chair
University of Virginia
Heather McPhillips, MD, Vice Chair
University of Washington
SESSIONS FOR COORDINATORS

This year, there are many sessions and workshops for coordinators, including the new “Coordinators’ Orientation and Mini-Plenary” on Wednesday afternoon. While tailored specifically for newer coordinators, seasoned coordinators are also invited to attend. Other “Coordinator-specific Sessions / Workshops,” filled with important and useful information, will be held on both Wednesday and Thursday afternoons and on Friday and Saturday mornings. You will want to be sure to attend the “Coordinators’ Task Force” break-out sessions throughout the meeting to network, brainstorm, plan for future meetings and workshops, and report on current projects. We will also join together for a “Coordinators’ Social” on Thursday evening. All coordinators are encouraged to attend for some great food and even better company! A final brief wrap-up session will be held on Saturday morning. Coordinators should note that they are encouraged to attend any and all non-Coordinator-specific sessions offered during the meeting.

COORDINATORS’ TASK FORCES

Professional Development Task Force
Co-Chairs: Vanessa Goodwin (University of Vermont) and Therese D’Agostino (Massachusetts General Hospital)
The Professional Development Task Force will serve as a resource for program coordinators’ career development and satisfaction. The goals and objectives of this task force will be based on, but not limited to, the following:
• Develop workshops for APPD meetings to enhance opportunities for professional development within the Coordinator's Section
• Identify methods for educating program chairs, department and hospital administration, and program directors about the roles and responsibilities of program coordinators; promoting a better understanding of the role of coordinator, both within the APPD and at regional and local institutional levels
• Develop updated model job description and/or assemble sample job descriptions for program coordinators, building upon the existing APPD job descriptions
• Update the existing program coordinator salary and benefits survey; promote availability
• Assess educational needs of program directors (both categorical and subspecialty directors), associate program directors, chief residents, program coordinators, and others associated with residency training programs
• Integrate fellowship coordinators and create specific track enhancing the fellowship coordinators’ experience within the APPD
• Develop medicine-pediatrics coordinator workshops during APPD Meetings specified for medicine-pediatrics track

Management/Supervision Task Force
Co-Chairs: Celeste Farley (University at Buffalo) and Teresa Woods (St. Louis University School of Medicine)
The Management/Supervision Task Force will serve as a resource for developing a structure for program coordinators in management/supervisory positions. This task force is available to all Program Coordinators who are interested in learning about supervision. The goals and objectives of this task force will be based on, but not limited to, the following:
• Create a forum where program coordinators as supervisors can meet yearly to discuss and share their experiences
• Develop job description for program assistants
• Develop a sub-committee for program assistants
• Develop management/supervision workshops for APPD Meetings
• Serve as a resource for membership at large with issues regarding supervision

Tools Task Force
Co-Chairs: Sandra Barker (Phoenix Children's Hospital/Maricopa Medical Center), Kathleen Sheppard (Children’s Hospital of Michigan) and Mary Anne Wesner (Geisinger Medical Center)
The Tools Task Force will serve as a resource for gathering information on technology programs that will improve and simplify the routine tasks of pediatric coordinators. The goals and objectives of this task force will be based on, but not limited to, the following:
• Gathering information on technology/software used in residency training programs
• Create a list of available technology programs
• Indicate how the technology is used, critique the software, giving pluses and minuses
• Create a mechanism for developing and sharing products to facilitate the administrative responsibilities of program coordinators
• Designing a database that will allow coordinators to list and critique available programs
• Share information, surveys and annual updates using the APPD listserv, newsletter, web page, and Tool Shed
• Enhance and revise the Coordinators' Handbook annually
• Develop technology workshops for APPD meetings
2012 ANNUAL MEETING
MARCH 28 - 31 ~ SAN ANTONIO, TX
THE EVOLUTION OF RESIDENCY TRAINING:
ADAPTING AND INNOVATING IN A NEW ERA

APPD MEETING SCHEDULE

WEDNESDAY, MARCH 28

7:00am Registration Begins
Registration Desk 2/Foyer

8:00 – 11:00am Forum for Directors of Small Programs/Affiliate Chairs
Salon GM
This forum plans to review the impact of new ACGME duty hours on small programs and ways to implement them. The goal is to have a more interactive session with the audience rather than formal presentations. Topics and speakers will include the following, moderated by Surendra Varma, MD, FAAP, FACE:
1. Milestones and Entrustment – Ed Zalneraitis, MD, University of Connecticut
2. Issue of Away Rotations to fulfill RRC Requirements – Ernie Guzman, MD, White Memorial Medical Center
3. Handoffs policy implementation in small programs – Curtis Turner, MD, Texas Tech University (Amarillo)
4. Six Flexible Months – Specific Challenges & Strategies – Diane Kittredge, MD, Dartmouth-Hitchcock Medical Center
5. NRMP Rule – 2012 and Beyond – Impact on IMG Recruitment – Surendra Varma, MD, Texas Tech University (Lubbock)
(“Small programs” have been defined as having 10 or less residents per year. However, many programs consider themselves “small” as compared to other larger programs in their vicinity. Any program that feels they may be having difficulty attaining programmatic goals due to the fact that their program is “small or medium” in size is welcome to attend. No numeric cutoff is necessary.)

8:00am – 1:30pm Coordinators’ TAGME Exam (prior registration necessary)

8:00am – 3:30pm Forum for Chief Residents
Salon E
Coordinated by Cynthia Ferrell, MD, MSEd, Pediatric Residency Program Director, Oregon Health Sciences University, Erin L. Giudice, MD, Pediatric Residency Program Director, University of Maryland, Kenneth B. Roberts, MD, University of North Carolina Hospitals, and Edwin L. Zalneraitis, MD, Pediatric Residency Program Director, University of Connecticut. Sponsored by the APPD Faculty and Professional Development Task Force.
Chief Residents face a diverse set of challenges as leaders in academic medical centers related to the multiple roles that they assume as leaders, clinicians, educators, administrators, and counselors. To be effective across these multiple domains, Chief Residents must have a broad skill set and acquire new skills, especially to address the leadership and administrative aspects of the job. The APPD’s Forum for Chief Residents is an educational session designed to teach key administrative, academic, and leadership skills in order to facilitate a successful year as a Chief Resident. The afternoon session will have two separate tracks: one for Rising Chief Residents and one for Graduating Chief Residents. The track for rising chiefs will focus on planning the chief resident’s academic year and the track for graduating chiefs will focus on professional development beyond the chief resident year. (Breakfast and Lunch will be included).

7:30–8:00am Breakfast (courtesy of APPD)
7:00–8:15am Introductions
8:15–9:30am McChief Rounds: Facilitating Chief Resident Led Educational Conferences
Matt McDonald MD, Robert McGregor MD, Bryon Lauer MD, Darshita Bhatia MD, Blair Dickinson, MD, and Elizabeth Maxwell MD, Drexel University College of Medicine
9:30–9:45am Break
9:45–11:00am Things I Know Now That I Wish I Knew Then
Lauren Becton MD, Elton Chambers MD, Mike Southgate MD, Kristina Gustafson MD, David Mills MD, David Sas MD, Medical University of South Carolina
11:00am–12:15pm Preparing for your Role as Resident Advocate: The Listener, the Spokesperson, and the Disciplinarian…All at the Same Time
Hillary Skelton MD, Derek Zhorne MD, Anna Rueda MD, Teri Turner MD MEd, Mark Ward MD, Baylor College of Medicine

12:15–12:45pm Lunch (courtesy of APPD)

12:45–2:00pm RISING CHIEFS’ TRACK - Planning the Chief Resident Year
Ed Zalneraitis MD, Lauren Becton MD, Elton Chambers MD, University of Connecticut School of Medicine, Medical University of South Carolina

GRADUATING CHIEFS’ TRACK - Create Your Future with Professional Development Planning
Cindy Ferrell MD MSEd and Erin Guidice MD, Oregon Health & Science University, University of Maryland School of Medicine

2:00–2:15pm Break

2:15–3:30pm RISING CHIEFS’ TRACK – Planning the Chief Resident Year, continued
Ed Zalneraitis MD, Lauren Becton MD, Elton Chambers MD, University of Connecticut School of Medicine, Medical University of South Carolina

GRADUATING CHIEFS’ TRACK – How to Use Emotional Intelligence to Help you Become a More Effective Leader and Communicator
Caroline Weingart MD and Maria Ramundo MD, Akron Children’s Hospital

11:00am – 3:30pm Pre-Conference Workshops (Two Topics offered)
(additional fee applies; includes boxed lunch)

Pre-Conference Workshop 1
Conference Room 1-4
Leading Teams, Managing People, and Making Projects Scholarly – Essential Professional Development Skills for Program Directors (Sponsored by the APPD Faculty and Professional Development Task Force)
Nancy D. Spector, MD, Vice Chair, and Clifton E. Yu, MD, Chair, APPD Faculty and Professional Development Task Force
This preconference workshop provides an opportunity for program directors and associate program directors to build administrative skills and to turn work into scholarship. This highly interactive workshop features a blend of brief didactic sessions interspersed with small group discussions, role plays, and individual self-reflective exercises. References and resources for further study will be provided.

The agenda includes three important topics:
1) Leading Teams led by Theodore C. Sectish, MD, Children’s Hospital/Boston Medical Center
2) Managing People led by John Mahan, MD, Nationwide Children’s Hospital/Ohio State University, Keely Smith, MD, University of Texas at Houston, and Megan Aylor, MD, Oregon Health and Science University
3) Making Projects Scholarly led by Janet Serwint, MD, Johns Hopkins University, Erin Giudice, MD, University of Maryland, and Patricia Hicks, MD, Children’s Hospital of Philadelphia

The selected topics for this pre-conference workshop session are based on the APPD membership needs assessment conducted by the APPD Faculty and Professional Development Task Force in 2011.

Pre-Conference Workshop 2
Salon CD
Teaching Residents to Teach Themselves: Creating Self-Directed, Lifelong Learners (Sponsored by the APPD Curriculum Task Force)
Karin Hillenbrand, MD, MPH, Brody School of Medicine at East Carolina University, Greenville, NC; Rebecca Blankenburg, MD, MPH, Lucile Packard Children’s Hospital, Stanford, Palo Alto, CA; Aditee Narayan, MD, MPH, Duke University School of Medicine, Durham, NC; Lavjay Butani, MD, Clerkship Director, Section of Pediatric Nephrology, Michele Long, MD, Co-Clerkship Director, Division of General Pediatrics, University of California/Davis

OBJECTIVES:
1. Recognize generational differences and other influences that may impact resident motivation for self-directed learning.
2. Teach residents to set ‘SMART’ goals.
4. Promote self-directed learning by incorporating a variety of teaching strategies.
5. Assist residents in creating and embarking upon post-residency learning plans.

DESCRIPTION:
Pediatric residents have typically spent their educational careers in settings where the curriculum, goals, outcomes, and deadlines are largely defined by others. Typical residents may be accustomed to being told what to learn, having the...
• curriculum taught to them, and taking ‘tests’ to assure competency. Upon completion of residency, however, expectations may change, often abruptly: practitioners must now be able to obtain and maintain certification, identify their own learning needs based on recognition of deficiencies in personal abilities as well as changes in medical knowledge and practice, find and use resources independently, and set personal and professional goals which allow their careers to evolve. Both the ACGME and the American Board of Pediatrics emphasize the importance of lifelong learning, and recognize residency training as one point along an educational continuum.

The workshop will begin with a discussion of generational differences and other motivational influences which may promote or impede the development of self-directed learning. Participants will then learn and practice a variety of methods they can use to encourage residents to develop habits of self-reflection and goal setting, as well as teaching strategies which have been successful in promoting self-directed, independent learning. Participants will be encouraged to share methods they have found effective in their own careers or with learners at their own institutions. Finally, the participants will divide into small groups to brainstorm for components of a post-residency learning plan that can be adapted for use in their home institutions, and identify resources available to graduates as their careers develop. Ideas will be shared during a concluding large group session, then compiled and provided to participants following the workshop. Participants will leave the workshop with concrete strategies to develop residents into life-long learners, as well as components of a post-residency toolkit for self-directed learning that they can give to graduating residents.

1:30 – 1:50pm  Coordinators’ Orientation
Salon GM
This special session has been added to provide a brief overview for coordinators who are *NEW* to the job. We look forward to welcoming you!

1:50 – 2:30pm  Coordinators’ Mini-Plenary
Salon GM
Please join us for this quick update on important events, deadlines and contact information specific to the AAP, ABP, ACGME, ECFMG, ERAS, TAGME, and the Coordinators’ list serve.

2:30 – 5:45pm  Coordinators’ Workshops
Salon GM

2:30-3:30  Workshop C1
FINDING THE CORE IN COORDINATOR
Ambrosya Amlong, BA, University of Iowa, Iowa City, IA
Participants of this workshop will be given an overview of what makes the coordinator the core of the residency and fellowship program success. This workshop will allow attendees to critically evaluate their role within their own institution, and determine if there are areas for improvement, collaboration or innovation. Attendees will have the opportunity to collaborate with coordinators from other programs to share their experiences of success or pearls of wisdom that come from longevity as a program coordinator. Participants will leave this workshop with concrete ideas that can be implemented in their own program.

3:30-3:45  BREAK

3:45-4:45  Workshop C2
GROWING YOUR INSTITUTION’S FUTURE: STUDENTS TO FELLOWS
Cindy Chuidian, BS, Jefferson Medical College/Al duPont Hospital for Children, Wilmington, DE, Jennifer Bishop, MBA, Crozer-Chester Medical Center, Upland, PA
This workshop will discuss the Residency Coordinator’s opportunity to “grow the nation’s doctors” at their home institution. The workshop will identify opportunities for Coordinators to encourage students from various medical schools to rotate through their hospital. The goal of course being to recruit the “cream of the crop” from these students. The second part of the workshop will focus on encouraging residents from other programs to visit your hospital for subspecialty rotations. Doing so gives you an opportunity to recruit fellows and plant the seeds for future referrals to your hospital. The third part of the workshop will be to ask small groups to share their experiences and ideas and report back.

4:45-5:45 Workshop C3
THE WINDS OF CHANGE: HOW CAN YOU AVOID GETTING BLOWN OVER?
Robin D. Hawkins, and June Dailey, Indiana University, Indianapolis, IN
Do you feel overwhelmed and stressed with all the changes? Do you have difficulty
organizing and maintaining these changes? In this workshop we will highlight changes in the role of the coordinator using examples of how residents and fellows have changed. We will interact as a group in discussions regarding recent changes to ACGME Program Requirements, duty hours monitoring, WebAds, use of ERAS with applicants, and the NRMP. With the use of an audience response system we will test your knowledge on the different changes that have occurred in the past few years and then discuss ways in which you did or could have handled those changes. We will break down into small groups and discuss best practice ideas on how changes can most effectively be addressed and how we can incorporate them in our daily routines.

3:45 – 5:45pm  Grassroots Forum for Program Directors  
Salon HK

The Grassroots Forum for Program Directors will focus on timely topics of interest to Program Directors. Similar to previous meetings, the facilitators will lead the discussion about educational innovation in an open forum, thus allowing us to learn from successful models from other residency programs. We will also focus on topics related to accreditation and training requirements to allow us to create change within our own residency program. This year’s facilitators will be Drs. Robert Vinci (Children’s Hospital/Boston Medical Center), Dan West (University of California/San Francisco) and Heather Fagan (University of Chicago).

Grassroots Forum for Associate Program Directors  
Salon I

The Forum for Associate Program Directors will review timely and important topics of interest to the APPD and will discuss organizational and career development needs specific to our group. Additionally, there will be short, peer-reviewed presentations from Associate Program Directors. We hope to build upon six years of successful meetings and invite you to bring your ideas to this energetic group session. Leaders: Drs. Marsha Anderson (University of Colorado Denver) and Aditee Narayan (Duke University), along with Drs. Jerry Larrabee (University of Vermont) and Heather McPhillips (University of Washington).

Grassroots Forum for Fellowship Directors  
Conference Room 17/18

The forum for subspecialty program directors will be an open discussion of hot topics raised by the participants. Topics include: ABP Subspecialty Clinical Training and Certification Initiative, transitions and supervision. In addition, we will discuss the growing needs of subspecialty program directors within the APPD. Facilitation by Dr. Chris Kennedy (University of Missouri at Kansas City).

5:45 – 6:45pm  Networking Reception  
Salon E

Plan to drop by and take advantage of this opportunity to meet, touch base and become reacquainted with your fellow APPD members.

THURSDAY, MARCH 29

7:45 – 9:00am  Breakfast and Platform Presentations - Best of Research and QI Abstracts  
Salon GHI

Platform Presentation 1

NATIONAL PEDIATRIC NIGHTTIME CURRICULUM FIELD TEST: ASSESSMENT OF CURRICULUM FEASIBILITY AND EFFECT ON RESIDENTS’ ATTITUDES, CONFIDENCE, AND KNOWLEDGE

Rebecca Blankenburg, MD, MPH, Lucile Packard Children’s Hospital at Stanford, Nicole Paradise Black, MD, Shands Children’s Hospital at University of Florida, Jennifer Maniscalco, MD, MPH, Children’s Hospital Los Angeles, H. Barrett Fromme, MD, MHPE, Comer Children’s Hospital at University of Chicago, Cynthia Ferrell, MD, MSEd, Doernbecher Children’s Hospital at Oregon Health and Science University, Erin Augustine, MD, Children’s National Medical Center, Jessica Myers, MD, Lucile Packard Children’s Hospital at Stanford, Christine Skurkis, MD, University of Connecticut, Lou Ann Cooper, PhD, Shands Children’s Hospital at University of Florida, Madelyn Kahana, MD, Lucile Packard Children’s Hospital at Stanford, Palo Alto, CA

Background: The 2011 ACGME work hour changes resulted in a substantial increase in pediatric nighttime (NT) rotations. NT brings the unique challenge of delivering resident education, traditionally provided by daytime conferences and clinical rounds. Methods: From July to December 2011, the Pediatric Nighttime Education Steering Group conducted an IRB-approved curricular intervention/field test at 89 pediatric and med-peds residency programs (46% of all programs nationally), involving approximately 2000 learners. The curriculum consisted of 10 web-based, case-based modules, and was implemented in a
variety of ways -- faculty led, senior resident led, or self-study computer modules. The curriculum was assessed for feasibility and with pre-post measures of attitudes, confidence, and knowledge. Preliminary Results: Feasibility: 84% of participating programs did not have a nighttime curriculum prior to this intervention. 66% of residents completed 6 or more of the 10 modules. Attitudes: Residents of all levels rated the national nighttime curriculum as a significant educational improvement over prior nighttime teaching (6.6/10 vs. 4.6/10). 75% believed the modules were most geared towards interns. Confidence: Resident confidence-post-curriculum significantly increased for all 10 curricular topics at all three resident levels, with the one exception of pain management in PGY3s (which approached significance, p = 0.06). Lowest rated confidence areas pre-curriculum were altered mental status, seizures, and shock. Knowledge: Resident knowledge significantly increased for PGY1s and PGY2s (p < 0.001), but not PGY3s. Conclusions: This study is the first large multi-center NT curriculum study. Residents believed that the curriculum improved their nighttime learning, and reported increased confidence in all NT topics except pain management in PGY3s. Knowledge significantly increased in PGY1s and PGY2s. These findings will lead to improvements in the national NT curriculum, and can guide future curricular efforts.

Platform Presentation 2
VALIDITY AND RELIABILITY OF THE WESTERN PEDSCO: A NOVEL STRUCTURED CLINICAL OBSERVATION TOOL TO MEASURE PEDIATRIC PATIENT ENCOUNTER SKILLS ACROSS THE CONTINUUM OF MEDICAL EDUCATION
Daniel C. West, MD, Alexis Jannicelli, Christy Boscardin, PhD, University of California, San Francisco, San Francisco, CA, Su-Ting T. Li, MD, MPH, University of California, Davis, Sacramento, CA, Vasudha L. Bhavaraju, MD, Phoenix Children’s Hospital/Maricopa Medical Center, Phoenix, AZ, Cynthia L. Ferrell, MD, MSED, Oregon Health and Science University, Portland, OR, Adam Rosenberg, MD, University of Colorado, The Children’s Hospital, Aurora, CO
Background: Currently available direct observation tools lack validity for encounters with children, use a rating scale that does not measure performance across the UME/GME continuum, and lack psychometric properties for competency-based assessment and advancement. Objective: Establish the validity and reliability of a newly developed structured clinical observation tool [Western Pediatric Structured Clinical Observation [Western PedSCO]]. Methods: From July 2010 to June 2011, third year medical students (MS3) and residents at 4 training programs in the Western Region of the APPD were observed by faculty members during patient encounters and assessed using the Western PedSCO. The tool consists of 4 domains: medical interviewing and data gathering (MIDG), physical exam skills (PE), medical decision making (MDM), and patient counseling (PC). Results: 283 observations of 130 residents and 22 MS3 were analyzed. Cronbach alpha and confirmatory factor analysis demonstrated very high construct validity [Cronbach alpha (.95 - .97); Comparative Fit Index 0.93; Tucker Lewis Index 0.90; Root Mean Square Error 0.07; Chi Square Test 2.5]. Mixed effects regression modeling showed that third year residents (R3) scored significantly higher than MS3 in all domains (domain, regression coefficient [95% confidence interval]) [MIDG, 1.23 (0.73-1.74); PE, 1.29 (0.78-1.74); MDM, 1.41 (0.93-1.89); PC, 1.47 (0.96-1.99)]. Analysis of the MIDG domain using Generalizability theory demonstrated that a 4 item assessment administered over 6 occasions yielded sufficient reliability for high stakes decision making (G-coefficient [0.83] and phi [0.81]) Discussion: The Western PedSCO assessment tool has strong construct and criterion validity. Based on preliminary evidence, the MIDG domain of the tool can be reliably administered for high-stakes, competency-based assessment and advancement. Additional data, including the other three domains, will be available for analysis in late 2011 and will be reported at the APPD meeting.

Platform Presentation 3
IMPLEMENTATION OF POSTPARTUM DEPRESSION SCREENING TOOL IN PEDIATRIC CLINIC: YEAR TWO OF A RESIDENT QI PROJECT
Vibhash Kumar, MBBS, Amina Rafique, MBBS, Nayf Edrees, MBBS, Amanda D. Osta, MD, Children’s Hospital University of Illinois, Chicago, IL
Background: Postpartum depression (PPD) affects about 12-13% of women. PPD has 2 peaks at 2 months and 6 months postpartum. In our pediatric resident clinic, prior to the implementation of our QI project in 2009, 0.5% of mothers up were being screened for PPD. In 2009-10, after implementation of our project, this number improved to 20%. Aim Statement: Objective screening for PPD using the Edinburgh scale will increase to at least 75% of mothers who bring their infants in for well child care in the first six months of life in 2010-11. Methods: We ran 3 PDSA cycles to increase PPD screening. We included mothers of infants who came in for well child care in the first six months of life in 2010-11. Methods: We ran 3 PDSA cycles to increase PPD screening. We included mothers of infants who came in for well child care in the first six months of life in 2010-11. Methods: We ran 3 PDSA cycles to increase PPD screening. We included mothers of infants who came in for well child care in the first six months of life in 2010-11. Methods: We ran 3 PDSA cycles to increase PPD screening. We included mothers of infants who came in for well child care in the first six months of life in 2010-11. Methods: We ran 3 PDSA cycles to increase PPD screening. We included mothers of infants who came in for well child care in the first six months of life in 2010-11. Methods: We ran 3 PDSA cycles to increase PPD screening. We included mothers of infants who came in for well child care in the first six months of life in 2010-11. Methods: We ran 3 PDSA cycles to increase PPD screening. We included mothers of infants who came in for well child care in the first six months of life in 2010-11. Methods: We ran 3 PDSA cycles to increase PPD screening. We included mothers of infants who came in for well child care in the first six months of life in 2010-11. Methods: We ran 3 PDSA cycles to increase PPD screening. We included mothers of infants who came in for well child care in the first six months of life in 2010-11. Methods: We ran 3 PDSA cycles to increase PPD screening. We included mothers of infants who came in for well child care in the first six months of life in 2010-11. Methods: We ran 3 PDSA cycles to increase PPD screening. We included mothers of infants who came in for well child care in the first six months of life in 2010-11. Methods: We ran 3 PDSA cycles to increase PPD screening. We included mothers of infants who came in for well child care in the first six months of life in 2010-11. Methods: We ran 3 PDSA cycles to increase PPD screening. We included mothers of infants who came in for well child care in the first six months of life in 2010-11. Methods: We ran 3 PDSA cycles to increase PPD screening. We included mothers of infants who came in for well child care in the first six months of life in 2010-11. Methods: We ran 3 PDSA cycles to increase PPD screening. We included mothers of infants who came in for well child care in the first six months of life in 2010-11. Methods: We ran 3 PDSA cycles to increase PPD screening. We included mothers of infants who came in for well child care in the first six months of life in 2010-11. Methods: We ran 3 PDSA cycles to increase PPD screening. We included mothers of infants who came in for well child care in the first six months of life in 2010-11. Methods: We ran 3 PDSA cycles to increase PPD screening. We included mothers of infants who came in for well child care in the first six months of life in 2010-11. Methods: We ran 3 PDSA cycles to increase PPD screening. We included mothers of infants who came in for well child care in the first six months of life in 2010-11. Methods: We ran 3 PDSA cycles to increase PPD screening. We included mothers of infants who came in for well child care in the first six months of life in 2010-11. Methods: We ran 3 PDSA cycles to increase PPD screening. We included mothers of infants who came in for well child care in the first six months of life in 2010-11. Methods: We ran 3 PDSA cycles to increase PPD screening. We included mothers of infants who came in for well child care in the first six months of life in 2010-11. Methods: We ran 3 PDSA cycles to increase PPD screening. We included mothers of infants who came in for well child care in the first six months of life in 2010-11. Methods: We ran 3 PDSA cycles to increase PPD screening. We included mothers of infant...
Platform Presentation 4

PEDIATRIC RESIDENT SELF-ASSESSMENT OF ACGME COMPETENCIES

Su-Ting T. Li, MD, MPH, University of California Davis, Daniel J. Tancredi, PhD, University of California, Davis, Sacramento, CA, Franklin Trimm, MD, University of South Alabama, Mobile, AL, Ann E. Burke, MD, Wright State University, Dayton, OH, Ann P. Guillot, MD, University of Vermont, Burlington, VT, Susan Guralnick, MD, Winthrop University Hospital, Mineola, NY, John D. Mahan, MD, Nationwide Children’s Hospital/The Ohio State University, Columbus, OH

Purpose: Determine factors associated with resident self-assessment of competencies and whether residents chose areas of self-assessed relative weakness to improve as part of their Individualized Learning Plan (ILP). Methods: Cross-sectional analysis of the American Academy of Pediatrics’ PediaLink ILP database for the 2009-2010 academic year. Pediatric residents self-assessed their competency in each of the 6 ACGME general competencies on a continuous Dreyfus scale from Novice to Proficient (0-100). They then chose at least 1 competency to focus on for improvement. We used multivariate regression to explore the relationship between overall confidence in core competencies and gender, level of training and MD/DO status. We used correlation to determine whether competencies residents chose to focus on for improvement were ones they rated themselves lower in. Results: 4167 residents completed an ILP on PediaLink in the 2009-2010 academic year. Residents’ confidence in their core competencies increased by level of training a total of 25 points, from an average overall rating of 48 in their first year of training to an average overall rating of 75 in their last year of training. Residents rated themselves as most competent in professionalism (mean: 75.3) and least competent in medical knowledge (mean: 55.8) and systems based practice (mean: 55.2). In the adjusted regression model, residents’ confidence in their core competencies increased by level of training. There was no difference based on type of medical degree. PGY1 female residents rated themselves slightly lower than PGY1 male residents (-2.9; [95% CI: -4.9 to -1.0]). In PGY3s, there was no difference based on gender or type of medical degree. Residents selected subcompetencies for focus which correlated to abilities they rated lower (p<0.01). Conclusions: While residents’ self-assessment of their competencies increased by level of training, residents continued to rate themselves as most competent in Prof and least competent in MK and SBP even as PGY3s. Residents chose subcompetencies which they rated as lower to focus on improving.

9:05 – 10:25am  APPD Awards and Annual Reports

Salon GHI

9:05  Welcome - Dr. Ann Burke
9:10  APPD LEAD - Dr. Franklin Trimm
9:15  APPD pages in Academic Pediatrics - Dr. Dan West
9:20  Award Presentations: Holm, Tunnessen and Berkowitz Awards - Drs. Susan Guralnick and Carol Berkowitz
9:50  Election Results/Farewell to Leaders - Drs. Susan Guralnick and Ann Burke
10:00  Special Projects Announcement - Dr. Javier Gonzalez del Rey
10:10  Introduction of Task Forces/Chairs - Dr. Javier Gonzalez del Rey
10:20  Finance Report - Dr. Adam Pallant

10:30am – 12:00pm  Task Force Meetings (open to all interested attendees)

see page 7 for details

Curriculum  Salon E
Evaluation  Salon LM
Faculty and Professional Development  Salon CD
Learning Technology  Salon JK
Research and Scholarship  Conference Room 13/14

Coordinators’ Task Force Meetings (open to all interested attendees)

see page 8 for details

Management/Supervision  Conference Room 3/4
Professional Development  Conference Room 17/18
Tools  Conference Room 1/2

12:00 – 1:30pm  Lunch on Own
12:00 – 1:30pm  Mentoring Session (Pre-registration necessary for participation)
Salon F
Mentoring Program Co-Chairs: Nancy Spector, MD and Rhonda Graves Acholonu, MD; Mentoring Program Planning Group: Marsha Anderson, MD, Janet Serwint, MD, Aditee Narayan, MD, Theodore Sectish, MD, Teri Turner, MD, and Cliff Yu, MD
The session will begin with a brief overview of the Mentoring Program goals and a review of available resources. Then, new and existing Mentor-Mentee dyads will meet over lunch to work on the Mentee’s professional development plan. (Lunch is provided, courtesy of APPD.)

Council of Regional Chairs Luncheon
Conference Room #16

1:30 – 2:00pm  APPD Presidential Address
Salon GHI
Ann Burke, MD, APPD President (2010-2012)

2:00 – 5:10pm  Special Plenary Presentations
Salon GHI

2:00  Welcome - Dr. Ann Burke, APPD President
2:10  American Board of Pediatrics (ABP) update - Dr. Gail McGuinness, Executive Vice President, ABP
2:20  Subspecialty Clinical Training Initiative - Dr. Gail McGuinness, ABP Executive Vice President, Dr. David Stevenson, Stanford University, and Dr. Robert Spicer, Children’s Hospital, Omaha/University of Nebraska/Creighton University
2:50  APPD LEARN - Dr. Alan Schwartz, APPD LEARN Director
3:00  Milestones - Dr. Carol Carraccio, Director, Competency-based Assessment Programs, ABP
3:20  Q & A Discussion
3:40  RRC update - Dr. Joseph Gilhooly, Chair, Pediatric Review Committee and Caroline Fischer, Executive Director, Accreditation Standards, ACGME Review Committee for Pediatrics
5:10  Conclude

5:15 – 6:15pm  Coordinators’ Workshop C4
Salon CD

DISSECTING THE NAS: WHAT WE KNOW AND WHAT WE DON’T KNOW
Teresa D. Flournoy, BGS, Cindy A. Ortiz, MBA, Kelly K. Laurent, MS, Children’s Mercy Hospitals and Clinics- UMKC, Kansas City, MO
In February 2012, the ACGME announced its planned implementation of the Next Accreditation System (NAS). Although not a lot of detail is available, the speakers will provide an overview of the NAS to program participants to include what is known and what is not known. More importantly, they will provide ideas about how to plan for this change and how to assure continued success in the day-to-day administration of the program.

6:45pm  Coordinators’ Social
Please join your fellow coordinators for dinner at a nearby restaurant (separate arrangements).

FRIDAY, MARCH 30

7:00 – 8:00am  APPD Governance Panel Discussion and Continental Breakfast
Salon HI
As APPD grows in size and influence, the leadership remains focused on preparing the organization for the future, while continuing to be relevant and responsive to the membership. This informal session will provide details and outline proposed changes to the governance structure, with time for questions and answers from the membership in attendance.
In our quest to advance competency-based medical education (CBME), self-directed learning (SDL) is often cited as an important tenet of CBME and of developing lifelong learning skills. While the construct of SDL provides a worthy foundation for lifelong learning, the self-assessment literature calls the ability of a learner to be truly self-directed into question. Thus, additional constructs and conceptual frameworks are necessary to understand lifelong learning skills in a more meaningful light and one in which the final goal is master learner rather than the self-directed learner. We will explore the role of several theories and constructs, including self-assessment, self-determination, reflection, self-monitoring and self-directed assessment seeking, in the context of their translation into the clinical learning environment as we work with participants to uncover practical strategies for developing the master learner. The major outcome of the workshop will be a tangible list of implications and responsibilities for the learner, the teacher, and the learning environment that will foster the development of lifelong learning skills that culminate in becoming a master learner. Our exploration will capitalize on the knowledge and background of workshop participants through a primary focus on small group work, information sharing, and building from the knowledge and ideas of everyone.

Measuring the attainment of a clinical competency by a trainee or the outcomes of an innovative program often requires development of new measurement tools, especially when the outcome is a subjective behavior or skill. However, developing valid and reliable measurement tools can present a daunting challenge for educators. This workshop is designed to provide educators with knowledge and strategies that can be used to design valid and reliable measurement tools. Workshop leaders will present an interactive didactic session focusing on the purpose of measurement tools and the key elements of item development, validity, measurement error and reliability. After the didactic session, participants will work in small groups to critique items and develop a plan to establish the validity of a mock assessment tool derived from a pre-workshop survey of participants. At the conclusion of the small group session, representatives from each group will present their ideas to the entire group of participants and workshop leaders for discussion and feedback. At the conclusion of the workshop, participants will be able to identify the key elements of validity and recognize common sources of measurement error that influence reliability. In addition, they will be able to identify strategies they can use to establish the validity and reliability of their own measurement tools for projects at their home institution. Participants will receive a detailed planning worksheet and an annotated bibliography of references and resources.

In this era of heightened awareness of patient safety, medical error has a serious impact on quality of care. This is a new arena for medical educators, as training programs struggle to incorporate this complex curriculum. A comprehensive, effective approach to patient safety education is both practitioner-focused and systems-based. The first layer of this curriculum begins with the practitioner. The literature supports that clinical reasoning can be improved through Diagnostic Error education. Continuous critical reflection is an important behavior leading to expertise. The second layer allows the learner to recognize that although errors may be practitioner-centered, many are systems-based. Recognition that patient care errors are often the result of a systems problem is a new and important concept. Understanding and addressing this is essential. Training programs would benefit from curricula that provide structured education in diagnostic and systems error experiential learning, while actively improving patient care. We introduced a series of workshops to learn and practice these skills. The session will begin with an overview of available Patient Safety curricular resources. We will then present the development and implementation of innovative curricula focusing on Diagnostic Error and Systems Error. After a review of the concepts of Diagnostic Error, the attendees will participate in a small group exercise, followed by a large group discussion of methods for implementing change to decrease diagnostic error. The Healthcare Matrix, a systems-based competency-based approach to analyzing and addressing error will then be introduced. The session leaders, residents and program directors, will discuss programmatic and institutional implementation. In small groups, participants will analyze a case utilizing the Healthcare Matrix, and develop an action plan for error prevention. The large group will discuss how similar programs can be brought to their home institutions and barriers can be overcome. Participants will leave with curricular materials, including a validated tool for experiential learning in systems-based error.
Mini-Course/Workshop 4
FROM GREAT PROGRAMS TO GREAT RESEARCH: BUILDING SCHOLARSHIP

- Alan Schwartz, PhD, APPD LEARN and University of Illinois at Chicago, Chicago, IL
- Hilary Haftel, MD, MHPE, University of Michigan, Ann Arbor, MI

This intensive interactive mini-course will assist participants in leveraging their daily activities as program directors into educational scholarship. In the first part of the course, participants will be introduced to a practical model of scholarship. Through interactive exercises, attendees will work together to select appropriate conceptual frameworks for educational research, how to approach research programmatically, and how to identify and refine research questions that are both important and feasible. In the second part of the course, participants will develop multiple study designs to address their research questions, and will evaluate the advantages and disadvantages of each approach. Emphasis will be placed on practical incremental development of research programs. Participants will be introduced to strategies for obtaining intramural and extramural resources for development of educational scholarship, including the Initiative for Innovation in Pediatric Education (IPE) and the APPD Longitudinal Educational Assessment Research Network (LEARN).

Workshop 5
LAUGHING YOUR WAY THROUGH THE PIF

- Adam Pallant, MD, PhD, Thomas Murphy, MD, Monika Page, MD, Bonnie O’Connor, PhD, Brown University, Providence, RI

Feeling overwhelmed by keeping up with all of the new RRC subtleties and documentation requirements? The goal of this workshop is to give extensive assistance and preparation for attaining all the new RRC goals and demands. Workshop participants will explore a variety of methods to create and coordinate streamlined tracking systems that both serve your needs as a pediatric program director/coordinator with enormous demands on your time and energy, and thoroughly document compliance with RRC requirements. Drawing upon our own successes and flops, as well as integrating lessons from pediatric colleagues and previous APPD workshop participants, we will discuss and generate practical formats to create a robust formula for your residents and program alike. By the end of the workshop, participants should leave with a structure to design and implement resident portfolios for tracking Individualized Curricular Plans, Quality Improvement Projects, Evidence Based Medicine Projects, patient and nursing feedback, and an initial assessment of incorporation of Milestones and Entrusted Professional Activities into regular activities. Additionally, program directors and coordinator participants will receive a model Program-Based Portfolio that can be used or modified to track key program features directly toward documentation for the PIF in preparation for upcoming RRC reviews.

Workshop 6
BUILDING A ROADMAP FOR SCHOLARSHIP IN YOUR EVERYDAY WORK

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

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

Workshop 7
FINDING BALANCE BETWEEN AUTONOMY AND SUPERVISION: A CHALLENGE OF TRAINING SENIOR RESIDENTS AND FELLOWS

- Jennifer Kesselheim, MD, MEd, Debra Boyer, MD, Children’s Hospital, Boston, Boston, MA
- Jim Bale, MD, University of Utah, Salt Lake City, Utah

Senior residents/fellows must demonstrate increasing autonomy, and programs must balance promotion of autonomy with the safety of adequate supervision. Program directors must design curricula for trainees and faculty members to achieve an optimal balance. Workshop: 1. Intro 2. Didactics- a. Review of pre-workshop survey b. Review data on autonomy and supervision with regards to: i. Educational experiences ii. Assessment tools iii. Faculty development strategies c. These domains (i-iii above) will serve as a conceptual model for the workshop. 3. Interactive exercise (all) a. Participants divided into groups of 6. b. Introduction of technique i. Groups are assigned a domain (i-iii above) and must consider how their program can better use this domain to promote autonomy, ensure supervision, and optimize the balance between the two. c. Affinity Map Exercise i. Each participant receives 10 sticky notes and brainstorm 10 responses to the central challenge posed above.
ii. Participants place notes onto larger paper. iii. The group works together to place all notes into categories. d. Dot voting i. Each member has 5 stickers to vote for their five favorite ideas. ii. The group identifies 5-7 ideas that have received the most votes. e. NUF Test i. Participants rate an idea on three criteria: Is it New, Useful and Feasible? ii. Each participant will rate each of the top ideas by assigning a score of 1-10 for New, Useful, and Feasible. iii. After 5-10 minutes of independent scoring, the group must come to a consensus. iv. Each idea receives a final score, ranging from 3-30 (the sum of the three sub-scores given.) 4. Group discussion- A spokesperson summarizes the group’s findings to the larger group. 5. Wrap-up- (All) Summary: Leaders will compile results from each table and distribute to all workshop participants.

Workshop 8

QUALITY IMPROVEMENT OF YOUR RESIDENCY PROGRAM: AN EXPERIENTIAL WORKSHOP ON HOW TO MAKE CHANGES THAT IMPROVE RESIDENT EDUCATION
Heather A. McPhillips, MD, MPH, Maneesh Batra, MD, MPH, Richard Shugerman, MD, Susan Marshall, MD, Emily Hartford, MD, Celeste Quitiquit, MD, Molly Martyn, MD, University of Washington, Seattle, WA

Background: The ACGME mandates that training programs utilize resident performance data as the basis for program improvement. The common PIF asks how each program is using the ACGME resident survey as a tool in this regard. In this workshop, participants will learn how to use resident data from the ACGME survey to identify a program improvement target. Participants will then learn a process to implement change in their educational program using quality improvement principles.

Workshop Format: After an introduction on applying LEAN principles to educational improvement projects, attendees will participate in an experiential learning process around standardizing patient handoffs. In our program this was identified as a factor in responses to our resident survey around service obligations interfering with education. A brief background on the importance of standard handoffs will be given by workshop leaders. In small groups, attendees will be given one of three published acronyms for handoffs with the task of modifying that tool to achieve small group consensus. The large group will reconvene to present the modified models and identify common themes. Workshop leaders will facilitate a discussion to integrate important features into one model to pilot/test. Workshop leaders will then discuss how to lead change and PDSA changes implemented in the educational program to maximize effectiveness. Attendees will be broken into triads to work on individualized plans for using this process to make changes in their program using a standard worksheet. Two to three examples from the group will be shared at conclusion of this workshop. Conclusion: The ACGME resident survey results can be used for program improvement. Using survey results, we were able to garner institutional support for a project to standardize handoffs. The process through which we made this change is generalizable to many educational improvements and allows programs to meet ACGME requirements.

8:00 – 10:00am

Coordinators’ Workshops

Salon F

Workshop C6
EMBRACING TECHNOLOGY AND MAKING IT WORK FOR YOU
Amy B. Gaug, BA, University of Minnesota Pediatric Residency, Minneapolis, MN
The goal of this workshop is to share with you the various tools that I use on a daily basis that make my life easier, more efficient and as paperless as possible, and hope that it inspires you to look at your processes and see how you can do the same. The University of Minnesota has been using Moodle in the classroom for several years now for distributing curriculum, classroom discussion boards, etc. I found a way to use this tool to my advantage and now use Moodle on a daily basis. Sites have been developed for Pediatric Intern Orientation, Pediatric Residency Applicants, Pediatric Intern Selection Committee, and also to assist other divisions and faculty with sites that are used to distribute curriculum to the Pediatric Residents. The benefits of this tool are many. It’s easy to use, saves time, is password protected, is much less cumbersome, updates in real time (unlike many web site updates), makes information distribution amazingly easy, and works seamlessly with the many Google applications (calendars, forms, etc.) that are also fantastic time savers. In addition to Moodle and various Google applications, I am always looking for new ways to use programs that people are familiar with and make the most of them. Moodle is a program that can be used easily, as is Blackboard and so many other programs that currently exist. I will explore in depth a wider range of programs, in addition to what I am currently using, and pass along how they might be useful to you. I also want to believe it is all about us, it is not. Interview day is the tool used to determine

Workshop C7
RECRUITING: IT IS NOT JUST DINNER AND DANCING
Beth Payne, MAEd, C-TAGME, The University of Texas HSC at San Antonio, San Antonio, TX, Melodie Allison, C-TAGME, Baylor College of Medicine, Houston, TX
The interview day is not solely about you or your program. As much as we want to believe it is all about us, it is not. Interview day is the tool used to determine
which candidates will fit best in your already functioning team. How can we entice applicants to choose our program? Interview season must be critiqued every year by asking yourself, your staff and your residents: How do we attract residents who share the same key values reflected in our program? How do you highlight the very best of your program? How do you assess your candidates while encouraging them to rank your program first? At the end of this workshop all participants should be able to: develop an interview day that will result in a successful match, establish a network to share ideas and concerns, format recruitment techniques to use year round and create a tool box for learners to pay it forward in their programs. Successful program is 100,000 man hours and all of our heart and soul. Happily placed residents working alongside happy faculty is PRICELESS.

10:00 – 10:15am  Break
Salon I Foyer

10:15am – 12:15pm  Workshop Session II
Workshop 9
Salon CD
ROUNDING LIKE A NINJA: PREPARING FACULTY AND TEAM TO EMPOWER SENIOR RESIDENTS DURING FAMILY CENTERED ROUNDS
Michael Weisgerber, MD, Medical College of Wisconsin, Milwaukee, WI, Megan Aylor, MD, Oregon Health & Science University, Portland, OR, Heather Toth, MD, Medical College of Wisconsin, Milwaukee, WI
Senior resident physicians (SR) are in their final stages of training and have one of the most challenging and important roles on the inpatient ward team. SR are expected to achieve competency in: making diagnoses and orchestrating plans for the care of complex patients; teaching interns, medical students, and families; and efficiently lead the team. Faculty are charged with helping SR develop into excellent clinician teachers and team leaders. This interactive workshop will provide the participant with strategies faculty and SR may use to promote SR leadership during Family Centered Rounds (FCR). The workshop will begin with a discussion of the concept of Senior Resident Empowerment Actions (SREAs) and small groups will brainstorm the SREAs they have found most useful in their practices. We will then introduce a framework to help participants learn to use SREAs in a memorable way (Rounding like a Ninja or Karate Kid and the 4 S’s). Participants will then practice the use of SREAs in a competitive, fun interactive rounding game (Rounding with the Stars) where participants must design a SREA based solution to a FCR scenario dilemma. Next, we will share video clips and discuss expert role modeling as another strategy to promote senior resident empowerment. The workshop will conclude with the participants committing to the use of one or more of these SR empowerment strategies for use at their own institutions.

Workshop 10
Salon KL
DOCTOR COACH: A LIFELONG LEARNING APPROACH TO TEACHING CLINICAL SKILLS
Kimberly A. Gifford, MD, Children's Hospital at Dartmouth Residency, Lebanon, NH, Su-Ting T. Li, MD, MPH, University of California Davis, Sacramento, CA, Mark Vining, MD, University of Massachusetts Medical School, Worcester, MA
This workshop is intended for participants who have attended a prior Doctor Coach workshop as well as those who are new to the model. A major goal of medical training is to teach physicians to become life-long learners. Residents and medical students develop this ability by repeatedly reflecting, setting goals, and practicing with the help of a faculty or resident “Doctor Coach,” who facilitates progression through these steps in the learning cycle until trainees internalize the steps to become their own coaches. The Doctor Coach lifelong learning approach to teaching clinical skills was developed based on adult learning theory, deliberate practice and coaching literature. Because Doctor Coach is based on fundamental coaching strategies, it is applicable to all clinical skills, unlike many published clinical teaching models which focus primarily on critical thinking skills or are designed for a specific teaching setting. It also includes strategies not well represented in the medical education literature, such as coaching about goal setting and practice. The Doctor Coach approach is taught to faculty and resident coaches through didactics that model the coaching strategies and introduce tools designed to help coaches to implement the strategies with learners during routine clinical encounters. During this workshop, short didactics will be used to introduce key Doctor Coach strategies of how to facilitate learner reflection, goal setting and practice. Following each didactic, participants will practice the coaching strategies through interactive exercises, with different activities and roles for participants who have attended a previous Doctor Coach workshop. Finally, participants will complete a coaching self-assessment and set goals to improve either their own coaching or their home institutions’ resident-as-teacher and/or faculty development programs. All participants will leave with a toolbox of strategies to assist in their coaching of lifelong learners.
Workshop 11
ASSOCIATE PROGRAM DIRECTORS: ADAPTING AND INNOVATING FOR A SUCCESSFUL APD CAREER
Marsha S. Anderson, MD, University of Colorado, Aurora, CO, Aditee P. Narayan, MD, Duke University Medical Center, Durham, NC, Jerry G. Larrabee, MD, University of Vermont, Burlington, VT, Heather A. McPhillips, MD, University of Washington, Seattle, WA, Lynn C. Garfunkel, MD, Univ. of Rochester and Rochester General Hospital, Rochester, NY
Background: The 2010 Associate Program Director (APD) Survey identified that 60% of APDs have been in their role for <2 years. Survey respondents identified a need for faculty development around peer networking, development of relationships to facilitate collaboration, and concrete steps for APD career success. Objectives: 1. Recognize the critical steps to acquire both training program knowledge/skills and individual professional development needed for a successful APD career; 2. Develop an individualized plan to address specific items in acquiring knowledge/skills and professional development; 3. Participate in a forum for networking between new APDs and more experienced APDs, whose programs have geographic and size similarities, to foster communication and collaboration. Workshop: Attendees will first be grouped by program size (small, medium, large). Small group discussion will focus on the training program knowledge and skills needed for success in APD roles and strategies for development. A report back to the large group will be followed by a brief presentation identifying critical knowledge/skills needed and development strategies. The group will re-divide based on geographic regions. Participants will discuss the steps needed for APD professional development. A report back to the large group will be followed by a brief presentation of crucial steps and strategies to achieve career success (e.g. finding a niche, collaboration, mentoring, networking, scholarly activity). Each participant will develop an individualized plan (IP), identifying at least 1 item in the knowledge/skills areas and 1 item in the professional development area the individual feels needs to be enhanced. A written 2-3 step personal action plan will be created for each item (including strategies) to achieve or develop the area. Facilitators will be available to review IPs. Attendees will leave the workshop with steps to enhance knowledge, skills, and professional development, and have an IP to begin the process. Throughout the workshop, participants will have a venue for networking and development of new or ongoing APD relationships.

Workshop 12
THE PEOPLE’S COURT: WHAT WOULD YOU DO ABOUT SERIOUS BREACHES OF PROFESSIONALISM IN TRAINEES?
Since professionalism represents a set of attitudes and values, educators are often faced with making value-based decisions on what actions to take after a trainee has demonstrated unprofessional conduct. Faculty struggle with balancing the public trust and furthering the careers of physicians entrusted to their training program. This workshop will introduce an ethical framework for evaluating a moral event as one potential starting point in analyzing cases of serious unprofessional conduct. This will be followed by a brief description of the workshop ground rules and setting up of a mock Graduate Medical Education Committee (GMEC), with each attendee a voting member. Workshop attendees will choose from 4 cases of breaches of professionalism. The workshop facilitators will successively present 3 of these cases before the mock GMEC. The attendees will anonymously vote using an audience response system for the action they feel most appropriate in each case. A facilitated discussion will then ensue, allowing members to discuss the rationale behind their vote in small groups. For some cases, additional information may be given after the initial vote including the resident’s perspective via a role play. The GMEC will vote again followed by a facilitated discussion about why (or why not) the results changed. At the end of the workshop, attendees will reflect upon lessons learned and what insights they gained. The voting patterns (normative feedback) and the rationales presented by the colleagues in adjudicating cases of unprofessional behavior should enhance the framework on which educators hang their future high stake decisions involving trainees’ careers. AGENDA: 1. Introduction: objectives, framework, ground rules, audience response system 2. Case #1 through 3: a) PD and/or Resident Presentation/Questions/Vote b) Small Group Discussion c) Sequel: PD Presentation/Questions/Vote d) Large Group Discussion 3. Wrap-up/Evaluations

Workshop 13
E-LEARNING 2.0: EXPLORING A ‘NEW FRONTIER’ FOR YOUR TRAINING PROGRAM
Kadriye O. Lewis, EdD, Cincinnati Children’s Hospital Medical Center, Cincinnati, OH, Cynthia L. Ferrell, MD, MSED, Oregon Health & Science University, Portland, OR, Teri L. Turner, MD, MPH, MEd, Baylor College of Medicine, Houston, TX, John D. Mahan, MD, The Ohio State University College of Medicine, Columbus, OH
E-learning is an educational methodology that will potentially define even more of the pediatric learning environment in the next decade. This method of learning makes it possible to engage learners in multiple ways, on multiple levels, utilizing all forms of electronically supported teaching and learning methodologies. Today’s learners are accustomed to interacting with others and with objects to obtain information -often with immediate feedback and satisfaction. Newer E-Learning formats, such as E-Learning 2.0, have the potential to dramatically expand educational opportunities for learners’ life-long learning needs. Contrasted with conventional e-learning systems, e-learning 2.0 emphasizes collaboration and social learning and the use of social software such as blogs, RSS, wikis, podcasts, and virtual worlds. This workshop is designed to help medical educators develop an understanding of e-learning 2.0 applications so they may integrate such tools into their curricula for medical students, residents and fellows. After a review of the key concepts and methods of e-learning in medical education, a variety of practical applications will be presented. These will include examples of interactive web based learning sites (virtual simulations, mashups, ...
and self-paced modules) and collaborative social learning sites such as (e.g., Twitter, wikis, blogs/microblogs, and voice threads).

Workshop 14

TRANSLATING THE PEDIATRICS MILESTONES INTO MEANINGFUL ASSESSMENT TOOLS FOR YOUR PROGRAM

Patricia J. Hicks, MD, Rebecca Tenney-Soeiro, MD, Jeanine M. Ronan, MD, Children’s Hospital of Philadelphia, Philadelphia, PA, Ann Burke, MD, Wright State University, Dayton, OH, Alan J. Schwartz, PhD, Department of Medical Education, University of Illinois, Chicago, Chicago, IL, Daniel J. Schumacher, MD, Cincinnati Children’s Hospital Medical Center, Cincinnati, OH, Susan Guralnick, MD, Stony Brook University School of Medicine, Mineola, NY

Assessment of a learner in the everyday clinical setting offers both the teacher and the learner the opportunity to gain valuable and practical information regarding learner performance in the real-world environment, where competent performance is critical. Assessment of learners in this setting is often limited to global ratings, Likert scales, or checklists, such as the mini-CER. Most of these tools are non-specific, making assessment and feedback vague and minimally helpful to the learner. The Pediatrics Milestones offer conceptual frameworks for assessing individual sub-competencies. To be meaningful, these milestones must be translated to describe the developmental progression that occurs in the authentic, or actual, clinical setting. Furthermore, grouping the sub-competencies into related clusters of activities and characteristics allows for assessment of a particular professional activity to take place in a specific clinical context. This workshop will engage participants in taking a group of 3-4 sub-competencies relevant to performance of an intern or sub-intern on a general pediatric inpatient setting and generating behavioral descriptors defining the progression of the learner within that specific clinical context. Workshop participants will then apply this set of descriptors as a newly developed assessment tool to score the performance of learners in standardized video cases. Concepts learned/emphasized in this process will include: (a) developing demonstrable and observable objective ratings; (b) rater training and calibration; (c) inter-rater reliability; and, (d) construct validity. Groups will discuss faculty development strategies and share ideas about how their newly developed tools could be disseminated within their programs. Participants will leave with copies of workshop materials to use at their own institution.

Workshop 15

INDIVIDUALIZING THE CURRICULUM FOR RESIDENTS: GREAT IDEA! HOW CAN WE IMPLEMENT?!

Julie S. Byerley, MD, MPH, University of North Carolina at Chapel Hill, Michael J. Steiner, MD, University of North Carolina, Chapel Hill, NC, Kaye Gable, MD, University of North Carolina, Greensboro, NC, Benny L. Joyner, MD, MPH, University of North Carolina at Chapel Hill, Chapel Hill, NC

An individualized and relevant curriculum is essential to maximize adult learning. The newly proposed requirements for Pediatric Residency training support this concept by including the statement that “The overall structure of the program must include: a minimum of six educational units of an individualized curriculum; The individualized curriculum must be determined by the learning needs and career plans of the resident and must be developed through the guidance of a faculty mentor.” Though most residency program directors will agree with this idea in concept, many will struggle with implementation given clinical service needs and structured additional requirements for the residency. In this workshop we will generate feasible plans to address this potential new requirement. We will first brainstorm ideas for an individualized curriculum. Presenters will briefly share their examples of individualizing curriculum including primary care tracks, individual goal setting in continuity clinic, critical care interest group activities, and special experiences in research, global health, and advocacy. Participants will be asked to contribute other current examples of individualized curricula at their institutions. We will then use an audience response system to prioritize several ideas to more fully develop in small break out groups. Each group of 4-8 participants will work to fully develop the individualized curriculum they have chosen to work on for implementation. Barriers will be listed and how to address those barriers will be discussed. Groups will then report back their implementation plans to the remainder of the workshop participants. Time will be protected at the end of the workshop for participants to write out their own plan for individualized curriculum implementation in their home program.

Workshop 16

“AND THE SURVEY SAYS...AGAIN” AN ADVANCED WORKSHOP FOR DESIGNING AND COLLECTING SURVEYS TO OPTIMIZE PROGRAM OUTCOMES

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

This workshop is a follow-up for participants who attended the basic workshop offered at the APPO meeting last year in Miami 2011. A well-executed survey can yield valid and reliable data that can provide critical information about program outcomes, resident recruitment, educational innovations and research, and quality improvement activities. However, optimal survey design can be very challenging as there are numerous common pitfalls that can yield data that are not valid, reliable or useful. Designed as a follow-up to the basic workshop, the goal of this workshop is to give participants an opportunity to practice applying the principles of effective survey design in a ‘hands on’ way with direct feedback from workshop leaders. The workshop will begin with a short review of the concepts and skills taught in the basic workshop. Participants will then work
in small groups where they will practice developing survey questions related to one of several topics provided by workshop leaders and informed by a pre-workshop survey. Each small group will practice using a detailed survey design and quality control worksheet to develop at least four survey questions each with a different response scale. Next the groups will develop a set of strategies to administer the surveys and collect data from respondents. This activity will be followed by a large group session facilitated by workshop leaders where each small group will report their work to the large group for feedback. The workshop will conclude with a brief didactic session reviewing strategies for analyzing and presenting survey data and a summary of key concepts. Participants will leave the workshop with an advanced understanding of optimal survey design, practice using a worksheet that provides a step-by-step guide to developing surveys, and a clear strategy that can be used to write valid survey questions and identify appropriate response scales for nearly any project.

10:15am – 12:15pm  Coordinators' Workshops

**Salon F**

10:15-11:15 Workshop C8
ENSURING THE CONTINUITY OF YOUR PROGRAM, THE COORDINATOR AND YOUR ACADEMIC YEAR

*Yvette M. Foster, BA, Elizabeth Payne, MAEd, University of Texas Health Science Center at San Ant, San Antonio, TX*

Recognizing that the Program Coordinator role is changing and change-over is inevitable, the Program Continuity Project aims to establish a living collection of documents that will encourage a continuous flow of information and practices within a given program. Establishment of this document and set of practices will help minimize any errors resulting from changeover and provide an opportunity for Program Coordinators to critically evaluate their information and procedures. This workshop will provide an overview of the need to assemble a desk manual and illustrate the benefits for continuity as a Program Coordinator. It will also demonstrate a desk manual is an inexpensive teaching tool and resource to the program and promote the support and retention of Program Coordinators. This presentation will also demonstrate how a Program Coordinator serves as a liaison between hospitals and associations and the importance of this relationship.

11:15-12:15 Workshop C9
BE INDISPENSABLE: AREN’T WE ALREADY?

*Cindy A. Ortiz, MBA, Teresa D. Flournoy, BGS, Children’s Mercy Hospitals and Clinics- UMKC, Kansas City, MO*

In this workshop, coordinators will discover even more ways to become indispensable in their roles as coordinator. Accountability, self-reliance, communication, and flexibility are just a few of the characteristics that the speakers will share with coordinators. Getting the job done is one thing, making yourself invaluable to your programs is what helps you make the most out of your role as a coordinator.

12:45 – 2:15pm  Regional Lunch Meetings

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

**Mid-America**  
Conference Room 3/4  
Western PA, OH, WV, KY, IN, MI  
Mid-Atlantic  
Conference Room 1/2  
Southern NJ, Eastern PA, DE, MD, Washington DC  
Midwest  
Salon GM  
IL, WI, MN, IA, MO, KS, NE, OK  
New England  
Conference Room 12  
ME, NH, MA, CT, VT, RI  
New York  
Conference Room 17/18  
NY, Northern NJ  
Southeast  
Salon E  
VA, NC, SC, GA, FL, AL, MS, LA, AR, TN, PR  
Southwest  
Conference Room 8  
TX  
Western  
Salon AB  
CA, NV, OR, WA, AK, CO, NM, UT, AZ, HI
2:15 – 3:45pm Poster Session (see page 31 for poster/abstract details)

Salon HI

*Posters will be available for viewing from 10:30am - 3:45pm*

3:30 – 5:00pm Coordinators’ Task Force Meetings (open to all interested attendees)

*see page 8 for details*

Management/Supervision

Professional Development

Tools

Conference Room 12

Conference Room 3/4

Conference Room 13/14

3:45 – 4:45pm Task Force Meetings (open to all interested attendees)

*see page 7 for details*

Curriculum

Evaluation

Faculty and Professional Development

Learning Technology

Research and Scholarship

Conference Room 17/18

4:45 – 6:15pm APPD Global Pediatric Health Education Meeting

Salon E

WELCOME all to the first annual meeting for those interested in any aspect of pediatric global health (GH) education. This short session is intended for any and all current or past GH (track) directors, potential GH directors/leaders, GH directors with no title, interested GH educators, interested GH learners, interested coordinators, those thinking about GH…. We will discuss some of the current issues in pediatric resident global health education. The intention is for interested pediatric educators to learn and work together to improve resident education in pediatric GH. We want the opportunity to convene with pediatric educators (at all levels) interested in improving pediatric GH education. Areas for discussion may include: curriculum, programming, faculty development, research, rotations, information dissemination, resources and a general networking and sharing of ideas. This meeting is open – we look forward to developing a network of interested educators to enhance pediatric trainees GH foundation.

SATURDAY, MARCH 31

7:30 – 8:00am Continental Breakfast

Salon I Foyer

8:00 – 9:00am Coordinators’ Workshop C5

Salon E

NOT EVEN MOTHER NATURE CAN STOP A SITE VISIT

Melodie S. Allison, C-TAGME, Baylor College of Medicine Pedi Residency Program, Peggy Womack, Baylor College of Medicine Pedi Emergency Medicine, Houston, Texas

Two small words have caused program directors, associate program directors and program coordinators to cringe: “Site Visit” Hearts raced, stomachs twisted into knots, and shoulders slumped as anxious looks appeared on all faces. Slowly, the anxiety would begin to subside as teams were formed, the IT department came through with the necessary statistics, residents responded to your survey, faculty uploaded their current CV’s, the site visit schedule took shape and small forests were sacrificed as you prepared the required documentation for the inevitable “Site Visit” Final 24 hours - Everything was a go. All hands were on deck. You were no longer as anxious. You were confident all was in order. ‘Bring It On! Little did you realize…….. *Mother Nature and the ACGME have a very different plan!*

8:00 – 9:00am Wrap-up Session from Grassroots Forums

Salon KH

9:00 – 9:15am Wrap-up Session from Coordinators’ Activities

Salon E
INTRODUCTION TO EDUCATIONAL SCHOLARSHIP: HOW TO MAKE YOUR GREAT IDEAS COUNT!
Su-Ting T. Li, MD, MPH, University of California, Davis, Sacramento, CA, Heidi M. Sallee, MD, Saint Louis University, St. Louis, MO, Richard S. Robus, MD, Blank Children’s Hospital, Des Moines, IA, Daniel C. West, MD, University of California, San Francisco, San Francisco, CA, Linda A. Waggoner-Fountain, MD, MEd, University of Virginia, Charlottesville, VA, Heather A. McPhillips, MD, MPH, University of Washington, Seattle, WA
This workshop will be lead by members of the Research and Scholarship Task Force and is designed to provide educators with the knowledge and skills to turn their educational innovations into educational scholarship. Presenters will begin with a short interactive didactic to introduce Glassick’s Criteria for Scholarship and briefly define 3 different types of educational scholarship (Discovery, Teaching, and Integration). Workshop participants will then break into facilitated small groups to critically evaluate three examples of educational scholarship in the areas of Discovery, Teaching, and Integration using an evaluation tool based on Glassick’s criteria. A facilitated large group discussion will allow representatives from each group to present their findings to the entire group of participants and workshop leaders for discussion and feedback. Participants will then work in dyads to develop a plan for turning their own educational innovations into educational scholarship using the iExcite Planning Worksheet followed by presentation to their small group with a workshop leader for feedback. Workshop leaders will conclude the session with a summary slide of common journals and peer-reviewed websites for educators to consider submitting material to and a discussion on how to choose a venue for dissemination. Participants will receive an annotated bibliography of references and resources, included published examples of the Scholarship of Discovery, Teaching...
and Integration. I-EXCITE: Identify the Problem, EXamine current situation, Create intervention or develop a curriculum, Implement intervention or curriculum, Test effectiveness and make modifications, Export model

Workshop 20
A BRAVE NEW WORLD: CREATING TRAINING PROGRAMS FOR HEALTH CARE REFORM
Adam Pallant, MD, PhD, Elizabeth Bird, MD, Bonnie O’Connor, PhD, Brown University, Providence, RI
Our health care system is under extraordinary scrutiny and debate. As congress battles out details of health insurance reform, our community of physician educators needs to articulate its role in the definition and creation of affordable, sustainable and accountable care. The exponential rise in the breadth, complexity, and specialization of pediatric care delivery calls for new collaborative approaches and unprecedented team work. A window of opportunity exists for us, as physician educators to embrace and lead change in the American pediatric health care model. Broadly, this workshop will accomplish 3 objectives:
1) Workshop leaders will first provide a succinct overview of the broad challenges and threats to current pediatric health care, and brief instruction in current and proposed changes in health care policy and laws. 2) We will then facilitate a discussion of our roles as physician educators in health care reform. In doing so, we will examine our professional structures, and the role of the APPD within the ACGME and RRC to ensure that pediatric education responds to a shifting and dynamic landscape.
3) Finally, we will brainstorm novel approaches to pediatric health care and to training physicians in the provision of care that is more affordable, accessible, and equitable. Breakout groups guided by workshop leaders will coordinate activities to first define vision and then begin to articulate strategic plans, models and methods in program design. Topics will include Accountable Care, The Collaborative Child Health Team, The Primary Care Pediatrician as Consultant, and Community-Based Child Outreach Teams. At the end of the workshop, participants will have a greater insight into the potential impact of health care reform on pediatric practice and training. Participants will explore new approaches to pediatric training that may be incorporated into novel programs in their own institutions. Most importantly, participants will collectively clarify our roles and responsibilities in shaping the future of pediatric health care delivery, as we train the next generation of pediatricians.

Workshop 21
TEAM BASED LEARNING: AN ACTIVE LEARNING STRATEGY FOR BOARD REVIEW
Priya Garg, MD, Danielle Lam, DO, Q Nguyen, MD, Floating Hospital for Children at Tufts Medical Center, Boston, MA
Team Based Learning(TBL) is a learner centered, instructor led, learning strategy that has been used in undergraduate medical education. TBL provides frequent opportunities for peers to enhance learning, as teammates talk and listen to one another to arrive at consensus decisions. It has been shown to increase examination performance for undergraduate medical students. Board review in graduate medical education has primarily focused on individual study and learning. Our institution decided to develop a formal board review series which would emphasize immediate feedback and peer discussion facilitated by senior residents to improve board review participation and performance. We have used a team based learning style conference to teach core board review topics while allowing a teaching resident to lead an interactive teaching strategy. This workshop will begin with a broad overview of TBL and the four essential components of TBL. We will give a brief summary of published data to date regarding TBL and the format of our current board review series and sessions. Workshop participants will then be organized into random groups and will participate in a TBL session about current Pediatric RRC requirements, similar to the format of a TBL board review session. Each participant will be given 5 minutes to review the guidelines and then will complete an individual readiness assurance test about the RRC guidelines. Participants will then discuss the same test in groups of 6-8 and come to consensus answers and be given an immediate feedback card to confirm their answers. Each question and answer will be discussed by the large group after all teams have completed the group test. Finally, another set of higher level questions will be distributed to the group and teams will explain their answers and decision making process to the large group after all questions have been completed. After completion of the TBL session, a large group reflection about the experience will occur. We will end the workshop with a summary of data regarding our performance experience with TBL board review and time for workshop evaluation.

Workshop 22
BE AN EDUCATIONAL CONSULTANT FOR A DAY: USING LEARNING STYLE THEORY TO DESIGN LEARNER-CENTERED EDUCATIONAL SESSIONS
Gregory H. Gorman, MD, Matthew D. Eberly, MD, Uniformed Services University of the Health Sciences, Clifton Yu, MD, Walter Reed National Military Medical Center, Bethesda, MD
Ever wonder what your college classmates who went into “consulting” do all day while you are rounding on the wards? Now is your turn to act as a consultant in the field you know best -- pediatric graduate medical education. This workshop will introduce the Kolb Learning Styles Inventory and the Visual-Auditory-Kinesthetic (VAK) learning styles framework. Participants will discover their own learning style preferences as a reflector, activist, theorist, or pragmatist by taking a learning styles inventory. Participants will then be formed into educational consulting teams of 4 to 6 people, with each group consisting of individuals with a variety of learning style preferences. Each team will be assigned the task of providing advice and ideas on how to structure an educational session on a pediatric topic such as febrile seizures, tumor lysis syndrome, cystic fibrosis, sickle cell disease, and others. After completing this task, each group will present their educational approach to their assigned topic to the rest of the workshop participants. The team’s advice, if followed, should allow the teacher to activate and engage as many learning styles as possible with their innovative ideas. The effectiveness of each group’s presentation will be measured by peer scoring based on the ability to appeal to each of the various learning styles. The workshop objective focuses on the
the new ACGME Common Program Requirements, we propose this year to focus on methods to teach Interpersonal and Learning, Professionalism, Systems Based Practice, and Quality and Safety initiatives. Based on requirements included in In this symposium in the past, the Curriculum Task Force has addressed curricular achievements in Practice Based learn skills that may be more difficult to define, and therefore increasingly time consuming to develop curricula around. competencies of medical knowledge and patient care. In addition to these areas of training, pediatric residents must create a mobile platform capable of addressing all these competing interests while functioning in the real world of the resident physician. Administrators, faculty, residents, coordinators, information technology, IT security and hospital leadership at two facilities were brought together as a team to create this new resident training tool using technology available from tablet computers. The goal of this workshop is to share the lessons learned while building this system and highlight the tangible benefits that were realized following its implementation. Towards this end, we will begin with a needs assessment and then a focused review by task using audience participation and small group discussion. This process is similar to the one followed by our team, and will include a review of the challenges we faced along the way. Next residents from our program will offer a hands on demonstrations in a small group setting, to allow participants to see and interact with a mock up of our system; participants will then be asked to provide comments and suggestions for improvement. Finally, we will present early data to wrap up our presentation using information on time savings and resident satisfaction along with our Top Ten Pearls for incorporating this type of tool into any residency program.

Workshop 23
LEARNING TO DO IT BETTER: IMPROVING PROFESSIONALISM AND COMMUNICATION AROUND DIFFICULT TOPICS USING STANDARDIZED PATIENTS (SPS) FOR COACHING AND FORMATIVE FEEDBACK
Ann P. Guillot, MD, MD, Jerry G. Larrabee, MD, Daniel Shumer, MD, Vanessa M. Goodwin, University of Vermont Pediatric Residency Program, Burlington, VT
Historically, residents’ skills around professionalism and communication have been learned by direct observation of others at the bedside or in the clinic. Over the last decade, systems have evolved around Objective Structured Clinical Exams (OSCEs) which utilize Standardized Patients (SPs) and scoring rubrics to give summative evaluation on a resident’s abilities in prescribed areas. Although most residents perform well enough to “pass” the OSCE, they generally wish to improve their skills well beyond the pass / fail expectation line when it comes to the domains of professionalism and communication. In this workshop, we will review and demonstrate our curriculum entitled PRELUDE (Pediatric Resident Experiential Learning Using Dramatic Encounters). We will explore the methodology behind this novel curriculum which hinges on the SPIKES protocol, resident mentors, faculty development, and the use of SPs in encounters around topics that have been chosen by the residents. We will show a video of a PRELUDE encounter to illustrate how our program transforms a classic OSCE into a formative feedback tool for residents in the domains of professionalism and communication. Following a brief segment on the principles of developing standardized scenarios, we will break out into small groups to provide participants with an interactive opportunity to create scenarios that are relevant to their own training programs. We will then reconvene to discuss the logistics of our PRELUDE program. Given that SPs are widely available in medical schools and teaching hospitals, we envision it is quite feasible that this type of program could easily be used at other institutions. We will explore scheduling issues, personnel costs and usage, and faculty development in support of our PRELUDE program so as to equip the participant with the tools and an action plan to establish a similar program at their own institution.

Workshop 24
HITTING WITH YOUR PROGRAM’S “SWEET SPOT”: USING TABLET COMPUTERS TO OPTIMIZE RESIDENT SCHOLARSHIP, TEACHING AND CLINICAL PERFORMANCE - ONE PROGRAM’S EXPERIENCE
Jon A. Courand, MD, Michelle Arandes, MD, Beth Payne, MAEd, UTHSCSA, San Antonio, Texas
The demand placed upon residents, program directors and housestaff offices is quickly approaching a functional limit with many programs finding themselves on the far end of their programmatic Starling Curve. Time for essential knowledge acquisition and clinical training of residents now competes with daily requirements for handover, duty hour logging, evaluations, surveys and required modules (ex. HIPAA training, Risk Management and Policies on use of Social Media). A year ago, the University of Texas Health Science Center at San Antonio, Department of Pediatrics began a program designed to create a mobile platform capable of addressing all these competing interests while functioning in the real world of the resident physician. Administrators, faculty, residents, coordinators, information technology, IT security and hospital leadership at two institutions were brought together as a team to create this new resident training tool using technology available from tablet computers. The goal of this workshop is to share the lessons learned while building this system and highlight the tangible benefits that were realized following its implementation. Towards this end, we will begin with a needs assessment and then a focused review by task using audience participation and small group discussion. This process is similar to the one followed by our team, and will include a review of the challenges we faced along the way. Next residents from our program will offer a hands on demonstrations in a small group setting, to allow participants to see and interact with a mock up of our system; participants will then be asked to provide comments and suggestions for improvement. Finally, we will present early data to wrap up our presentation using information on time savings and resident satisfaction along with our Top Ten Pearls for incorporating this type of tool into any residency program.
Communication Skills which affect coordination of patient care delivery, including patient care handovers, use of electronic medical records, and discharge planning. **OBJECTIVES:** Participants will: (1) identify a variety of curricular approaches utilized in various programs to teach interpersonal skills and effective communication, such as for transitions in care and use of electronic medical records, and (2) adopt and/or adapt practical examples of curricular practices of real programs for use in their own programs. **DESCRIPTION:** The session will follow the style of a platform session with moderators. Five program directors will present an overview of their curriculum to address specific communication skills (patient care handovers, use of electronic medical records, and discharge planning). After each presentation there will a 5-10 minute question and answer session. Each participant will leave the workshop with new ideas for teaching aspects of interpersonal and communication skills that can be practically and easily implemented into their own local program curricula.

**SPEAKERS WILL INCLUDE:**
- Sarah Rawstron: “Sign Out Competence: Easier Said than Done”
- David Johnson: “Development of a Simulation-based Module to Teach Handovers to Pediatric Residents”
- Robyn Strosaker: “Teaching Residents to ‘Teach-Back’: Does a Structured Curriculum including Simulation Improve Pediatric Resident Communication Skills?”
- Suzanne Lopez: “Resident Curriculum to Improve Effective Electronic Medical Record Documentation”
- Julie Noffsinger: “Effectiveness of a Discharge Education Curriculum for Interns Rotating on an Inpatient Pediatric Ward”

**Workshop 26**  
**SALON D**  
**PREPARING LOCALLY TO WORK GLOBALLY: ENSURING SUCCESSFUL GLOBAL HEALTH ELECTIVES THROUGH MENTORSHIP AND PRE-TRAVEL PREPARATION**  
Nicole E. St Clair, MD, Medical College of Wisconsin, Milwaukee, WI, Maneesh Batra, MD, MPH, University of Washington School of Medicine, Seattle, WA, Cindy Howard, MD, MPHTM, University of Minnesota, Minneapolis, MN, Donna M. Staton, MD, MPH, AAP/Section on International Child Health, Los Altos Hills, CA, Sabrina Wagner, MD, University of Wisconsin, Madison, WI

In our profession, we mandate that medical trainees be adequately prepared for patient care activities: we demonstrate proper scrub technique before entering the operating room, provide NRP training before NICU rotations, and teach PALS prior to placing a resident on a code team. We do this for two purposes—to optimize patient care and to equip trainees to succeed. Consider, now, a global health elective in a country where resources are scarce, morbidity is high, and diseases are unfamiliar—where, for example, overaggressive management of severe malnutrition can precipitate congestive heart failure. Insufficient preparation, coupled with suboptimal supervision, can lead to delayed diagnoses, improper use of resources, poor patient care, unsafe working conditions, and stressful experiences for trainees. Why, then, do many pediatric residency programs not provide formal preparation for residents engaging in global health electives? This workshop will provide pediatric residency program leaders with straightforward methods to prepare residents for global health electives. We will emphasize the importance of ensuring safety and supervision during global health electives, and will review ways to optimize the resident’s experience while minimizing the burden placed on the overseas site. Through an interactive, case-based format we will discuss suggested timelines for preparation, introduce useful preparation checklists, review medicolegal and ethical considerations, and provide resources to help your institution develop policies surrounding international electives. Resources provided will include an introduction to web-based modules that will provide a comprehensive pre-departure curriculum for pediatric residents (anticipated rollout 2012-13), as well as sample documents that can be adapted at your institution to facilitate seamless pre-travel preparation for residents. The workshop, led by global health track directors, will be pertinent for programs with all levels of global health infrastructure.

**Workshop 27**  
**CONFERENCE ROOM 1-4**  
**SHINING LIGHT ON THE DARK NIGHT - DEVELOPING COMPREHENSIVE CURRICULA FOR YOUR NIGHTTIME EXPERIENCES**  
Cynthia L. Ferrell, MD, MSED, Megan E. Aylor, MD, Oregon Health & Science University, Portland, OR, Karen S. Leonard, MD, Ann P. Guilhot, MD, University of Vermont Pediatric Residency Program, Burlington, VT

With implementation of new ACGME common program requirements, pediatric educators must think differently about resident education at night. In a needs assessment survey completed by Blankenburg et al in 2010, only 30% of pediatric programs had night time curricula at night. Dr. Blankenburg’s group has created one tool to be included in night time education, but programs must have a formalized way of thinking about the complete spectrum of learning at night. Gone are the days when nighttime is crisis management and holding down the fort until 7:00am. Programs must create structured experiences for learners present in the hospital during the dark hours, while maintaining graduated autonomy for residents. While the prospect of this has struck fear in the hearts of program directors, the charge is far from impossible. This task-oriented workshop will approach the creation of structured learning experiences for residents working in the hospital at night. In small generation-based groups, we will perform a needs assessment addressing the specific opportunities available to learners at night. To assure a uniform curricular planning experience, we will briefly review an easy, 3-step process in curriculum development. In small groups, we will develop learning objectives, instructional strategies, and evaluation methods that are appropriate for a nighttime curriculum. After sharing their work products, participants will head home with building blocks to continue the development of institutional specific nighttime curriculum.
Workshop 28
PATIENT HANDBOFFS: A PRACTICAL APPROACH TO IMPLEMENTING A CURRICULUM, PROVIDING OBSERVATION & GIVING FEEDBACK
Stephanie Dewar, MD, University of Pittsburgh, Pittsburgh, PA, Linda A. Waggoner-Fountain, MD, University of Virginia, Charlottesville, VA
Patient handoffs between physicians are crucial elements in the effective and safe care of patients. The recent ACGME revisions in resident duty hours have resulted in more frequent transitions of care between residents who generally do not receive adequate training and experience in this vital process during medical school. We will present a review of the current literature around physician handoffs and discuss the current ACGME/RRC requirements for resident instruction in order to guarantee safe patient handoffs. Several approaches to the successful implementation of a standardized curriculum will be shared along with data as to the success after implementation of a curriculum. Attendees will observe & participate in simulated sign-out training sessions. Tools for observation and feedback of resident sign-out will be reviewed and utilized. Emphasis will be placed on the location, timing, and the quality of content of communication involved of the verbal sign-out process.

Workshop 29
SOCIAL MEDIA AND MEDICAL PROFESSIONALISM: HOW I TWEETED MY WAY OUT OF PEDIATRICS
Michael P. McKenna, MD, Indiana University, Indianapolis, IN, Allison Brindle, MD, Rita Pappas, MD, Cleveland Clinic, Cleveland, OH
Social media provides an excellent opportunity for pediatricians to network with other physicians, conduct scholarship and teach patients as well as learners. Unfortunately, it can also be an outlet for unprofessional behavior. In this workshop, attendees will reflect on professionalism problems that they have seen at their institutions. There will be a brief review of the current literature on medical professionalism and social media and the social media policies at our institutions. Participants will then break into small groups and have a hands-on experience with cases of unprofessional behavior on social networking sites. Cases will include cyberstalking, inappropriate disclosure of patient information on social media, online “friendships” with patients or their family members, use of discriminatory language on social networking sites and depiction of medical professionals using excessive alcohol or illicit substances. The small groups will formulate strategies to target these specific infractions, including consequences for unprofessional behavior online and how to prevent these occurrences in the future. At the end of the session, the small groups will present their work to the larger group for discussion. Attendees will leave the session with tools they can take back to their institution to educate learners of all levels about unprofessional behavior on social media sites.

Workshop 30
RESIDENT BURNOUT: CONSTRUCTING A PROGRAM TO FOCUS ON DIAGNOSIS, PREVENTION AND INTERVENTION
Scott Holliday, MD, Jonathan Thackeray, MD, Rajesh Donthi, MD, Cynthia Holland-Hall, MD, John D. Mahan, MD, Nationwide Children’s Hospital/OSU, Columbus, OH
Burnout is a psychological term for the experience of long-term exhaustion, depersonalization and diminished interest in life and career. Physicians are particularly prone to burnout with up to 40% of general practitioners reporting significant burnout. Recent studies and our own data highlight the high incidence of burnout in residents. We have utilized the most well-studied measurement of burnout, the Maslach Burnout Inventory (MBI), to define levels of emotional exhaustion, depersonalization and threats to sense of accomplishment in our residents over the last 3 years. Burnout can be seen as the antithesis of engagement, and thus as a distinct threat to continued learning and performance. In response to burnout levels in our residents we have designed specific educational modules and offered individualized interventions designed to enhance resiliency. This workshop is designed to help program directors, coordinators and faculty to understand the concept of burnout and methods for detection, prevention and intervention. Participants will initially complete and self-score their own MBI to better appreciate this tool. The science underlying the construct of burnout will then be explored through presentation and group discussion. The presenters will then describe 3 activities derived from their experience with residents: Burnout - self-analysis and understanding - an interactive discussion based on video triggers, 2) Understanding Emotional Intelligence and Resiliency - a presentation and group discussion for residents and 3) Individualized Burnout Interventions - one on one sessions developed by a psychologist working with the residency program. Participants will then self-select into small groups organized around developing activities to impact on burnout detection, prevention and implementation at their own programs. Each group will then present their work to the larger group followed by a general discussion to identify common themes and opportunities for implementation.

Workshop 31
DESIGNING A BOOT CAMP FOR PEDIATRIC FELLOWS
Debra Boyer, MD, Children’s Hospital, Boston, Boston, MA, Chris Kennedy, MD, Children’s Mercy Hospital, Kansas City, MO, Donald Boyer, MD, Children’s Hospital of Philadelphia, Philadelphia, PA, Jim Bale, MD, University of Utah, Salt Lake City, Utah
Rationale: The current learning environment, impacted by reductions in duty hours and changes in pediatric practice, create a need for enhancing the basic skills of trainees entering fellowship programs. Structure of Workshop: 1. Introduction 2. How to perform a Needs Assessment a. Introduction to purpose of a needs assessment b. Task to group: Each participant defines their target group of learners c. Each participant completes a worksheet describing their target learners/anticipated needs. Each
• learner creates a needs assessment to determine learner needs d. Large group breaks into dyads/triads to review and refine questions e. Representatives of three dyads or triads present their worksheet results and describe their needs assessment.
• How to identify and assess resources needed for Boot Camps a. Brief introduction of resource needs b. Task to group: In dyads/triads, identify and assess what resources are needed to develop their boot camp c. Representatives of two or three dyads present their needs. This will be followed by a large group discussion. d. Presentation by facilitators describing resources/negotiation strategies that were needed and identified for current local, regional and national Boot Camps. Additional discussion on how to approach funding sources.
• Course Development a. Introduction on developing course objectives and boot camp development b. Task to group: In dyads/triads, develop one learning objective, a Boot Camp activity to address this objective, and an assessment tool c. Discuss as a large group creative ideas. Example of a Boot Camp activity a. Distribute learning objectives for a specific boot camp activity already designed (Pneumovac) b. Participants will participate in this boot camp activity c. Group discussion regarding how this activity accomplished the stated goals/objectives and how to assess this activity.
• Workshop 32
  **LET’S GET PRACTICAL! DECONSTRUCTING THE CORE COMPETENCIES IN BUILDING GLOBAL EVALUATIONS OF RESIDENTS**
  **Jacob Robson, MD, Duncan Henry, MD, Robert Vinci, MD, James Moses, MD, MPH, Boston Combined Residency Program in Pediatrics, Boston, MA**
  Do your residents stare blankly at their global evaluations, trying to interpret their systems based practice score and wondering how to identify their strengths and weaknesses, in hopes of becoming a stronger clinician? Does your faculty wonder how to use competency based assessments in identifying residents ready for supervisory responsibility and increasing autonomy? This workshop offers residency leadership a potential framework for creating an alternative to generic, competency-based global evaluations. We will share our experiences in the Boston Combined Residency Program, where we have moved to rotation-specific evaluation forms that use innovative educational practices such as modified behavioral anchors and Entrustable Professional Activities (EPAs). We will guide workshop participants through our 3-step process of creating rotation based evaluation forms, beginning with creation of standardized, common items that can be tracked across rotations. We will then show how we used rotation-based objectives as specific points of assessment, with behavioral anchors to guide scoring. We will assist participants in the creation of their own rotationally-based evaluation items and associated rubrics. Lastly, we will discuss our process of defining, creating and incorporating rotation-specific EPAs into global evaluation forms. EPAs have been offered as an exciting adjunct to competency-based assessment, yet their concrete definition and practical implementation in resident evaluation is not widespread. We view EPAs as key activities in pediatric training that can be used to assess trainees’ professional progression and readiness for additional responsibility. We will facilitate small group discussion about an operational definition of EPAs, share our personal experience in starting to work with them, and help participants to identify EPAs within the context of their own programs. Finally, we will demonstrate how rotation-specific objectives and EPAs can be aggregated to highlight the longitudinal process of core competency attainment across a three-year residency curriculum.

• 12:45 – 2:15pm  **Council of Task Force Chairs Luncheon**
  **Conference Room 8**
Program Development: In 2008, our institution implemented a “Customizable Pathway System” to allow residents with a clear career goal to tailor their education. Using the six-step approach to curriculum development established by Kern et al., we must examine their own programs and decide how they will integrate an individualized curriculum into resident training.

Introduction: With the new ACGME common program requirements for pediatrics upon us, many pediatric residency programs are asked to complete a pre-visit survey on home safety and environmental hazards, and are asked to complete a post-visit survey upon completion of each visit. Each family is given a home health visit conducted by a resident and faculty mentor, and is provided with home safety equipment and written instructions on its use free of charge. Through review of this pre- and post-survey data collection, we are seeing a significant impact of the home safe home program on pediatric resident education and with family education in injury prevention and environmental health. Home Safe Home has been a curriculum requirement at CHLA for over 2 years, with more than 70 homes in the greater Los Angeles area visited and greater than 60 residents involved in the project. Through Home Safe Home, pediatric resident injury prevention counseling skills have improved. Residents feel more comfortable and effective providing home injury prevention tips to their continuity clinic patients. Cultural awareness in home safety and environmental health anticipatory guidance is enhanced, as demonstrated through self-efficacy questionnaires. Also, residents better understand the practical limitations of their medical treatment plans, in the context of the social, environmental, and economic environments in which their patients live.

Poster Number 2

ESTABLISHING A RESIDENCY-DRIVEN SCHOOL-BASED MEDICAL HOME IN HAITI: OUTCOMES AFTER ONE YEAR

Jeri W. Kessenich, MD, Katherine E. Kruse, MD, Grand Rapids Medical Education Partners/Michigan Sta, Grand Rapids, MI

Health care in the developing world often lacks a primary care focus. Haiti, the poorest country in the Western Hemisphere, exemplifies this phenomenon. Haitian children commonly experience tuberculosis (TB), Dengue Fever, malaria, HIV, routine viral infections and malnutrition. Since the earthquake in 2010, many remain homeless and without adequate access to health care. The Michigan State University Grand Rapids Pediatrics Residency partnered with a local nonprofit organization to establish a pediatric medical home in a school in Port au Prince, in October of 2010. Eighty eight school children received complete histories/physicals, vision/hearing testing, and screening for anemia, TB, and HIV. At baseline the incidence of underweight was 30%; anemia 60% and positive TB skin test 20%. All children were HIV negative. Interventions implemented included a daily meal and filtered drinking water at school, daily multivitamin with iron, weekly malaria chemoprophylaxis, semiannual deworming, treatment of acute and chronic health problems, and basic health education. Follow up visits with repeat hemoglobin testing and growth measurements were done by teams of Pediatrics residents and faculty 4, 6, and 12 months later. Analysis of data from the first year of clinic operation revealed average gains in hemoglobin of 1.3 gram/dL; stature of 5 cm; weight of 3 kg; and weight percentile of 2.3. There was a marked decrease in somatic complaints, low rates of school absenteeism and no suspected cases of malaria during this time. Future plans include ongoing quarterly visits by residents and faculty, follow up of children with positive TB tests, provision of a longitudinal health education curriculum, and employment of a Haitian community health worker to reinforce education and medication compliance between medical team visits. This initiative highlights the role residency programs can have in promoting primary care initiatives in the developing world.

Poster Number 3

CUSTOMIZABLE PATHWAYS FOR RESIDENTS: ONE PROGRAM’S EXPERIENCE WITH AN INDIVIDUALIZED CURRICULUM

Sara M. Mullerer, MD, Kimberly Boland, MD, University of Louisville, Louisville, KY

Introduction: With the new ACGME common program requirements for pediatrics upon us, many pediatric residency programs must examine their own programs and decide how they will integrate an individualized curriculum into resident training.

Program Development: In 2008, our institution implemented a “Customizable Pathway System” to allow residents with a clear career goal to tailor their education. Using the six-step approach to curriculum development established by Kern et al., we created one pathway for primary care and one for fellowship. General features of both pathways include: assigning a mentor in the resident’s field of choice; scheduling “priority” to ensure career-specific rotations early in the PGY-3 year; and carving out one week from a block elective rotation for an “additional experience” related to the resident’s career path. Specific features of the Primary Care Pathway include: an extra block rotation in a community private practice; primary care business workshops;
and creation and maintenance of an online database for helpful links, articles, and protocols related to primary care. Specific features of the fellowship pathway include: an extra block of research if desired and extra procedure time. Discussion: Initial survey data indicates that pathway participants found the program did improve their preparedness for their ultimate career path. Benefits of the program thus far include creation of new electives and creating extra procedure opportunities. However, the individualized rotations have been somewhat difficult to schedule and track. Also, five out of the 13 residents who entered the pathways have changed or are wavering in their career choice, indicating that career-specific rotations should be left mostly to the PGY-3 year. Conclusion: The transition to an individualized curriculum for all residents will require committed faculty mentors, flexible scheduling, and organized tracking. Based on our program’s experience, an individualized curriculum can be implemented without sacrificing a well-rounded education or patient coverage.

Poster Number 4
HOW SHOULD WE TEACH QUALITY?
Caroline U. Okorie, MD, MPH, Cynthia L. Ferrell, MD, MSEd, Jessica A. Hoseason, MD, Windy Stevenson, MD, Oregon Health and Science University, Portland, OR
Given the emerging clinical importance of Quality Improvement (QI) competency, coupled with new ACGME stipulations and time constraints of residency, an efficient and effective QI curriculum is essential. Objective: To efficiently and effectively develop pediatric residents’ QI competency in the context of a group project. Methods: We hypothesized that a resident-driven, group-project based curriculum is a sustainable way to teach QI. Starting August 2010, we dedicated a monthly noon conference to QI, led by faculty mentors. These sessions aimed to optimize resident involvement and integrate QI into program culture. We used an iterative Delphi method to identify, select, and focus a project. Sessions included both didactic and working components; residents learned QI principles and used the Plan-Do-Study-Act (PDSA) cycle to shape and advance the project. Recent sessions have focused on clinical expectations, obtaining and reporting pertinent data, and interfacing with the electronic medical record (EMR). Results: Residents have been enthusiastic participants. In 2010-11, each of our 39 residents attended an average of 4 out of 11 QI meetings (min=1, max=7). By the 4th session, the project aim was determined: To have >95% of those patients with a BMI ≥ the 85th percentile, have as such noted on their EMR problem list. Residents reported the project strengths as repetition of core QI concepts at each session, applicability of the process, and the guidance of faculty mentors. While a resident-driven approach encourages ownership, achieving group consensus was time-consuming, and was more efficient when faculty leaders provided focused direction. Other opportunities for improvement include more succinct review sections and regular group updates. Conclusion: QI training can be effectively incorporated into pediatric residency training. A resident-driven, project-based model can effectively engage the entire residency program in one longitudinal effort, simultaneously providing education and direct project involvement. The project continues for 2011-12 with the addition of email-distributed minutes, web-accessibility of sessions, and monthly data reporting.

Poster Number 5
IMPROVING RESIDENT CONTINUITY OF CARE
Kimberly A. Gifford, MD, Children’s Hospital at Dartmouth University Residency Program, Lebanon, NH
Background: While continuity of care is the cornerstone of the medical home and pediatric residents participate in a “continuity clinic,” the principals of continuity are often not taught explicitly. Goal: To improve resident understanding and utilization of effective strategies to promote continuity of care. Method: The 14 PL2-3 residents at the Children’s Hospital at Dartmouth completed an anonymous online survey at the beginning and end of the 2010-2011 academic year, which included knowledge about and use of effective practices to promote continuity. The baseline survey results prompted discussion among continuity clinic teams about how to improve continuity and were reinforced by preceptors and through monthly group emails. Responses to free text questions were categorized by type of continuity described and assignments were confirmed by two independent raters. Pre vs post intervention response means of 6-point Likert scale questions (6=always, 4=usually, 3=sometimes, 1=never) about use of practices to promote continuity of care were compared using T-tests. Results: All residents described relational continuity at both times; however, after the intervention more residents described informational (73% vs 39%) and management (27% vs 7%) continuity. At baseline, residents more often reported using strategies to find information (such as reviewing notes and problem lists), than sharing information about their visit with others (by forwarding notes or updating the problem list). Similar trends in use of most strategies were found after the intervention, except that more residents reported forwarding notes to specialists when they made a referral (4.5 vs 3.4, p=0.01). Discussion: While residents have a good understanding of relational continuity, there are significant gaps in their understanding and use of effective practices to promote informational continuity. Our educational intervention improved resident knowledge and promotion of informational continuity. This brief educational intervention was integrated into our overall curriculum for continuity clinic and could easily be replicated at any residency training program.

Poster Number 6
THE TOM SAWYER METHOD: PARTNERING WITH RESIDENTS TO ACHIEVE MULTI-FACETED IMPROVEMENTS IN ASTHMA CARE
Kathleen W. Bartlett, MD, Katharine Kevill, MD, Julie Wood, DO, Duke University Pediatrics, Durham, NC
Background: According to the Pediatric RRC, program directors must ensure that residents are integrated and actively participate in interdisciplinary clinical quality improvement (QI). In addition, institutions are placing greater emphasis on QI to meet regulatory requirements. Without appropriate guidance in selection and implementation of QI topics, resident projects
may be ineffective or unsustainable. Methods: Duke Childrens Asthma Improvement Initiative was launched in 2009 with endorsement from the institutional QI oversight committee. This multidisciplinary group identified aspects of asthma care that could be improved to comply with national asthma guidelines. Residents were invited to partner with the group to address the measures targeted for improvement. Dyads of residents worked on projects including 1) transitioning to metered-dose inhaler (MDI) earlier in the hospital course, 2) asthma device teaching, 3) use of an asthma admission orderset, 4) asthma discharge instructions in the ED, and 5) decreasing time to initial treatment in the ED. Residents were uniquely positioned to understand the systems that contributed to the problems identified. Results: Residents gathered baseline data, partnered with stakeholders to design interventions, used PDSA cycles to test change, and reported follow-up data. Often residents suggested novel interventions that would not have been considered without their input. Transition to MDI prior to discharge improved from 48% to 86%; device teaching improved from 33% to 95%; use of the asthma orderset increased; use of asthma discharge instructions in the ED increased; and the time to initial treatment in the ED decreased. The success of the asthma initiative led to expansion of resident involvement in a range of institutional QI efforts. Conclusions: Identifying institutional priorities for QI and connecting residents with the teams that are addressing them will result in more rigorous and rewarding QI experiences for the residents as well as more innovative and viable interventions. Institutions can benefit from resident involvement in QI initiatives.

Poster Number 7
JUST A CLICK AWAY: UTILIZATION OF AN AUDIENCE RESPONSE SYSTEM TO IMPROVE BOARD EXAM PREPARATION

Vasudha L. Bhavaraju, MD, David E. Brodkin, MD, Phoenix Children's Hospital/Maricopa Medical Center, Phoenix, AZ

Background: Maintaining a high board pass rate is a common goal across residency programs, however, there are no standard methods for integrating board preparation into the curriculum. While core medical knowledge is important, practice with typical board questions is vital. Historically, at our board review conferences, residents individually read sample board questions aloud and verbally selected an answer. A designated senior resident would then discuss the correct choice. Residents were surveyed and felt that this method was not interactive or effective. The purpose of this project was to incorporate a set of changes, including an audience response system (ARS), to improve resident satisfaction of our board review series. Methods: Each month, a faculty member gave 1-2 senior residents a tutorial on ARS software and guidelines for the session. The residents compiled board questions on a specific specialty and prepared explanations of answers along with helpful tips and associations. Those who attended the sessions used an ARS to anonymously answer questions. Invited subspecialists served as resources. Copies of the questions and answers were posted on the residency website. Evaluations were distributed to attendees. Results: From January 2010 to August 2011, 17 board review sessions utilized the new format. Residents felt that the sessions were helpful for board exam preparation (4.95 on Likert scale 1-5), the ARS was an effective tool (4.97) and the subspecialist input was a positive addition (4.67). Residents commented that the most beneficial aspects of the conference were the interactive nature, use of the ARS, and the targeted explanations of correct and incorrect answer choices. Conclusion: Use of an ARS along with faculty guidance for preparation, addition of subspecialists, and availability of an on-line study guide, allowed our program to improve resident satisfaction of our board review conferences. In the future, we can use the ARS to track individual resident or class performance at the sessions and perhaps find a correlation with in-training exam scores.

Poster Number 8
THE BIRTH OF A MULTICENTER COLLABORATIVE FOR EDUCATION-BASED RESEARCH - THE EDUCATION IN PEDIATRIC INTENSIVE CARE (E.P.I.C.) INVESTIGATORS

David A. Turner, MD, Pediatric Critical Care Medicine, Duke University, Durham, NC, Denise M. Goodman, MD, MS, Pediatric Critical Care, Northwestern University, Chicago, IL, for the Education in Pediatrics Intensive Care Investigators

Introduction: The relatively small size of pediatric subspecialty training programs leads to educational curricula that are individualized and program specific. This individuality makes it difficult to determine the most effective, or even most common, educational strategies. Given that many educational needs overlap across programs, multi-center collaboration represents a potentially valuable strategy to improve trainee education. We hypothesized that applying a model similar to that used by clinical research networks could successfully be undertaken to create a multi-center collaborative for education-based research. Methods: Two pediatric critical care medicine (PCCM) fellowship program directors (PDs) developed a proposed structure for an education-based research collaborative. This structure included guidelines for meetings, participation, project selection, and dissemination of results. Invitations to participate in this collaborative were then sent to all 66 PDs at accredited PCCM fellowship programs. Following an initial conference call for interested participants, the group was established and project development was undertaken. Results: A multi-center education-based research collaborative, the Education in Pediatric Intensive Care (E.P.I.C.) Investigators, was established over an 8 week period. The first conference call included 13 participants from 11 institutions. To date, the group has conducted 12 bi-monthly “meetings” via conference call, including a total of 24 participants from 21 institutions. Over the course of 6 months, the structure of this collaborative was established and the first research project was successfully undertaken. Conclusions: Development of a multi-center collaborative focused on research in medical education is possible, and the E.P.I.C. Investigators represent a novel mechanism to pool resources and improve research in education. Partnership of this nature in education-based research also has broad potential applicability across multiple disciplines and may become a new paradigm to improve graduate medical education.
We conclude that home visits are useful for ongoing care. Follow up questionnaires reported a continued impact on clinical practices and improved relationships with patients and families, improved trust toward doctors, and building stronger relationships with patients. There were no concerns for safety.

Themes included: more understanding of the lack of social support for families; improved insight into cultural beliefs to help minimize judgment and tailor anticipatory guidance; and differences between poverty in residents’ native countries and that seen in Brooklyn, specifically a breakdown of family structure. Additionally, residents commented on the warm welcomes from minimizing judgment and tailor anticipatory guidance; and differences between poverty in residents’ native countries and that seen in Brooklyn, specifically a breakdown of family structure. Additionally, residents commented on the warm welcomes from residents and faculty members.

Feedback after visits was overwhelmingly positive. The changes successfully improved overall quality of sign-out, based on resident surveys, and reduced time spent in sign-out to an average of 30 minutes per session. Subsequent follow up and adherence to our standard formats continued to vary over time and by resident team. Through focus groups, it was noted that many of the obstacles were systems issues that would be better addressed in real time. A system was designed for weekly peer evaluation to occur. Using an adapted version of the “Handoff CEX Instrument” developed by Farnan et al, a peer evaluates and rates the resident team as a whole unit and through direct feedback, provides additional qualitative comments to identify strengths and areas needing further improvement immediately following the patient hand-off session. Through peer observation and direct feedback, we aim to both identify and address specific problem areas to improve the overall quality and efficiency of resident patient handoffs. Maintenance of the improvement process includes direct feedback of the peer evaluators as well as continued post-handoff evaluations to monitor metrics of perceived quality, time spent during handoffs, and adherence to standard formats.

Resident patient handoff skills are important for both patient safety and inter-professional communication and are especially pertinent given the increasing number of handoffs with new duty hour restrictions. At our institution, residents recognized sign-out as an area needing improvement, as sessions often lasted over an hour, lacked a standard format, varied in quality, and compromised resident time and attention spent in patient care. These identified gaps were reviewed during a resident retreat, where a needs assessment focused on multiple changes to improve sign-out length, including tethering a written sign-out to the EMR and devising standard formats for both the written and verbal sign-out. Theses changes were first tested using the new formats on real patients during several training sessions and subsequently trialed in real time on the inpatient ward.

Despite objective data showing disappointing progress in improving sign-out overall, we (residents and faculty observers) feel out competency grades will be instituted to increase the perceived importance of this competency for the individual resident.

Since 2007 we have been working on improving the efficiency and comprehensiveness of resident sign-out. As a baseline we observed evening sign-out without feedback (96 observations). In phase 1 we observed sign-out, then immediately gave constructive feedback at the end of the session. Also included were 3 other interventions: 1) new intern flow/sign-out sheets, 2) junior responsibility for sign out, not seniors, 3) sign out at the bedside. We collected 137 observations after these changes.

In August 2009, Phase 2 was started with the addition of a monthly orientation session by the PD and APD to each team. We gave clear instructions on essential and optional information to sign-out on every patient, and the importance of providing an overnight plan on each patient was also stressed. Observations were collected on sign-out in phase 2 (204 observations).

Sustained improvements in sign-out were seen in phase 1 and 2 in the following areas: junior signing out (baseline 32%, phase 1 99%, phase 2 87%); introducing new team to patients (baseline 20%, phase 1 100%, phase 2 96%), and giving a clear overnight plan (baseline 37%, phase 1 65%, phase 2 75%). However, in phase 2 other important information was still not consistently signed out despite emphasis in the monthly orientation [vital signs (57%), intravenous access (56%), intravenous fluids (56%), diet (45%)]. New phase 3 changes now include a) a revised junior sign-out sheet with asterisks indicating essential sign-out information, b) increased weekly observations by the 4th year chief on the morning sign-out, and c) individual sign-out competency grades will be instituted to increase the perceived importance of this competency for the individual resident.

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International Medical Graduates (IMGs) face many challenges in acculturation and patient care. Community experiences are crucial in residency, required by the ACGME, and especially important for IMGs. Thus, many residency programs incorporate home visits. The literature reports educational value of home visits in internal and family medicine in the context of eldercare, palliative care, and readmission rates. Relevant pediatric literature focuses on using home visits to assess safety and teach about special needs children, rather than on gaining community perspective. No studies report on IMGs’ experience with home visits. We set out to assess perception of home visits by our pediatric IMGs, and to see if home visits aid in understanding patients and communities. All 36 of our residents are IMGs. Our home visit program started in 2008 with assistance from an Arnold P. Gold Foundation Home Visit Grant. Each month, 3 residents (one per year) and a faculty member visit residents’ own continuity clinic patients. Visits begin en route with a discussion of visit principles and goals and end with reflection over lunch at a neighborhood restaurant, to aid in exploration of the community. Afterward, residents complete a narrative evaluation. Thirty evaluations and faculty notes were reviewed. Feedback after visits was overwhelmingly positive. Themes included: more understanding of the lack of social support for families; improved insight into cultural beliefs to help minimize judgment and tailor anticipatory guidance; and differences between poverty in residents’ native countries and that seen in Brooklyn, specifically a breakdown of family structure. Additionally, residents commented on the warm welcomes from families, improved trust toward doctors, and building stronger relationships with patients. There were no concerns for safety.

Follow up questionnaires reported a continued impact on clinical practices and improved relationships with patients and families. Our home visit program is enjoyable for our IMGs and gives residents insight into their patients and the community.

We conclude that home visits are useful for ongoing care.
Poster Number 12
IDENTIFYING STRENGTHS AND WEAKNESS WITHIN CURRENT HANDOFF PRACTICES AMONG PEDIATRIC RESIDENTS
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Background: Limiting resident duty hours may have benefits for safety and education, but leads to decreased continuity of care and increased patient handoffs among residents. Frequent handoffs and poor sign-out practices are linked to adverse events, near-misses and prolonged hospitalizations. Our residency program at Emory, along with many medical schools and residency programs, offers no structured teaching to prepare interns and residents regarding how to handoff patients. Objective: The objective of this project is to improve current methods of verbal and written transfer of care among pediatrics residents at Emory University by demonstrating current practices, identifying weaknesses, and developing targeted strategies to address each weakness. Methods: In order to identify areas that were in need of improvement, a pilot survey was developed and administered to pediatric residents during the spring of 2011. It addressed residents’ opinions on current practices of verbal and written transfer of care. Results: The survey was administered to 73.8% (n=45) of pediatric residents. Pediatric residents agree that signing-out patients is an important part of the day (97.8%). Survey results indicated that the majority of residents (57.78%) did not agree that they received adequate sign-out education during medical school. Also most residents were unsatisfied with supervision (73.33%) and feedback (64.44%) provided by senior residents during sign-out. Also 64.5% of pediatric residents identify frequent interruptions as a limiting factor in effective handoffs. Conclusions: Our pilot survey identified one strength: residents’ recognition of the importance of handoffs. It also identified lack of education, supervision and feedback as well as frequent interruptions as weaknesses in our current practice. Given these findings, our preliminary intervention to improve transfer of care is to institute a structured curriculum to teach components of a well-designed hand-off, standardization of hand-off communications, and techniques for senior residents to supervise and provide feedback to interns during handoff.

Poster Number 13
2011 DUTY HOUR CHANGES: UNINTENDED CONSEQUENCES ON RESIDENT QUALITY OF LIFE OR STILL A TIME OF TRANSITION?
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Background: On July 1, 2011, the ACGME established new duty hour regulations which affected residency training nationwide. These changes were developed based on substantial evidence of the relationship between physician fatigue and medical errors. In response to these changes, we transitioned to a day team/night team model for all training levels of pediatric residents. We wanted to assess resident satisfaction with our new structure. Methods: We surveyed our residents to evaluate their job satisfaction, perceived educational experience, and perception of the quality of patient care in the new system. 37 pediatric residents were surveyed in September, 2011, 6 months after implementation of the new curriculum for PGY2-3 residents, and 3 months after the arrival of PGY1 residents. Results: 100% of residents were aware of the new duty hour regulations, and 82% reported compliance with them more than 75% of the time. 86% of PGY2-3 residents believed the changes had a negative effect on the quality of patient care. 71% of PGY2-3 residents, and 55% of all residents, reported a decrease in job satisfaction. 86% of PGY2-3 residents, and 64% of all residents, believed their educational experience has been negatively affected by the new duty hours. Conclusion: In our program, the new duty hours have had a significant impact on resident quality of life—most notably for PGY2-3 residents. Despite our efforts to implement a system compliant with the ACGME while continuing to provide a strong educational experience for our residents, they believe their residency experience has suffered as a result of the changes. It remains to be seen whether our results reflect the unintended consequences of the new duty hour regulations or merely resistance to change. Clearly, we must continue to work to support our residents during this transition period. Future research should focus not only on the effect of the medical training system on patient care, but also on our ability to sufficiently train residents to be strong and committed pediatricians who are passionate about their profession.

Poster Number 14
IMPLEMENTING INNOVATION: INDIVIDUALIZING THE RESIDENCY EXPERIENCE
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Background: Programs are challenged to prepare trainees for specific and focused careers in the care of children and adolescents. Objective: To evaluate the inaugural year of a program designed to individualize residency. Design/Methods: All residents (n=27) were divided into groups (PODs) based on their expressed career goals. There were 5 in all: two groups of prospective general pediatricians, and one group each of specialists, intensivists (including neonatology and emergency medicine), and undecided individuals. The residents were committed to their choice of POD for the year. Each group had two faculty facilitators. The PODs met for 90 minutes of protected time weekly. The topics (e.g. humanism, ethics, insurance, billing, malpractice) were standardized but the cases and readings were individualized for each POD. Learning modalities included case-based discussions, readings from science and literature, and sessions with patients, families, nurses, and pediatricians. Assessment modalities included weekly minutes, questionnaires, reflective writing, and focus groups. Results: The PODs experience was rated as good or excellent by 80% of residents and 100% of faculty. The residents indicated that PODs addressed issues not covered in other forums (88%) and provided information they will need after residency (80%).
Residents felt PODs was better than the traditional large group morning report in promoting bonding with fellow residents (76%), encouraging active participation (88%), allowing close work with a faculty member other than their mentor (72%) and addressing careers (80%), psychosocial concerns (88%), professionalism (84%), and parents' perspectives (84%). Faculty viewed PODs small group format as conducive to residents learning (90%) and active participation (100%). They felt PODs was an effective format for addressing psychosocial issues (100%). Ninety percent were very satisfied with their experience as a facilitator. Conclusion: PODs was well accepted by residents and faculty. Residents reported that PODs addressed unique issues relevant to their individual future careers.

Poster Number 16
INTRODUCTION OF AN ELECTRONIC INDIVIDUAL DEVELOPMENT PROGRAM CURRICULUM IN A PEDIATRIC RESIDENCY TRAINING PROGRAM
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Background: Creating an Individual Development Plan (IDP) is a critical tool to track progress in professional development. An IDP is a collection of evidence of achievement of professional competency, critical reflection, and self-directed generation of individual learning plans for next steps. Electronic portfolios facilitate a single location for learners to collect and organize evidence of their progress and to facilitate convenient and instantaneous sharing and feedback from advisors and mentors. Objectives: (1) Determine the technical feasibility of implementing an electronic IDP (eIDP); (2) document adoption by residents; and (3) determine residents' perceptions of an eIDP. Methods: We used a web-based portfolio tool and introduced eIDPs to residents in a staggered process. Residents were asked to document their learning plans, career development plans, project plans and other evidence of professional development in the eIDP. We measured use by residents and surveyed their perceptions. Results: There were 85 residents: 29 R3s, 27 R2s, and 29 R1s. An eIDP was completed by 86% of all residents: 72.4% (21) R3s, 100% (27) R2s, and 86.2% (25) R1s. In a survey of residents N=33 (38% of residents), 7% used the eIDP tool only once, 70% used the eIDP 2-5 times, 23% used the eIDP more than 5 times. 93% created a learning plan, 30% created a career development plan, 17% used the eIDP to explore the tool or another personal use. Identified barriers to use included concerns about amount of time needed to complete IDP assignments (83%), not having enough protected time (57%), remembering logon passwords (43%) and how to use features (67%), and finally knowing how to create a learning plan based on reflection of personal competency (40%). Conclusions: We were able to successfully implement an eIDP program with 86% of residents completing an activity associated with career development using the electronic platform. We are continuing to use eIDPs within our program and providing additional curriculum around identifying learning goals and creating career plans.

Poster Number 15
LESSONS LEARNED FROM IMPLEMENTATION OF A CAREER FOCUSED LONGITUDINAL BLOCK FOR THIRD YEAR RESIDENTS
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Background: Pediatric residency training currently is structured around 1-month rotations. Residents' career goals are not always explicitly addressed in rotation design. Opportunities for prolonged mentorship and specific focus on skills needed for post-residency career are limited. Objective: To describe lessons learned from implementation of a career focused longitudinal block -- developed as part of the Initiative for Innovation in Pediatrics Education (IIPE) -- where residents individualize clinical experiences based on their career path. Program Description: Third-year residents elect to participate in the program for 4 months. Their schedule is based on their stated individual learning goals and Entrustable Professional Activities (EPAs). Each resident receives structured mentoring and observation (with feedback). The first cohort of 11 residents began the program in 2010-2011 with 5 residents in primary care, 2 in hospitalist pediatrics, and 4 in subspecialties. Results: Formative program evaluation after 1 year revealed 4 key lessons: 1) Individualizing curriculum and schedules is difficult for residents to do alone. 2) Structured mentoring and observation is difficult to sustain over 4 months 3) Residents easily identify broad areas where they need to focus their learning, but have difficulty developing and completing more specific learning goals and perceive this process as busywork. 4) Residents and faculty understand and like the concept of EPAs but only rarely use them for schedule development or mentorship. Discussion: These lessons prompted program changes for the second resident cohort. Specifically: 1) Administrative support was increased and specific tools (annual calendar, electronic monitoring and reminder system, mentor orientation packet and a mentor advising form) were developed to alleviate scheduling challenges and assure completion of mentor meetings and observations 2) Learning goals will be reframed as a cognitive process that guides residents from broad areas of learning to a specific focus. 3) Instructions regarding use of EPAs will be more accessible and specific.

Poster Number 17
TELEPHONE TRIAGE: EXPANDING NIGHT ROTATION CURRICULUM BEYOND THE INPATIENT UNIT
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Telephone triage has traditionally offered many obstacles for adequate training. Although parent phone calls are ubiquitous throughout pediatrics, there has not been a widely accepted nor well-described specific curriculum for pediatric training in this domain. Additionally, resident graduates from our program have consistently suggested that more training in telephone triage would be helpful as they begin their careers in primary care or fellowship training. We identified the newly evolving night curriculum as an ideal place for Telephone Triage training. We developed goals and objectives for Telephone Triage
training and chose Barton Schmitt’s Pediatric Telephone Protocols as the resource for our curriculum. Following a core lecture, each senior resident is then scheduled 1 week during each night rotation to take overnight home call for the patients of the program’s continuity clinic. The recurrent nature of senior resident night rotations during the second and third years of training allows for a longitudinal component to the curriculum. This then offers a graded scale toward autonomy within the curriculum. The typical night includes between 4 and 8 phone calls. The residents each have remote access to the EMR and therefore documentation of a telephone encounter for each call is mandatory. The residents are evaluated by both the attending on call as well as by randomly selected parents. We are looking at the success of the curriculum by evaluating resident’s comfort with triaging over the phone, utilizing triage resources, and looking at evaluations of residents over time. Though still a relatively new curriculum, preliminary results show improvement in all domains of residents’ comfort and there appears to be an early trend toward improved evaluations of residents’ abilities with telephone triage. We conclude that a Telephone Triage is an important and useful element of pediatric training, and it is a prime adjunct to the evolving night rotation curriculum.

Poster Number 18

ASSESSING PEDIATRIC RESIDENT CURRICULAR INTERESTS IN GLOBAL HEALTH

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Global health experiences have become an important component of pediatric residency training. Over 7% of pediatric residents participate in global experiences during their training. Before initiating a formal global health curriculum, our program wanted to determine what curricular topics most interested pediatric residents regardless of their international elective interest. A survey was created on Survey Monkey® and emailed to all 39 pediatric residents at Tufts Medical Center in June 2011. The survey consisted of 35 questions in the following areas: resident prior global health and travel experience, global health curricular interest, and prior domestic international health experiences. The curricular topics surveyed were based on the American Academy of Pediatrics International Child Health global health curriculum objectives. 62% of pediatric residents completed the survey. 91% were very or somewhat interested in learning about health promotion and injury/disease prevention activities, in interpersonal communication 77% were interested in effective communication approaches for health care delivery in communities with limited literacy and education, in practice based learning 86% were interested in standardized guidelines for diagnosis and treatment of common conditions in developing countries, and in professional practice 73% were interested in advocacy for families in navigating healthcare system complexities. We concluded that our residents were most interested in global health curricular topics that related to international communities both domestically and abroad. We recognize that our study was limited by a small sample size, within one institution and that survey responses may have been biased by those with interest in global health. Our next steps are to create a 2 year global health curriculum with didactics and journal clubs with a focus on identifying domestic parallels to global health topics.

Poster Number 19

PROVIDING MEDICAL STUDENTS AND RESIDENTS WITH INFORMATION ABOUT A CAREER IN THE PEDIATRIC SUBSPECIALTIES: THE COPS PEDIATRIC SUBSPECIALTY DESCRIPTIONS

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Introduction: Choosing a pediatric subspecialty career can be difficult. Impressions about opportunities in the subspecialty are often based upon a trainee’s limited exposure at one institution and may not represent the typical experience in the subspecialty. In addition, easy access to accurate information about pediatric subspecialty careers to aid in decision-making is lacking. Objective: In order to provide this information, the Council of Pediatric Subspecialties (CoPS) created detailed descriptions of individual pediatric subspecialties on its website. Methods: Members of the CoPS Communication Task Force developed a pediatric subspecialty description template to promote uniformity of information. This was modified based upon input from CoPS representatives, medical students and trainees. The template included information about clinical responsibilities, career opportunities, lifestyle, compensation, applying for fellowship, overall benefits of a career in that particular pediatric subspecialty and relevant journals and hyperlinks. Descriptions were completed by the appropriate CoPS subspecialty representative and edited by the Task Force to ensure standardization. Each completed description was then posted on a separate webpage in a dedicated area of the CoPS website (www.pedsubs.org). Results: Launched in April 2010, the site now includes 19 descriptions. An introductory page provides information about alternative pathway training and resources for international medical graduates. The number of page views has steadily increased from approximately 1200 in the 2nd quarter of 2010 to over 5800 in the 2nd quarter of 2011. The section now averages over 2000 views per month with the hematology-oncology, critical care and neonatology pages receiving the most visits. Conclusions: These pediatric subspecialty descriptions were created through a cooperative effort of CoPS. The increasing number of page views suggests that it is serving more and more as a resource for those considering a pediatric subspecialty career.
Poster Number 20

EFFECTIVENESS OF A DISCHARGE EDUCATION CURRICULUM FOR INTERNS ROTATING ON AN INPATIENT SERVICE

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Background: Unlike adult literature, there is little data on what information should be given to families of pediatric patients at the time of hospital discharge. Pediatric residents currently receive minimal education on this topic. Objective: To improve interns' comfort and ability in providing discharge education to patients and to increase the frequency they provide it.

Methods: A discharge education curriculum was created using expert consensus. The curriculum was taught to interns midway through a 4-week inpatient rotation. To assess comfort and behaviors regarding discharge education, interns completed pre and post curriculum surveys utilizing a 4-point Likert scale and free text comments. Discharge education skills were evaluated by hospitalist attendings using a 12-item yes/no observation checklist. Data was analyzed using the independent samples t-test along with the Cohen's D effect size value where d>0.8=large effect and d>2=optimum effect. Results: There were 21 interns enrolled in the study. The post-curriculum group showed increased comfort in providing discharge education (t-value 3.52, p<0.01, d=1.23) and interns reported they would provide more discharge education in the future (3.64/4, sd=0.50, where 1=none of the time, 4=all of the time). Interns rated the curriculum favorably (3.5/4, s=0.53, where 1=strongly disagree, 4=strongly agree). Performance on the observation checklist improved after receiving the curriculum (t=4.97, p<0.01, d=2.11). Specifically, more interns asked families about barriers to filling scripts or ability to follow-up (t=4.67, p<0.01, d=2.04).

Discussion: Although a small sample size, there was significant improvement in intern discharge education comfort and skills. A knowledge evaluation piece could be studied in the future. Residents receiving this training may provide better patient care by identifying barriers to care prior to hospital discharge and may result in patients receiving more frequent and more complete discharge instructions. The curriculum could be broadened to teach medical students and residents at other institutions.

Poster Number 21

HOSPITALIST FACULTY DEVELOPMENT TO IMPROVE THE QUALITY AND CONSISTENCY OF FEEDBACK GIVEN TO PEDIATRIC RESIDENTS ON AN INPATIENT SERVICE

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Background: The importance of high quality feedback in the training of residents has been well studied. Lack of formal training in how to give feedback as well as patient care demands often prevent faculty from giving timely and constructive feedback. Objective: Improve the quality and consistency of resident feedback given by pediatric hospitalists on an inpatient ward. Methods: In 2009, pediatric hospitalist faculty completed a 1-hour workshop on the ACGME competencies and how they relate to residents rotating on the wards. For example, they were asked to list resident behaviors they would observe in the 6 core competencies. Next, the same faculty completed a 3-hour feedback workshop with a didactic and then practiced role play giving feedback to ward residents using the competency framework. Hospitalist faculty rotate for 7 day blocks on the inpatient wards, and residents rotate for 4 weeks. Hospitalist faculty were asked to do feedback Fridays each week utilizing their new knowledge and skills giving feedback to the residents. In 2010, refresher workshops were given to hospitalist faculty.

Questions regarding the quality and consistency of feedback from hospitalists were asked on the resident annual survey using a 4-point Likert scale (1=poor, 4=excellent). Results from 2009 (year prior to intervention) and 2010, 2011 (after intervention) were compared using a 1-way ANOVA. Results: There was a significant increase in the means of both quality and consistency ranked on the survey from 2009 - 2010 and 2009 compared to 2011, but no changes from 2010-2011. Mean quality values from 2009, 2010, and 2011 were 3.63, 3.89, 4.08 (f-value=3.75, degrees 2, 157, p<0.01. Mean consistency values from 2009, 2010, and 2011 were 3.55, 3.89, 3.96 (f=3.59, degrees 2, 157, p<0.05). Discussion: A brief educational intervention can make significant improvement in resident perceptions of the quality and consistency of feedback they receive. Future directions could be to publish feedback curriculum or offer workshops at meetings to improve feedback quality at other institutions.

Poster Number 22

MONITORING CONFERENCE ATTENDANCE: USING THE IPAD® TABLET TO TRACK ATTENDANCE, PROVIDE FEEDBACK TO RESIDENTS, AND MAP TO THE AMERICAN BOARD OF PEDIATRICS’ CONTENT SPECIFICATIONS

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Background: New duty hour standards in 2011 create challenges for residency training programs to ensure adequate exposure of housestaff to key educational curricula. Methods: Chief residents equipped with an iPad used the Numbers® spreadsheet application program to track attendance at two educational conferences aimed at different levels of training. Each spreadsheet identified the names of the potential conference attendees and the topic presented. Attendance was recorded in the spreadsheet and subsequently each topic was mapped to American Board of Pediatrics’ content specifications. Results: During the first 3 blocks of the 2011-2012 academic year data were available for 63 educational conferences. Overall attendance for 15 core conferences meant for all Pediatric residents was 46% of the available attendees. Attendance varied by resident training level (58% of interns, 62% of juniors, 22% of seniors). Average overall attendance for junior/senior resident case-
Poster Number 23
TEACHING RESIDENTS HOW TO TEACH
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Objective: With most of our program graduates pursuing academic careers, it is necessary to develop effective teaching skills during residency. A rigorous elective curriculum incorporating one-on-one teaching, literature review, direct observation, feedback, and reflection was created to foster resident teaching skills. Methods: One senior resident per month rotated through 4 one-week modules on bedside teaching, clinical reasoning, giving feedback, and EBM. An assigned faculty member met with the resident twice each week. First, they reviewed the week’s objectives, relevant literature, discussed teaching strategies, and planned teaching sessions. The resident then led daily teaching sessions, received daily written feedback from learners, and maintained a journal describing their teaching encounters including areas of strength and opportunities for improvement. At the end of the week, the faculty member directly observed the resident in the teaching role, provided immediate feedback, and reviewed the resident’s journal. Final rotation feedback was given based on summative written self-reflection and a final action plan was created to guide future teaching. Results: The teaching elective was effective. Medical students and interns benefited directly by having a senior resident dedicated to teaching. Learner feedback and real-time faculty feedback reinforced teaching strengths and identified areas for improvement. Narrative self-reflection documented effective ways that residents improved their teaching. Examples included engaging different learning styles, summarizing key points at the bedside, and applying evidence in a case-based fashion. Residents gained confidence in their teaching and crafted written action plans for continued improvement. Conclusions: A resident teaching elective is a useful way to foster teaching skills for those pursuing academic careers. An effective structure includes literature review, discussing key strategies, real-time observation with immediate feedback, and written reflection. Residents found engagement of teaching faculty with direct observation and feedback to be the most helpful component of the elective.

Poster Number 24
ASSESSING THE NEED FOR A SURGERY CURRICULUM FOR PEDIATRIC RESIDENCY TRAINING
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INTRODUCTION: Appropriate evaluation and treatment of common surgical problems is a vital part of residency training in pediatrics. However, there is concern that this need is not always met by existing residency curricula. To address this, the American Academy of Pediatrics (AAP) Section of Surgery Committee on Resident Education was tasked with developing a pediatric surgery curriculum for the benefit of pediatric residents and practicing pediatricians. Our first step was to complete a needs assessment of the curriculum to guide us. METHOD: We conducted a survey of members of the AAP Section on Medical Students, Residents, and Fellowship Trainees, Section on Young Physicians, and members of the Association of Pediatric Program Directors. The surveys focused on what trainees currently do, what young physicians experienced in training, and what program directors currently believe is critical to becoming a well-rounded pediatrician. RESULTS: The respondents included 389 residents, 86 young physicians, and 70 program directors. Of those responding, 60% currently have a general pediatric surgery curriculum. Over 90% have a mandatory or elective rotation. Didactic and mixed clinical exposures such as workshops or isolated days in clinic were variable. Less than 2% of responders have a web-based curriculum. All groups agreed that a general pediatric surgery experience was important, but this varied within the groups. Most program directors (81%) agreed or strongly agreed that this topic should be part of a training program while only 64% of residents thought it was important or very important. Interest in a web-based curriculum or CME was expressed by 52% of residents, 78% of young physicians, and 34% of program directors. We asked for topics that should be included and there was concordance on 10 of the top 12 topics. CONCLUSION: Given these results, a web-based curriculum in general pediatric surgery is currently in development and we plan on studying its use and effectiveness over the next year. We have chosen 12 topics, the 10 agreed on by the three groups as well as a module each on ENT and orthopedic surgery.

Poster Number 25
UTILIZING COMPUTER TECHNOLOGY IN RESIDENT EDUCATION: SUSTAINABLE WAYS TO BRING INFORMATION TO THE RESIDENTS (AND VICE-VERSA)
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In order to provide residents with maximum access to program information and educational resources, our residency program has introduced several technological modalities, including a robust resident-centered website, publish-to-web tool, Chief Resident Blog, and teleconferencing. The resident-centered website (peds.stanford.edu) serves as the main housestaff portal for accessing up-to-date information about rotations, schedules, conferences, as well as providing a means of text-paging residents, fellows, faculty and staff. Other useful resources are posted as well, including career resources, morning report and noon conference presentations, resident photos, professional links, and more. As content grows, the ability to organize and update information becomes more challenging, as the site has to be accessible and sustainable without a large information
• technology support network. We are utilizing online documents (via Google®) and their publish-to-web tool to make automatic website changes whenever original documents are modified. In July 2011, a Chief Resident blog was introduced to communicate with residents, and help direct them to important resources within the growing website. Regular posts regarding rotations, treatment guidelines, schedules, announcements, and general resident resources are communicated in searchable blog format. Providing easily accessible information is a priority to help meet needs in resident education. Opportunity for anonymous feedback from residents is provided on the blog as well. Reviewing website analytics has helped us to assess the usefulness of the blog and website and helped guide how we share information with busy residents. Finally, a trial of teleconferencing resident noon conferences has been started to provide an additional means of improving resident education. Residents at off-site hospitals can watch and participate in lectures, in real time, using a commercially available program (GoToMeeting®). These technological modalities can be used in any residency program to improve communication and reach this new generation of learners.

Poster Number 26
FIRETRUCKS, BABY CHICKS AND WIZARD OF OZ: CREATING AND IMPLEMENTING A NEW INTERN BOOT CAMP TO BUILD SKILLS IN CRITICAL THINKING, CLINICAL REASONING AND SELF-REFLECTION.
Sahar N. Rooholamini, MD, MPH, Lucy C. Lee, MD, Michael Tracy, MD, Rebecca Blankenburg, MD, MPH, Madelyn Kahana, MD, Lucile Packard Children’s Hospital at Stanford, Palo Alto, CA
Critical thinking and self-reflection are core skills that enable residents to identify gaps in their knowledge and clinical practice. Incorporating these skills into the residency curriculum in a structured, productive way with protected time for resident and faculty interaction can be challenging. We created an Intern Boot Camp in our residency program that took place for one hour each week during the first nine weeks of intern year. All interns were required to attend. The Intern Boot Camp curriculum was created to address the issues and challenges encountered frequently by physicians, beginning in internship, with a focus on building lifelong strategies for learning and self-assessment. Boot camp topics were designed by the residency program leadership in consultation with faculty members interested in resident education. These topics included: clinical reasoning (including an innovative firetruck exercise designed to develop group reasoning abilities), getting the most out of continuity clinic (with a demonstration involving several live baby chicks), learning to tell a patient's story (with a Wizard of Oz exercise), triaging and contingency planning, professionalism and teamwork, learning styles, teaching in the context of a busy service, giving feedback and surviving the stresses of intern year. We measured the effectiveness of the curriculum with a questionnaire that included pre- and post- confidence scores for each learning objective. Interns identified “teaching in a busy clinical context”, “optimizing continuity clinic”, and “contingency planning” as the areas in which they had the lowest confidence pre-curriculum. The Boot Camp sessions led to significant improvements in intern confidence in all subject areas (paired t-test; p-value < 0.0001). In our experience, Intern Boot Camp worked well as a method to introduce critical thinking, clinical reasoning and self-reflection skills early in residency.

Poster Number 27
DEVELOPMENT AND IMPLEMENTATION OF A PEDIATRIC ADDICTION TRAINING PROGRAM
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Background: High risk behaviors, such as alcohol and substance abuse, are commonly established in childhood and adolescence. Training the next generation of pediatricians and adolescent medicine specialists to intervene at the early stages of substance and alcohol use is crucial to decrease the morbidity and mortality associated with these harmful practices.
Objectives: The Pediatric Addiction Training Program (PATP) was developed by a team of experts in addiction medicine and pediatric graduate medical education. The program's goal is to provide information, resources, and skills practice for effective prevention, diagnosis, intervention, and referral of alcoholism and other adolescent addictions. Methods: PATP is an 8-hr course offered to pediatric residents and adolescent medicine fellows during 2 evening sessions. The sessions are facilitated by faculty with expertise in addiction medicine. The key elements of the curriculum are achieved using a combination of didactic sessions and experiential learning. This includes: attendance at an Alcoholic Anonymous (AA) meeting with an affected teen; pairing with an AA Teen Buddy; instruction and practice in motivational interviewing. Pre/post test evaluations of knowledge, attitudes and beliefs toward addiction were administered to participants. Results: Approximately 8 trainees from academic centers in NYC have participated in this pilot program. Paired t-test analysis was performed on data from surveys that were completed by participants (n=4). Participants had a positive change in almost every area of knowledge, attitudes and beliefs about addiction. Statistically significant changes were seen in areas of knowledge: knowing how to ask key questions about substance use, responding effectively to denial, and contracting with patients about setting goals for treatment. Qualitative data about the participants' experience were also collected. Conclusion: PATP is an innovative educational program for pediatric trainees and can provide information, tools and skills needed to effectively identify and provide care for adolescents with alcohol and drug addiction.

Poster Number 28
QUIP IT: ESTABLISHING A QUALITY IMPROVEMENT ROTATION FOR RESIDENTS
Molly Martyn, MD, Emily Hartford, MD, Celeste Quitiquit, MD, Maneesh Batra, MD, MPH, Susan Marshall, MD, Heather McPhillips, MD, Richard Shugerman, MD, University of Washington, Seattle, WA
Background: The ACGME requires that residents participate in a quality improvement project to develop skills in analyzing existing practices, identifying areas for improvement, and implementing change. In recognition of this requirement and to...
better prepare physicians to be leaders in the field of quality improvement (QI), we developed an innovative resident rotation entitled Quality Improvement Project (QuIP). Methods: The QuIP rotation occurs during a protected 2 week block in the R2 or R3 year. To maximize the experience, residents identify their learning goals prior to the start of the rotation and are paired with a faculty mentor. In collaboration with our hospital QI department and continuity clinic sites, we created a list of potential QI learning options and projects available to the residents. Residents provide a one page report of their project outcome at the end of their rotation and receive evaluative feedback from their rotation mentor. Results: A total of 26 residents will complete a QuIP rotation in AY 2011-12. In addition to training in the fundamentals of QI, residents have participated in hospital process improvement workshops, conducted literature reviews to inform best evidence practice guidelines, assisted in developing clinical pathways, and explored process improvement initiatives within the resident continuity clinics. We have received positive feedback from hospital QI groups and an increasing number of requests for resident involvement in ongoing projects. Conclusions: Based on initial resident, hospital, and continuity clinic response, the QuIP rotation has provided valuable educational opportunities in QI processes, project development, and continuing collaborations. Given the time limitations during residency, supporting resident participation in ongoing work increases the likelihood of a tangible product and resident satisfaction with QI training. Future studies will evaluate both.

Poster Number 29
THE USE OF PATIENT SIMULATION IN A PEDIATRIC CARDIOLOGY ROTATION: IMPROVING RESIDENT EDUCATION IN PEDIATRIC CARDIOLOGY DIAGNOSIS AND MANAGEMENT

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High Fidelity Patient Simulation (HFPS) has become a commonplace tool in graduate medical education for improving clinical skills and medical knowledge. With the increasing reliance upon advanced diagnostic tests and resident duty-hour changes, there are decreasing opportunities for pediatricians in training to become proficient in certain knowledge and skills. HFPS has been utilized extensively in mock codes and crisis training to teach clinical skills in a controlled setting without risk to patients. To date, there is scant literature exploring the use of HFPS in a subspecialty rotation and its incorporation into basic resident education. All PGY2 pediatric residents rotate through a one month cardiology rotation at our quaternary care children’s hospital. All residents complete an online curriculum focused on basic cardiology knowledge and a post curriculum quiz. After randomization into two groups, the study group participates in a fully debriefed HFPS session. All residents complete a second case-based quiz. Pre and post curriculum surveys are completed by all residents and the study group completes a post-simulation session survey. Since Oct 2010, 27 residents have participated (n=16 in the study group). All have completed the online curriculum, knowledge quiz, case-based quiz, and 100% of the study group have completed the simulation session and post simulation survey. Residents overwhelmingly felt the HFPS was useful and their level of confidence in approaching a pediatric cardiac patient problem improved after the simulation session. In addition, preliminary data shows improved scores on the case-based quiz for the study group versus the control group. Incorporation of HFPS into a pre-existing pediatric cardiology rotation is feasible and well received. Preliminary data suggests that simulation is of educational benefit. Further data is needed for statistical analyses and will be performed at completion of the study. Our study suggests that targeted simulation sessions may readily be incorporated into pediatric subspecialty rotations.

Poster Number 30
DEVELOPMENT OF A SIMULATION-BASED MODULE TO TEACH HANDOVERS TO PEDIATRIC RESIDENTS

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BACKGROUND: High quality handovers are vital for patient safety, but recent ACGME restrictions have increased the number of handovers per patient during a given hospitalization. Programs are also now required to provide handover education and evaluation; however, limited data exist regarding the optimal methods to teach and evaluate handovers. OBJECTIVE: Develop a simulation-based module to teach and evaluate handovers. METHODS: Deficiencies were identified in handover education within a residency program, prompting development of an educational module. This module includes a simulation-based experience in which two trainees complete a standardized, computer-based scenario and then handover to one another. One trainee completes a computerized, time-lapsed scenario that simulates the admission and first day of clinical decision making for a patient. This trainee then provides handover to a peer, who uses this information to complete a scenario representing the overnight progression of the same patient. Clinical decision making occurs in the simulations analogous to an actual shift. The trainees then reverse roles for scenario two. Following the simulated experience, the trainees complete a knowledge assessment, while a facilitator guides peer to peer feedback and provides structured handover teaching. RESULTS: Pilot data were collected from 14 trainees. On a Likert scale of 1-5 (1 strongly disagree, 5 strongly agree), trainees viewed the module as an effective teaching tool (4.3), were more comfortable with peer-to-peer feedback after participating (3.9), and characterized the module as “interactive and engaging.” Trainees also disagreed with the statements: “Practicing handovers on simulated patients is not an effective way to teach handovers” (1.7) and “this module is not an effective way to improve my comfort with handovers” (1.7). CONCLUSIONS: Handovers are an important element of trainee education. A module that includes both computer-based and interactive components improves trainee comfort with handovers and represents a potential mechanism to improve handover education. Further investigation is needed to assess the impact of such a module on handovers and patient outcomes.
Poster Number 31
CAN A RESIDENT SAFETY CURRICULUM HELP PEDIATRIC RESIDENTS FEEL SAFE USING THE SAFETY EVENT REPORTING SYSTEM?
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BACKGROUND: Quality improvement and patient safety training are ACGME Practice Based Learning and Improvement and System Based Practice competencies. A safety education needs assessment at this institution showed that residents feel obligated to use the Safety Event Reporting System (SERS), but are uncomfortable reporting (p<0.05). Previous studies identify time constraints and lack of report feedback as barriers to reporting. A disparity in reporting exists between nurses and physicians and amongst physicians depending on training level. Few innovative educational strategies are described which engage residents in safety event investigation, increase their usage of event reporting systems, and result in changes that impact outcomes. GOALS: Identify barriers to pediatric resident usage of SERS. Impact attitudes of pediatric residents towards SERS. Increase pediatric residents as event reporters. DESCRIPTION: Pediatric residents participate in a 4 week curriculum within a required outpatient rotation. A pediatric quality officer mentors residents in reviewing a reported pediatric safety event, identifying contributing factors, performing a root cause analysis, and engaging multidisciplinary healthcare team members. Residents propose and present an action plan at Pediatric M&M Conference and Pediatric Quality Council.
EVALUATION: Resident attitudes and perceived barriers to safety event reporting are measured with pre- and post-curriculum surveys. Summary of the surveys show that for questions addressing attitudes about error reporting, there was an average improvement of 0.85 points on a 5-point scale. The average improvement on the questions addressing barriers was 0.83. The number of pediatric events reported in SERS by residents prior to, during, and after curriculum implementation have not changed significantly. DISCUSSION: Although the curriculum is improving resident attitudes and identifying barriers towards SERS, residents are not becoming more frequent SERS reporters. Further investigations including resident focus groups are planned to further identify barriers to SERS usage.

Poster Number 32
GLOBAL PEDIATRICIANS IN TRAINING: AN INNOVATIVE CURRICULUM TO DEVELOP FUTURE PEDIATRIC LEADERS IN GLOBAL CHILD HEALTH
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Despite the medical advances of the past century more than 8 million children under five years of age die each year from preventable causes. This harsh reality highlights a critical need for the development of leaders in global child health; however, there are currently few formal training programs that provide physicians with the skills and mentorship necessary to become global pediatricians. In response to this need, we developed a Global Child Health Elective for residents interested in a career in global child health. The month-long elective introduced core topics such as causes of child morbidity and mortality worldwide, social determinants of disease and health, cultural compassion, and humanistic clinical care in resource-poor areas. Learners engaged in interactive sessions on leadership, management, and communication skills, workshops on developing community-based health initiatives, and site visits to community organizations promoting child health in Hartford. A one-week cultural immersion experience in Guatemala highlighted some of the major inequalities encountered globally. Participants completed a pre- and post-elective global health knowledge exam and self-assessment of advocacy skills, humanistic behaviors, and ability to identify resources. Mean score on the knowledge pre-test was 54% (SD 4.0) with mean post-test score 75% (SD 7.5), p-value 0.003. All learners reported gaining significant knowledge and skills during the elective as well as increased confidence in their ability to improve child health locally and globally. One resident reflected, “Prior to this elective I felt as though I had a decent amount of experience abroad, but I quickly realized that I had never formally learned about the major problems surrounding global health.” The Global Child Health Elective at the University of Connecticut School of Medicine is a novel program that provides pediatric residents with the core knowledge, communication skills, cultural sensitivity, and humanistic values that will allow them to provide patient-centered care that is ethical, professional, and medically appropriate for the world’s children and their families.

Poster Number 33
“SEE ONE, DO ONE, TEACH ONE,” A THING OF THE PAST: USING SIMULATION TECHNOLOGY TO TEACH PEDIATRIC PROCEDURAL SKILLS
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BACKGROUND: Duty hour limitations and increasing use of physician extenders have impacted the logistics of resident education, resulting in concern about residents achieving proficiency in performing procedures. A survey of faculty and residents in the Pediatrics and MedPeds Residency programs at UIC indicated that residents were not meeting the minimum frequency requirements for competency in many of the RRC required procedural skills and that residents were being instructed how to perform these skills in an unstandardized manner. Thus, we set out to use simulation to standardize instruction of and ensure a proficient knowledge base in performing common procedures. PROGRAM INNOVATION: Six procedures were selected: Umbilical catheter placement, endotracheal intubation, bag-valve-mask ventilation, intravenous
(IV) line placement, intraosseous line placement, and lumbar puncture. PGY1-PGY4 residents’ baseline knowledge was assessed via a written pretest and a performance evaluation by trained instructors of each of the procedures on pediatric task trainers using standardized checklists. Later in the academic year, residents were given two didactic sessions reviewing the indications, complications, and contraindications for each procedure; and they were provided with the checklists and given access to online videos outlining the steps of each procedure. Results of an ongoing summative assessment show statistically significant improvement (using McNemar test) of the percentage of residents who successfully performed IV line placement (p=0.013), bag-valve-mask ventilation (p=0.012), and umbilical catheter placement (p=0.001). DISCUSSION: Simulation cannot replace patient care experiences but it is a viable means of enhancing resident education and preparedness. We sought to capitalize on this by using pediatric-specific simulation technology and didactics for procedural skill instruction and found statistically significant improvement in our residents’ ability to execute several common clinical procedures. Based on these results, we plan to extend the use of simulation for training in code-scenarios and additional procedures, such as urinary catheterization.

Research Posters
Poster Number 34
CHIEF RESIDENT MENTORSHIP OF PL-2 PEDIATRIC RESIDENTS
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Phoenix Children’s Hospital/Maricopa Medical Center Pediatric Residency Program has implemented, as of July 1, 2011, a formal Mentorship Program by the four Chief Residents of second year (PL-2) residents. Chief Residents meet with the PL-2s within two weeks of their inpatient ward rotation to discuss team leadership, learner feedback and teaching tips. The Chief Resident directly observes rounds, non-formal teaching and one senior morning report session of the PL-2s during their ward rotations. The Chief Residents mentor the PL2s in concepts of good teachers and leaders, adult learning theory, methods for teaching, priming and modeling, negotiating plan with attendings, elements and scenarios of feedback. Goals of this curriculum include improvement of teaching, feedback and leadership skills of the PL-2 participating in ward rotations, identification of new areas of resident mentorship as perceived by the residents and improvement of overall job satisfaction. The outcomes of this Mentorship Curriculum was assessed mid 2011-2012 academic year, through PL-2 resident self-assessment questionnaires and Chief resident direct observation forms (n=23). The data was compared to a historical self-assessment survey of current PL-3 residents (n=31) who did not receive Mentorship. Self-confidence in teaching ability and awareness of expectations as teacher improved with statistical significance as a result of Mentorship P<0.05. Seniority (PL3) was associated with self-assessed improvements in leadership of the team (control, role of team members, format of rounds and feedback). The levels of anxiety regarding teaching was individual specific not maturity driven. Mentorship was responsible for early improvements of all resident teaching and feedback skills tested and very high perception of enjoyment and improvement from the PL2s. This study identifies future mentorship items to include methods for improvement of resident confidence and self recognition of own limitations in the context of formal teaching. Questionnaires and Direct observation forms, Chief Resident Mentorship Items will be presented as part of the poster at APPD meeting.

Poster Number 35
WHAT ARE RESIDENTS LEARNING AT NIGHT? A QUALITATIVE AND QUANTITATIVE ASSESSMENT OF RESIDENT SELF-IDENTIFIED LEARNING THEMES
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Background: Nighttime rotations bring a unique challenge for providing the teaching that was previously available during daytime conferences and rounds. In order to improve nighttime education, many educators have wondered what residents actually learn at night and how to best capture these learning experiences, especially in the context of the new work hours. Methods: During a 6 month period, pediatric residents on nighttime rotations at Lucile Packard Children’s Hospital at Stanford were given a survey requesting 4 self-identified learning topics and 4 triggers which prompted the associated learning points. 58 surveys were completed (response rate of 91%). 267 learning topics and 238 learning triggers were identified. Qualitative analysis was conducted by three authors and responses were categorized by theme. Chi-square analysis compared themes based on resident level. Results: 1) Learning theme categories differed significantly between R1s, R2s, and R3s (p=.03). Medical knowledge was the most frequent learning theme for all three levels. R1s identified learning points on practice-based learning and improvement (R1 8%, R2 4%, R3 2%) and systems-based practice (R1 15%, R2 2%, R3 11%) more often than R2s and R3s. R2s identified clinical decision-making learning points more frequently (R1 19%, R2 32%, R3 18%). R3s identified learning points on supervising more often (R1 2%, R2 0%, R3 9%). 2) Learning triggers also differed significantly between R1s, R2s, and R3s (p=.002). Specific patient encounter was the most frequent learning trigger for all three levels. R1s identified formal teaching as a learning trigger more frequently than R2s and R3s. (R1 21%, R2 0%, R3 5%). Conclusions: What residents learn at night and what triggers their learning differ significantly by resident level. Understanding these learning points and triggers can help guide educators in better creating nighttime curricula and tailoring teaching to the level of learner.
Poster Number 36

TEACHING AND EVALUATING COMMUNICATION AND PROFESSIONALISM ACROSS PEDIATRIC CRITICAL CARE MEDICINE FELLOWSHIPS

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Introduction: Communication and professionalism are crucial elements of graduate medical education, but teaching and evaluating these two areas are often challenging. Despite their importance, little is known regarding the teaching and evaluation modalities utilized by pediatric critical care medicine (PCCM) programs. We hypothesized that teaching and evaluation techniques for communication and professionalism are diverse among PCCM training programs. Methods: The Education in Pediatric Intensive Care (E.P.I.C.) Investigators developed a survey based on the requirements of the ACGME and the ABP. After development and piloting, surveys were sent to the 66 program directors (PDs) of accredited PCCM fellowships. Results: 67% of PDs responded, representing educators for 73% of current PCCM fellows. Respondents had a median of 4 years of experience, 36 ICU beds, 7 fellows, and 12 teaching faculty in their programs. Faculty role modeling or direct observation with feedback were the most common modalities used to teach communication, and 54% of PDs indicated that these were most important. Faculty role modeling was also the most commonly used technique to teach professionalism in 7 out of 16 content areas and was judged by 59% of PDs to be most important. For 7 other professionalism content areas, didactics were most common, but only 19% of PDs reported didactics as most important. Evaluations by members of the multidisciplinary team were used most commonly for assessment. The use of a specific teaching technique was not related to program size, PD experience, participation in an ACGME review, or availability of faculty with training in medical education. Conclusions: Teaching communication and professionalism involves a range of modalities, but PCCM programs primarily use faculty role modeling and direct observation to teach communication, and faculty role modeling and didactics to teach professionalism. Opportunities exist to expand the use of other techniques and to determine the optimal methods to bolster resident and fellow education in these areas.

Poster Number 37

HOW WELL DO PEDIATRIC CRITICAL CARE FELLOWSHIP PROGRAMS COMPLY WITH ACGME REQUIREMENTS FOR TEACHING PROFESSIONALISM AND COMMUNICATION?

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Introduction: Communication and professionalism are key educational competencies established by the ACGME that include a number of required content areas. These competencies are often difficult to teach, and little data exist regarding whether training programs provide formal instruction in all mandatory areas. We hypothesized that many pediatric critical care medicine (PCCM) programs lack a structured method to teach required elements of communication and professionalism. Methods: The Education in Pediatric Intensive Care (E.P.I.C.) Investigators developed a survey based on the requirements of the ACGME and ABP. After development and piloting, the surveys were sent to the 66 program directors (PDs) of accredited PCCM fellowships. Results: Survey response rate was 67%. PD respondents had a median experience of 4 years, a median of 7 fellows and 12 teaching faculty, and 66% had participated in an ACGME review. 32% of programs had no mechanism to teach communication and working effectively within a non-clinical group, and 18% did not teach communication through medical records. In one quarter of programs, there was no method to teach fellows to communicate as consultants outside of the ICU and no formal mechanism to teach the maintenance of professional standards. 18% had no method to teach peer review. There was no system to help fellows learn the impact of grief and loss on themselves in 18% of programs, and 14% did not formally teach trainees professional boundaries. Deficiencies were unrelated to program size, PD experience, ACGME review participation, or the presence of faculty with advanced medical education training. Conclusions: Within PCCM fellowships, a structured mechanism does not exist to teach required components of the ACGME competencies of communication and professionalism. Given the traditional difficulties teaching these important competencies, deficiencies of this nature likely exist broadly within GME and represent opportunities to implement novel educational techniques to improve the educational process.
CREATION OF A LEARNING GOAL SCORING RUBRIC
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Background: Creation of learning goals is an essential component of lifelong learning. In order to be effective, learning goals (LGs) must be well crafted. No tool currently exists to assess the quality of LGs. Objective: To describe the development and preliminary validation of a LG scoring rubric. Methods: After a literature search, iSMART (Important, Specific, Measurable, Accountability, Realistic, Timeline) was selected as the framework for the scoring rubric. Iterative revisions from draft to final rubric were made by the 4 authors using repeated application to sample LGs and discussion. The final rubric scores 4 items: Specific & measurable goal; Important goal; Realistic, multisource plan; Outcome measures. Each item is scored on a scale with descriptive anchors from 0(low) to 3(high). Twenty-three learning goals completed by 3rd year pediatric residents were scored with the final rubric; 11 residents had previous training in writing learning goals and 12 did not. Inter-rater reliability was assessed using intraclass correlation coefficient (ICC). Differences between trained and untrained residents’ scores were assessed using t-test. Residents’ attitudes to lifelong learning were assessed by the Jefferson Scale of Physician Lifelong Learning (JeffSPLL) and correlated with their score. Results: The ICC for absolute agreement was 0.92 for the entire rubric and 0.86, 0.70, 0.73, 0.73 for the 4 items respectively. Residents trained in writing LGs scored significantly higher than untrained (8.5 vs 5.3 p<0.05). Lack of correlation (r = .167) between quality of LGs and the JeffSPLL indicate that the rubric captures a
different, distinct variable. Discussion: Evidence for the following facets of validity for the scoring rubric is provided: content, internal structure, and relationship to other variables. The rubric can be used to assess goal writing skills and as a resident feedback trigger. We plan to create a means of scoring goal outcomes to determine if a better stated learning goal leads to higher goal achievement. We will further investigate the rubric’s validity at different institutions with a larger sample of learning goals and more raters.

Poster Number 41

“BUCKING THE NORMS” : RESIDENT PERCEPTIONS OF A LONGITUDINAL BLOCK EXPERIENCE
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Background: One month rotations with curricular content and patient exposure that is generally not directly determined by a resident’s career goals is the norm for pediatric residency training. In contrast, at the University of Colorado, we have implemented a 4-month Longitudinal Block (LB) where residents individualize clinical experiences based on their career path. The experience includes individualized learning goals, mentoring, direct observation, group seminars, and customized clinical experiences. Purpose: To describe initial resident perceptions of participation in an individualized career focused LB. Methods: After the first year of the initiative, one-hour interviews were conducted with all 11 LB participants (5 residents in primary care, 2 in hospitalist pediatrics, and 4 in subspecialties). Two one-hour focus groups were also conducted with 8 of the 11 participants. Two researchers independently analyzed and coded all qualitative data, identifying emergent themes using grounded theory. Results: Five themes emerged: 1) “Bucking the norms” 2) Empowerment of residents 3) Professional development 4) Faculty roles 5) Benefit of group interaction and peers. Residents were aware that this experience was different from their standard residency education. Even though they felt empowered to individualize their experience, there were limitations to what they could achieve because of cultural norms and hierarchy. The experience enhanced their professional development by providing continuity with patients, opportunities to see the results of their decisions, support for their career choice, and feedback after observation. Faculty had multiple roles as leaders, mentors, and facilitators, and no negative faculty attitudes emerged. Even though this was an individualized experience, residents described benefits from talking with peers about the experience. Discussion: Addressing cultural norms and the medical hierarchy will need to be addressed as individualization becomes more prevalent. Individualization still relies heavily on faculty mentoring and facilitation and benefits from group interaction and peer input.

Poster Number 42

USE OF WIKI-BASED TECHNOLOGY TO DOCUMENT RESIDENT-DRIVEN QI PROJECTS
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Background: Wiki-based technology has come into widespread use in the last decade. It provides an opportunity for individuals to update a webpage which is then shared with either a select group or all users. Our objectives were (1) to determine the technical feasibility of implementing wiki sites for documentation of UCSF pediatrics residents’ continuity clinic-based QI projects; and (2) to document adoption of this technology by residents and faculty. Methods: Clinic pods (n=19, 2-5 residents/pod) had a timeline with monthly dedicated sessions, and were expected to document their project on a wiki page. Wikis were available for viewing by all residents, faculty, and program directors. Viewers could leave feedback in a comments section on the page. We reviewed the QI wiki sites for all continuity clinic pods, including reports of total number of views and edits per page. Edit Reports included the date and time of each edit/update, as well as the name of the editor. After de-identification, we calculated mean number of edits per page. Edits were included if they occurred >30 minutes since the last edit. Results: Wiki pages were viewed an average of 65 times/page (by either residents or faculty). Pages were edited 2-5 times/pod (mean=3). Edits were performed by a total of 28 discrete residents (mean = 1.5/group) on 19 pages. This represented approximately 2/3 of residents. In two groups, clinic faculty also made edits. 17 sites had direct feedback from at least one program-level faculty member about the project (mean # of comments = 2). Conclusions: Wiki-based websites were easily implemented and were well-utilized for documentation and feedback on residents’ QI projects. They provide an ideal forum for giving feedback on group-based works-in-progress. The technology is easy to use (in our program residents received minimal technology instruction). The current generation of trainees is well-adapted to use online modalities for reporting their work. Our next steps are to engage more residents in the updating process. In addition, we hope to engage more clinic faculty in documenting feedback on the websites.

Poster Number 43

END OF LIFE EDUCATION FOR PEDIATRIC RESIDENTS DURING A PEDIATRIC INTENSIVE CARE ROTATION
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Objectives: The aim of this study was to provide training to pediatric residents in end of life (EOL) care and to better prepare them to communicate with parents in difficult situations. Methods: 8 PL-2 residents participated in an EOL curriculum comprised of didactic lectures and small group discussions. Topics included communication skills, pain management and discussing end of life with families. 9 PL-3 residents did not receive the curriculum during the study and served as the
control group. Pre- and post surveys on confidence levels were completed by all residents. Both groups participated in an objective structured clinical exam (OSCE) with the following scenarios: an end of life discussion, withdrawal of mechanical ventilation and pain management in an adolescent. Encounters were video recorded and resident performance was evaluated by five observers using a checklist for each scenario. Analysis included: 1) paired t-test to assess the change in the level of confidence, 2) independent t-test to assess OSCE ratings performance differences between control and intervention group. Results: 17 residents participated in the study, 8 intervention and 9 controls. Pre and post mean comfort level scores for all residents showed a significant change from 63 +/- 9 to 86 +/- 9, p < 0.01. Independent t-tests comparing PL-2 and PL-3 OSCE scores were significant for the EOL scenarios (48 +/- 7 vs. 41 +/- 10.9; p = 0.002), mechanical ventilation withdrawal scenario (30.97 +/- 2.7 vs. 29.26 +/- 3.19; p = 0.013) and the adolescent scenario (20.9 +/- 2.89 vs. 18.91 +/- 2.88; p = 0.02). All subjects reported increased confidence after participating in the OSCE scenarios and qualitative data from the resident surveys demonstrated their increased confidence in handling EOL situations and difficult conversations with families. Conclusion: Participating in the EOL course resulted in significant differences in the confidence level, knowledge and skills of the PL-2 residents. Participating in the OSCE sessions improved the confidence of all residents, regardless of education received.

Poster Number 44
THE EFFECTS OF A DAY/NIGHT SHIFT SYSTEM ON INTERN SLEEP, WORK LOAD, AND CONFERENCE ATTENDANCE.
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Background: The ACGME regulations limit interns to 16 continuous duty hours beginning July 1, 2011. The impact of this rule on sleep, work load, and conference attendance is unknown. Objective: To conduct a trial of a ward shift system compliant with the 2011 ACGME regulations and to compare sleep time, sleep quality, patient load, hours worked, and conference attendance with a q 4 call schedule. Research methods: We implemented a two month trial of a pediatric ward system with 12 hour daytime and 12 hour night-time shifts. We surveyed interns (PL1s) daily during the trial and during two call ward blocks regarding average daily sleep, patient load, hours worked, and conference attendance. The daily hospital census was recorded. Parametric and nonparametric statistical methods were used to compare results. Results: Twenty-five interns completed 78% of 896 surveys. PL1s on both day and night shifts worked fewer total hours/week than during q 4 call (73.2±4.2 and 71.6±2.7 hrs. on shifts vs. 79.6±5.6 hrs in the call system; P<0.01). Residents on shifts cared for more patients/day when the ward census was high (95% CI: 7.88-8.12 vs. 95% CI: 5.67-6.69; P<0.001) and cared for no fewer when the ward census was lower. Hours of daily sleep did not differ between PL1s on day and night shift, but PL1s working night shifts slept more hours/day than those on the q4 call schedule (95% CI: 6.64-7.71 v. 95% CI: 5.45-6.71; P<0.05). Overall sleep quality did not differ between shift and call schedules. When the ward census was high, PL1s on the day shift attended fewer conferences than PL1s on the call schedule (none v. 30% of morning report; 14% v. 39% of noon conference; P<0.05). Discussion: These results indicate that even though interns might work fewer total hours in a shift system, they may actually care for more patients. Sleep quantity and quality were largely unaffected. PL1 conference attendance suffered in the new system indicating that programs may need to implement new strategies to preserve didactic opportunities for resident education.

Poster Number 45
DOES A NEONATAL NIGHT SHIFT TEAM INCREASE HOUSESTAFF EXPOSURE TO RESUSCITATIONS?
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Background: Given ACGME duty hour changes, pediatric residency programs have changed from call to shift systems. These changes may pose challenges in preserving high quality resident education and providing sufficient patient exposure. We hypothesized that a night shift system would increase exposure to neonatal resuscitations and enhance housestaff education. Methods: We created a night shift system, the newborn resuscitation team, comprised of one intern and one resident, who cover the NICU (level 3) and newborn nursery (level 1-2) and perform all nighttime resuscitations. The traditional coverage consisted of three housestaff, one covering the NICU and two covering the newborn nursery, on q4 call. During the study period, 19 nights were pilot resuscitation team nights and 30 were traditional call nights. On each post-call morning, housestaff completed surveys delineating numbers of deliveries attended, separating term and pre-term births, and procedures, burden of patient care, hours of sleep, and autonomy. Housestaff experiences in each system were compared using linear regression methods with log transformation and Wilcoxon rank sum test. Results: 26 different housestaff worked the overnight shifts. During the pilot nights, NICU housestaff attended 3.1 fold more (95% CI.: 2.0-4.0, p<.0001) term newborn resuscitations than during the traditional call nights (geometric mean 2.3 vs. 0.7) and 2.8 fold more (95% CI.: 1.6-4.0, p<.0001) total resuscitations than in the traditional call nights (geometric mean of 2.9 vs. 1.1). We observed no difference in number of deliveries attended by the newborn nursery housestaff. We found no significant differences in the hours of sleep, number of procedures and burden of patient care. All housestaff in the pilot and traditional q4 call groups reported an appropriate amount of autonomy during the overnight shift. Discussion: The redesign of the traditional call structure to a night shift system can allow for increased overnight exposure to resuscitations and neonatal care, while maintaining housestaff autonomy and a high quality experiential education.
THE NEW ERA OF NIGHTTIME EDUCATION: WHAT DO RESIDENTS WANT?
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Background: The 2011 ACGME work hour changes resulted in a substantial increase in pediatric nighttime rotations. Nighttime rotations bring the unique challenge of delivering resident education, traditionally provided by daytime conferences and rounds. As programs balance the new ACGME regulations with educational goals, it is vital to understand residents’ attitudes toward nighttime teaching. Methods: Between June and August 2011, the Pediatric Nighttime Education Steering Group conducted an IRB-approved, anonymous on-line survey of pediatric and med-peds residents; 2,185 surveys were completed. An additional 124 surveys were completed by program directors/associate program directors (PDs/APDs) at the 2011 APPD Curriculum Task Force Meeting to rank nighttime teaching topics in order of importance. Results: 1) Quantity/quality: 64% of residents feel there is not enough teaching on nighttime rotations. 46% feel the current quality of teaching is “fair” or “poor”. 2) Teaching methods: 66% of residents believe nighttime teaching sessions are valuable, 69% believe a standardized nighttime curriculum would improve education, and 82% of residents believe case-based learning would be the best teaching approach. 3) Timing: 91% of residents think nighttime teaching sessions should be 30 minutes or less and 65% believe they should occur before midnight. Residents overwhelmingly commented that the timing of nighttime teaching should be flexible. 4) Teaching Topics: Residents and PDs/APDs have similar top choices for nighttime teaching topics (respiratory distress and shock as #1 and #2), however PDs/APDs placed a greater emphasis on communication topics such as handoffs (ranked #3 by PDs/APDs and #28 by residents). Conclusions: Residents want more teaching at night and are in favor of a standardized, case-based curriculum, with flexible teaching times. Residents’ perceptions of important nighttime teaching topics are similar to PDs/APDs in terms of medical topics, but communication topics, such as handoffs, rank lower.

POSTER NUMBER 46
IDENTIFYING GAPS BETWEEN FACULTY AND RESIDENT EXPECTATIONS OF RESIDENT AUTONOMY
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Background: With the advent of work hours restrictions and generational changes in residents, the culture of residency is shifting. Residents are regaled with faculty anecdotes, “When I was a resident...,” and faculty members are frustrated by residents who seem to have different educational expectations and priorities. This subjective evidence suggests a cultural divide, but there are few evidence-based reports to substantiate or clarify areas of divergence. Goal: To objectively identify specific differences in how pediatric residents and faculty perceive resident autonomy and expectations. Design: Parallel surveys were distributed to all pediatric and medicine-pediatric residents and to pediatric faculty who regularly interact with residents at the University of Rochester Medical Center. The surveys contained questions about resident performance, work ethic, autonomy, and faculty-resident interactions. The 16-question resident survey and the 20-question faculty survey included seventeen parallel items. Several questions allowed for multiple responses and comments. Results: Of the 78 residents and 100 faculty members who received the survey, 77% of residents and 67% of faculty responded. Residents at all levels differed significantly from faculty in their perception of residents’ ability to present a complete HPI and thorough patient assessment. They also differed significantly on residents’ degree of autonomy, faculty encouragement of residents’ independent thought, and amount of faculty feedback. Of the 17 parallel responses, residents differed significantly with the faculty on 10 at p < .001 level and on 6 others at p < .05 level. Their sole area of agreement was how often faculty provide too much direction. Conclusions: We found a gap between faculty and residents in their perceptions of resident autonomy and of faculty support for resident autonomy. Given the importance of autonomy in independent practice after residency, further studies are needed to investigate the validity and possible sources of these differences in perceptions, so that strategies to enhance resident autonomy in training can be developed.

POSTER NUMBER 47
STATE OF MEDICAL HOME EDUCATION IN PEDIATRIC RESIDENCY PROGRAMS
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Intro: The US Dept of Health and Human Services, via Healthy People 2020 (HP 2020), identifies health goals for the coming decade. One goal is fostering medical homes that are family-centered, culturally-competent, comprehensive, coordinated systems for all children, including those with special health needs. To achieve this goal, physicians must understand the medical home, beginning in training. A workgroup comprised of members from the AAP, National Center for Medical Home Implementation, APPD, APA, residents, national experts and families was established to create a flexible, standardized medical home curriculum for training programs. We conducted a needs assessment on the current state of medical home
education in pediatric programs. Methods: An anonymous electronic survey was sent to all program directors (PDs) through the APPD in the spring 2011. Fifty-six surveys were completed (28%). Data were analyzed via descriptive statistics. Results: Respondents represented all APPD regions, with 69.6% academic, 8.9% community, and 21.4% both. Average size was 48 categorical pediatric residents. Respondents indicated their satisfaction with their current curricula in the following domains: care partnership support 33% (patient/family centered care, communication); clinical care information 33%; care delivery management 8.2% (care coordination, transition to adult care); community resources/linkages 16.3%; practice performance 26.5%; and payment/finance 10.2%. Key barriers to implementing a medical home curriculum included: faculty time (69%), resident schedules (80%), lack of expertise (53%), finances (46.9%). Only half the programs had faculty champions/resources for teaching medical home. Detailed analyses were performed for various components of each domain to inform creating a national curriculum. Areas for improvement include care delivery management, community resources/linkages, and payment/finance. Conclusions: PDs recognize the importance of teaching medical home in training, but identified many opportunities for improvement. A curriculum addressing these needs is helpful to meet the goals of HP 2020.

Poster Number 49
SHORTENING RESIDENT DUTY HOURS - DOES IT SHORTCHANGE STUDENT LEARNING?
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Background: Recent attention has focused on change in resident duty hours as it pertains to resident education and patient safety, but there are no published data on the impact of these changes on medical student performance and mixed data on the impact on student perceptions during third-year clerkships. In July 2004, 24-hour call was completely eliminated from the UMDNJ-New Jersey Medical School pediatric residency program. We analyze the effects of this change in resident duty hours on medical students’ performance and perceptions in the pediatric clerkship. Objectives: This study aims to determine if changes in resident duty hours affected our students’ perceptions of the quality of their clerkship experience and/or their grades. Methods: Medical students are surveyed at the end of each clerkship using a 1-5 Likert scale with 3=average, 4=well above average, 5=exceptional. Students evaluate the quality of their clinical experiences, attending and resident teaching, and the overall quality of the clerkship. Evaluation component means were calculated for each academic year. Mean clinical, OSCE and shelf exam grades for each academic year were also recorded. Data were analyzed for approximately 130 students per year. The aggregate data from four years before and four years after implementation of the change in resident duty hours were analyzed using ANOVA to determine any differences in grades or evaluations. Results: There were no significant differences in the students’ evaluations of the overall quality of their pediatric clerkship (p=0.9), nor inpatient (p=.87) or nursery (p=.25) components of the rotation before and after the change in resident duty hours. Student evaluation of resident and attending teaching also evidenced no significant differences pre- and post-change (p=.06 and .18 respectively). Students’ clinical performance, OSCE and shelf exam grades were not significantly different pre- and post-change (p=.055, .67 and .05 respectively). Conclusion: Program-wide reduction in resident duty hours did not adversely affect medical student performance or perceptions in this pediatric clerkship.

Poster Number 50
NIGHTTIME RESIDENT EDUCATION PILOT: A STANDARDIZED, WEB-BASED CURRICULUM
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Background: With the 2011 ACGME resident work hour restrictions, there has been a substantial increase in the number of nighttime rotations in pediatric residency programs. Because of the increase of these rotations, nighttime education must be optimized for residents who miss daily didactic sessions such as morning report and noon conference. Objective: A pilot nighttime curriculum was created, implemented and evaluated for effectiveness (change in confidence and knowledge) and feasibility. Methods: A standardized, web-based nighttime curriculum of 10 case-based topics was implemented from March to June 2011. Attendings were expected to lead the teaching session; but if they were unavailable, senior residents would teach. This curriculum was evaluated using attending and resident pre-/post-implementation surveys administered in February and June 2011, resident pre-/post-rotation confidence and knowledge assessments, and teaching frequency data. Results: 1) Though the number of attending-led formal teaching sessions did not significantly increase during the curriculum implementation, resident perception that nighttime teaching sessions met educational goals increased significantly (p < .01). 2) Night float intern confidence increased significantly overall and specifically in 7 of 10 module topic areas after the night float curriculum was implemented (p < .03). 3) Night float senior confidence did not increase overall but did increase significantly in 1 of 10 module topics, arrhythmias (p=.04). 4) Pre- and post- rotation knowledge scores were not significantly different. Conclusions: A standardized, web-based nighttime curriculum increased intern confidence in most areas covered by teaching modules. The curriculum did not increase the number of attending-led teaching sessions which occurred, but did increase resident perception of teaching and overall rotation educational value. This pilot did form the basis of the national nighttime curricular effort.
Based on learning style preference (p = 0.04). There was a linear increase in scores from diverging-assimilating-converging learning. Results: There was a statistically significant difference (SSD) in baseline scores on pre-education concept maps immediately post-education and one week later. Concept maps were scored using a standardized structural scoring method. All residents were taught how to develop a concept map. The participants completed three concept maps; pre-education, receive either a control lecture or a session on respiratory arrest using an expert concept map as an advance organizer. Learning Style Inventory (LSI). As part of a previous study, 46 pediatric residents were randomized by month of service to use of Concept Mapping has demonstrated the ability to enable deeper and more meaningful learning. Meaningful learning is required to transition from novice to master clinician. Aim: The purpose of this study was to determine if individuals with LEARNING STYLES AND CONCEPT MAPPING: THE CHICKEN OR THE EGG Teri L. Turner, MD, MPH, MEd, Mark A. Ward, MD, Anne C. Gill, DrPH, MS, Baylor College of Medicine, Houston, Texas Background: Individuals have unique and varied learning styles and prefer to organize information in different ways. The use of Concept Mapping has demonstrated the ability to enable deeper and more meaningful learning. Meaningful learning is required to transition from novice to master clinician. Aim: The purpose of this study was to determine if individuals with certain learning styles inherently create more elaborate concept maps without any prior content teaching using concept maps and to determine whether the use of an expert concept map as an advance organizer or one’s learning style is the more powerful predictor of deeper and more meaningful learning. Methods: Residents, prior to training, completed the Kolb Learning Style Inventory (LSI). As part of a previous study, 46 pediatric residents were randomized by month of service to receive either a control lecture or a session on respiratory arrest using an expert concept map as an advance organizer. All residents were taught how to develop a concept map. The participants completed three concept maps; pre-education, immediately post-education and one week later. Concept maps were scored using a standardized structural scoring method. The more elaborate a concept map, the higher the score. A concept map that is more elaborate is felt to represent deeper learning. Results: There was a statistically significant difference (SSD) in baseline scores on pre-education concept maps based on learning style preference (p = 0.04). There was a linear increase in scores from diverging-assimilating-converging learning style preferences based on the Kolb were: 13% Divergers, 28% Assimilators, 38% Convergers and 20% Accommodators. There were averaged for each individual resident. In-training examination results were used to measure cognitive performance. Results: There was an extremely weak positive correlation (r = 0.1) between the average LOR score and the overall preceptor evaluation of clinical performance during residency. There was also an extremely weak negative correlation with cognitive assessment (r = -0.09). Conclusion: LORs can be time-consuming for faculty to write and also for residency programs to review. Based on our findings, LORs do not correlate with performance during the first year of training. Consideration should be given to different mechanisms of identification of the strengths and weaknesses of residency candidates prior to post-graduate training that may better predict performance.

Lack of Predictive Value of Letters of Recommendation: An Exercise in Futility Teri L. Turner, MD, MPH, MEd, Mark A. Ward, MD, Anne C. Gill, DrPH, MS, Baylor College of Medicine, Houston, Texas Background: Residency programs attempt to select the best residency candidates among applicants to their programs. Criteria commonly used in making the selection include personality, communication skills, medical school grades and performance, United States Medical Licensing Examination scores, Dean's letters, and letters of recommendation (LORs). Aim: To determine if LORs scored with a previously validated rubric correlate with cognitive and/or clinical competencies during the first year of pediatric training using standardized testing and preceptor evaluation performance measures. Methods: One hundred and twelve LORs for 35 of the 41 entering residents of the class of 2010 were blindly reviewed by a nurse educator using a validated 7-point Likert-type scoring system previously described by Girzadas, et al (1998). We conducted a previous pilot study demonstrating an inter-rater reliability of 0.7 between a physician rater and this same nurse educator using this validated scoring system. Mean LOR scores for each applicant were calculated. Residents were evaluated during the 2010-2011 academic year by faculty preceptors on each of the resident's individual rotations using a 7-point Likert-type scoring system. The faculty evaluated the residents on each of the six core competencies. Faculty evaluations for all the competencies were averaged for each individual resident. In-training examination results were used to measure cognitive performance. Results: There was an extremely weak positive correlation (r = 0.1) between the average LOR score and the overall preceptor evaluation of clinical performance during residency. There was also an extremely weak negative correlation with cognitive assessment (r = -0.09). Conclusion: LORs can be time-consuming for faculty to write and also for residency programs to review. Based on our findings, LORs do not correlate with performance during the first year of training. Consideration should be given to different mechanisms of identification of the strengths and weaknesses of residency candidates prior to post-graduate training that may better predict performance.

Poster Number 51

Lack of Predictive Value of Letters of Recommendation: An Exercise in Futility

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Poster Number 52

Physician Know Thy Learners: A 5-Year Description of Learning Styles Across the Generations

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Background: Much has been written about learning styles. However, less attention has been given to intergenerational differences in those styles. Aim: To describe the learning preferences of residents over a five year period spanning two generational cohorts and to compare and contrast learning style preferences based on demographic and performance variables. Methods: All individuals (n = 250) entering pediatric residency training between the years 2006-2010 were surveyed on their learning style preferences using the Kolb Learning Style Inventory (LSI) and the VARK guide to learning styles. This sampling methodology included 2 generational cohorts, Generation X (born 1960-1980) and Generation Y (1980-2000). In examining generation differences we studied the entering class of 2006 (Gen X, n = 49) and compared this data to the class of 2010 (Gen Y, n = 52). Descriptive statistics were performed on all 250 residents. Results: The overall distribution of learning style preferences based on the Kolb were: 13% Divergers, 28% Assimilators, 38% Convergers and 20% Accommodators. There was a statistical significant (p = 0.043) difference (SSD) between male and female residents. Male residents were more likely to be Assimilators and Convergers than their female counterparts. No SSD was noted between AOA residents and non-AOA residents, Medicine-Pediatric and Pediatric residents or pediatric residents who chose primary versus subspecialty care as a career choice. There was a SSD (p = 0.03) between the percentage of learners who had Diverging styles on the Kolb LSI between the class of 2006 and 2010. Upon examination of the learning style preferences on the VARK, there was a shift from single preference (primary Read-Write) to multi-modal preference between these 2 cohorts (p = 0.06). Conclusions: Shifts have occurred in the learning style preferences of residents over time with a decrease in traditional learning strategies such as reading and reflecting. Teachers need to understand learner preferences, teach to all styles and not connotate “different” styles from our own with “wrong”.

Poster Number 53

Learning Styles and Concept Mapping: The Chicken or the Egg

Teri L. Turner, MD, MPH, MEd, Baylor College of Medicine, Houston, Texas, William B. Cutrer, MD, MEd, Vanderbilt University School of Medicine, Nashville, Tennessee

Background: Individuals have unique and varied learning styles and prefer to organize information in different ways. The use of Concept Mapping has demonstrated the ability to enable deeper and more meaningful learning. Meaningful learning is required to transition from novice to master clinician. Aim: The purpose of this study was to determine if individuals with certain learning styles inherently create more elaborate concept maps without any prior content teaching using concept maps and to determine whether the use of an expert concept map as an advance organizer or one’s learning style is the more powerful predictor of deeper and more meaningful learning. Methods: Residents, prior to training, completed the Kolb Learning Style Inventory (LSI). As part of a previous study, 46 pediatric residents were randomized by month of service to receive either a control lecture or a session on respiratory arrest using an expert concept map as an advance organizer. All residents were taught how to develop a concept map. The participants completed three concept maps; pre-education, immediately post-education and one week later. Concept maps were scored using a standardized structural scoring method. The more elaborate a concept map, the higher the score. A concept map that is more elaborate is felt to represent deeper learning. Results: There was a statistically significant difference (SSD) in baseline scores on pre-education concept maps based on learning style preference (p = 0.04). There was a linear increase in scores from diverging-assimilating-converging learning styles.
New Professionalism Challenges in Medical Training: An Exploration of Social Networking

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Background: The practice of medicine in the new millennium is enhanced by innovative technology that yields unprecedented speed of communication but may also present new risks for unprofessional behavior. We conducted a survey to determine program directors’ perceptions and experiences with residents’ use of social networking sites (SNS). METHODS: A survey was sent to directors (PDs) and associate directors (APDs) of pediatric residency training programs within the United States who are members of the APPD in fall 2011. RESULTS: Seventy PDs and 72 APDs (representing 99 of 197 residency programs) responded to the survey. One-third of respondents report being “very familiar” with social networking and 23% use SNS “daily or often.” The majority (88%) believe their residents access SNS “weekly” or “daily” while at work to “friend” peers (90%) and, to a lesser extent, current or former supervisors (28% and 28% respectively), current or former supervisors (31% and 31% respectively), and current or past patients (32% and 26% respectively). A majority (70%) of PDs and APDs rated “friend” peers while at work to be “completely appropriate” whereas only 1% of respondents rated “friend” current or past patients as “completely appropriate.” 78% of respondents believe inappropriate behavior on SNS is “somewhat” or “very” prevalent and 91% are “somewhat” or “very” concerned that these behaviors may become more common. While 55% of respondents state that their institution has a SNS policy, 25% were unsure of whether such a policy existed. Of those who report having a SNS policy, only 48% reported familiarity with the policy. Residency programs educate trainees about SNS and e-professionalism via intern orientation (48%), written guidelines (29%), ad hoc remediation (18%), faculty development (12%), full curriculum (11%), and monitoring of residents’ behavior (9%). After evaluating several SNS scenarios, respondents rated “friend” patients and posting content about patients to be always inappropriate. Most respondents (91%) expressed disapproval of residents posting negative thoughts about their workplace. However, 29% of respondents believed it was acceptable for PDs and APDs to access resident applicants’. OUTCOMES: As medical educators teach trainees to exhibit ideals and optimal attributes of our profession, appropriate use of social networking sites will need to be included in the training process. Our survey yields meaningful data that will form a foundation for these curricular efforts.

Poster Number 54

Comparison of Institutional Coverage Models in the Era of Duty Hour Restrictions

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Background: Compliance with 2011 Common Program Requirements necessitated that programs revise coverage models. Quality resident education and patient care must continue within increased time constraints. Limited evidence exists regarding the most effective model to address these concerns. OBJECTIVE: To compare coverage models for Pediatric inpatient services at three different institutions. METHODS: Distinct models of coverage for pediatric inpatient services were identified at three institutions, referred to as P1, P2, and P3. Models include traditional night float teams (P1), every other night teams (P2) and every fourth night call for senior residents with traditional night float for interns (P3). Included in evaluation of each program is duty hour adherence and conference and continuity clinic attendance. Subjective data is obtained through resident survey. Analyses compare results from each institution. RESULTS: Data collection is currently ongoing at all 3 sites, though IRB approval is pending at P1. Preliminary results reveal that trainees at P2 attended 53% of conferences, worked a mean of 62.5 hours/week, had (0) duty hour violations, and attended clinic 50% of weeks. At P3, senior trainees attended 68% of conferences, worked 63.9 hours/week, had (1) duty hour violation, and attended clinic 97% of weeks. P3 interns attended 58% of conferences, worked 63.1 hours/week, and attended clinic 84% of weeks. Notable trends in survey data include: ability to participate in educational events 100% (P2) and 80% (P3); positive perceptions of continuity of care 67% (P2) and 100% (P3); appropriateness of workload 83% (P2) and 100% (P3); satisfaction with balance between personal and professional life 66% (P2) and 50% (P3); and feelings of burnout once a month or more 83% (P2) and 67% (P3). Fatigue scores suggest notable levels of fatigue at each institution. CONCLUSIONS: Preliminary data suggest many similarities in trainee experience and some unexpected differences. Further consideration of these differences is necessary in anticipation of future duty hour regulations as training programs aim to balance duty hour adherence, resident quality of life, and preservation of the educational experience.
A PROSPECTIVE RANDOMIZED TRIAL OF THE EFFECTIVENESS OF LUMBAR PUNCTURE SIMULATION TRAINING IN PEDIATRIC RESIDENTS

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Introduction: There is a clear emphasis on “real and/or simulated training” of procedures in the proposed ACGME program requirements for pediatrics. Recent evidence has shown a formal curriculum of patient simulation training could improve resident competency in core procedural skills. However, studies are needed to determine if pediatric procedural simulation training results in improved real patient performance. Objectives: The objectives of our study are to measure: 1. The difference in success rates, defined as successfully obtaining cerebral spinal fluid (CSF) in performing lumbar punctures (LP) between the control and study group. 2. The difference in number of LP attempts prior to obtaining CSF between the control and study group. 3. The proportion of patients with traumatic LPs, defined as CSF red blood cells (RBC) >400, between the control and study group. 4. The perceptions of the study group on LP simulation education. Materials/Methods: This is an IRB approved study. PL-1 residents were prospectively randomized. The control group received the historical gold standard of LP procedural education, which is the “see one, do one, teach one” model. The study group received a LP tutorial and patient simulation in addition to standard training. The study group completed a survey before and after simulation education. Residents’ procedure logs and patient charts were reviewed to obtain patient age, successful completion of LP, number of attempts, and number of CSF RBC.

Results:

<table>
<thead>
<tr>
<th>Control Group</th>
<th>Study Group</th>
</tr>
</thead>
<tbody>
<tr>
<td>Participants with ≥ 1 LP attempt recorded</td>
<td>12</td>
</tr>
<tr>
<td>LP's attempted (individual patient encounters)</td>
<td>30</td>
</tr>
<tr>
<td>Total number of LP attempts</td>
<td>45 (1.5 attempts/LP)</td>
</tr>
<tr>
<td>CSF successfully obtained</td>
<td>16 (53.3%)</td>
</tr>
<tr>
<td>CSF obtained on 1st attempt</td>
<td>10 (33.3%)</td>
</tr>
<tr>
<td>Number of traumatic LP's (rbc &gt;400)</td>
<td>5 (31.3%)</td>
</tr>
</tbody>
</table>

Although data trended towards better success rates and decreased traumatic taps with the simulation exposed study group, none of the data showed statistical significance. The study will continue with tracking of the first 5 LPs of intern year for both groups and will continue with an additional recruitment of 31 new interns this summer. Survey data of the study group did reveal significant improvement in confidence level following simulation. Further subject recruitment and data collection will help determine if pediatric LP procedural simulation training results in improved real patient performance and outcomes.

Poster Number 57
E-LEARNING SOFTWARE TO ENHANCE PEDIATRIC MEDICAL EDUCATION
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Background: Medical educators face many challenges in teaching future physicians. Resident duty hour reform has resulted in a potential decline in teaching opportunities. E-learning technologies offer trainees flexibility and the ability to tailor their experiences to meet their personal objectives. Objective: This study aimed to show that trainees at a large tertiary care children’s hospital exposed to on-line lessons during their inpatient ward and emergency department (ED) rotations performed better on a post-test than those exposed to traditional learning. Trainees were also expected to prefer computer based learning. Methods: SoftChalk® software was used to develop interactive learning tutorials. Students and residents rotating in the ED and on the wards over a 12-month period were enrolled. The control group continued with the current educational experience while the study group was exposed to the E-learning modules. Both groups were given a pre- and post-test which had 16 questions, 5 of which were study specific questions addressed in the on-line modules. A survey of the educational experience was given to the trainees at the end of the rotation. The paired t-test was used to compare pre- and post-test scores. Results: Six months of data showed that trainees in both the study and control groups had similar improvements in post-test scores. The mean test score of the control group was 9.8 (+/- 1.9) on the pre-test and 10.4 (+/- 1.7) on the post-test (p=0.129) while the study group showed a pre-test mean score of 10.1 (+/-2.8) and a post-test mean score of 10.7 (+/- 1.9) (p=0.118). However, when comparing the scores of the study specific questions, the study group showed a statistically significant improvement. The study group pre-test mean score was 2.8 (+/-1.2) which improved to a post-test mean score of 3.3 (+/- 1) (p=0.018). Survey results showed that most trainees preferred live lectures or a combination of lectures and computer based modules rather than computer training alone. E-learning technology has the potential to augment traditional medical education techniques including knowledge acquisition in pediatric residencies.
POST DISCHARGE PHONE-CALL IMPROVES ASTHMA CARE FOR INNER CITY PEDIATRIC PATIENTS
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Background: Following hospitalization for asthma exacerbations, children with public health insurance are less likely to fill their prescriptions and more likely to utilize the emergency room. Readmission rates for asthma are higher among children on Medicaid, of a racial minority, or in crowded housing conditions and in poverty. Given its significant morbidity, addressing the problem of racial and socioeconomic disparities in asthma outcomes is a priority. Aim: Among patients discharged with a diagnosis of status asthmaticus from an urban hospital inpatient pediatric service, we aimed to 1) increase the rate of initial post discharge primary care provider (PCP) follow up by 25% and; 2) increase the rate of discharge pharmacy adherence by 20% within a 6 month period. Methods: Interventions using the Plan-Do-Study-Act (PDSA) approach, based on the IHI Model for Improvement were implemented. Cycle 1 focused on gathering baseline data on compliance with outpatient PCP appointments and post discharge pharmacy adherence. Cycle 2 involved a phone call by the pediatric resident to the patient’s family at 48hr post discharge. In cycle 3 the pediatric intern made the 48hr post discharge call. During cycle 4 the post discharge phone call was made at 24hr post discharge. Analysis: Baseline data was collected from November 2010 through January 2011. Run charts were used throughout each PDSA cycle, examining outcome measures of 1) percentage of outpatient PCP follow up and; 2) percentage of post discharge pharmacy adherence. Results: Baseline data demonstrated, of all discharged patients, 50% followed up with their PCP and; 43% filled their required prescriptions. At the end of the final iteration of change patient compliance with PCP follow up post discharge improved to 80%; and pharmacy adherence improved to 75%. Conclusion: PCP follow up and adherence to medications are influential factors in the management of pediatric asthma and prevention of hospital readmission; more so in a pediatric population of lower socioeconomic status. This study shows that a post discharge phone call at 24h leads to improved PCP and prescription compliance for this population.
**A QUALITY IMPROVEMENT INITIATIVE TO INCREASE NURSING ATTENDANCE ON PEDIATRIC HOSPITALIST**

**Elena Aragona, MD, Jose Ponce Rios, MD, Priya Garg, MD, Elisabeth Schainker, MD, MSc, Julia Aquino, MD, Floating Hospital for Children at Tufts Medical Center, Boston, MA**

**Background:** The AAP states that family-centered care is built upon collaboration between patients, families, and a multidisciplinary team. Nurses are an integral component of the team but are frequently absent from rounds at our institution.

**Objective:** The aim of our quality improvement project was to increase nursing presence on pediatric hospitalist family centered rounds (FCR) to an attendance rate of 80% in a 5-month period. Design/Methods: This QI project took place on the pediatric ward at an urban academic medical center. In August 2011 a nurse focus group was conducted (n = 10) and an 11 question online survey was sent to pediatric residents, nurses and hospitalist attendings to determine perceptions of FCR and perceived barriers to nurse attendance. Based on survey results, 4 Plan-Do-Study-Act (PDSA) cycles were completed. In the 1st PDSA cycle, interns were asked to call nurses prior to rounding on their patient. In the 2nd PDSA cycle, senior residents called nurses. In the 3rd PDSA cycle, teams rounded on all patients of a given nurse at a time. In the final PDSA cycle, nurses were called 5 minutes prior to rounding on their patient. The initial survey was redistributed to residents, nurses, and hospitalist attendings following completion of the four PDSA cycles to assess if perceptions of FCR have changed since the introduction of these interventions. Results: Between July and November 2011, data was collected during FCR on 461 patients using a standardized collection tool that documents census, attendance and time spent per patient. Our survey response rate was 89%. Focus group and survey results indicated that lack of communication, rounding order and patient care responsibilities can prevent nurses from attending FCR. Our initial nursing participation rate on pediatric hospitalist FCR in late July 2011 was 27%. During our first FCR cycle (mid-August), nurse attendance rose to 31%. During the second FCR cycle (early September), nurse attendance rose to 65%. Average nurse attendance was 58% during both the third and fourth FCR cycles (in late September and late October, respectively). There was no relationship between nurse:patient ratio and nurse attendance on FCR. Results are being compiled from the post-intervention surveys.

**IMPROVING CONTINUITY CARE CLINIC FLOW & EFFICIENCY: A RESIDENT QUALITY IMPROVEMENT PROJECT**

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Continuity care clinics (CCC) provide important longitudinal care experience for pediatric residents; ACGME requires a minimum one half-day CCC session/week for a minimum 36 outpatient clinic weeks/year. In CCC, residents assume responsibility of care for a progressive number of well patients & those with complex/chronic problems on a regular, continuing basis. To develop proficiency in comprehensive care, the flow & efficiency of the clinic experience is vital. As second-year residents, we addressed communication related to immunization ordering/administration in our CCC as a targeted intervention to improve clinic flow & efficiency. A root cause analysis of multiple factors related to increased clinic length of stay (LOS) identified that CCC nurses did not have a definitive indicator of the end of a patient visit. Our aim statement was: The CCC will improve communication between residents & nurses involving patient immunization hand-off, resulting in an average decreased LOS of 10 minutes (defined at time of check-in to time of discharge) within 3 months of the intervention. LOS data was collected from the electronic medical record during pre- & post-intervention periods. Interventions included: 1) Immunization orders left on clipboard in patient room for nurse to collect; 2) immunization orders not placed until attending reviewed; 3) nurses assigned to patient upon review of orders. A histogram graph of LOS duration over time showed mean LOS decreased from 2:15 hours pre-intervention to 1:45 hours post-intervention, with skewing of histogram bars toward a decreased LOS. A control chart of LOS during intervention had a high average LOS of 2:01 hours & a minimum average LOS of 1:45 hours post-intervention, for a total 16 minute decrease in average LOS. Residents learned to understand how nursing processes impact LOS. Focusing on improved resident/nurse communication around immunization ordering & administration allowed LOS to be significantly reduced following this intervention. Continued focus on communication, monitoring of LOS and a continued QI resident project will sustain improvement.

**IMPROVING THE RATE OF VITAMIN D SUPPLEMENTATION IN INFANTS**

**Melissa D. Garganta, MD, April Buchanan, MD, Greenville Hospital Systems, Greenville, SC**

**Introduction:** The 2008 AAP Guidelines for Vitamin D supplementation that all infants consuming less than 1L of Vit D fortified formula daily receive supplementation with at least 400IU of Vit D daily, beginning in the first days of life are not followed in the pediatric clinic. Aim: Measure and demonstrate a medium effect in supplementation of infants taking less than 32oz of formula daily over 6 months. Setting: Resident Pediatric Clinic in Greenville, SC. Patients: 551 Infants seen at the newborn follow up, bilirubin check, wk, and 2, 4, 6, 9 or 12 month well visit. Methods: In PDSA Cycle 1 the rates of supplementation were measured by chart review of 282 visits over a 2 week period. In PDSA Cycle 2, barriers to compliance and MD knowledge of guidelines was determined by administering a questionnaire to physicians. In PDSA Cycle 3 interventions were made by educating physicians on the current guidelines through informative material, posting reminders in physician work areas and adding cues to EMR templates. Rates were again determined by chart review of 269 visits over a 2 week period and compared
to pre-intervention rates. Clinical significance was determined by Yates Chi square and clinical effect size measured by Cohen D method. Results: Prior to the quality improvements 72% of infants were not supplemented and 28% of infants were appropriately supplemented. The most common physician identified barriers to supplementation were physicians forgetting to supplement and physician and parent education of guidelines. Statistically significant improvements in the supplementation rates were observed between all visits (p < 0.0001), particularly in the NB (p < 0.0001), bilirubin check (p < 0.015) and 2 wk old visits (p = 0.0009). The Cohen D effect size is 0.627 for all visits indicating a medium clinical effect and 1.3 for the NB, bilirubin check and 2wk visits indicating a large effect. Conclusions: Interventions from this QI project resulted in clinically significant improvement in AAP guideline compliance. A sampling of charts will be reviewed every 3 months to determine if improvement is sustained with results provided to the residents.

Poster Number 63
BUNDLED CLINIC-BASED INTERVENTION IMPROVED 2-DOSE FLU VACCINE COMPLIANCE
Emily M. McElveen, MD, Daniel Adams, MD, National Capital Consortium, Bethesda, MD

Over 200,000 patients are hospitalized annually for influenza-related illness; kids are more vulnerable than healthy adults. Vaccination is the best prevention. Thus, the CDC recommends annual flu vaccination for all children aged 6 months through 18 years of age, with specific guidance that previously unimmunized children aged 6 months through 8 years should receive a 2-dose vaccine series during their first season of flu vaccination. Prior research demonstrates that while two doses of vaccine decreased the number of office visits for influenza-like illness (ILI), one dose of vaccine had no effect on visits for ILI. Average national compliance with the 2-dose recommendation is less than ideal. A retrospective analysis estimated 37% overall compliance. The aim of this project was to design a clinic-based intervention to improve observance of the 2-dose flu vaccine recommendation for patients less than 2 years of age. The bundled intervention included provider education, reminder cards, and phone call reminders. The provider education session reiterated the flu vaccination recommendations, specifically the 2-dose recommendation. The reminder cards were given to patients’ families at the time of their initial vaccination indicating the need for a second immunization in one month’s time. Finally, families were called at least 1 month after administration of their initial flu vaccine to remind them of the need for a second dose. The E-immune immunization database was used to analyze the 2-dose vaccine compliance rates for patients less than 2 years old who received their first flu vaccine from October 2010 - February 2011. Our clinic population’s compliance initially mirrored the national population at 37.5%. There was a statistically significant improvement in the 2-dose vaccine compliance rate after implementation of the bundled intervention (53.8%, p < 0.005). This process improvement project demonstrated that a clinic based bundled intervention comprised of physician education, reminder notes, and phone follow-up produced a statistically significant improvement in the 2-dose flu vaccine compliance rate for children less than 2 years old.

Poster Number 64
ACCELERATING CSF TO LAB IN NEONATAL FEVER WORKUPS
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Introduction/Objective: To decrease the length of time from trainee signing up to see patient until cerebrospinal fluid (CSF) arrival in lab during septic workups of the febrile infant under 90 days of age. Methods: We undertook a quality improvement project based on the Institute for Healthcare Improvements Model for Improvement, using Plan-Do-Study-Act cycles to achieve rapid improvement in our measures. We implemented a checklist designed to streamline preparation for the LP and remind the user to perform a timeout. A checklist was selected because it would be accepted readily and would be especially useful for trainees, who usually perform the procedure. The primary outcome measure was the number of minutes from trainee assuming care of the patient until the samples were logged as received in lab. Secondary outcomes included whether the checklist was useful to providers and whether a procedural time-out was performed. In cycle 1 the checklist was introduced. In cycle 2, the LP was performed prior to collection of blood and urine samples. Results: The means of the primary outcome during cycles 1 and 2 were 162 minutes and 124 minutes respectively. Time out compliance rate was 75% during cycle 1 and 100% during cycle 2. Providers found the checklist helpful 50% and 63% of the time during cycles 1 and 2 respectively. Conclusions: The time until CSF was received in lab during septic workups of the febrile infant under 90 days of age. A sampling of charts will be reviewed every 3 months to determine if improvement is sustained with results provided to the residents.

Poster Number 65
DECREASING CYCLE TIME IN A MULTI-DISCIPLINARY CLINIC
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BACKGROUND: Multidisciplinary clinics optimize multiple provider-patient interactions, but can cause longer visits. AIM: Decrease total cycle time in a multi-disciplinary clinic by 10% from March-December 2011. METHODS: In a multidisciplinary, resident continuity clinic serving children 0-5 years old at high risk for abuse, nutritionists, social workers, and physicians collaborate to provide comprehensive care. At visits, patients are seen by these 3 providers sequentially. P: Theorized potential causes for long cycle times; D: Created a tool to evaluate barriers; collected data on 3 time periods: time to room, time in room, total time in clinic; S: Implemented evaluation; found the tool successful in increasing provider awareness of patient
Adopted use of tool as a way of tracking patient flow and decreasing “in-room” time; Identified lack of provider communication (while patient in room) as a barrier to decreasing total cycle time; Developed pre-clinic “huddle” to streamline communication and anticipate barriers to patient flow; Tracked patient cycle time; Adopted huddles

RESULTS:

Average time in min (1st, 2nd cycle): time to room (24, 33), time in room (72, 64), total time (95, 88)

CONCLUSIONS: While total time only decreased by 7%, we did see an 11% decrease in time patients spent in a room. This points to the importance of either heightened provider awareness of patient flow or improved communication between providers to help manage cycle time. The 38% increase in time to room was an unanticipated result that may be due to more thoughtful rooming of patients based on provider availability. Further, there may have been differences between cycle 1 and cycle 2 because of resident experience level. Within cycle 2, there was likely greater variability based on higher numbers of residents in clinic or other provider-based factors, given the unchanged time to room. Overall, this has been a positive experience for our clinic—providers appreciated the tracking system as a way to manage flow and improve communication.
ASSOCIATION OF PEDIATRIC PROGRAM DIRECTORS

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Capital View Hotel
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Wednesday evening, October 3

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