2016 Annual Meeting

APPD 2016
Annual Spring Meeting

March 30 - April 2, 2016

Education in the New Era of NAS
(Scales*, Fusion*, Improv*, and all that Jazz*)

*Scales - practice, practice, practice
*Scales - practice, practice, practice
*Improv - innovation
*Fusion - working together
*Jazz - networking in New Orleans!

New Orleans, Louisiana
New Orleans Marriott

*This activity has been approved for AMA PRA Category 1 Credit™
Welcome to the APPD 2016 Annual Spring Meeting in New Orleans!!

We are thrilled to welcome you to New Orleans for EDUCATION IN THE NEW ERA OF NAS: Scales, Fusion, Improv, and all that Jazz! We look forward to lots of learning and lots of fun this spring. The meeting is a collaborative effort among board members, executive committees, task force leaders and members, pediatric educational group leaders and members and a diverse group of APPD members – all of whom we thank profusely. Without your effort, your time and your participation this meeting would not exist.

We are all engaged in the important work of training the next generation of pediatricians to promote the health of children: developing curricula, assessing learners and programs, promoting wellness and resilience, encouraging self-reflection and self-directed learning, providing forums for mentoring, considering ideal ways to select, teach, guide, and launch the pediatric workforce of the future.

This year, our meeting reflects this diversity in the many activities of our membership. We are pleased to present some of our member’s outstanding research, allow you to choose from a large variety of innovative and engaging workshops, as well as attend an outstanding poster session, with a significant contribution by our trainees! Between the sessions, workshops, task force meetings and mini-poster symposia, we challenge you to practice, improve, work together, and create with us!!

We will present the new APPD Strategic Plan: Vision 2020 that charts a course for our organization into the future and will engage all members at multiple levels.

We are so pleased to provide this annual meeting as an opportunity to learn, share and celebrate with our colleagues and friends at APPD!

Dena Hofkosh, MD, MEd
APPD President
Children’s Hospital of Pittsburgh of UPMC

Lynn C Garfunkel, MD
APPD 2016 Annual Spring Meeting Program Chair
University of Rochester and Rochester General Hospital

WiFi Access for Conference Attendees
APPD is pleased to provide Wifi access for all conference attendees in meeting rooms. Please use the following code to log-on: APPD2016

APPD Mobile APP Available
All you need to know about the Annual Meeting is now available on the APPD Mobile APP. For downloading information, please see page 94.
## Schedule-At-A-Glance

### APPD 2016 Annual Spring Meeting
March 30- April 2, 2016
New Orleans, Louisiana

*Detailed program begins on page 12*

### Tuesday, March 29, 2016

<table>
<thead>
<tr>
<th>Time</th>
<th>Event</th>
<th>Location</th>
</tr>
</thead>
<tbody>
<tr>
<td>7:30am-6:00pm</td>
<td>APPD LEAD Meeting <em>(LEAD Cohort Only)</em></td>
<td>Galerie 5</td>
</tr>
<tr>
<td></td>
<td>APPD Board of Directors Meeting</td>
<td>Board Room</td>
</tr>
</tbody>
</table>

### Wednesday, March 30, 2016

<table>
<thead>
<tr>
<th>Time</th>
<th>Event</th>
<th>Location</th>
</tr>
</thead>
<tbody>
<tr>
<td>7:30am-11:30am</td>
<td>APPD LEAD Meeting <em>(LEAD Cohort Only)</em></td>
<td>Studio 2</td>
</tr>
<tr>
<td>8:00am-5:30pm</td>
<td>Forum for Chief Residents</td>
<td>Bissonet</td>
</tr>
<tr>
<td>9:30am-11:30am</td>
<td>Forum for Directors of Small Programs and Affiliate Chairs</td>
<td>Studio 9-10</td>
</tr>
<tr>
<td></td>
<td>Fellowship Program Directors’ Session</td>
<td>Balcony I K</td>
</tr>
<tr>
<td>9:30am-5:00pm</td>
<td>Coordinators’ Session <em>(lunch on your own)</em></td>
<td>Acadia</td>
</tr>
<tr>
<td>11:00am-12:30pm</td>
<td>Lunch on your own</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Council of Regional Chairs Lunch Meeting</td>
<td>Studio 7</td>
</tr>
<tr>
<td></td>
<td>Council of Task Force Chairs Lunch Meeting</td>
<td>Studio 1</td>
</tr>
<tr>
<td>11:30am-1:00pm</td>
<td>Share Warehouse Editorial Group Lunch Meeting</td>
<td>Studio 6</td>
</tr>
<tr>
<td>12:45pm-3:45pm</td>
<td>PMAC/APPD LEARN Talking Poster Session</td>
<td>Carondelet</td>
</tr>
<tr>
<td>4:00pm-6:00pm</td>
<td>Grassroots Forum for Associate Program Directors</td>
<td>Galerie 5-6</td>
</tr>
<tr>
<td></td>
<td>Grassroots Forum for Fellowship Program Directors</td>
<td>Balcony I K</td>
</tr>
<tr>
<td></td>
<td>Grassroots Forum for Program Directors</td>
<td>Galerie 2-3</td>
</tr>
<tr>
<td>6:00pm-7:00pm</td>
<td>Networking Reception</td>
<td>Carondelet</td>
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### Thursday, March 31, 2016

<table>
<thead>
<tr>
<th>Time</th>
<th>Event</th>
<th>Location</th>
</tr>
</thead>
<tbody>
<tr>
<td>7:00am-8:30am</td>
<td>Continental Breakfast</td>
<td>Acadia Foyer</td>
</tr>
<tr>
<td></td>
<td>Task Force Meetings</td>
<td>see pages 15</td>
</tr>
<tr>
<td>8:45am-10:00am</td>
<td>APPD Members Meeting; Awards and Annual Reports</td>
<td>Acadia / Bissonet</td>
</tr>
<tr>
<td>10:15am-11:45am</td>
<td>Special Interest Symposia</td>
<td>see pages 16-17</td>
</tr>
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### Schedule-At-A-Glance

<table>
<thead>
<tr>
<th>Time</th>
<th>Event</th>
<th>Location</th>
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<tbody>
<tr>
<td>12:00pm-1:30pm</td>
<td>Platform Presentations with boxed lunch</td>
<td></td>
</tr>
<tr>
<td>2:00pm-2:45pm</td>
<td>Presidential Address</td>
<td>Acadia / Bissonet</td>
</tr>
<tr>
<td>2:55pm-4:05pm</td>
<td>Special Invited Speakers</td>
<td>Acadia / Bissonet</td>
</tr>
<tr>
<td>4:10pm-5:15pm</td>
<td>Key Stakeholders Session</td>
<td>Acadia / Bissonet</td>
</tr>
<tr>
<td>5:30pm-7:00pm</td>
<td>Faculty Mentoring Session (closed session; pre-registration required)</td>
<td>Galerie 6</td>
</tr>
<tr>
<td>6:30pm-7:30pm</td>
<td>APPD LEAD Reunion (graduates only)</td>
<td>St. Charles</td>
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**Friday, April 1, 2016**

<table>
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<tr>
<th>Time</th>
<th>Event</th>
<th>Location</th>
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<tbody>
<tr>
<td>7:00am-8:30am</td>
<td>Regional Breakfast Meetings</td>
<td>see page 20</td>
</tr>
<tr>
<td>9:00am-11:00am</td>
<td>Workshop Session 1</td>
<td>see pages 20-23</td>
</tr>
<tr>
<td>11:00am-1:00pm</td>
<td>Lunch On Your Own (please stop by to visit the Posters in Acadia / Bissonet)</td>
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<tr>
<td>1:15pm-3:15pm</td>
<td>Workshop Session 2</td>
<td>see pages 24-27</td>
</tr>
<tr>
<td>3:30pm-5:30pm</td>
<td>Poster Session (posters will be on display 10:00am-5:30pm)</td>
<td>Acadia / Bissonet</td>
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**Saturday, April 2, 2016**

<table>
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<tr>
<th>Time</th>
<th>Event</th>
<th>Location</th>
</tr>
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<tbody>
<tr>
<td>7:00am-8:30am</td>
<td>Continental Breakfast</td>
<td>Acadia</td>
</tr>
<tr>
<td></td>
<td>Pediatric Education Group (PEG) Meetings</td>
<td>see page 27</td>
</tr>
<tr>
<td>8:45am-10:15am</td>
<td>Workshop Session 3</td>
<td>see pages 27-31</td>
</tr>
<tr>
<td>10:30am-12:00pm</td>
<td>Workshop Session 4</td>
<td>see pages 31-34</td>
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CME Information

Accreditation Statement
This activity has been planned and implemented in accordance with the accreditation requirements and policies of the Accreditation Council for Continuing Medical Education (ACCME) through the joint providership of Amedco and the Association of Pediatric Program Directors (APPD). Amedco is accredited by the ACCME to provide continuing medical education for physicians.

Credit Designation Statement
Amedco designates this live activity for a maximum of 23.0 AMA PRA Category 1 Credits™. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

<table>
<thead>
<tr>
<th>Session Time</th>
<th>Session Title</th>
<th>Credit Hours</th>
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<tbody>
<tr>
<td>Wednesday, March 30-7 hours</td>
<td>9:30am-11:30am Forum for Directors of Small Programs and Affiliate Chairs</td>
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<td></td>
<td>Fellowship Program Directors' Session</td>
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<tr>
<td></td>
<td>12:45pm-3:45pm PMAC/APPD LEARN Talking Poster Session</td>
<td>3.0</td>
</tr>
<tr>
<td></td>
<td>4:00pm-6:00pm Grassroots Forum for APDs</td>
<td>2.0</td>
</tr>
<tr>
<td></td>
<td>Grassroots Forum for FPDs</td>
<td>2.0</td>
</tr>
<tr>
<td></td>
<td>Grassroots Forum for PDs</td>
<td>2.0</td>
</tr>
<tr>
<td>Thursday, March 31-7.5 hours</td>
<td>10:15am-11:45am Special Interest Symposia</td>
<td>1.5</td>
</tr>
<tr>
<td></td>
<td>12:00pm-1:30pm Platform Presentations with boxed lunch</td>
<td>1.5</td>
</tr>
<tr>
<td></td>
<td>2:00pm-2:30pm Presidential Address</td>
<td>0.5</td>
</tr>
<tr>
<td></td>
<td>2:40pm-5:15pm Key Stakeholders Session</td>
<td>2.5</td>
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<tr>
<td></td>
<td>5:30pm-7:00pm Faculty Mentoring Session</td>
<td>1.5</td>
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<tr>
<td>Friday, April 1-4.0 hours</td>
<td>9:00am-11:00am Workshop Session 1</td>
<td>2.0</td>
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<tr>
<td></td>
<td>1:15pm-3:15pm Workshop Session 2</td>
<td>2.0</td>
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<tr>
<td>Saturday, April 2-4.5 hours</td>
<td>7:00am-8:30am PEG Meetings</td>
<td>1.5</td>
</tr>
<tr>
<td></td>
<td>8:45am-10:15am Workshop Session 3</td>
<td>1.5</td>
</tr>
<tr>
<td></td>
<td>10:30am-12:00pm Workshop Session 4</td>
<td>1.5</td>
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</table>

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

**APPD Patron ($1000 or more)**
- Patricia Hicks, MD, MHPE
- R. Franklin Trimm, MD

**APPD Sponsor ($500-$999)**
- Dena Hofkosh, MD, MEd
- Shilpa J. Patel, MD

**APPD Supporter ($250-$499)**
- Susan Bostwick, MD
- Carol D. Berkowitz, MD
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- Tammy Camp, MD
- Paulo Pina, MD
- Adam Rosenburg, MD
- Teri Turner, MD, MPH, MEd

**APPD Friend (up to $249)**
- Paul Cooper, MD
- Ketan Kansagra, MD
- Charlene Larson Rotandi, AB, AA
- Henry A. Schaeffer, MD
- Daniel J. Schumacher, MD, MEd
- Nevin W. Wilson, MD
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*Duke University Medical Center*

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*Albany Medical Center*

Michelle Brooks (2015-2018)  
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Pamela Carpenter C-TAGME (2014 - 2017)  
*University of Utah*

Teresa Hudson, C-TAGME (2013-2016)  
*St. Louis University*

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*University of Washington/Seattle Children’s*

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Chair-Elect (2015-2016) / Chair (2016-2017)  
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*Oregon Health and Science University*

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*Vanderbilt University School of Medicine*

*Children's Mercy Hospital*

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Katherine Mason, MD (2015-2018)  
*Rainbow Babies & Children's Hospital*

Kathleen McGann, MD (2013-2017)  
*Duke University Medical Center*

Pnina Weiss, MD (2013-2016)  
*Yale University School of Medicine*
APPD 2016 Annual Meeting Program Committee

Executive Planning Committee

Lynn C. Garfunkel, MD, Program Chair
University of Rochester/Rochester General Hospital

Cynthia Ferrell, MD, MSEd, Program Co-Chair
Oregon Health Science University

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

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Vanderbilt University School of Medicine

Charlene Larson Rotandi, AB, AA
Stanford University

Daniel J. Schumacher, MD, MEd
Cincinnati Children’s Hospital Medical Center

Program Committee Members

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Rainbow Babies & Children’s Hospital

Andrea Asnes, MD
Yale School of Medicine

Michelle Barnes, MD
University of Illinois at Chicago

Elizabeth Braunlin, MD, PhD
University of Minnesota

Michelle Brooks
Stanford University – Lucile Packard Children’s Hospital

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University of Utah, Primary Children’s Medical Center

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University of Utah, Primary Children’s Hospital

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University of Louisville School of Medicine

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Alston (Trey) Dunbar, III, MD, MBA
Our Lady of the Lake Regional Medical Center

Mackenzie Frost, MD
UT Southwestern/Children’s Medical Center

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Bruce Herman, MD
University of Utah Pediatric Residency Program

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Troy Johnston, MD
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The Brookdale Hospital & Medical Center

Jodi Leonard
Oregon Health Sciences University

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Renuka Mehta, MBBS
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Heather Peters, MD
Valley Children’s Healthcare

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Michael Pitt, MD
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Caroline Rassbach, MD
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Stanford University School of Medicine

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St. Louis University/SSM Cardinal Glennon Children’s Hospital

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Cincinnati Children’s Hospital Medical Center

Daniel Sklansky, MD
University of Wisconsin

Mark Vining, MD
University of Massachusetts Memorial Medical Center

Anne Warwick, MD, MPH
USUHS, Department of Pediatrics
APPD Regions

In addition to the national organization, pediatric programs in APPD are divided into regions. These regional groups have leadership opportunities, meetings, and activities which are a vital part of the APPD. All attendees are welcome to attend Regional Breakfast Meetings on Friday from 7:00-8:30am (see page 20 for location of your region’s meeting).

www.appd.org/activities/regions.cfm

APPD Council of Regional Chairs

CoRC Chair
Program Director, Albert Einstein College of Medicine, Jacobi Medical Center
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Mid-America Region
Kimberly Boland, MD (2015 - 2018)
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Pediatric Residency Program Coordinator
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Western Region
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Western Region
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Vanderbilt University Medical Center
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W. Michael Southgate, MD (2013 - 2016)
Pediatric Residency Program Director, Medical University of SC
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Join an APPD Task Force!

- Task Force meetings will be held on Thursday, March 30 from 7:00-8:30am. Grab your breakfast and see what the task forces are all about (see page 15 for room locations). All are welcome! www.appd.org/activities/taskforce.cfm

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

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

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

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

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

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

  *Assessment Task Force:
  - Mark Vining, MD, Chair (2015-2017)
    *University of Massachusetts
  - Carrie Rassbach, Vice Chair (2015-2017)
    *Stanford University

  *Curriculum Task Force:
  - Rebecca Blankenburg, MD, MPH, Chair (2013-2016)
    *Stanford University
  - Helen Barrett Fromme, MD, MHPE
    *Vice Chair (2013-2016)/ Chair (2016-2018)
    *University of Chicago

  *Learning Technology Task Force:
  - Emily Borman-Shoap, MD, Chair (2015-2017)
    *University of Minnesota
  - Pamela Carpenter, C-TAGME
    *Vice Chair (2015-2017)
    *University of Utah

  *Research and Scholarship Task Force:
  - Su-Ting T. Li, MD, MPH, Chair (2015-2017)
    *University of California (Davis) Health System
  - Erika Abramson, MD, Vice Chair (2015-2017)
    *New York Presbyterian - Weill Cornell
Join an APPD Pediatric Education Group!

APPD Pediatric Education Groups (PEGs) were created as an avenue for APPD members to collaborate and communicate with others who share a common area of interest. Meetings will be held on Saturday, April 2 from 7:00am-8:30am. See page 27 for room locations.

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

LESBIAN-GAY-BISEXUAL-TRANSGENDER-QUEER/QUESTIONING-ALLY (LGBTQA) PEG
- The LGBTQA (Lesbian-Gay-Bisexual-Transgender-Queer/Questioning-Ally) Pediatric Education Group is working on two aspects of LGBTQ well being. The first goal is addressing education of future pediatricians about LGBTQ health concerns. The second set of goals focuses on promoting a safe and inclusive work environment for LGBTQ residents and staff. Workgroups focus on each of these areas. The PEG has identified a number of inclusive strategies to incorporate when recruiting and interviewing residency applicants. Both workgroups are working on a needs assessment to identify current curriculum and training in LGBTQ health and the perceived safety and supportiveness of workplace environments. The results of this needs assessment will be used to develop and prioritize next steps for the PEG. Participation in the LGBTQA PEG is open to all members. We invite you to join us and participate in addressing the group goals.
  - Michelle Brooks, Co-Leader
  - Brian Lurie, MD, Co-Leader

UNDER REPRESENTED MINORITIES IN PEDIATRIC GRADUATE MEDICAL EDUCATION PEG
- Pediatric program directors are in a unique position to recruit and mentor underrepresented minority (URM) house staff. As well, it is critical for program directors to provide instruction regarding culturally effective healthcare and support a training environment that reflects the diversity of their patient population. Therefore the URM in Pediatric GME PEG aims to foster diversity in pediatric GME through addressing recruitment, mentorship, and support of URM pediatric housestaff, designing tools for program directors to support diversity, and cataloging pediatric-specific curricula which address healthcare disparities and cultural competency. We welcome all interested members of the APPD to join us in addressing these goals through participation in the URM in Pediatric GME PEG.
  - Aisha B. Davis, MD, Co-Leader
  - Patricia Poitevien, MD, MSc, Co-Leader

HEALTHCARE SIMULATION IN PEDIATRICS PEG
- The Healthcare Simulation in Pediatrics PEG has an overall goal of exploring, disseminating and sharing simulation methods used in healthcare to teach and assess these skills in pediatric residents and fellows: • Procedural Skills; • Resuscitation Skills; • Communication Skills; • Exam Skills; • Data gathering and emotion handling skills; • Teamwork and interprofessional skills. We will accomplish this by working collaboratively to develop simulation cases and curricular materials that can be shared, particularly around milestones, teamwork, and procedures. We will work with the Society for Simulation in Healthcare in the efforts to standardize simulation terminology, as well as collaborating with simulation research networks on projects. Participation in the Simulation in Healthcare PEG is open to all members. We hope you will join us and participate in our efforts.
  - Sharon Calaman, MD, Co-Leader
  - Ariel Frey-Vogel, MD, Co-Leader
APPD Share Warehouse

The APPD Share Warehouse is a unique opportunity for members to collectively share and use content that supports the mission of pediatric residency education. The APPD Share Warehouse is a virtual, web-based, collaborative project that provides a place for APPD members to browse, search, use, and share resources, including policies, curricula and evaluation tools. Learners, leaders, and all team members may benefit from a rich repository of information and practical applications for our diverse needs.

The APPD Share Warehouse is emblematic of our community of members: innovative, collaborative, and scholarly. Learning together from our shared work cultivates great new solutions and ignites innovation. Sharing and networking in this virtual space can foster new partnerships and collaboration. Members may share their work and report its use as part of their portfolio of scholarship.

Share Warehouse Design and Editorial Team

Abhay Dandekar, MD
Share Warehouse Team Leader
Kaiser Permanente Northern California

Alan Chin, MD
University of California-Los Angeles

Ashweena Gonuguntla, MD
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Tara McKinley, MA
University of Louisville

Michelle Miner, MD
Southern Illinois University

Brad Olson, MD
SUNY Upstate

Sydney Primis, MD
Carolinas Medical Center - Levine Childrens' Hospital

Visit the APPD SHAREWAREHOUSE at www.appd.org/sharewarehouse

Association of Pediatric Program Directors
“Innovation, Collaboration, Communication, Scholarship”
APPD LEAD
APPD Leadership in Educational Academic Development
(APPD LEAD)

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

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

A call for applicants for Cohort 5 is underway. The deadline for applications for this group is April 30, 2016. Visit www.appd.org/ed_res/LEAD.cfm for details. For more information about LEAD, look for the APPD LEAD poster near the registration area, during the Poster Session on Friday, and on page 97 of this program.

LEAD Council Members / Faculty
Susan Bostwick, MD, MBA, Chair
New York Presbyterian Hospital/Cornell Campus

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

John Frohna, MD, MPH
University of Wisconsin

Hilary Haftel, MD, MHPE
University of Michigan

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

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

Rebecca Swan, MD
Vanderbilt University School of Medicine

Linda Waggoner-Fountain, MD, MEd
University of Virginia

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

Andrea Asnes, MD
Yale-New Haven Medical Center
What drives the delivery of high quality pediatric resident education by a sub-specialty service? A quality improvement project in the section of pediatric cardiology

Michelle Barajaz, MD
BCM/Children’s Hospital of San Antonio
If you build it, will they come? Candidate attitudes towards new residency programs

Michelle Barnes, MD
University of Illinois at Chicago
Community Pediatrics and Advocacy Training
Collaborative: Developing a Roadmap for the Future

Emily Borman-Shoap, MD
University of Minnesota
It’s Time for a PEP Talk: Implementing Personal Engagement Plans for Pediatric Residents

Cynthia Chang, MD
Staten Island University Hospital
Implementation of a Childhood Obesity Intervention as a Pediatric Resident Community Outreach Project

Robert Dabrow, MD
Florida Hospital Medical Center Ped Residency
Creating a dedicated block for simulation/procedural (SIM) experiences. Lessons learned for program implementation

Roberta Kato, MD
Children’s Hospital of Los Angeles
Objective Metrics for Flexible Bronchoscopy Competency

Teresa Lemma, MD
Richmond University Medical Center
The effect of pediatric board preparation on ITE scores
Alisa McQueen, MD
University of Chicago Medicine
*Truth is Stranger than Fiction: pediatric residents’ communications skills with simulated vs. actual patients*

Monique Naifeh, MD
Oklahoma University Health Sciences Center
*The Effect of Mindset in Performance and Burnout in Graduate Medical Education*

Sue Poynter Wong, MD
Cincinnati Children’s Hospital Medical Center
*Implementation of a Novel Assessment Tool Using Observable Practice Activities Mapped to the Pediatric Milestones*

Jerri M. Rose, MD
Rainbow Babies & Children’s Hospital
*A Survey Study to Inform Development of a Curriculum Related to Child Poverty and Social Determinants of Health for Pediatric Emergency Medicine Fellows*

Ramzan Shahid, MD
Loyola University Medical Center
*Emotional Intelligence in Peds and Med-Peds Residents*

Amy Stier, MD, MME
University of Iowa -Children's Hospital
*Resident Debriefing – A Needs Assessment*

Ronald Sutsko, MD
University of South Florida
*Are Pediatric Residents Adequately Prepared by their Residency to Enter Neonatal-Perinatal Medicine Fellowship Programs*

Rebecca Wallihan, MD
Nationwide Children’s Hospital/Ohio State University
*Resident Research Training: A Novel Approach to the Needs Assessment*

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**APPD LEARN**

*LONGITUDINAL EDUCATIONAL ASSESSMENT RESEARCH NETWORK*

APPD LEARN is APPD’s research network, open to all member programs, with over 130 currently participating. During the past year, APPD LEARN has helped initiate new studies on CCC member milestone judgments (Schumacher, PI), scholarly activity during residency (Abramson, PI), and resilience and burnout (Mahan and Batra, PIs). In addition, APPD LEARN has several active collaborative studies, including the Pediatrics Milestones Assessment Collaborative (with the American Board of Pediatrics and National Board of Medical Examiners) and assessment of the relationships between entrustable professional activities and milestones in the Pediatric subspecialties (with the Council of Pediatric Subspecialties, the American Board of Pediatrics, and the new Subspecialty Pediatrics Investigator Network) and in general Pediatrics (with the American Board of Pediatrics). We will be holding a special joint PMAC/APPD LEARN talking poster session at the meeting showcasing some of the ongoing work. Please visit with us during the meeting to learn more about your educational research network and how you can become involved!

Alan Schwartz, PhD, APPD LEARN Director
Beth King, APPD LEARN Program Manager
Marina Seyon, APPD LEARN Program Assistant

APPD LEARN has its own web site at http://learn.appd.org
APPD MEETING SCHEDULE

Tuesday, March 29

7:30am-6:00pm
APPD LEAD Meeting (LEAD Cohort only)
Galerie 5

APPD Board of Directors Meeting
Board Room

Wednesday, March 30

7:30am-11:30am
APPD LEAD Meeting (LEAD Cohort only)
Studio 2

8:00am - 5:30pm
Forum for Chief Residents (Breakfast and Lunch will be included)
Bissonet

Blair Dickinson, MD, MS, Associate Residency Program Director, St. Christopher’s Hospital for Children, Jay Homme, MD, Residency Program Director, Mayo Clinic, Edwin Zalneraitis, MD, Residency Program Director, University of Connecticut, and the Chief Resident Forum Planning Committee (Megan Aylor, MD, Associate Residency Program Director, Oregon Health & Science University, Erin Giudice, MD, Residency Program Director, University of Maryland Children’s Hospital, Sophia Goslings, MD, Associate Residency Program Director, University of South Alabama, Ross Myers, MD, Associate Residency Program Director, UH Rainbow Babies & Children’s Hospital, Maria Ramundo, MD, Residency Program Director, Akron Children’s Hospital, Glenn Rosenbluth, MD, Associate Residency Program Director, University of California, San Francisco, Ana Creo, MD, Chief Resident, Mayo Clinic, Daria Ferro, MD, Rita Guevara-Dohmen, MD, and Sophie Katz, MD, Chief Residents, St. Christopher’s Hospital for Children, Valerie Gribben, MD, Taylor Louden, MD, and Jaime Peterson, MD, Chief Residents, Lucile Packard Children’s Hospital - Stanford, Patti Jo Jaiyeola, MD, and Nicole Mallory, MD, Chief Residents, University of California, San Francisco, Ashley Nor, MD, Chief Resident, Akron Children’s Hospital, Lisa Pomeroy, MD, Chief Resident, University of Connecticut, Ashley Nord, MD, Chief Resident, Akron Children’s Hospital, Lisa Pomeroy, MD, Chief Resident, Texas Tech University Health Sciences Center, James van Buren, MD, Chief Resident, University of South Alabama)

Rising Chief Residents and Graduating Chief Residents are invited to attend this forum! Chief Residents face a diverse set of challenges in academic medical centers related to the multiple roles that they assume as leaders, clinicians, educators, administrators, faculty-resident liaisons, and mentors. Chief Residents can position themselves for success by developing leadership and administrative skill sets in advance of the position. The APPD’s Forum for Chief Residents is a series of educational sessions designed to help residents learn key administrative, academic, and leadership skills in order to facilitate a productive and fulfilling year as a Chief Resident, and to be able to use the Chief Resident year for enhancing success in subsequent years. This one-day forum will include a variety of interactive workshops led by experienced program directors and current Chief Residents to address these administrative, academic, and leadership topics relevant to Chief Residents. There will be opportunities to network with current and rising Chief Residents from around the country. Components of the day will be focused to the rising Chief Residents and graduating Chief Residents to acknowledge the differences in their perspectives and needs.
Forum for Chief Residents (detailed schedule)
7:30 – 8:00  Breakfast  Blair Dickinson, MD, MS, Jay Homme, MD  Co-Chairs, Chief Resident Forum Planning Committee
8:00 – 8:15  Welcome and Introductions  Blair Dickinson, MD, MS, Jay Homme, MD  Co-Chairs, Chief Resident Forum Planning Committee
8:15 – 9:30  Fear Factor  Chief Residents: Patti Jo Jaiyeola, MD, Ashley Nord, MD, Lisa Pomeroy, MD  Faculty: Sophia Goslings, MD, Ross Myers, MD, Maria Ramundo, MD
9:30 – 9:45  Break
9:45 – 10:45  Residents Experiencing Difficulty  Chief Residents: Matthew Kiel, MD, Nicole Mallory, MD, Lisa Pomeroy, MD, Christine Pulice, DO  Faculty: Erin Giudice, MD, Sophia Goslings, MD, Ed Zalneraitis, MD
10:45 – 12:15  Speed Chiefing  Chief Residents: Daria Ferro, MD, Rita Guevara-Dohmen, MD, Patti Jo Jaiyeola, MD, Sophie Katz, MD, James van Buren, MD  Faculty: Blair Dickinson, MD, MS
12:15 – 1:00  Lunch (Seating by APPD Region)

RISING CHIEF RESIDENT TRACK  Bissonet
1:15 – 2:30  Not Your Typical Morning Report  Chief Residents: Daria Ferro, MD, Rita Guevara-Dohmen, MD, Valerie Gribben, MD, Taylor Louden, MD, Sophie Katz, MD, Jaime Peterson, MD  Faculty: Blair Dickinson, MD, MS
2:30 – 2:45  Break
2:45 – 3:30  Planning the Chief Resident Year  Chief Residents: Ana Creo, MD, Wallis Molchen, DO, Christine Pulice, DO  Faculty: Erin Giudice, MD, Ed Zalneraitis, MD

GRADUATING CHIEF RESIDENT TRACK  Studio 3-4-5
1:15 – 2:15  Debriefing the Chief Year  Jay Homme, MD, Ross Myers, MD, Glenn Rosenbluth, MD
2:15 – 2:30  Break
2:30 – 3:30  Professional Development Planning and Mentoring  Chief Resident: Ashley Nord, MD  Faculty: Megan Aylor, MD, Maria Ramundo, MD
3:30 – 3:45  Break
3:45 – 4:30  “Show Your Best” Graduating Chief Resident Presentations  Bissonet  Platform Presentations
“Milestone of the Week: An educational innovation”  Gabriella Bluett-Mills, MD, MPH, and Margaret P. Huntwork, MD, MSEd, Chief Residents, Tulane/Ochsner
“A Unique, Multifaceted, Longitudinal Wellness Curriculum”  Julie Sanville, DO, and Anne Hanley, DO, Chief Residents, Baystate Medical Center/Tufts University School of Medicine
“Incentive Plans Help Engage Residents in Institutional Quality and Safety Initiatives”  Meg Kirkley, MD, MPH, Olivia Hoffman, MD, and Danielle Arnold, MD, Chief Residents, University of Colorado

Abbreviated Platform Presentations
“Productive Pumping! Helping Trainees Increase Clinical Time’’  Ana L. Creo, MD, and Heather N. Anderson, MD, Chief Residents, Mayo Clinic
“Chief Rounds: Didactics for Millennials’’  Luke Shieh, MD, Catherine Polak, MD, and Beth Ann Papas, MD, Chief Residents, Children’s Hospital of Pittsburgh of UPMC
“The PICU Passport: An Innovative Approach to Streamlining Pediatric Resident Learning in the PICU”  Dan McKeone, MD, and Adil Solaiman, MD, Chief Residents, Penn State Children’s Hospital
4:30 – 5:00  The Chief Handoff  Jay Homme, MD
5:00 – 5:15  Top 10 Great Things About Chief Year  Ross Myers, MD
5:15 – 5:30  Wrap – Up and Evaluations  Blair Dickinson, MD, MS, and Jay Homme, MD
Thursday, March 31

9:30am-11:30am  Forum for Directors of Small Programs and Affiliate Chairs  
**Studio 9-10**

Abhay Dandekar, MD, Kaiser Permanente Northern California and Keith Mather, MD, University of Oklahoma School of Community Medicine (Tulsa)

“Small programs” have been traditionally defined as having 10 or less residents per year. However, many programs consider themselves “small” as compared to other larger programs in their vicinity. This forum will highlight the experiences, successes, and challenges facing program directors to effectively educate and manage in these environments. The discussion will aim to stress best practices and cultivate collaboration and group solutions. No numeric cutoff is necessary and any program that feels they may benefit from participating is welcome to attend.

9:30am-11:30am  Fellowship Program Directors’ Session  
**Balcony 1-K**

The 2 hour session will be divided into two small workshops including a Fellow Leadership Curriculum and the Approach to the Difficult Learner. Leaders: APPD Fellowship Directors’ Executive Committee / Geoffrey Fleming, MD, Bruce Herman, MD, Angela Myers, MD, MPH, Kathleen McGann, MD, Pnina Weiss, MD, Kathy Mason, MD

9:30am-5:00pm  Coordinators’ Session (lunch on your own)  
**Acadia**

9:30-9:45am  Welcome and Introductions of the Coordinators Executive Committee

9:45-11:30am  Coordinator Workshop: COLLABORATION DRIVES INNOVATION: WHY TEAMWORK IS CRITICAL IN THE NEW ERA OF NAS  
Charlene Larson Rotandi, Megan Christofferson, Susan Freeman Ike, and Meghan Stawitcke, Stanford University, Palo Alto, CA

Many programs are struggling to understand and implement all the new requirements of the Next Accreditation System (NAS). Program coordinators have an opportunity to collaborate with their programs on innovative ways to meet these needs. In fact, innovation is a critical part of NAS, as programs that report high-quality outcomes are expected to innovate beyond standard processes. The workshop will provide background on NAS and its impact on programs, and help program coordinators identify opportunities for collaboration to drive innovation in their own programs.

11:30-12:15pm  Mentoring Session

12:15-12:30pm  Coordinators’ Group Photo  
This time-honored tradition continues! Please listen for details about location during coordinator morning sessions.

12:30-2:00pm  Lunch On Your Own

2:00-2:45pm  ERAS Demo and Update

3:00-5:00pm  Coordinator Table Talks  
This forum, introduced in 2014, will again be an opportunity for coordinators to hear information on topics of interest based on recent feedback. Participants will move from table to table in a “speed dating” format in this highly interactive format. Table Talks topics may include the following: ERAS, FSMB, AAP, ABP, MedHub, New Innovations, E*Value, Mentoring and Leadership, Utilizing Technology and the APPD ShareWarehouse, APPD Coordinators’ Executive Committee, Fellowship Best Practices, Residency Best Practices, Essentials for the New Coordinator and Prioritizing Your Day, Scholarly Activity, Preparing and Submitting an Abstract, and Coordinator Wellness.

11:00am - 12:30pm  Lunch on Your Own

Council of Regional Chairs Lunch Meeting  
**Studio 7**

Council of Task Force Chairs Lunch Meeting  
**Studio 1**
Thursday, March 31

11:30am-1:00pm Share Warehouse Editorial Group Lunch Meeting
  
  **Studio 6**

12:45pm - 3:45pm PMAC/APPD LEARN Talking Poster Session
  
  **Carondelet**

Programs participating in the Pediatrics Milestones Assessment Collaborative data collection will present scholarship focused on the PMAC processes and outcomes at their programs, and APPD LEARN investigators will present updates from their studies. The session will open with a general orientation to PMAC and APPD LEARN data collection efforts by PMAC Director Patricia Hicks, MD, MHPE and APPD LEARN Director Alan Schwartz, PhD. Attendees may then visit posters and discuss the work with participating programs. Each program will then make a brief oral presentation of their findings and respond to questions. Finally, Stanley Hamstra, PhD, Vice President for Milestone Research and Evaluation at ACGME, will offer reflections and concluding comments. Everyone is encouraged to attend.

4:00pm - 6:00pm Grassroots Forum for Associate Program Directors
  
  **Galerie 5-6**

The Forum for Associate Program Directors will review timely and important topics of interest to the APD and will discuss organizational and career development needs specific to our group. We invite you to bring your ideas and questions to this energetic group session to add to our discussion. Leaders: Drs. Sue Poynter (University of Cincinnati), Michelle Barnes (University of Illinois-Chicago), and Rhett Lieberman (UPMC Medical Education).

4:00pm - 6:00pm Grassroots Forum for Fellowship Program Directors
  
  **Balcony I-K**

This moderated open forum is designed specifically for subspecialty fellowship directors and coordinators to discuss a variety of current trends in fellowship education. We anticipate your active participation. Registrants may be surveyed prior to meeting to identify potential topics of interest. Leaders: APPD Fellowship Directors’ Executive Committee / Geoffrey Fleming, MD, Bruce Herman, MD, Angela Myers, MD, MPH, Kathleen McGann, MD, Pnina Weiss, MD, and Kathy Mason, MD.

6:00pm - 7:00pm Networking Reception
  
  **Carondelet**

Thursday, March 31

7:00am-8:30am Continental Breakfast
  
  **Acadia Foyer**

Task Force Meetings
(visit www.appd.org/activities/taskforce.cfm for Task Force descriptions)

  - Assessment Task Force **Galerie 4-5**
  - Curriculum Task Force **Carondelet**
  - Faculty and Professional Development Task Force **Galerie 1-2**
  - Learning Technology Task Force **Studio 3-4-5**
  - Research and Scholarship Task Force **Studio 7-8**
7:30am-8:30am  APPD Members’ Meeting: Awards and Annual Reports

**Acadia/Bissonet**
Welcome and Updates on Executive Committees, Task Forces, Regions (CoRC), Pediatric Education Groups (PEGs) and APPD Strategic Plan: Vision 2020 – Dena Hofkosh, MD, MEd, APPD President

**Project Updates**
- Pediatric Fellowship Start Date – Richard Mink, MD, MACM
- APPD ShareWarehouse – Abhay Dandekar, MD
- APPD LEARN – Alan Schwartz, PhD, APPD LEARN Director
- APPD View Pages – Robert Vinci, MD, Associate Editor, APPD
- Treasurer’s Report – Javier Gonzalez del Rey, MD, MEd, APPD Secretary/Treasurer
- Special Project Grants – Javier Gonzalez Del Rey, MD, MEd
- Election Results – Patricia Hicks, MD, MHPE, APPD Past President
- Farewell to Exiting Leaders – Dena Hofkosh, MD, MEd
- Thank You to Program Chair – Dena Hofkosh, MD, MEd

Research, QI and Trainee Research Awards – Lynn Garfunkel, MD, 2016 Program Chair
- Holm Award and Acceptance – Patricia Hicks, MD, MHPE
- Tunnessen Award and Acceptance – Patricia Hicks, MD, MHPE
- Berkowitz Award and Acceptance – Patricia Hicks, MD, MHPE
- APPD LEAD Graduation – Susan Bostwick, MD, APPD LEAD Council Chair

10:15am-11:45am  Special Interest Symposia

**Assessment Task Force**  **Galerie 4-5-6**
The APPD Assessment Task Force will host a 2nd Annual Mini Poster Symposium. We hope to build on the success of our similar session last spring, where program assessment innovations ranging from direct observation, CCC efficiency, web-based milestone mapping, evaluation of faculty, and simulation evaluation are among the diverse topics presented. The format of the session will be as roundtable discussions to allow for demonstration of specific, unique assessment tools or practices.

**Curriculum Task Force**  **Carondelet**
The APPD Curriculum Task Force, hosting a mini poster symposium for the third year, will focus on curricular needs identified by the membership, specifically (1) wellness, (2) business of medicine or (3) population health (healthcare disparities, ACOs, clinical practice effectiveness, medical home, etc). Presentations will include a description of the curriculum, including goals and objectives, educational activities, assessment and evaluation.

**Faculty & Professional Development Task Force**  **Galerie 4-5-6**
This session, hosted by the APPD Faculty & Professional Development Task Force, will give accepted abstracts a chance to present their faculty (or chief resident) development, educator development, mentoring, and professional development work to their peers. It allows for networking and interchange of ideas that may improve projects or inform future projects. We hope this opportunity will engage both experienced and new/junior members in presentation of their scholarly work and will facilitate networking and collaboration.

**Global Health PEG**  **Studio 3-4-5**
The APPD Pediatric Global Health Educators Group (GH PEG) invites you to the 2nd Annual APPD GH PEG Abstract Symposium. The theme for this session is Global Child Health: Educational Innovations, Partnerships & Advancements and include global health education research, quality improvement, or descriptive reports of curricula in global health.

**Learning Technology Task Force**  **Galerie 1-2**
The APPD Learning Technology Task Force will host a highly interactive table talk session, describing best practices and showcasing the latest technology used by program leadership. Participants will rotate from table to table as hosts demonstrate various tech or programs they have implemented or found useful in program administration or medical education. We hope to provide an opportunity for APPD members to share best practices and to create new applications for technology to enhance trainee learning, while responding to the needs, challenges and opportunities of the digital age.
Under-Represented Minorities in Pediatric GME PEG

During previous sessions of the APPD Underrepresented Minorities (URM) in Pediatric Graduate Medical Education PEG, focused on diversity and inclusion and implicit bias, there was a call from participants to learn more about best practices in these areas. This topic symposium will share curricular and program enhancements targeting three areas: 1) Recruiting practices to enhance diversity, 2) Support and inclusion of residents from races and ethnicities underrepresented in medicine, and 3) Curricula focused on bias or cultural competency.

Results

Surveys were completed by 37 PDs (100%) and 800 trainees (48%). All (100%) PDs believe that service can, in the absence of formal teaching, be considered educational. While only 68% of residents agreed (p=0.017). Residents were significantly more likely than PDs to endorse definitions for service obligations, only 37% of residents agreed (p=0.017). Similarly, when asked how often service is compromised by excessive service obligations, only 37% of residents agreed (p=0.017). When asked how often service is compromised by excessive service obligations, only 37% of residents agreed (p=0.017). Similarly, when asked how often service is compromised by excessive service obligations, only 37% of residents agreed (p=0.017). Similarly, when asked how often service is compromised by excessive service obligations, only 37% of residents agreed (p=0.017).

Objectives: Create and disseminate an open-source e-learning environment where global health educators could receive the necessary training to implement SUGAR at their institutions, and encourage collaboration and ownership of future projects. Methods: We incorporated feedback from the study facilitators through surveys to determine which aspects of training were integral for successful implementation. Using this information, we created training videos of live annotated SUGAR sessions that were posted with free downloadable cases at sugarprep.org. We offered to assist any user interested in leading a spin-off project with the tech and research support to do so. Results: Since the initial debut of the curriculum at APPD in 2014, more than 100 SUGAR facilitators have been trained from over 80 institutions in 6 countries. There are currently several collaborative SUGAR projects being led by over a dozen people trained in the curriculum. These spin-offs include: SUGAR CANE (Cases About Non-Medical Events) which focus on challenges encountered in travel in low and middle income countries; SPICE (SUGAR: Practical Information from Core Educators) which is looking to gather teaching insights for facilitators; SUGAR-4-All which is studying the impact of facilitating cases for those not interested in global health; as well as individuals taking the lead on expanding with case designers from surgery, emergency medicine, OB, family medicine, clinic environments, immigrant health, and cases for medical students. Conclusions: By creating and disseminating an open-source curriculum that fills a need of global health educators and offering support, multiple novel collaborative projects have emerged. This process could serve as a model for other educators with a novel curriculum looking to disseminate and expand their idea.
EDUCATION CONTINUUM

Platform Presentation 3

ADDRESSING THE IMPACT OF CHILD POVERTY: A NEW CURRICULUM FOR PEDIATRIC PROVIDERS ACROSS THE EDUCATION CONTINUUM

Elizabeth R. Hanson MD, MA, University of Texas Health Science Center School of Medicine at San Antonio, San Antonio, TX, Melissa Klein MD, MEd, Cincinnati Children’s Hospital Medical Center/University of Cincinnati College of Medicine, Cincinnati, OH, Benard P. Dreyer MD, New York University School of Medicine, New York, NY, Michael A. Barone MD, MPH, Johns Hopkins University, Baltimore, MD, Michelle M. Barnes MD, University of Illinois College of Medicine at Chicago, Chicago, IL, Lisa J. Chamberlain MD, MPH, Stanford University, Palo Alto, CA

Background: One in five US children live in poverty, which adversely affects health and development. While there are existing curricular resources on advocacy, a gap exists pediatric training on the specific links between poverty, health and advocacy for children. The APA Taskforce on Child Poverty formed the multidisciplinary Child Poverty Education Subcommittee (CPES) to address this curricular need. Design/Methods: CPES members were recruited from key stakeholders in the child health and medical education communities. The CPES first identified the key domains of a novel child poverty curriculum not well addressed in current curricula. Utilizing the principles of backward design, the CPES drafted goals and objectives and built interactive learning modules targeted to those objectives. Work was done asynchronously in small workgroups with group discussion and consensus building through virtual, telephone, and face-to-face interactions. Results: Four curricular domains were identified: epidemiology, pathophysiology, social determinants of health, and leadership and taking action. Each domain contains two learning goals with 3-4 objectives per goal. The final curriculum consists of four interactive modules, one per domain, structured utilizing the flipped-classroom model with a brief amount of pre-work, a 1 hour face-to-face session, and additional in-depth follow-up activities for the advanced learner. Facilitator guides accompany each module to allow standardization and dissemination of the educational components. Conclusions: A national curriculum on child poverty is crucial for future pediatricians as they care for children at a time of increasing wealth inequity, child health disparities and known negative impacts of poverty on health. This curriculum addresses current gaps in pediatric education in a flexible and customizable structure to allow for easy dissemination across programs and learner levels.

Platform Presentation 4

PEDIATRIC RESIDENT MINIMUM MILESTONE EXPECTATIONS BY LEVEL OF TRAINING

Su-Ting T. Li MD, MPH, University of California (Davis) Health System, Sacramento, CA, Ann E. Burke MD, Wright State University, Dayton, OH, Ann Guillot MD, University of Vermont Medical Center, Burlington, VT, Alan Schwartz PhD, University of Illinois College of Medicine at Chicago, Chicago, IL, Kimberly A. Gifford MD, Lebanon, NH, Franklin Trimm MD, University of South Alabama, Mobile, AL, John D. Mahan MD, Nationwide Children’s Hospital/Ohio State University, Columbus, OH, Susan Guralnick MD, Winthrop-University Hospital, Mineola, NY, Daniel J. Tancredi PhD, University of California (Davis) Health System, Sacramento, CA

Background: The ACGME requires biannual reporting of milestones on all pediatric residents. Milestone expectation of performance at each level of training is unknown. Methods: Cross-sectional survey of pediatric program directors (PDs) on their program’s milestone expectations before residents are ready to supervise and before residents are ready to graduate. PDs were asked to indicate the minimum milestone levels, at which, if not achieved, they would provide an unsatisfactory evaluation to the American Board of Pediatrics. PDs who did not already have milestone expectations in place in their programs were asked to indicate what milestone expectations they were considering for use in their program. Results: 58% (117/199) of pediatric program directors responded to the survey. Most (80%; 76/95) programs did not have minimum milestone expectations before residents are ready to supervise or minimum milestone expectations for graduating residents (84%; 80/95). Minimum expectations before a resident was ready to supervise was highest for help-seeking behavior (Prof4; mean milestone level expectation: 2.74), humanism (Prof1; 2.73), incorporating feedback (PBLI3; 2.63), and duty and accountability (Prof2; 2.62) and lowest for identifying learning activities (PBLI2; 2.19) and quality improvement (PBLI3; 2.22). Minimum expectations for graduates was highest for help-seeking behavior (Prof4; 3.49) and diagnostic and therapeutic decision making (PC4; 3.42) and lowest for identifying learning activities (PBLI2; 2.90), advocacy (SBP2; 2.93), and quality improvement (PBLI3; 2.95). Conclusions: While most pediatric residency programs do not have set minimum milestone expectations for their residents to progress from one level of training to the next, PDs do recognize the relative importance of different subcompetencies in allowing a resident to supervise and allowing a resident to graduate and practice independently without supervision. The higher milestone level expectations for help-seeking relative to other competencies suggests that knowing when to ask for help is one of the most critical skills for entrustment decisions.

Platform Presentation 5

CREATION AND VALIDATION OF ENTRUSTMENT SCALES FOR THE COMMON PEDIATRIC SUBSPECIALTY ENTRUSTABLE PROFESSIONAL ACTIVITIES (EPAS)

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GRADUATING PEDIATRIC RESIDENT TRAINING AND COMFORT WITH ACGME REQUIRED PROCEDURES
Daniel J. Schumacher MD, MEd, Cincinnati Children’s Hospital Medical Center/University of Cincinnati College of Medicine, Cincinnati, OH, Mary Pat Frintner MSPH, Elk Grove Village, IL

Introduction: The Accreditation Council for Graduate Medical Education expects graduating pediatric residents to be able to perform a number of procedures without supervision. Methods: National, random sample of graduating pediatric residents surveyed in 2015 (n=1,000; response=54%) about training and self-perceived competency for 15 ACGME-required procedures. Chi-square tests examined for differences in career goals for 1) comfort with performing procedures unsupervised, and 2) desire for more training on the procedure. Results: Resident career goal distribution was 49% subspecialty, 40% primary care, and 11% hospitalist. Most residents reported formal training in the procedures, ranging from 56% for simple dislocation reduction to 100% for neonatal resuscitation (Table). The majority successfully completed the procedures at least once. However, 41% had not completed reduction of a simple dislocation, and over half desired more training in this as well as temporary splinting of fractures, peripheral intravenous catheter placement, and neonatal intubation. Less than half felt comfortable performing reduction of simple dislocations (38%) or temporary splinting of fractures (48%) unsupervised. 91% did not feel comfortable performing at least 1 procedure unsupervised. 18% were not comfortable performing the majority of the procedures (8 or more) unsupervised. Comfort with performing procedures unsupervised did not vary by resident career goal for 13 of the 15 procedures. Residents with subspecialty goals (compared to primary care and hospitalist) were more comfortable placing umbilical catheters (58%, 47%, and 48%, p<.05) and resuscitating neonates (79%, 68%, and 69%, p<.01) unsupervised. Residents with primary care goals were more likely (compared to subspecialty or hospitalist) to want more training in giving immunizations (35%, 26%, and 23%, p=.05), incision and drainage of abscess (40%, 31%, and 20%, p<.05), and temporary splinting of fracture (69%, 55%, and 56%, p<.01). Conclusion: More training across a number of ACGME required procedures is needed to prepare residents for unsupervised practice.
3:15-3:25  Q&A with Dr. Remley
3:25-3:55  David G. Nichols, MD, MBA, President and CEO of The American Board of Pediatrics
3:55-4:05  Q&A with Dr. Nichols

4:10pm - 5:15pm  Key Stakeholders Session

Acadia/Bissonet

4:10-4:30  ABP Update: Gail McGuinness, MD, Executive Vice President, American Board of Pediatrics
4:30-5:00  ACGME Update: Suzanne Woods, MD, FAAP, FACP, Chair RC for Pediatrics; Caroline Fischer, Executive Director, Review Committees for Pediatrics and Physical Medicine and Rehabilitation, ACGME; and Laura Edgar, EdD, CAE, Executive Director, Milestones Development, ACGME
5:00-5:15  Q&A with ABP and ACGME

5:30pm - 7:00pm  APPD Speed Mentoring Session for Faculty

Galerie 6
(Pre-registration required as this session is limited to 30 participants and requires advance preparation)

The speed mentoring session is closed for further enrollment. Due to the highly individualized structure of this session, registration was limited. All registrants that we were able to accommodate in this session have received confirmation of their registration and were asked for supplementary materials (CVs). Prior to the session, participating mentors and mentees CVs were shared for review. Each mentee will bring specific questions to the session and will then spend ten minutes with each of the five mentors for one-on-one interactions. The speed mentoring session will conclude with a small group debrief.

Friday, April 1

Regional Breakfast Meetings
Mid-America: West PA, OH, WV, KY, IN, MI  Galerie 3
Mid-Atlantic: Southern NJ, East PA, DE, MD, Washington DC  Studio 1-2
Midwest: IL, WI, MN, IA, MO, KS, NE, OK, SD  Carondelet
New England: ME, NH, MA, CT, VT, RI  Galerie 6
New York: NY, Northern NJ  Studio 9-10
Southeast: VA, NC, SC, GA, FL, AL, MS, LA, AR, TN  Galerie 1-2
Southwest: TX  Studio 7-8
Western: CA, NV, OR, WA, AK, CO, NM, UT, AZ, HI  Galerie 4-5

9:00am-11:00am  Workshop Session 1

WORKSHOP 1: NEIGHBORHOODS, MAPS, & POVERTY: HOW TO CREATE A CURRICULUM ON THE GEOGRAPHICAL-CONTEXT OF HEALTH

Francis J. Real MD, Cincinnati Children’s Hospital Medical Center/University of Cincinnati College of Medicine, Cincinnati, OH, Kate Distler, Children’s Hospital/Boston Medical Center, Boston, MA, Andrew Beck, Cincinnati Children’s Hospital Medical Center/University of Cincinnati College of Medicine, Cincinnati, OH, Megan Tschudy MD, MPH, Johns Hopkins University, Baltimore, MD, Melissa Klein MD, MEd, Cincinnati Children’s Hospital Medical Center/University of Cincinnati College of Medicine, Cincinnati, OH

More than 16 million children in the United States live in households with incomes below the federal poverty level. Poverty adversely impacts health outcomes across the lifecourse. Additionally, poverty concentrates in certain neighborhoods often in close proximity to academic medical centers. Still, residents and faculty who work in the medical center may have a limited...
understanding of the health-related risks and assets present within their patients' home neighborhoods. Moreover, curricula for residents frequently consider topics, such as poverty, more broadly, without an in-depth look at contextual, neighborhood-based factors of relevance to the patients they treat. As such, in this highly interactive workshop, participants will be provided a framework on the importance of neighborhood context and risk and resource assessment in medical practice. Participants will consider their institutions' role within surrounding neighborhoods and their approach to education on this topic. Video clips and individual reflection will be utilized to energize the audience around the theme of poverty. Discussion of the clinically relevant information that can be obtained from mapping local regions will be discussed, and participants will learn how to create maps of their home neighborhoods. Participants will work in small groups to identify the critical topics and resources needed for the foundation of a neighborhood-based curriculum. Based on these activities, participants will create their own education module and determine optimal delivery methods for their targeted learners. Finally, participants will discuss which key stakeholders are necessary in order to bring their blueprint for their curriculum to life at their home institution.

**WORKSHOP 2: OUT LOUD - EDUCATIONAL ACTIVITIES TO PROMOTE THE HEALTH AND WELL-BEING OF LGBTQ PATIENTS**

Brian Lurie MD MPH, Atlantic Health Program, Morristown, NJ, Anna Dusseau BHCA, Children's Hospital Medical Center of Akron/NEOMED, Akron, OH, Emily Allen MD, Children's Hospital/Boston Medical Center, Boston, MA, Beth Payne MAEd, C-TAGME, University of Texas Health Science Center School of Medicine at San Antonio, San Antonio, TX, Michelle Brooks, Stanford University, Palo Alto, CA, Paulo Pina MD MPH, St. Barnabas Hospital, Bronx, NY, Yasmin Pedrogo MD MSEddLc, University of Puerto Rico, San Juan, PR, Jeremiah Cleveland MD, Maimonides Medical Center/Infants and Children's Hospital of Brooklyn, Brooklyn, NY

**Balcony L-N**

Although the majority of adolescents identifying as a sexual minority will grow up to be healthy and resilient, significant health disparities exist for this population. Many health care providers find it difficult to care for them because of lack of formal training and few professional resources. Currently, there are no uniform training requirements on LGBTQ health at the graduate medical education level. In addition, recent studies show that even in undergraduate medical education the median time dedicated to LGBTQ related content is five hours over four years, while one third of all medical schools report no hours. Barriers to content inclusion include lack of curricular materials demonstrated to be effective, absence of faculty willing or able to teach relevant content, and lack of instructional time. There is a need for specific evidence-based educational interventions to improve Pediatric residents' knowledge, skills, and attitudes to caring for LGBTQ individuals. In this highly interactive workshop, participants will enhance their own knowledge and develop the necessary tools enabling them to teach Pediatric trainees the knowledge, skills, and attitudes needed to care for sexual minority and gender non-conforming youth. After starting with a pair share activity identifying challenges faced when teaching dynamics of working with this population, participants will play an interactive game familiarizing them with definitions and health disparities which disproportionately affect this protected group. Participants will then be introduced to small group activities designed to help residents recognize how biases can affect their behavior and communication skills. Afterwards, through analyzing videos and using role play, participants will identify positive and negative approaches when communicating and interviewing LGBTQ patients. In small groups, participants will then develop an educational activity to use in their own program to promote the health and well-being of LGBTQ patients. Concluding with a summary of lessons learned participants will leave with a faculty guide that consists of all educational strategies discussed.

**WORKSHOP 3: BEYOND NUMBERS: BUILDING YOUR SKILLS IN QUALITATIVE RESEARCH**

Alyssa Bogetz MSW, Stanford University, Palo Alto, CA, Erika Abramson MD, New York Presbyterian Hospital (Cornell Campus), New York, NY, Catherine Distler MD, Arabella Simpkin MD, MA, Children's Hospital/Boston Medical Center, Boston, MA, Su-Ting Li MD MPH, University of California (Davis) Health System, Sacramento, CA

**Studio 9-10**

Qualitative research methods are uniquely valuable tools for translational researchers, medical educators and quality improvement allies. In this highly interactive workshop, participants will be introduced to the principles of rigorous qualitative research and the philosophical foundations underpinning this methodology. Throughout the workshop, participants will work in expert-facilitated small groups to develop a qualitative research question, discuss sampling and data collection strategies, create interview questions and practice analyzing data. By the end of the workshop, participants will be able to recognize when qualitative methodologies can be useful for their own research and will be able to implement strategies to ensure the methodological rigor and trustworthiness of their qualitative research projects.

**WORKSHOP 4: TURNING YOUR RESIDENT SURVEY STUMBLING BLOCKS INTO STEPPING STONES: USING A COLLABORATIVE QI FRAMEWORK TO MAKE A DIFFERENCE IN RESIDENT EDUCATION**

Nicole M. Paradise Black MD, MEd, L Daphna Y. Barbeau MD, Price S. Ward MD, University of Florida, Gainesville, FL, Michael C. Weisgerber, Medical College of Wisconsin Affiliated Hospitals, Milwaukee, WI, Steve Paik MD, EdM, New York Presbyterian Hospital (Columbia Campus), New York, NY, Valerie Gribben MD, Taylor Louden MD, Jaime Peterson MD, Rebecca Blankenburg MD, MPH, Stanford University, Palo Alto, CA

**Galerie 3**

Do certain areas of the ACGME survey plague you no matter what you try? Do you wonder what other programs’ ACGME...
survey data look like or what they might be doing better and/or different from your program? Solutions for Patient Safety (SPS) is a network of more than 80 children’s hospitals with a shared goal of reducing and eliminating serious harm for the children being cared for in their hospitals. They share their successes and failures with an “all teach, all learn” philosophy and utilize quality improvement (QI) methodology to realize their shared goal. The purpose of this workshop is to apply the same transparent, collaborative QI processes to resident education with the yearly ACGME survey providing the topic areas and initial data points. Prior to the workshop, participants will be asked to submit their ACGME survey data, desired areas of improvement, and noted areas of strength. The pre-conference submission will allow work groups to be formed with varying degrees of success and needing improvement on topics and/or similarity in program type/size. After introductions, there will be a brief overview of SPS and review of QI methods. Participants will work through two educational issues of their choice, acting as an expert/consultant for one and receiving help/advice for the other. The process will begin with participants working in pre-determined small groups and applying QI methods to address their first educational issue. Everyone will come back to the larger group to discuss their findings and then return to another set of pre-determined small groups to address another educational issue. After rejoining the large group to discuss the second educational issue, the participants will participate in a gallery walk in order to fully review the collaborations and projects developed during the workshop and provide feedback. The workshop will conclude with next steps for projects and networks and commitment to change.

WORKSHOP 5: THE NEXT ERA IN PATIENT SAFETY: STRATEGIES TO DECREASE DIAGNOSTIC ERROR AND IMPROVE THE DIAGNOSTIC PROCESS IN YOUR PROGRAM

Andrew P. Olson MD, University of Minnesota, Minneapolis, MN, Emily Ruedinger MD, University of Washington, Seattle, WA, Emily Borman-Shoap MD, University of Minnesota, Minneapolis, MN

Studio 1-2

Diagnostic error leads to 40,000-80,000 deaths each year in the United States. The Institute of Medicine released a report in 2015 that called for increased education and research on the diagnostic process. This report includes the recommendation that providers across the continuum of training receive education on the diagnostic process and about diagnostic error. Further, there is a call for accreditation and certification entities to require documentation that trainees are receiving high-quality education and assessment on clinical reasoning, communication, and team-based care. In the wake of this report, it seems likely that diagnostic error, along with its causes and mitigation strategies will gain increased attention from the ACGME and other medical education agencies. Medical educators must be prepared to explicitly implement strategies to improve the diagnostic process and decrease diagnostic error in their training programs. Indeed, this topic spans many of the current milestones including developing clinical judgment (PC-4), functioning on inter-professional teams (SBP-3), incorporating feedback into daily practice (PBLI-4), building comfort with managing ambiguity (PROF-6), and family communication skills (ICS-1). This workshop will build on our successful presentation from last year with expanded content and interactivity. We will describe & demonstrate a longitudinal curriculum in medical decision-making and diagnostic error. We will pay special attention to tools programs can use to increase trainees’ expertise in collaborating in the diagnostic process. Attendees will practice analyzing cases of diagnostic error to identify causative factors and also practice giving feedback to trainees about the diagnostic process. Each attendee will leave the workshop with immediately implementable curricular interventions to improve shared diagnostic reasoning and focus on improving diagnostic accuracy in their training programs.

WORKSHOP 6: CAPTURING THE TEACHABLE MOMENT: USING JUST-IN-TIME SIMULATION TO DEVELOP CLINICAL REASONING AND LEADERSHIP SKILLS IN PEDIATRIC TRAINEES ACROSS THE CONTINUUM

Kheyandra D. Lewis MD, Blair Dickinson MD, MS, Emmanuelle Topiol MD, Taylor Wheaton MD, Sharon Calaman MD, St. Christopher’s Hospital for Children, Philadelphia, PA

Galerie 1-2

In the era of duty hour restrictions, teaching clinical reasoning and leadership skills becomes even more critical with increased transitions of care and less time spent at the hospital. Just-in-time simulation is a novel technique in which simulation is applied to a real patient case currently being cared for by the learner. In simulating clinical deterioration, the learner improves their clinical reasoning skills in developing situational awareness and potential contingency plans before deterioration occurs in the actual patient to facilitate creating a shared mental model among the team. The simulation cases additionally allow the learner to develop skills in identifying patients at risk for deterioration. Just-in-time simulation can also be applied to multiple clinical scenarios (a challenging parent, anticipating abnormal test results, and competing clinical tasks) in order to develop skills needed to prioritize clinical and professional tasks while leading a team. In this workshop, faculty will explore with group participation the importance of contingency planning, particularly related to transitions of care. We will review simulation as an educational strategy, principally the just-in-time model, which provides the learner with teaching just prior to an anticipated patient need or outcome. Participants will work in small groups to design a just-in-time simulation and receive feedback from faculty. Through video examples, participants will apply basic principles of debriefing in large group demonstration and discussion. Faculty, including the trainees, will discuss applications of simulation beyond just clinical skills, such as leading a team, delegating, and prioritizing, that can be incorporated into this just-in-time simulation curriculum. Participants will brainstorm effective implementation strategies that can be used with or without the use of technology or simulation mannequins, and will leave with resources to design just-in-time simulations at their home institution.
WORKSHOP 7: RESILIENCE IN THE FACE OF GRIEF AND LOSS
Albina S. Gogo MD, Sacramento, CA, Susan Bostwick MD, New York, NY, Ann Burke MD, Wright State University, Dayton, OH, Annamaria Church MD, University of Tennessee College of Medicine at Chattanooga, Chattanooga, TN, Dena Hofkosh MD, UPMC Medical Education, Pittsburgh, PA, Megan McCabe MD, Montefiore Medical Center/Albert Einstein College of Medicine, Bronx, NY, Amanda Osta MD, University of Illinois College of Medicine at Chicago, Chicago, IL, Janet Serwint MD, Johns Hopkins University, Baltimore, MD

Objectives: 1. Describe the AAP curriculum: Resilience in the Face of Grief and Loss. 2. Describe the intersection between resilience and burn-out prevention. 3. Identify five adaptive life strategies to maintain resilience in the moment and long term. 4. Draft a personal wellness plan. 5. Identify ways to utilize the components of the curriculum for yourself and in your curriculum. The practice of pediatrics is rewarding but can also be demanding and stressful. Developing and maintaining resilience is crucial in preventing burn-out, major depression, and dissatisfaction with career choice, yet this has, historically, not been addressed in most training programs. In response to a request by the AAP Section of Medical Students, Residents and Fellowship Trainees to address this deficiency, members of the AAP, APA, and APPD have collaborated in developing a novel curriculum that focuses on promoting resilience in the face of grief and loss. In this interactive workshop we will use a train the trainer model to introduce components of the new curriculum. Using small group and large group discussions we will discuss techniques for reflection, meditation, and identify in the moment, after the moment and long-term strategies for resilience. Participants will also complete their own wellness-learning plan. Ways of incorporating the curriculum in one’s training program will also be discussed. At the end of the workshop, participants will receive the link to the curriculum, including ready-to-use presentations, handouts, and facilitator instructions.

WORKSHOP 8: “AND THE SURVEY SAYS?”: DESIGNING SURVEYS TO EFFECTIVELY MEASURE OUTCOMES IN EDUCATIONAL PROGRAMS
Timothy W. Kelly MD, Daniel C. West MD, San Francisco, CA

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

WORKSHOP C9: PROGRAM COORDINATOR WELLNESS: COMBATING BURNOUT AND PROMOTING CAREER SATISFACTION
Susan M. Freeman Ike BS, Stanford University, Palo Alto, CA, Pamela Carpenter BA, C-TAGME, University of Utah, Salt Lake City, UT, Charlene Larson Rotandi AB, AA, Stanford University, Palo Alto, CA, Kelley Pike BA, Albany Medical Center, Albany, NY, Meghan Stawitcke BA, Megan Christofferson BA, Stanford University, Palo Alto, CA, Jaime D. Bruse C-TAGME, University of Utah, Salt Lake City, UT, Emily Johnson MA, Stanford University, Palo Alto, CA

Carondelet

Stress can have an immense impact on mental and physical health; it has even been shown to affect the physiology of the brain. As essential players in an educational program’s overall success, program coordinators often experience stressful situations. As such, burnout is an issue for many program coordinators, as their positions seem to have a high turnover rate that can be disruptive to training programs. Research supports several approaches and techniques that help not only mitigate occupational burnout but also allow people to flourish in their positions. We believe that an increased focus on coordinator wellness could decrease feelings of burnout and increase program coordinator retention. The workshop will explore suggestions for ensuring a program coordinator thrives at GME administration, rather than surviving a year in the program. We believe those who thrive at work handle stress well, avoid burnout, and experience vitality in the workplace. The workshop will also provide coordinators with simple daily activities and effective work-life balance strategies, to help increase overall satisfaction. In the end, coordinators can acknowledge their own stressors and institute a variety of strategies to optimize personal wellness and model wellness within their programs.
in community pediatrics and advocacy, a gap exists in resources for teaching the specific links between poverty, health care disparities, and child poverty. While there are existing curricular resources, the Accreditation Council on Graduate Medical Education (ACGME) Pediatric Milestones and the American Board of Pediatrics Entrustable Professional Activities contain elements that require a working knowledge of the intersection between poverty and health. Learning to care for children in poverty is integral to the core requirements of pediatric training. Several of the Accreditation Council on Graduate Medical Education (ACGME) Pediatric Milestones and the American Board of Pediatrics Entrustable Professional Activities contain elements that require a working knowledge of the intersection between poverty and health. As poverty is a key contributor to health care disparities, training in child poverty also addresses core elements in the ACGME Clinical Learning Environment Review (CLER) Pathways to Excellence. While there are existing curricular resources in community pediatrics and advocacy, a gap exists in resources for teaching the specific links between poverty, health care disparities, and child poverty.

**Workshop 10: The ACGME Self-Study: Taking Advantage of a Remarkable Opportunity for Stakeholder Engagement, Learning, and Program Growth**

Susan Guralnick MD, Mark Corapi MD, Nick Berbari MD, Jonathan Rodriguez MD, Winthrop-University Hospital, Mineola, NY

**Workshop 11: Maximizing Who You Bring to the Table: Professional Success Through the Myers Briggs Lens**

Anda K. Kuo MD, University of California (San Francisco), San Francisco, CA, Tyler Reimirschel MD, Vanderbilt University, Nashville, TN, Blair J. Dickinson MD, MS, Sharon Calaman MD, St. Christopher’s Hospital for Children, Philadelphia, PA

**Workshop 12: Addressing the Impact of Child Poverty: A New Curriculum for Pediatric Providers in Training**

Elizabeth R. Hanson MD, MA, University of Texas Health Science Center School of Medicine at San Antonio, San Antonio, TX, Susan Bostwick MD, New York Presbyterian Hospital (Cornell Campus), New York, NY, Melissa J. Ruiz MD, Kaiser Permanente Southern California (Los Angeles), Pasadena, CA, Cara Lichtenstein MD, MPH, Children’s National Medical Center, Washington, DC, Melissa Klein MD, MEd, Cincinnati Children’s Hospital Medical Center/University of Cincinnati College of Medicine, Cincinnati, OH, Michelle M. Barnes MD, University of Illinois College of Medicine at Chicago, Chicago, IL

**Workshop Full**
and advocacy for children. This dynamic group of physicians, educators and advocates from the APA Taskforce on Child Poverty’s Education Subcommittee will share recently created innovative work developed to address this need. This highly interactive workshop will offer participants the opportunity to explore an already developed curriculum and devise ways to adapt it for implementation in their home institutions. The workshop will begin with a discussion of the gap in current medical education training on child poverty and its link to health. Using a train the trainer model, participants will divide into small groups that represent the four curricular domains: epidemiology of poverty, social determinants of health, biomedical influences of poverty and leadership and advocacy. The small groups will work together to utilize curricular components and devise implementation and evaluation for trainees at their home institutions. A large group discussion will then focus on implementation challenges and opportunities. At the conclusion of the workshop, participants will leave with a toolbox that can be used to implement the curriculum in their respective educational settings.

WORKSHOP 13: A SILENT CURRICULUM: ROLE OF IMPLICIT BIAS IN OUR DAILY WORK
Patricia Poitevien MD, MSc, New York, NY, Amanda D. Osta MD, University of Illinois College of Medicine at Chicago, Chicago, IL, Megan Aylor MD, Oregon Health and Science University, Portland, OR, Brian Lurie MD MPH, Atlantic Health Program, Morristown, NJ, Aisha B. Davis MD, Children’s National Medical Center, Washington, DC

Galerie 3
A Silent Curriculum: Role of Implicit Bias in our Daily Work Medical school teaches us to diagnose and treat patients using pattern recognition. This pattern recognition serves a purpose when creating illness scripts and differentials. However, this way of thinking may also perpetuate implicit biases, and consequently contribute to health care disparities. In this highly interactive workshop, participants will use individual work, videos, pair/share, and large group work to reflect on the impact of implicit bias in our daily work as physicians, but also as program directors and advisors. Prior to the workshop, participants will take an Implicit Association Test (IAT), which will help prime participants for the discussion. They will then be introduced to explicit and implicit bias, and will reflect on how they may have been affected by bias, and on how bias may have influenced their interaction with a learner, a colleague, or a patient. In small groups, participants will read and discuss an article published in JAMA in May, 2015 by a medical student entitled “A Silent Curriculum:”, and the results of their IAT. Participants will watch videos that demonstrate the impact of bias on patient care and recruitment of applicants. In small groups, they will discuss reactions to these videos, and possible ways to mitigate this bias. Using case scenarios participants will discuss the impact of bias on our roles as program leaders (recruitment and remediation), advisors(mentorship), and physicians (bedside teaching and patient care). In the large group report out, we will discuss the role of mindfulness to mitigate these biases in the teaching, mentoring, and clinical environment. Participants will leave the workshop with a toolbox of how to teach about bias at their home institutions.

WORKSHOP 14: FORMATIVE TO SUMMATIVE: TRANSFORMING FEEDBACK INTO EFFECTIVE WRITTEN ASSESSMENTS
Whitney L. Browning MD, Nashville, TN, Sarah F. Denniston MD, Baylor College of Medicine (San Antonio), San Antonio, TX, Karin B. Gray MD, University of Vermont Medical Center, Burlington, VT, Natalie G. McKnight MD, Virginia Commonwealth University Health System, Falls Church, VA, Kira A. Molas-Torreblanca DO, Children’s Hospital of Los Angeles, Los Angeles, CA, Barrett B. Fromme MD, Chicago, IL

Studio 9-10
It is human nature to desire feedback on how we perform a task. Nowhere is this more apparent than in our high-achieving medical students and pediatric residents. However, in the era of competency-based assessment and the next accreditation system, formative feedback and effective summative assessments are essential tools in the educational process and progression through the pediatric milestones. In addition, as program directors, we rely on summative assessments to monitor our learners’ progress. Clearly, the quality of these assessments is important to both the learner and residency program leadership. This highly interactive workshop will explore how to transform formative feedback into effective summative assessments. The workshop materials can be adapted for faculty development at home institutions. Following a brief introductory small group activity, the workshop will begin with a didactic reviewing formative feedback versus summative assessments. Key characteristics of effective summative assessments will be discussed. Small groups will then be assigned different hypothetical learners (the struggling learner, the ambivalent learner, the excelling learner, etc.). Role-play scenario videos will be shown to demonstrate formative feedback sessions for these different learners in the small groups. Using a summative assessment template, participants will each transform the observed formative feedback and subsequent learner performance into written summative assessment. Participants will then exchange written assessments with a participant from a different small group and take on the roles of the hypothetical learner and the learner’s program director. They will provide feedback on the effectiveness of the assessments from the perspective of both the learner and program director. In addition to the written summative assessment template, feedback resources will be provided during the workshop. These materials can be brought back to home institutions to help strengthen and standardize their feedback process. Finally, we will strategize ways to provide faculty development in feedback and assessments.
Training programs in graduate medical education face the challenge of developing trainee expertise despite limitations in resident work hours. The model of trainee learning takes place on the fly during the clinical day. At the same time, the role of consultation in the practice of medicine is increasing. Therefore, the specialty consultation represents an important opportunity for resident self-directed learning. Fellow teaching in the setting of inpatient consultation may also have a broad reaching impact by improving patient care, increasing resident knowledge, empowering the primary team to participate in care decisions and improving the teaching skills of future faculty. However, teaching in the setting of consultation can be challenging due to a number of factors such as time constraints, resident and fellow perceptions/misperceptions and familiarity and barriers posed by hospital systems. Previous research, including work done by our group, has demonstrated that many of these barriers are amenable to intervention. Such interventions include enhancing and improving both resident and fellow communication skills, hospital systems to facilitate resident-fellow interactions, fellow teaching skills and resident engagement, specifically in the setting of consultation. This workshop will examine factors affecting the resident-fellow relationship, propose interventions to enhance resident-fellow interactions and introduce participants to the PARTNER framework of teaching during consultation which fellows can utilize to facilitate their teaching in the inpatient setting. Additionally, we will teach the PAGE mnemonic as a guide for residents to frame an initial consult question. Therefore, this workshop will be applicable to those in both residency and fellowship training programs with the goal of positively impacting fellow-resident clinical interactions.

As educators we strive to instill in our residents strong clinical initiative and ownership of their patients and education such that they will be prepared for unsupervised practice in their careers. However, many extrinsic forces in the forms of pre-medical societal trends, heightened clinical supervision, perceived pressure from health care system performance measures, electronic medical record tasks, and the extra caution inherent in the field of pediatrics, may act to decrease residents intrinsic motivation. With diminished intrinsic motivation, residents are less likely to take the clinical and educational ownership that they need to become strong physicians once out of supervised settings. Hundreds of studies in educational and workforce settings have shown that decreased intrinsic motivation is detrimental to learning, creativity, problem solving ability, mood, and job satisfaction. However, there is also strong evidence that implementing changes based on Self-Determination Theory (SDT) can promote and restore intrinsic motivation to improve the aforementioned outcomes. Residency programs can foster a culture of intrinsic motivation using the core SDT tenets of Autonomy, Competence and Relatedness. This highly interactive workshop will focus on providing participants with methods to foster intrinsic motivation and ownership in clinical settings based on SDT principles. It will also address constructing clinical and educational frameworks for rotations in the context of the millennial learner. Participants will work in groups specific to clinical environment (outpatient, inpatient, and subspecialty) to develop and vet techniques in specific settings, then work to derive unifying themes for implementing SDT principles across the spectrum of residency.

Constructive feedback is critical to practice improvement. The NAS highlights this by including residents' ability to incorporate formative evaluation and feedback into daily practice as one of the milestones (PBLI 14). High-quality feedback is grounded in direct observation, and the ACGME accordingly requires that programs document direct observation of residents' skills. Creating the time and infrastructure for direct observation and thoughtful, timely feedback can be challenging. However, the shift in many institutions toward patient and family centered care (PFCC) creates a natural environment for this to occur because multiple team members are present simultaneously. PFCC demands nuanced communication skills; providers require support and education to become adept at working within this model (6). The NAS recognizes that the ability to communicate effectively is a skill that can be fostered over time (ICS-1). In this workshop, we will briefly describe how the disparate goals of key stakeholders in our hospital converged to present a sustainable avenue for providers to receive direct observation and feedback on their PFCC communication skills. While this program was initially instituted as a faculty development and MOC project, it quickly became apparent that residents were eager participants in the feedback exchange. What was a serendipitous upshot for us can serve as a more intentional prototype for others. After a brief overview of how we were able to

**Workshop Full**
create this program, attendees will work in pairs to identify priorities of the key stakeholders in their own institution that could be leveraged to implement a similar initiative. We will then work as a large group to explore barriers to faculty & resident engagement. We will provide a framework for how we overcame one of these barriers by incentivizing participation with MOC, and explore other strategies to mobilize faculty. Finally, as a group, we will then tackle the issue of how to utilize this type of observation to inform summative evaluation of residents on the milestones.

WORKSHOP C18: STEERING THE ELEPHANT: BALANCING CHANGE MANAGEMENT LESSONS FROM THE BUSINESS WORLD WITH THE EMOTIONAL HEART OF PEDIATRIC EDUCATION  
Brian A. von Rueden MM, MBA, Nancy Irizarry BS, Sharon M. Unti MD, Nathan Pajor MD, Kristen E. Rao MD, Elizabeth A. Byrne MD, MPH, McGaw Medical Center of Northwestern University, Chicago, IL

Carondelet
The landscape of Graduate Medical Education is continually shifting in the era of NAS: with increased demands for compliance on all levels, how can programs facilitate overarching process improvement and cultural change? As Program Coordinators, we are inclined to focus on details, but cannot lose sight of the big picture. While organizational behavior and process management are hot topics in the business world, valuable lessons have gone unnoticed in educational circles. Applying important concepts tested in corporate environments to the balancing act of running training programs, participants will learn the value of emotional investment in successfully implementing change. Understanding that these helpful tools may not have obvious applications to residency and fellowship programs, interactive small groups will evaluate strategies to address practical scenarios that programs may encounter. This workshop will consist of a didactic portion presented by program directors, coordinators, and chief residents to illustrate roles involved in a collaborative approach to positive change implementation. Participants will also complete a skills inventory to recognize how to incorporate personal passions and life lessons into daily work thereby diversifying approaches and perspectives. Several lessons by Kotter and Heath will be introduced, along with Book Club style recommendations for continued learning on the topic. Attendees will discuss and identify takeaway goals that best apply to their home training program environments.

3:30pm-5:30pm Poster Session (Posters will be on display from 10:00am-5:30pm.) 
See pages 35-94 for full poster abstracts.
Acadia/Bissonet

Saturday, April 2

7:00am - 8:30am Continental Breakfast
Acadia

Pediatric Education Group (PEG) Meetings 
(visit www.appd.org/activities/PEGs.cfm for PEG descriptions)
Carondelet

Pediatric Global Health Educators
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Healthcare Simulation in Pediatrics
Cabin

LGBTQA
Cabin

Under Represented Minorities in Pediatric GME
Galerie 1-2

8:45am-10:15am Workshop Session 3
WORKSHOP 19: THE ACGME SELF-STUDY AND PROGRAM IMPROVEMENT: NEW TOOLS, NEW WAYS OF THINKING
John G. Frohna MD, MPH, University of Wisconsin, Madison, WI, Kim Gifford MD, Dartmouth-Hitchcock Medical Center, Lebanon, NH, Alex Rakowsky DO, Nationwide Children’s Hospital/Doctors Hospital, Columbus, OH, Priya Garg MD, Tufts Medical Center, Boston, MA

Galerie 4-5
The program self-study is a key piece of the Next Accreditation System. Some of the language and concepts may seem foreign to program directors, especially those who are not scheduled for a site visit in the next 3-5 years. Rather than viewing the WebADS updates, the Annual Program Evaluations (APEs), the ACGME Surveys, and other requirements as boxes to be checked, this workshop will highlight a new perspective for participants. The self-study, and its elements, can be used as an overarching framework that can help drive the other activities. This highly interactive workshop, based on the preliminary experience of programs participating in the APPD Self-Study Collaborative, will help all programs identify things that they can do now to begin to think differently about opportunities for program improvement. Participants will bring their program aims and reflect on these
Physician training has long focused on acquisition of medical knowledge, communication and self-improvement. Through advocacy experiences, program directors can develop methods to assess resident performance in Systems-Based Practice, as entering orders safely, communicating with nurses and families effectively, or prioritizing a list of clinical “to dos”. Without specific training in the student’s future clinical environment. In a highly interactive format, participants in this workshop will learn about a novel approach to address the transition from medical school to intern year. Using Kern’s Six-Step Approach to Curriculum Development as a framework and capitalizing on adult learning principles, participants will work in small groups to conceptualize, design and plan a short Intensive Clinical Orientation for Residents (ICOR) to bring back to their institutions.

Participants will discuss and investigate the challenges faced by new interns and training programs during the transition to intern year, discuss various educational strategies to address these challenges and leave with a plan to institute an ICOR curriculum. Participants will leave with selected tools and a workbook for use in completing their future self-studies.

WORKSHOP 20: GENERAL PEDIATRICS ENTRUSTABLE PROFESSIONAL ACTIVITIES: WHERE ARE WE AND WHERE SHOULD WE GO FROM HERE?
Ann E. Burke MD, Wright State University, Dayton, OH, Michael Barone MD, MPH, Johns Hopkins University, Baltimore, MD, Carol Carraccio MD, MPh, Chapel Hill, NC, Marsha S. Anderson MD, MPH, University of Colorado, Aurora, CO, Anna Kuo MD, Atlanta, GA, Sue Poynter MD, Cincinnati Children’s Hospital Medical Center/University of Cincinnati College of Medicine, Cincinnati, OH, Kenya McNeal-Trice MD, University of North Carolina Hospitals, Chapel Hill, NC, Sharon Calaman MD, St. Christopher’s Hospital for Children, Philadelphia, PA, Jerry Larrabee MD, University of Vermont Medical Center, Burlington, VT

Salon E-H
The American Board of Pediatrics has embraced the concept of Entrustable Professional Activities (EPAs) as described by Olle ten Cate to use as a framework for informing curriculum, assessment and decisions for entrustment. The APPD helped the ABP define and refine the seventeen general pediatrics EPAs (GP EPAs). Further, the pediatric subspecialties are describing their own specific professional activities. The APPD formed an EPA writing group to describe the scope of practice for each of the seventeen general pediatrics EPAs. That work will be completed in February 2016. The writing group seeks the thoughtful input from the APPD community on this first draft of EPAs. This workshop will be a venue for that review and feedback. Additionally, there will be rich, vibrant discussion regarding how programs envision using the EPAs in assessment and entrustment decisions. Many programs are already using some of the EPAs and others are writing their own for specific rotations. Dr. Carraccio will set the stage by describing what EPAs are and how they can be used in general pediatrics and subspecialty programs to inform curriculum and assessment. She will answer the questions: Why do we need EPAs when we have competencies and milestones? and What is the added value of EPAs to assessment? Then a brief description of the work of the GP EPA writing group will occur. Participants will then self-select to a small group based on which EPA they choose to review. The primary author from the writing group will facilitate each small group and actively listen and get input. Groups will briefly report a summary of their EPA to the larger group. There will be two cycles to allow for review of EPAs. After this, participants will work in small groups to discuss ways they foresee using EPAs in their programs and to share ideas around assessment and entrustment with EPAs. Participants will leave with an understanding of the EPAs and will have an opportunity to help shape them into meaningful tools to assist with resident teaching and assessment. We want to make the development and use of the EPAs a community effort.

WORKSHOP 21: DEVELOPING AN INTENSIVE CLINICAL ORIENTATION FOR RESIDENTS: BETTER PREPARING INTERNS FOR RESIDENCY

Galerie 3
The AAMC has published a list of tasks and responsibilities - core Entrustable Professional Activities (EPAs)- that all graduating medical students should be expected to be able to perform on day one of residency without direct supervision. However, most new interns start internship with little preparation or training in how to carry out the daily activities of internship, such as entering orders safely, communicating with nurses and families effectively, or prioritizing a list of clinical “to dos”. Without standardized training early in intern year, the experiences and training of early interns are random, and bad habits can be learned early that may persist for a prolonged period of time. Current intern orientations typically focus on non-clinical activities. Although some medical schools have started to offer preparatory experiences, they are limited as they do not give specific training in the student’s future clinical environment. In a highly interactive format, participants in this workshop will learn about a novel approach to address the transition from medical school to intern year. Using Kern’s Six-Step Approach to Curriculum Development as a framework and capitalizing on adult learning principles, participants will work in small groups to conceptualize, design and plan a short Intensive Clinical Orientation for Residents (ICOR) to bring back to their institutions. Participants will discuss and investigate the challenges faced by new interns and training programs during the transition to intern year, discuss various educational strategies to address these challenges and leave with a plan to institute an ICOR curriculum.
WORKSHOP 23: YOU DOWN WITH YOUR PD? (YEA, YOU KNOW ME!): HOW TO CULTIVATE A WINNING RELATIONSHIP BETWEEN CHIEF RESIDENTS AND PROGRAM DIRECTORS

Tara W. Bamat MD, Nicole R. Washington MD, Philadelphia, PA, Michael D. Fox MD, Pittsburgh, PA, Beth Rezet MD, Lisa Zaoutis MD, Children’s Hospital of Philadelphia, Philadelphia, PA, Benjamin Miller MD, Andrew J. Nowalk MD, PhD, UPMC Medical Education, Pittsburgh, PA

Chief Residency is a uniquely rewarding and challenging year. Chiefs are introduced to a world of administration, education, and patient care, all while guiding residents through their professional and personal struggles. Program Directors (PDs) additionally have the unique opportunity of mentoring the Chiefs, hopefully developing the next leaders in academic medicine. With such important responsibilities, a positive dynamic between PDs and Chiefs benefits both parties for their personal and professional growth and sets the tone for the residency program. In the ideal working relationship, the Chiefs feel supported and mentored and the PDs have full confidence in their Chiefs. There are, however, many barriers that can impede the development of this winning relationship and the mentor and mentee need to have a clear sense of their roles and expectations. 1,2,3 Indeed, perhaps the first step to a successful year is identifying the shared goals and vision for the program and expectations of each other. This workshop serves to identify those barriers and offer solutions in an interactive way so that both PDs and Chiefs can have the most productive year. Many workshops focus on preparing Chiefs for administrative tasks, educational duties, and issues they may face with residents, but few workshops target the relationship between the Chiefs and the PDs. The workshop will use small and large group discussion to identify the responsibilities of the Chiefs and PDs. Often unclear expectations of responsibilities of one’s role can lead to communication issues and this exercise serves to give us a firm foundation of what is expected in each role. Then, using the same format, we will discuss what both parties would want from each other and what barriers exist to achieving these goals. For example, many Chiefs desire to grow professionally during this year, but get overwhelmed by administrative responsibilities and need the PD to guide them in their professional growth. In addition, Chiefs often serve as the middle man and may be left to deliver messages to the residents on behalf of program leadership that may be difficult. Additionally, PDs may have issues with Chiefs who “go rogue” and thus may have difficulty balancing the desire to provide their Chiefs with autonomy without decisions being made without their input. Lastly, PDs and Chiefs will role-play some of these scenarios and brainstorm best practices on how to navigate these situations while maintaining a productive working and mentor-mentee relationship. The wrap-up of the workshop will include offering concrete tips that surfaced throughout the workshop to help PDs and Chiefs develop that winning relationship and having the participants state take-home points that they can use when they return to their home institution to cultivate these relationships.

WORKSHOP 24: YOUR CLINICAL COMPETENCY COMMITTEES ARE BUSY, BUT WHAT DOES EVERYONE ELSE THINK?

Mark Vining MD, University of Massachusetts, Worcester, MA, Jennifer DiPace MD, New York Presbyterian Hospital (Cornell Campus), New York, NY, Geoffrey Fleming MD, Vanderbilt University, Nashville, TN, Mackenzie Frost MD, University of Texas Southwestern Medical School, Dallas, TX, Sara Multerer MD, University of Louisville, Louisville, KY, Charlene Larson Rotandi BA, Stanford University, Palo Alto, CA, Carrie Rassbach MD, Stanford University, Stanford, CA

Programs have spent much effort, innovation and time in the last three years developing meaningful core rotation assessments that align with reportable subcompetencies and worded in milestone-based language. Multi-source assessments, still a requirement from ACGME and a rich source of important data on resident knowledge, skills and attitudes, have often taken a backseat due to the tremendous effort to prepare for semi-annual milestone reporting. This workshop was developed by members of the APPD Assessment Task Force to share Multi-source assessment tools that have been successfully integrated into programs that provide data on specific subcompetencies. Data collected from these tools are either designed with milestone-based language or can easily map to the milestones, and thus can inform the work of Clinical Competency Committees for both milestone assignments and global evaluation of resident progress. A specific effort will be made to share tools that address subcompetencies that are difficult to assess using standard end-of-rotation evaluations. After discussing barriers and successes from a variety of programs, presenters will highlight innovative tools designed to collect self, peer,
WORKSHOP 25: HOW DO I LIVE IN A GREYSCALE MEDICAL SPACE?
Arabella L. Simpkin MD, MA, Catherine Distler MD, Boston, MA

Practicing medicine involves inherent ambiguity and uncertainty, arising from limitations of knowledge, diagnostic uncertainty, treatment uncertainty, and unpredictable patient response. This can be in contrast to health professions training and what patients expect. Early in their careers health professionals must learn to sit comfortably with ambiguity and find strength in this greyscale space if they are to survive and thrive. Research has shown that low tolerance of ambiguity is linked with low patient and physician satisfaction, increased risk of burnout, disillusionment, and mental health consequences. The implications for patients and society are also significant, with diminished productivity, ineffective communication and patient care, and medical errors. How to foster tolerance of ambiguity in health professionals is not well described, yet is an ACGME milestone. This workshop discusses the importance of anticipating ambiguity in clinical decision-making and using ambiguity as a prompt for cognitive reflection and deeper understanding. It reflects on the integrative nature of medicine, the complexity inherent in the field, and the importance of relationships in clinical care. It considers the demands of making decisions based on imperfect data with uncertain outcomes, with particular regard to how that impacts burnout. It brings what it means to be tolerant of ambiguity into the consciousness of healthcare professionals and seeks to equip participants with tools necessary to discuss uncertainty with patients and colleagues as well as the tools to embrace and thrive in a career that requires comfort in ambiguity. It aims to teach participants how to model tolerance of ambiguity in an interdisciplinary team, and how to navigate the space between knowing and not knowing, empowering participants to travel into this space and find strength there. The topic embraces medicine as a science and an art, highlighting the breadth of competencies that encompass professional identity formation. We have used instructional design approaches that challenge assumptions, embrace complexity, but offer frameworks, clarity, and specific and practical objectives for the learners.

WORKSHOP 26: ACHIEVING EXCELLENCE THROUGH DIVERSITY AND INCLUSION: GME BEST PRACTICES FROM RECRUITMENT THROUGH GRADUATION

Workforce diversity is a critical component of an outstanding training environment. As children and families in the United States become increasingly different from the current pool of pediatricians, enhancing both the diversity of our workforce and our cross-cultural communication skills are imperative. In this workshop we will discuss how diversity and inclusion strategies can enhance your residency or fellowship program through pipeline strategies, residency and fellowship recruitment, training and skill development, and peer and faculty support. We will provide materials for training about provider bias including awareness training (implicit bias), self-reflection practices and case-based learning. We will provide resources for best practices in recruitment and retention of a diverse workforce. Finally, we will provide participants with a toolkit for training in cross-cultural communication including evidence-based tools such as Kleinman’s Questions and LEARN (listen, explain, acknowledge, recommend, negotiate) and clinical cases for discussion with housestaff and faculty. Participants will have an opportunity to share their unique program challenges and current successes. This workshop is suitable for both coordinators and program directors.

WORKSHOP 27: WELLNESS ON A BUDGET: PRACTICAL SOLUTIONS FOR YOUR PEDIATRIC RESIDENCY
Valerie Gribben MD, Stanford University, Palo Alto, CA, Megan Furnari MD, Oregon Health and Science University, Portland, OR, Laura Bachrach MD, Stanford University, Palo Alto, CA, Hilary McClafferty MD, University of Arizona, Tucson, AZ, John Mark MD, Caroline Buckway MD, Stanford University, Palo Alto, CA

Carondelet

As the national discussion of physician well-being begins to extend beyond the concept of burnout, pediatric residency programs are searching for innovative solutions to address the evolving needs of their trainees. This interactive workshop stems from the real-world experiences of physicians at different levels of training who have established successful wellness curricula within their institutions. The workshop will be broken into three parts: wellness solutions for an individual, a pediatric program, and the culture of medicine as whole. At each tier, group facilitators will offer affordable solutions that have proven effective. In small groups, the majority of the workshop will focus on helping participants outline implementable blueprints for wellness at their home institutions. Following each small group session, a large group discussion will give participants a chance to address and learn tools for overcoming the common barriers to wellness initiatives. The experiential nature of this workshop will be furthered enhanced by participants being able to choose activities from the “Wellness Toolkits” of the group facilitators to try out for themselves. The session will conclude with a request for collaboration between programs in crafting a nationwide “Wellness Toolkit” stocked with ideas from which all programs can benefit.
**WORKSHOP C28: CONFLICT RESOLUTION IN AN EDUCATIONAL ENVIRONMENT**

*Kelly K. Laurent MS, Tiffany Chow MS, Children’s Mercy Hospital, Kansas City, MO*

**Galerie 1-2**

Conflict will always exist in the workplace; however, it does not have to be negative. This workshop will focus on conflict resolution, and provide the opportunity for coordinators to take inventory of their daily interactions with others. Coordinators will learn how to work as a team to resolve conflict. The presenters will discuss different conflict styles and strategies for resolving conflict. Participants will have an opportunity to work in small groups on conflict-based scenarios to brainstorm solutions. Participants will leave the workshop with positive approaches to conflict resolution, and the skills necessary to facilitate a courteous and non-confrontational solution. Additionally, participants will have basic knowledge of conflict styles and how to apply conflict resolution which will lead to their personal and professional growth.

10:30am-12:00pm  Workshop Session 4  (choice of 9)

**WORKSHOP 29: THE DIAGNOSIS AND MANAGEMENT OF THE LEARNER IN DIFFICULTY**

*Bennett G. Miller MD, Rhett Lieberman MD, Michael D. Fox MD, UPMC Medical Education, Pittsburgh, PA*

**Salon E-H**

Medical trainees who experience difficulty in their learning are common in all levels of training. Learners in difficulty are a challenge to program leadership as assessment and management of these trainees can demand significant educational and administrative efforts. Unfortunately, many program leaders, administrators, and faculty may lack tools and resources to systematically and consistently diagnose and manage learners in difficulty. This interactive workshop will provide a mix of short didactics, case-based approaches, and small working groups to build a framework in the approach to these learners that mimics how we think about clinical medical problems. We will focus on both the diagnosis and the management of the learner in difficulty. During the workshop participants will review definitions and factors that contribute to learning difficulty in medical training. In small breakout groups, participants will use a case-based approach to review techniques and practice a straight-forward method to diagnose the learner in difficulty. Strategies for management to address learners in difficulty will also be identified and demonstrated. We will also present factors known to promote resilience, as this is an important characteristic of successful learners. Participants will again work in small groups to reinforce and trial these techniques of management using case-based scenarios. These small work groups will share elements of their approaches to diagnosis and managing the learner in difficulty with the larger group. Lastly, the facilitators will present an example of a systematic method to address learners in difficulty within our program, and participants will share and discuss methods and techniques to develop a consistent programmatic approach to this issue.

**WORKSHOP 30: POWERPOINT UNPLUGGED: EMBRACING THE EDUCATIONAL POWER OF AN EFFICIENT AND EFFECTIVE CHALK TALK**

*Micahel B. Pitt MD, University of Minnesota, Minneapolis, MN, Charles Morrow MD, McGaw Medical Center of Northwestern University, Chicago, IL, Emily Borman-Shoap MD, Thomas George MD, Sonja Colianni MD, University of Minnesota, Minneapolis, MN*

**Studio 9-10**

With electronic slide preparation well-established as a presentation crutch, the effective chalk talk where the educator is armed only with a writing utensil and a writing surface is a disappearing art form in medical education. This workshop will aim to empower educators to revive that art with practical evidence-based skills to prove the pen (or dry erase marker) can be mightier than the PowerPoint. Participants will learn strategies to build a bank of educational content to draw upon easily as a mini-chalk talk when an appropriate topic is triggered in any in-patient or out-patient clinical setting. This will enable educators to seize teachable moments on-the-fly regardless of time limitations. In addition to practical skills including what and where to write, who should do the writing, and what types of figures work well, attendees will learn how to convert existing content into ideal chalk talks as well as create new content in front of learners. Each tip discussed is grounded in adult learning theory, and participants will also receive instruction in such concepts as spaced learning, just-in-time teaching, teaching scripts, peer teaching, game-based learning, and more. In this highly interactive workshop participants will learn and demonstrate effective facilitation skills and immediately implement chalk talk best practices in mentored small groups. After learning some basic strategies, participants will rotate through stations based on their interest where they will hone their skills and receive immediate feedback. While special attention will be paid to learning how to give mini-chalk talks in the clinical setting, the skills learned will be applicable for teaching in all scenarios across the continuum of audiences. Participants will leave with a tool-kit of chalk talk strategies that they can immediately utilize when the next teachable moment presents itself.

**WORKSHOP 31: BUILDING SCHOLARLY CONCENTRATIONS IN YOUR PROGRAM: DEVELOPING INNOVATIVE CURRICULA IN ADVOCACY, GLOBAL HEALTH, MEDICAL EDUCATION AND QUALITY AND PERFORMANCE IMPROVEMENT**

*Alyssa Bogetz MSW, Stanford University, Palo Alto, CA, Anda Kuo MD, University of California (San Francisco), San Francisco, CA, Erika Abramson MD, New York Presbyterian Hospital (Cornell Campus), New York, NY, Ariel Winn MD, Children’s Hospital/Boston Medical Center, Boston, MA, Caroline Rassbach MD, Taylor Louden MD, Jaime Peterson*
Galerie 1-2

The ACGME requires residents to participate in scholarly activity and programs to allocate adequate educational resources to facilitate resident involvement in scholarship. For many institutions, acquiring the resources to fulfill these requirements is problematic. This workshop will enable participants to conceptualize, plan and begin to implement a scholarly project curriculum in a concentration area of their interest. In a highly interactive format, participants will select one of four facilitated small groups (Community Engagement and Advocacy, Global Health, Medical Education, Quality and Performance Improvement) to explore ways to build new or advance existing scholarly curricula in the chosen area. Workshop facilitators will provide a brief review of highly successful scholarly concentrations programs. Then, using Kern’s model of curriculum development and with direct guidance and feedback from workshop facilitators, participants will formulate goals, learning objectives, educational methods and assessment strategies for their curricula. Throughout the workshop, facilitators will share lessons learned from developing such curricula and will assist small groups to identify key stakeholders, strategic partnerships and resources needed for program implementation at individual institutions. Participants will outline a comprehensive roadmap to support scholarly concentration program implementation at their home institutions and will leave the workshop with a concrete plan and toolkit of resources to enhance the quality of their scholarship programs and of their residents’ scholarship.

WORKSHOP 32: COGNITIVE BOOT CAMP: MODELING EXPERT THINKING FOR SUPERIOR CLINICAL REASONING AND MEDICAL DECISION MAKING

Brian Rissmiller MD, Satid Thammasitboon MD, Moushumi Sur MD, Baylor College of Medicine (Houston), Houston, TX, Maria Marquez MD, Georgetown University Hospital, Washington, DC, Corey Chartan DO, Baylor College of Medicine (Houston), Houston, TX, Andrew Olson MD, University of Minnesota, Minneapolis, MN

Studio 1-2

The goal of medical education is to cultivate learners in acquiring organized knowledge and skills necessary for becoming competent practitioners while aiding the acquisition of the tools of lifelong learning needed for the progression towards expertise. The Institute of Medicine’s landmark article, Improving Diagnosis in Healthcare, cites enhanced professional training in the diagnostic process as a key goal. Traditionally, the fundamentals of clinical reasoning are often taught via a hidden curriculum in the form of apprenticeship between novices and experts. Given restricted clinical exposure in current medical education, the opportunities for this modality of learning have diminished and novel approaches to teaching are needed to promote expedient development of diagnostic expertise. We propose that instruction to facilitate the development of these cognitive skills needs to be explicit. Our workshop will outline methods for guiding learners to model expert thinking aimed at enhancing cognitive skills necessary for expertise development. The workshop will engage participants through reflection on a dramatization of expert thinking and introduce the concept of dual process model of reasoning. An interactive didactic session will explore how experts use pattern recognition and illness scripts. In module 1, participants will work as pairs to explicitly practice pattern recognition and the construction of illness scripts. A second didactic session will describe the processes of systematic analysis and metacognition. In module 2, participants will work in small groups to use a cognitive autopsy to practice de-biasing and case reframing to bring the unconscious aspects of metacognition (planning, perspective taking, regulation and reflection) to the conscious level to cultivate learner metacognitive skills. To conclude, the workshop facilitators will discuss the continuum of expertise development and share innovations used to teach clinical reasoning. Participants will brainstorm practical strategies for incorporating the learned lessons into various settings at the individual’s institution.

WORKSHOP 33: CULTURALLY EFFECTIVE HEALTH CARE: ESTABLISHING A MULTI-MODAL CURRICULUM FOR PEDIATRIC TRAINEES AND THE INTER-PROFESSIONAL TEAM

Patricia M. Notario MD, Mark M. Butterfly MD, Lisa Marie Piwoszkin DO, Imelda Huerta-Galvez MD, Advocate Christ Medical Center, Oak Lawn, IL

Galerie 6

The American Academy of Pediatrics defines culturally effective health care (CEHC) as the delivery of care within the context of appropriate knowledge, understanding, and appreciation of cultural distinctions, including beliefs, values, actions, customs, and unique health care needs of distinct populations. A wide variety of CEHC training methods have been described but all focus on its implications for patient care in an environment of rapidly changing demographics. While it is crucial for trainee education, CEHC training must also be extended to the broader inter-professional care team in order to truly impact patient care. This workshop will review the literature on CEHC and the establishment of educational curricula on the topic within pediatric training programs. In small groups, participants will brainstorm how to engage key stakeholders and determine methods to integrate CEHC tenets into trainee education. Next, with facilitator guidance, participants will construct goals and objectives and design educational strategies based on their learners’ needs. Then presenters will lead examples of hands-on skills sessions and role-play to address how to perform a sociocultural assessment, interact with interpreters, and negotiate a care plan. Participants will work in small groups to identify potential barriers to curricular implementation and solutions, develop methods to evaluate their curricula, and brainstorm ways to engage the inter-professional team. In this interactive workshop participants will collaborate on curricular development, and they will leave the workshop with resources, strategies, and collaborative partners with whom they can implement future curricula.
WORKSHOP 34: ACE IN THE HOLE: SURE METHODS TO TEACH ADVERSE CHILDHOOD EXPERIENCES  
Marie A. Clark MD, MPH, Jerri Rose MD, Case Western Reserve University/University Hospital Case Medical Center/  
Rainbow Babies, Cleveland, OH, Jennifer Wolford DO, MPH, UPMC Medical Education, Pittsburgh, PA, Ross Myers MD,  
Allayne Stephens MD, Keith Ponitz MD, Case Western Reserve University/University Hospital Case Medical Center/  
Rainbow Babies, Cleveland, OH  

Studio 3-4  
Adverse Childhood Experiences (ACES) are defined as traumatic events early in life that impact an individual’s physical and  
emotional health over the lifespan. Recent discoveries have brought about a greater understanding of the impact of ACES from  
the cellular level to the public health arena. The American Academy of Pediatrics in its 2012 Policy Statement and Technical  
Report underscores the essential roles pediatricians play in efforts to prevent, assess and treat the effects of ACES. The goal of  
this workshop is to prepare participants to instruct pediatric residents about ACES with novel and interactive methods. We will  
first review ACES, including the original ACES study, new specific pediatric-focused research, and recommendations from the  
American Academy of Pediatrics. We will highlight the importance of this information for trainee education and the context in  
it which it may be taught in residency. Next, we will break into small groups to demonstrate three novel approaches for teaching  
ACES: 1) CityMatch Life Course Game, 2) Home Visits: Providing Trauma-Informed Care, and 3) Harvard Center on the  
Developing Child Resiliency Game. We will conclude with an interactive, small-group discussion on how competency-based  
assessments may be incorporated into ACES instruction. Participants will leave the workshop with resources and guidelines to  
implement each novel approach, as well as competency-based evaluations, in their own training programs.

WORKSHOP 35: FAKE IT ‘TIL YOU MAKE IT: INCORPORATING TECHNOLOGY TO ENHANCE RESIDENCY  
EXPERIENCE FOR THE NON TECH SAVVY CHIEF RESIDENTS, FACULTY, AND COORDINATORS.  
Jalene Shoener, MD, Jennifer Vu, MD, Stan Sonu, MD, Rush University, University of Illinois at Chicago, Amanda Osta, MD,  
Michelle Barnes, MD, University of Illinois at Chicago, Chicago, IL  

Carondelet  
Welcome to the age of technology: where we are continually connected to each other and the world with the click of a button  
or the swipe of a screen. The medical education climate has evolved over the last decade due to the incredible advancement in  
software and mobile devices. Residency experience can be both enhanced and streamlined through thoughtful and  
creative use of technological tools designed for communication and educational purposes. This workshop is designed for  
educators who desire to incorporate technology into their residency program but may be unfamiliar with available platforms  
and how these tools can be adapted or integrated easily. Several affordable programs and applications will be reviewed that  
facilitate improved communication with residents and complement the many educational needs of learners such as case-based  
learning, didactics and board review. The workshop will begin with a presentation of various tools that have been helpful to enhance presentations including: strategic PowerPoint slides, programs like Poll Everywhere and Socrative. We will  
review how to creatively integrate various audience response modalities to further enhance didactics and case conferences.  
Participants will experience these interactive programs first-hand throughout the session using their mobile device or tablet.  
A portion of the workshop will be dedicated to discussing methods to simplify communication with the goal of reducing  
email fatigue via intuitive websites and mobile compatible platforms that are practical and effective. Participants will receive a  
guide of programs and applications discussed during the session and ideas for integrating them into residency programs.  
Participants will hopefully leave inspired to engage their learners in creative and unique ways!

WORKSHOP 36: RETHINKING ADULT LEARNING PRINCIPLES IN MEDICAL EDUCATION: FIVE TEACHING  
PERSPECTIVES  
Kadriye O. Lewis EdD, Kansas City, MO, Cheryll Albold PhD, Mayo Clinic College of Medicine (Rochester), Jacksonville, FL  
Galerie 4-5  
Adult learning has been the cornerstone of educational methodology for medical learners after adopting Malcolm Knowles’  
theory of andragogy. However, given the many criticism of conventional view of adult learning theory, adult learners, and  
emerging changes in medicine, medical educators need to rethink the concept of teaching adults from the five perspectives  
on teaching (Transmission, Apprenticeship, Developmental, Nurturing, and Social Reform) In the field of medical education,  
our learners, medical students and residents in training, are adults. By the time we as medical educators begin the educational  
process with them, they have already been in the business of learning for close to twenty years. They have progressed through  
many stages of learning how to learn and have developed a pattern of learning that will continue throughout their lifetimes.  
Teaching adults is a complex, challenging, and often uncertain process. It requires continual inquiry and revisiting of our  
teaching methods. There is no one recipe for how best to teach our adult learners. This workshop will introduce the Teaching  
Perspectives Inventory (TPI) model that covers five common perspectives on teaching adults. The workshop will share various  
pedagogies that align with TPI. The workshop will also focus on new views of adult education, including Brookfield’s six  
principles of the effective practice of adult education and Vella’s 12 principles of effective adult learning. Finally, participants  
will leave the workshop with strategies for innovative adult learning instructional design, implementation, and learning  
evaluation that they can apply them in their own teaching environments.
WORKSHOP 37: BEST PRACTICES IN MEDICAL DOCUMENTATION: A CURRICULAR MODULE FOR PEDIATRICIANS AND SPECIALISTS
Megan E. McCabe MD, Montefiore Medical Center/Albert Einstein College of Medicine, Bronx, NY, Katherine Mason MD, Case Western Reserve University/University Hospital Case Medical Center/Rainbow Babies, Cleveland, OH, Veronica Armijo-Garcia MD, University of Texas Health Science Center School of Medicine at San Antonio, San Antonio, TX, Richard Mink MD, UCLA Medical Center, Torrance, CA, Hossein Tcharmtchi MD, Baylor College of Medicine (Houston), Houston, TX, Jason Werner MD, St. Louis University School of Medicine, St. Louis, MO

Studio 7-8
High quality documentation is of critical importance to clinical care and multidisciplinary communication and also has implications for individual provider and institutional medico-legal risk. Accurate and informative documentation of significant changes in patient status and outcomes of conversations with families and patients is expected of all care providers, but formal training methodologies in medical documentation are not well described. Maintenance of comprehensive, timely, and informative medical records is one of the seven interpersonal and communication skills competencies identified by the ABP/ACGME Milestones project. The Education in Pediatric Intensive Care (E.P.I.C.) Investigators, in collaboration with colleagues from institutional legal and risk management departments, created a curricular module which addresses a range of skills relevant for all pediatric providers and allows learners to develop skills in medical documentation of unexpected clinical events and family conferences. The module is interactive in nature. Learners will first self-assess their current medical documentation skills through the use of a baseline clinical vignette. A brief didactic session will identify the necessary and sufficient elements of medical documentation that best meet clinical and medico-legal communication standards. Learners will then practice documentation of events via case vignettes and videos. They will utilize a review checklist on both sample notes and their own notes in small groups with facilitated discussion. We will use a train the trainer model to allow workshop participants to practice the curriculum and identify ways to apply it to their own environments. This workshop will appeal to a broad audience of trainees, program directors, and individual practitioners seeking to enhance their documentation and teaching skills.

WORKSHOP C38: COMBAT BOOTS TO WHITE JACKETS: YOUR VETERAN STUDENT
Jenna Jelinek, University of Nebraska Medical Center College of Medicine, Omaha, NE

Galerie 3
Combat Boots to White Jackets Your Veteran Student; Veteran issues are currently a single highlight of social media and national news. From VA healthcare to PTSD, the needs of veterans has never been as discussed as the current time. Vietnam-era veterans are finally recognized without the public hate they experienced upon their return home, and disabled veterans are in the spotlight as models, fitness gurus, authors, and philanthropists. One struggle almost every modern-day, GWOT (Global War on Terror) veteran will struggle with at some point is returning to school to either begin, work towards, or complete a degree. A major group of today’s highlighted student populations consists of veterans. These are individuals who have made a home within the city of their last duty station, moved back home, or chose a brand new city for a brand new beginning. They are Citizen Soldiers who are still on duty with Reserve and National Guard units whose deployments and training may disrupt the traditional academic year. These students are often non-traditional, older than your fresh-out-of-high-school-and-pre-med group of students, and bring a unique perspective to the classroom setting. These differences make it difficult to socialize and develop relationships within the learning environment. Today’s veteran students need support both inside and outside of the classroom; empathetic faculty and staff who are familiar with current issues relative to veteran students. With Combat Boots to White Jackets: Your Veteran Student, I will be introducing the hot topics of the needs of veteran students in order to empower faculty and staff with the beginning tools if their veteran student comes to them in a time of need. Often, a supportive ear and help accessing resources available on campus and locally can make a world of difference to a veteran student, and can be the bridge between failing and graduation.
Poster Session Details
Friday, April 1, 3:30 - 5:30 pm

Acadia/Bissonet

PLEASE NOTE THAT POSTERS WILL BE ON DISPLAY FROM 10:00 AM-5:30 PM

Posters will be separated into the following topics areas in the Poster Session:

- ACGME: Posters 1-9
- Program Improvement / QI: Posters 10-19
- Evaluation / Feedback: Posters 20-30
- Curriculum / Education: Posters 31-62
- Mentoring / Scholarship / Faculty Development: Posters 63-71
- Wellness: Posters 72-84
- Collaboration / Communication: Posters 85-102
- Advocacy: Posters 103-110
- Global Health: Posters 111-116
- Skills / Procedures: Posters 117-128
- Fellows: Posters 129-133

ACGME

1. DOES THE ACGME SURVEY TELL US WHAT WE NEED TO KNOW: USING A GRADUATE SURVEY TO FIND OUT (Descriptive Abstract)
   - Cynthia Katz MD, Sarah Rawstron MBBS, Sonia Desikan MD, Kenneth Bromberg MD, Brooklyn Hospital Center, Brooklyn, NY
   - Background: In 1998 the ACGME proposed a means of assessing educational outcomes in residency (the Outcome Project), and then in 2013 added a section to their annual survey targeting graduating residents to improve outcomes assessment. The reliability of this data, obtained from residents while still in training, is not known. We administered a survey to former residents 1, 2, and 3 years after graduation to compare to our ACGME surveys.
   - Methods: Emails were sent to the last 3 classes of graduated residents (2012-2014, 36 individuals) containing a link to an anonymous survey via Google forms. Sixteen questions addressed weak areas reported in our 2013-2015 ACGME surveys: satisfaction of residency preparation for procedures (6), patient management skills training (6), and continuity clinic experience (4). We also solicited information on current practice demographics and overall satisfaction with various educational topics (coding and billing, evidence based medicine, communication, conducting QI, life-long learning, and work-life balance). Likert scale rankings on both surveys were collapsed into favorable and unfavorable/neutral responses and then compared.
   - Results: Survey responses: 31 ACGME, 29 graduate surveys. Of the 16 questions modeled after the ACGME survey, 3 showed discordant responses reflecting resident dissatisfaction: 1) learning management of behavior/mental health problems (27% greater in our survey); 2) continuity clinic patient variety (21% greater in our survey); and 3) ownership of patients (16% less in our survey). Feeling ownership of continuity patients increased from 67% to 90% from 2013 to 2014, during Patient Centered Medical Home certification. Other notable responses for questions not in the ACGME survey concerned areas of dissatisfaction with training: billing and coding preparation: 59%; making a transition to career: 45%; learning to manage work-life balance: 17%. Demographic information reported sub-specialty training increased from 50% for 2012 and 2013 grads, to 78% for 2014. All except one respondent would highly or definitely recommend our program to others.
   - Conclusion: We did not expect the high degree of concordance between the ACGME survey and our survey administered after 1-3 years of post-residency perspective. The additional questions in our graduate survey provided valuable information for program evaluation. Based on this feedback, we plan to incorporate more behavioral health, billing and coding, transition to careers, and wellness curricula. Our data supports the accuracy of the ACGME survey to assess most program outcomes. Asking additional questions to residents while still in training might be a useful tool to assess program outcomes.

2. SIX MONTHS OF INDIVIDUALIZATION—HAVE WE HIT THE MARK? A NATIONAL SURVEY OF PEDIATRIC PROGRAMS (Descriptive Abstract)
   - Nicole M. Paradise Black MD, MEd, University of Florida, Gainesville, FL, Ashweena Gonuguntla MD, Michigan State University, Lansing, MI, Erik Black PhD, University of Florida, Gainesville, FL, H. Barrett Fromme MD, MHPE, Chicago, IL, Catherine Distler MD, Ariel Winn MD, Children’s Hospital/Boston Medical Center, Boston, MA, Pamela Dietz MD, Maine Medical Center, Portland, ME, Tai Lockspeiser MD, MHPE, University of Colorado, Aurora, CO, Carmela Meyer EdD, University of North Carolina Hospitals, Greensboro, NC, Ayoade Adeniyi MD, MBA, Bronx-Lebanon Hospital Center, Bronx, NY, Jeremiah Cleveland MD, Maimonides Medical Center/Infants and Children's Hospital of Brooklyn, Brooklyn, NY, W. Michael Southgate MD, Medical University of South Carolina, Charleston, SC, Lanessa Bass MD, MEd, University of Arkansas for Medical Sciences, Little Rock, AK, Anagha Loharikar MD, McGaw Medical Center of Northwestern University, Evanston, IL, Erika Abramson MD, MS, New York Presbyterian Hospital (Cornell Campus), New York, NY, Daniel West MD, University of
California (San Francisco), San Francisco, CA, Rebecca Blankenburg MD, MPH, Stanford University, Palo Alto, CA

**Background**: The 2013 ACGME and Pediatric RRC standards require pediatric residency training include a minimum of six educational units (20% of training) of individualized curriculum (IC). As programs balance this standard with other program goals and needs, it is vital to understand the manner in which programs design, structure, implement and assess IC. **Methods**: Between August and October 2015 the IC work group, a subgroup of the APPD Curriculum and Research and Scholarship Task Forces, conducted an IRB-approved email survey of US pediatric programs that included quantitative and qualitative questions. Descriptive statistics were used to describe the results. **Results**: 54% response rate, partial responses included. 1. Support: 55% of PDs are most responsible for tracking/monitoring IC. Few programs receive monetary (10%) or FTE (14%) support for IC. 2. Implementation: Leading challenges include compliance with other standards, clinical care, and resident and faculty understanding of the standard. 60% of respondents are double-counting 1-3 of their IC and additional subspecialty experiences. 47% of respondents feel the impact of IC is positive, 44% mixed and 2% negative. 3. Longitudinal frameworks (LFs, e.g., tracks): 40% of programs use LFs to address IC, with 85% of LFs having a clinical focus and 45% scholarly. 4. Timeline: 78% of programs begin IC decision-making in PGY-1; though 6% begin in recruitment (i.e., apply in Match) and 4% in PGY-3. 42% of IC experiences begin in PGY-1, 51% in PGY-2. 5. Modification: Remediation (50%) and addressing other learning needs (56%) are main reasons for IC plan modification. 6. Assessment and evaluation: Few programs have implemented effective methods for assessment and evaluation. **Conclusions**: Even though meeting the IC standard presents challenges for programs (significant work for PDs, little to no extra funding/FTE, underdeveloped assessment and evaluation methods, and “double-counting”) it is striking that only 2% of programs report a negative impact. More information is needed regarding the long-term impact of the IC standard.

3. LEARNER SELF-ASSESSMENT AS A CONTRIBUTION TO COMPETENCY ASSESSMENT (Research Abstract)

**Kimberly A. Gifford MD, Dartmouth-Hitchcock Medical Center, Lebanon, NH, Ann E. Burke MD, Wright State University, Dayton, OH, Franklin Trimm MD, University of South Alabama, Mobile, AL, John D. Mahan MD, Nationwide Children’s Hospital/Ohio State University, Columbus, OH, Alan Schwartz PhD, University of Illinois College of Medicine at Chicago, Chicago, IL, Su-Ting T. Li MD, MPH, Sacramento, CA, Ann P. Guillot MD, University of Vermont Medical Center, Burlington, VT, Susan Guralnick MD, Winthrop-University Hospital, Mineola, NY**

**Background** While physician’s internal thought processes are critical to learning and practicing medicine, external measures of competence are viewed as the gold standard for competence assessment. **Aim** To describe the potential role of self-assessment (SA) to improve the accuracy of competence assessment. **Method** We surveyed pediatric program directors (PDs) to examine two attributes for each ACGME competency: percent of residents for whom PDs thought their Clinical Competency Committee (CCC) assessment was accurate within 0.5 milestone level (CCC accuracy), and how well CCC assessment vs learner SA reflected PD perception of the learner’s true competence. **Results** PDs thought CCC ratings were least accurate for QI (57%), advocacy (63%), and ambiguity (65%) and most accurate for the patient care (PC) competencies (86-89%), except transfer of care. PC and trustworthiness were also the competencies for which PDs felt that CCC assessment better reflected learner’s true competence than SA. PDs thought SA was the same or better than CCC assessment to reflect the learner’s true competence for PBLI1 (self-assessment), PBLI2 (learning methods), and PROF4 (help-seeking). PD-perceived accuracy of the CCC assessment is associated with the degree to which CCC assessment (relative to SA) reflects the learner’s true competence (Figure 1). PDs thought that the skill of assessors was the biggest limitation to the accuracy of their CCC assessments. **Conclusion** To improve CCC accuracy, we need better approaches to examining learner’s skills performance. For some competencies, such as QI, we may lack opportunities for observation. Assessing competencies that involve learner internal thought processes presents another challenge, and external assessment alone may not be the best approach. To improve our ability to assess these competencies, we need better ways for learners to make their internal thought processes more visible. Integrating learner reflections through self-assessment may add insight to the CCC assessment for some competencies.
4. CHANGES IN NICU DUTY HOURS CORRELATION WITH MEDICAL KNOWLEDGE (Descriptive Abstract)
Robert Brooker MD, St. Louis University School of Medicine, Heidi Sallee MD, St. Louis, MO

Introduction: Duty hour regulations went into place in 2009 limiting the work week for interns at no more than 80 hours and post-call days be limited to patient care hand-offs and education only. This has created the concern that resident educational opportunities would be diminished. A decrease in patient contacts has been reported. There is no clear consensus regarding the influence of duty hours regulations on objective GME outcomes in the USA. Methods: This is a retrospective review of residents who completed the Pediatric Residency at St. Louis University. In July of 2009, the residency program enacted changes in the NICU rotation: residents no longer took overnight call in the NICU and the number on continuity clinic sessions was decreased during the NICU month. Two epochs of the three consecutive years before and after these changes were identified for comparison. Results: The numbers of patients covered per resident per day did not change during the time frame examined. The number of duty hours per week decreased with these changes from an average of 73 to an average of 67. The number of diminished/missed rounding decreased from 11 per 28 day period to 4 per 28 day period. The patient care continuity increased with less patient hand-offs. Subtest performance in NICU related content compared to the average performance on all subtests was higher for residents who trained in the second epoch than in the first. Conclusions: Since the institution of changes in the NICU rotation, the performance in the subtest category of Neonatology has improved compared to other subtest performances. Changes made that could have facilitated maintenance of educational standards included less fragmented patient care, addition of structured educational content and increased number of opportunities of informal bedside teaching encounters.

5. HARNESSING ILPS FOR PROGRAM EVALUATION - AN UNTAPPED RESOURCE IN THE AGE OF APES AND SELF-STUDY REPORTS (Descriptive Abstract)
Cherie Lewis MPH, Savanna Carson MS, Alan Chin MD, Kate Perkins MD, PhD, James Lee MD, UCLA Medical Center, Los Angeles, CA

Background: Resident annual individualized learning plans (ILP) facilitate self-assessment and individual feedback, but have less commonly been utilized for program assessment. Methods: We designed a new ILP tool incorporating specific questions about our program’s tracks and resources, as well as open-ended questions for resident self-assessment on the milestones (MS), career preparation (CP), well-being (WB), and quality improvement (QI). By distributing the ILP through our institutional residency management system, we were able to export both quantitative (MS) and qualitative (CP, WB, QI) data for analysis. Results: 72/80 residents completed the ILP between June and September 2015. MS self-assessment scores were comparable to clinical competency scores for each class. Aggregates of resident MS self-assessment revealed common themes within each competency. For example, in PBLI 58% of residents identified their ability to self-assess as a strength, but 49% identified quality or practice improvement as a weakness. With respect to CP, 88% of residents planned elective opportunities currently available in the training program. However common themes emerged about elective experiences and/or resources that would be helpful if available or developed, e.g., procedure experience (35%), additional reproductive health experience (24%), and networking with faculty (15%). Residents also identified common barriers in QI education: 38% of residents identified a QI project but had not yet made progress and 43% felt as though they needed more education. Regarding WB, 65% of residents listed spending time with family or friends as a strategy, 43% noted time as an obstacle, and 29% mentioned residency sponsored social and well-being events or schedule modifications to spend time with peers, friends or family as solutions. Discussion: Patterns in resident MS self-assessment, CP, QI and WB provide useful data for individual resident mentorship. It also provides a new data resource for program improvement plans which is an unanticipated benefit and a highly useful tool in the age of ACGME self-study reports.

6. GRADUATING RESIDENT PREPARATION FOR SELECT ACGME REPORTING COMPETENCIES (Research Abstract)
Daniel J. Schumacher MD, MEd, Cincinnati Children’s Hospital Medical Center/University of Cincinnati College of Medicine, Cincinnati, OH, Mary Pat Finnert MPSPH, Elk Grove Village, IL

Introduction: The Accreditation Council for Graduate Medical Education (ACGME) currently requires biannual reporting of resident development in 21 competencies. To aid program evaluation, resident self-assessment of preparation in these areas is important. Methods: National, random sample of graduating pediatric residents surveyed in 2015 (n=1,000; response=54%) about their ability (poor, fair, good, very good, excellent) in 12 of the 21 ACGME reporting competencies. Residents also ranked 2 competencies for which they felt most- as well as least-prepared. Chi-square tests examined for differences in the ranked competencies across career goals (primary, hospital, or subspecialty care). Results: The majority of residents reported very good or excellent ability in the 12 assessed competencies (Table). 55% of residents also reported that communicating effectively with patients, families, and the public across a broad range of socioeconomic and cultural backgrounds was their first or second choice for areas of most preparation (Table). Residents indicating a subspecialty career choice were less likely (48%) than either those with primary care (60%) or hospitalist medicine (82%) goals to rank this in their top 2, p<0.05. The second highest area for being chosen in the top 2 for most prepared was working in inter-professional teams (36% of residents). The majority of residents (60%) reported that systematically analyzing practice using QI methods, and implementing changes with the goal of practice improvement was their first or second choice for least prepared. Discussion: High ratings in the timely and important areas of effective communication across a broad range of socio-economic and cultural backgrounds as well as working in interprofessional teams is reassuring. However, resident reports concerning QI and practice improvement suggest there may be improvement opportunities in the experiences of many residents in this area.
7. WALKING THE CLER PATHWAYS TO EXCELLENCE BY INVOLVING RESIDENT PHYSICIANS IN A SAFETY CULTURE (Descriptive Abstract)
Shiva Zargham MD, Karin Hillenbrand MD, MPH, Rashmi Patel DO, Vidant Medical Center/East Carolina University, Greenville, NC

**Background:** The ACGME Clinical Learning Environment Review encourages clinical sites to engage residents in learning to provide safe, high quality patient care. One of the six “Pathways to Excellence” delineates pathways for enhancing resident education about patient safety. **Objective:** The Pediatric Chief Residents revised departmental conferences to incorporate the Patient Safety Pathways and to more fully engage residents in a safety culture. **Methods:** During monthly Quality and Safety conferences, each resident on the inpatient team is tasked with presenting a safety event or near miss during their inpatient experience. The lead senior resident chooses one event and describes an intervention implemented. Residents then enter the events into the system-wide online safety net. Quarterly Morbidity and Mortality conferences address core safety topics, focus on sentinel events from across the department, and more fully review the events on the inpatient service. **Results:** Through these initiatives, residents have demonstrated progress in achieving the PS Pathways. All residents now verbally report events during the Quality and Safety conference, and the institution has documented an increase in events reported by pediatric residents into the system-wide safety net. **Conclusion:** Implementation of resident-led safety conferences has resulted in forward progress of our residents along the CLER Patient Safety Pathways. They provide a platform by which residents can systematically address patient safety issues and develop interventions which can ultimately result in safer, higher quality care.

8. HOW MUCH SUPERVISION IS REQUIRED AT THE BEGINNING OF INTERN YEAR? (Research Abstract)
Carolyn H. Marcus MD, Ariel S. Winn MD, Theodore C. Sectish MD, Children’s Hospital/Boston Medical Center, Christopher P. Landrigan MD, MPH, Boston, MA

**Background:** The AAMC has published a list of core EPAs that all graduating medical students should be able to perform on day one of residency without direct supervision. It is unknown how much supervision new interns actually need when performing these activities. **Objectives:** To assess how much supervision residents and attendings perceive that new interns need when performing the EPAs. **Methods:** An electronic survey was sent to residents in a pediatric residency program (N=152) asking them to rate how much supervision they felt they themselves needed at the beginning of their intern years when performing 14 activities. They rated each activity on a 5-point scale, ranging from “I had knowledge about this but could not do it” to “I was able to function as a supervisor for this.” A survey was also sent to hospitalists (N=50) asking them to rate the amount of supervision they perceive new interns to need when performing the same activities. **Results:** 65 residents (43%) and 27 attendings (54%) responded. For 8 of 14 activities, the residents’ perceptions of their own abilities to perform the activities independently as interns were significantly greater than the attendings’ perceptions of interns’ abilities. For
example, 88% of residents responded that, as new interns, they could have gathered a history and performed a physical exam independently, whereas only 19% of attendings believed that new interns could do so (P<0.001). For prioritizing a differential diagnosis, the results were 29% for residents and 4% for attendings (P=0.004); for calling a consult, the results were 43% for residents and 11% for attendings (P=0.003). Conclusion: Contrary to AAMC recommendations, neither residents nor attendings uniformly felt that new interns could perform the EPAs without direct supervision. Residents' perceptions of their own abilities to perform activities without supervision when they were new interns differ from attendings' perceptions of new interns' abilities, with a greater proportion of residents perceiving that they were able to perform numerous tasks without supervision. This discrepancy warrants further investigation and intervention.

9. IS THE JULY EFFECT REAL? PEDIATRIC TRAINEE MEDICAL ERRORS AND ADVERSE EVENTS AT A LARGE TRAINING CHILDREN’S HOSPITAL (Research Abstract)
Ankoo Y. Shah MD, MPH, Andrew Abreo MD, Nicole Akar-Ghibril MD, Rahul Shah MD, MBA, Children's National Medical Center, Washington, DC

Background: The July Effect is a phenomenon that suggests increase medical errors and worse patient care in July compared to other months due to an influx of new doctors. However, research in this area is focused on mortality data or adult patients. The aim of this study is to analyze pediatric trainee medical errors from May through September 2013 at a large tertiary care children's hospital to determine if there are more medical errors and adverse events from those errors in July. Methods: Three independent researchers reviewed in a blinded fashion each medical error which is institutionally electronically collected by RLSolutions system. Cases that all three agreed were included; others were discussed between the three to determine inclusion. Reviewers evaluated if the error resulted in an adverse event. Results: There are a total of 382 trainees (117 pediatric residents, 81 non-pediatric residents, 164 fellows) at the institution. Pediatric residents had more medical errors in July (31) compared to May (16, p=0.021), June (16, p=0.030), August (19, p=0.12), or September (23, p=0.48). Fellows had more medical errors in September (12) compared to July (5, p=0.042). Also there was no significant difference in the amount of adverse events by trainees in July (7) compared to May (5), June (8), August (4), or September (8). The most common adverse events were delay in pain being addressed and unnecessary venipuncture. Conclusion: In this single center large tertiary care teaching children’s hospital, there is a significant increase in medical errors caused by pediatric residents in July and in medical errors caused by pediatric fellows in September. However, there is no statistical difference in patient adverse events. Therefore, pediatric patients do not experience a July Effect. Increased hospital and trainee safety measures may have contributed to steady adverse events despite increase pediatric trainee errors.

10. AMBULATORY BASED QUALITY IMPROVEMENT IN A PEDIATRIC RESIDENCY PROGRAM (Descriptive Abstract)
Rajni Sandhu MD, Jennifer Simmons MD, Shiva Zargham MD, Jennifer Crotty MD, Karin Hillenbrand MD, Greenville, NC

Purpose: East Carolina University’s (ECU) pediatric residency program integrated a structured quality improvement (QI) project into its annual curriculum. Based on the Associates in Process Improvement’s Model for Improvement with implementation of the Plan-Do-Study-Act cycle, the program sought to increase resident exposure to practice-based learning, QI, and leadership skills needed to improve healthcare delivery. Methods: All residents are divided into 4 ambulatory continuity groups at the beginning of their training. The continuity clinic director selects an annual overarching topic of study. All residents complete the American Academy of Pediatrics online module “QI in Pediatric Care - QI Basics” and the Institute for Healthcare Improvement’s Open School Modules on patient care quality. Each group begins a project by reviewing current practices and establishing measures to study a baseline and track potential changes. Using this data, each group creates an aim statement which is a proposal focused on a time-specific, measurable, and population-targeted goal. Reflecting upon its practice baseline and aim statement, each group proposes a final QI intervention that is implemented. Piloted intervention results are tracked and presented at a QI conference for group feedback. Successful interventions are then scaled for broader practice. Results: Over the last 7 years, 100% of ECU’s pediatric residents have been exposed to QI education and have participated in 3 QI projects during their training. Starting in 2008, surveys have been sent to our residency graduates assessing readiness for QI. Since implementing this QI project in 2008, the percentage of graduates reporting adequate preparedness has risen to and remained at 100%. Conclusion: Implementation of a QI program in a residency curriculum provides invaluable lessons in study design, data collection, analysis, teamwork, and process improvement that increases resident competency in practice-based learning and improvement. With the growing focus on quality initiatives in healthcare delivery, our QI model can be continually refined and broadened to other residency programs.

11. THE MULTIPLE MINI-INTERVIEW FOR PEDIATRIC RESIDENT SELECTION (Descriptive Abstract)
Chelsey Sandlin MD, Bonnie Desselle MD, George Hescock MD, Louisiana State University, New Orleans, LA, Aryn Karpinski PhD, Kent, OH

Background: Most residency programs use the traditional interview in the selection process, but evidence demonstrates that its subjectivity produces low reliability/validity with potential for bias. The Multiple Mini-Interview (MMI) format utilizes a series of brief encounters with standardized questions used to evaluate non-cognitive skills. Studies support that MMIs...
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12. INDIVIDUALIZED HANDOFFS OBSERVATION DATA CAN IMPROVE RESIDENT ADHERENCE TO AND EFFECTIVENESS OF A STANDARDIZED HANDOFFS MODEL (QI Abstract)
Patricia M. Notario MD, Lisa Marie Piwoszkin DO, Advocate Christ Medical Center; Melissa Boling DO, Kent Nelson MD, Advocate Christ Medical Center, Oak Lawn, IL

Background Effective patient handoffs are key to patient care and safety. Studies demonstrate that the use of evidence-based, standardized handoff models increases provider satisfaction and compliance with key handoff elements. Baseline analysis of handoff effectiveness at our institution revealed 58.6% of nurses and 59.3% of residents perceived negative patient outcomes as a result of resident handoffs received. In addition, baseline observations of resident handoffs showed inconsistent inclusion of specific handoff-related information. Aim Statement Our objective is to study the impact of a program-specific resident handoff curriculum with the goals of reaching 80% compliance in consistent use of a standardized method and reducing perceived negative patient outcomes to less than 50% by June 2016. Interventions We designed a program-specific handoff framework and initiated an educational curriculum Fall 2013 including biweekly handoff observations by faculty. Using serial PDSA cycles we implemented process changes including a revised faculty observation tool to prompt immediate verbal feedback, longitudinal and individualized handoff compliance reports, and regular individual progress reports discussed with each resident. Measures The faculty observation tool was used during regular intervals to evaluate morning and evening handoffs. Individual residents were evaluated for verbal and written inclusion of specific elements based on our standardized handoff model. The room setting, frequency of interruptions and overall appropriateness of handoffs were noted. Results Data from a 3-month period in 2014 was compared to the same period in 2015. Verbal handoffs that included patient status updates increased from 59% to 86% (p<0.003). Similarly, although not statistically significant, verbal inclusion of specific problem-based directives increased from 73% to 78% in 2015 (p<0.08). Data collection for longitudinal handoff reports is ongoing. The post-intervention surveys at months 10 and 22 following the start of this project revealed a decrease to 39.6% of nurses (p<0.05) and 38.4% of residents (p=0.07) as perceiving negative patient outcomes related to resident handoffs. Conclusions and Next Steps Consistent handoff education and evaluation through immediate verbal feedback and longitudinal, individualized data reports can improve compliance with a standardized handoff model and decrease perceived negative patient outcomes. Next steps include candid handoffs observations to ensure sustained improvement and accountability.
13. PEDIATRIC POWER (QI Abstract)
Hanna C. Jaworski MD, Grand Rapids Medical Education Partners/ MSU/Helen DeVos Children’s Hospital, Candace Smith-King MD, Grand Rapids, MI

Background Helen DeVos Children’s Hospital Academic General Pediatrics (HDVCH AGP) clinic desired to find a proven method to improve its precepting and clinic experience. We reviewed an evidence-based intervention which showed positive results using the POWER (Prepare, Orchestrate, Educate, Review) method of active precepting (Lillich, Mace, Goodell, & Kinnee, 2005). This model was modified and Pediatric POWER was implemented at the clinic. Aim Statement We plan to improve the resident and preceptor experience and improve teamwork and communication between physician and nursing staff over a 2 month period of Pediatric POWER implementation. Interventions Intervention methods were implemented within the areas of Prepare, Orchestrate, Educate, and Review. Prepare methods included pre-clinic huddles and setting learning goals. Orchestrate methods included anticipation of resident needs and schedule demands, preceptor circulation through rooms, and adjustment of treatment and follow up plans. Educate interventions included use of clinical pearls, standard staffing expectations, and microskills. Review methods included review of learning goals, safety concerns, and general feedback. Measures Clinic experience data was obtained through surveys to patients/families, staff, residents, and preceptors regarding their clinic and/or staffing experience. Pre and post surveys were collected prior to implementation and 2 months following implementation, allowing us to capture data from the same resident cohort. Pre and post time studies were completed to identify efficiency changes. Statistical analysis of surveys used the T-test and time study analysis used the Mann-Whitney Test. Statistical significance was noted if p<0.05.

Results Significant improvement was noted in several areas within the resident survey including overall staffing experience, staffing responsiveness to schedule demands, active involvement in in-room exam and education, and wait time for staffing. Time study analysis showed significant improvements in registration, rooming, resident history/exam, and staffing times, thus reducing the median length of total visit time from 47 to 42 minutes. Conclusions and Next Steps The implementation of Pediatric POWER improved resident experience in continuity clinic and clinic efficiency. We will continue Plan, Do, Study, Act cycles to further adjust the method components of Pediatric POWER, as it has shown great promise for improving the clinic experience.

<table>
<thead>
<tr>
<th>Overall, how satisfied are you with your staffing experience in the pediatric resident continuity clinic?</th>
<th>Pre</th>
<th>Post</th>
<th>p-value</th>
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<td>4.7±1.2</td>
<td>5.4±0.8</td>
<td>0.003*</td>
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<tr>
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<tr>
<td>Post-surveys n=12</td>
<td></td>
<td></td>
<td></td>
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</tbody>
</table>

14. IMPROVING SAFE SEX PRACTICES IN ADOLESCENTS AND YOUNG ADULTS (QI Abstract)
Dana Clifton MD, Jane Trinh MD, Suzanne Woods MD, Duke University Hospital, Durham, NC

Background Adolescents and young adults (AYA) engage in high-risk sexual activity at early ages. Approximately 50% of 12th graders in North Carolina report having had sex in the past 3 months. Nearly one-half of new sexually transmitted infections (STIs) occur among people aged 15 to 24 years. At well visits, approximately 60% of pediatricians report discussing STIs, abstinence, and contraception; however; only 22% distribute condoms, with safe sex counseling often limited by insufficient time. The CDC endorses that any education provided to patients lowers the likelihood of sexually risky behaviors. Aim Statement In our combined internal medicine and pediatrics (Med-Peds) clinic QI project, we aimed to increase the frequency of safe sex counseling and condom distribution among sexually active AYA by 25% over recurrent 2-3 month cycles. This project also aimed to enhance the collaborative nature of the physician-nursing relationship in a resident continuity clinic. Interventions Baseline data collection was completed for annual and return visits in sexually active patients aged 13-26 years. During the PDSA cycles, we introduced interventions to improve safe sex counseling and condom distribution. In the first cycle, residents were made aware of the availability of condoms and the location of condoms was changed. In the second and third cycles, nursing staff was engaged. Measures We measured the proportion of sexually active patients who received verbal or written safe sex information and condoms after each intervention. Results Baseline survey of Med-Peds physicians revealed time as a limiting factor in safe sex counseling. Condom distribution was limited by lack of knowledge of condom availability. At baseline, 59% of 13-26 year old patients endorsed sexual activity. Among sexually active patients, 12% reported perfect condom use. Physicians provided 38% of sexually active patients verbal or written safe sex information and 2% received condoms. After the first PDSA cycle, 58% of those sexually active received verbal or written safe sex information. Condom distribution increased to 16%. After the next two PDSA cycles, 63% received verbal or written safe sex information and 23% were given condoms. Conclusions and Next Steps Increased awareness of low rates of safe sex counseling in an ambulatory setting can increase rates of safe sex counseling and condom distribution. Increased accessibility of condoms and engaging nursing staff can increase rates of safe sex counseling and condom distribution, emphasizing the need for a multi-faceted approach to education for AYA.
15. CONTINUOUS PROGRAM IMPROVEMENT THROUGH THE LENS OF HARRY POTTER: INITIATION OF A SOCIETY CUP (Descriptive Abstract)

Kim B. Hoang MD, Anita Mantha MD, Rachelle Weinstein MSW, Teri Turner MD, MPH, MEd, Baylor College of Medicine (Houston), Houston, TX

Background: In 2012, the Baylor College of Medicine pediatrics program initiated a society framework modeled after the house system seen in Harry Potter. The society system serves to break down a large residency program into smaller learning communities to allow residents to influence the program and to foster relationships amongst other trainees and faculty. In 2014, we surveyed all residents to analyze their current views on the society system to evaluate whether it was meeting resident and program expectations. With the results of the survey, an initiative called the Society Cup was launched. Objectives: The Society Cup was created to incorporate the residents’ opinions, to increase resident satisfaction and involvement, and to target program goals. Methods: A pre-survey was sent to PGY2, PGY3 and PGY4 residents in 2014 assessing their perception of the society system, their expectation, and their recommended changes. The Society Cup was implemented the fall of 2014 and consists of three categories: altruism, academic, and recreation. Residents earn points for their society in each category throughout the year. At the end of the year, the society with the most points is awarded the Society Cup. A post-survey was then sent to all residents in 2015 to evaluate the responses to changes implemented. Results: Pre-survey results (n=54) revealed 65% of residents strongly agree that societies are an opportunity to build relationships and 40% agreed they enable professional development. The post-survey (n=50) showed an improvement in the perception of these society goals with more than 60% strongly agreeing to both statements. The post-survey showed that majority of residents agreed that the Society Cup increased social events within the program. Objectively, it also increased the percentage of required monthly PREP questions completed. Conclusions: The residents view the society system positively. The Society Cup was created with initial data consistent with an increase in social events and required academic activities. However, more longitudinal data is needed to determine the efficacy of the Society Cup.

16. FROM PILOT TO POLICY: IMPLEMENTATION OF A PEDIATRIC RAPID RESPONSE TEAM USING KOTTER’S CHANGE THEORY (QI Abstract)

Adam Szadkowski, Melissa Cercone, Madison, WI

Background: Implementation of a Pediatric Rapid Response Team (PRRT) has been associated with reduced mortality. Our hospital historically relied on an informal process of critical care consultation triggered by physician concern or a Pediatric Early Warning System (PEWS); however, there was marked variation in the perceived role and performance of this consult service. Aim Statement Our goal was to develop a formal PRRT process and justify its adoption as policy within one year. Six month feasibility process measure goals included: 100% PRRT activation via paging, 100% 15 min PRRT response time, and 100% complete team (MD/RN/RT) response. Interventions We utilized the model for improvement and Kotter’s change theory to generate an inter-professional shared vision for the PRRT. We communicated with and empowered participants via educational sessions every 3 months, through 3 PDSA cycles Measures Baseline perceptions from residents, RNs, and RTs were collected via pre-intervention surveys. Post-intervention surveys and focus group data were collected at the 1st cycle. Page operator and log data of PRRT responses, focus group feedback, and PEWS scores were collected at the 2nd and 3rd cycle. Results The plan for a new PRRT team was formalized in 4 months. Universal page activation was 79% (23/28) after the 1st cycle and 64% (9/14) after the 2nd cycle, and 100% (28/28) for the 3rd cycle. Complete team activation and response within 15 min were each 100% after the 1st and sustained in the 2nd cycle. Focus group feedback during the 1st, 2nd and 3rd cycles demonstrated sustained positive impressions of the PRRT as a more structured, collegial, and a less intimidating process. There was no statistical difference in average PEWS scores from PRRT events where disposition was to remain on the ward vs. transfer to the PICU. Conclusions and Next Steps Utilizing the model for improvement and Kotter’s change theory we demonstrated a PRRT team was feasible and well-received by inter-professional stakeholders. Our PRRT will be policy beginning 2016.
17. WAIT HERE WHILE I GET MY ATTENDING: IMPROVING FLOW IN RESIDENT CONTINUITY CLINIC
(QI Abstract)

Richard Cabrera MD, Cynthia Katz MD, Adeola Akinlonu MD, Brooklyn Hospital Center, Areej Alwahab MD, Ingrid Dea Roches MD, Obinna Ego-Osuala MD, Riwaaj Lamsal MD, Ning Yang MD, Stephen Ajl MD, Brooklyn Hospital Center, Brooklyn, NY

Background: In a busy clinic, optimizing workflow can decrease patient wait times, enhance doctor-patient interaction, and improve the patient-physician overall experience. In our 14 exam room continuity clinic, residents have identified locating attending preceptors as a workflow bottleneck. This bottleneck created 3 main problems: 1) numerous interruptions during patient encounters while others search for attendings; 2) increased wait time for patients until attending are located; and 3) residents foregoing quality time with patients while they search and wait.

Aim Statement: We sought to develop a low cost resident driven quality improvement project that would improve resident and patient continuity clinic experience. Our aim was to decrease interruptions to patient encounters to less than twice per session, and decrease average wait time to less than 4 minutes per patient over 3 months. Interventions: We used the Plan-Do-Study-Act (PDSA) model for improvement, to investigate changes that we predicted would improve workflow and enhance resident and patient experience. A pre-intervention baseline collection (2 weeks) was followed by 2 post-intervention cycles (3 weeks and 2 weeks). The primary intervention was the implementation of an electronic hyperlinked whiteboard/spreadsheet installed on every clinic computer that includes both a wait list and location list to track the status and location of residents and attendings, updated in real time. The residents were responsible for updating these lists and the attendings were responsible for checking them frequently. The second PDSA cycle included adding additional fields to the spreadsheet to help locate attendings, as well as continued education of participants.

Measures: 1) Interruptions to patient encounters 2) Average wait time

Results: A total of 152 resident-patient interactions were included in this project: 43 patients in the pre-intervention data, and 109 patients post-intervention cycles. Clinic afternoon sessions included 3-6 residents and 3-4 attending preceptors. Baseline average interruptions were 4.6 times per session (range 1-8), and average wait time to present was 4.6 minutes per patient (range 1 to 11.25 minutes). Post-intervention data showed an average of 0.7 interruptions per session (range 0 to 3) and an average wait time to present of 2.2 minutes per patient (range 0.1 to 5 minutes). Additionally, residents reported decreased frustration and increased satisfaction in being able to spend more time with their patients inside the exam room while waiting for the attending to arrive, rather than using that time looking for an attending.

Conclusions and Next Steps: Through the use of a free electronic whiteboard, accurate logging, and multiple rapid improvement cycles, we met improvement goals set in our AIM statement and significantly decreased the total number of interruptions and average resident wait time per patient to present to an attending. Resident-patient interaction, intimacy and privacy were improved by fewer interruptions. Hawthorne effect likely explains the lower than anticipated wait times during our pre-intervention data collection, and those wait times were likely underestimated compared to post intervention data that used timestamps. Future cycles to sustain our improvement include the participation of ancillary staff as well broadening our intervention to other resident clinic days. Additional proposed steps include implementation of radio frequency identification (RFID) cards to automate the ability of residents and staff to find attendings without the need to input data manually.
Poster Abstracts

18. IMPROVING ADVERSE PATIENT SAFETY EVENT REPORTING BY PEDIATRIC RESIDENTS (QI Abstract)

David Ashby DO, Mehgan Teherani MD, Amanda Kuch MD, Angela Ibragimov MD, Richard Engel MD, Vasudha Bhavaraju MD, Ann Beasley MD, Ryan Bode MD, Phoenix Children’s Hospital, Phoenix, AZ, Lilia Parra-Roide MD, St. Joseph’s Hospital & Medical Center, Phoenix, AZ, Lindsey Query MD, Medical College of Wisconsin Affiliated Hospitals, Milwaukee, WI

Background Reporting adverse events is fundamental in identifying patient safety vulnerabilities and improving the culture of safety. Resident house staff across the country under report witnessed adverse events leading to breaches in patient safety. The ACGME initiated CLER program is designed to provide feedback in 6 areas including patient safety. Patient Safety Pathway 1 mandates that residents know their role, responsibility and how to report patient safety events. Our 98 pediatric residents are on the front lines of care at Phoenix Children’s Hospital, but rarely reported patient safety events. Aim Statement To increase adverse event reporting by at least twenty percent of house staff (twenty five resident reports) from 10/2014-3/2015. Interventions Cycle 1: Residents educated on adverse events and how to report. Cycle 2: Report data collected and reviewed with residents. Gifts were raffled for residents who submitted reports. Cycle 3: A laminated badge card with instructions on how to report events was created for residents. Cycle 4: Quality Department added a resident field to Event Report Form. Current: Creating a process to provide residents with outcome data and changes made as a result of their reports. Measures The number of adverse event reports filed by pediatric residents was tracked. Results Resident adverse event reports increased from 0 per month to an average of 7.5 per month from 10/2014-8/2015 and a total of 50 reported events from 10/2014-3/2015 (see TABLE 1).

Conclusions and Next Steps Educating Pediatric Residents on their roles and responsibilities to report adverse safety events along with the process of filing reports led to a residency-wide change in the culture of reporting. These reports identified patient safety vulnerabilities and opportunities for change. Offering an incentive initially increased adverse safety event reporting; however, this is not required to create a sustainable event reporting process. Next Steps: 1. Residents will participate in clinical site patient safety investigations to help identify causes of events and institute systems-based changes. 2. Provide feedback to residents on select individual safety reports and system change outcomes. 3. Implement a similar QI project with Fellows and Attending Physicians.

19. UTILIZING PEDIATRIC CHIEF RESIDENTS IN PATIENT FLOW MANAGEMENT: A SYSTEMS-BASED PRACTICE (Descriptive Abstract)

Tolu Adebanjo MD, MPH, Natalie Villafranco MD, Nicole Hannemann MD, Kimberly Lehecka MD, Michelle Lyn MD, Deborah Hsu MD, MEd, Baylor College of Medicine (Houston), Houston, TX

Background: Waits, delays, and cancellations occur frequently in healthcare. Pediatric residents are sometimes unaware of how their daily work habits impact patient flow. Chief residents are leaders with detailed knowledge of inpatient structure and resident daily work flow. Spurred by a need for cultural change to improve patient flow metrics, our hospital administration created a new role, the Patient Flow Chief (Flow Chief), for pediatric chief residents. Objectives: Describe the creation of an innovative role for pediatric chief residents in patient flow management and assess the Flow Chief’s effect on resident behaviors that influence patient flow. Methods: Setting: Urban quaternary care children’s hospital. In our new role, we conducted a needs assessment through discussions with hospital administrators and survey distribution to all pediatric residents to gauge their views on census alerts, discharge barriers, and medical milestones. Six months post-implementation, we re-surveyed all residents to assess for behavior changes. Results: Our needs assessment identified gaps in addressing discharge barriers, identifying safety issues, resident education on patient flow concepts, and working relationships between residency representatives and hospital administrators. Based on these findings, the Flow Chief role consists of 1) participating in administrative meetings 2) developing targeted resident education 3) troubleshooting physician-related discharge barriers 4) participating in quality improvement initiatives. Response rates for pre- and post-implementation resident surveys were 66% & 55% respectively. 47% pre- vs 60% post-implementation respondents indicated expediting discharges when the hospital was on census alert. 49% vs 61% indicated communicating patient discharge barriers with nursing. 72% vs 84% indicated knowing their patient’s medical milestones. Conclusion: Pediatric chief residents can serve an important role to drive cultural change in patient flow management. Study of the Flow Chief’s impact on patient flow and safety at our hospital is ongoing.
EVALUATION / FEEDBACK

20. IMPLEMENTING A MILESTONE-BASED SYSTEM OF PEDIATRIC FACULTY EVALUATION (Research Abstract)

Richard J. Mazzaccaro MD, PhD, Kris A. Rooney MD, Elaine A. Donoghue MD, Lehigh Valley Health Network/University of South Florida College of Medicine, Allentown, PA

Background: While milestones have now become standard tools for assessing resident performance, a milestone-based system may also have a role in evaluating the teaching performance of faculty. Purpose: To develop and implement a novel set of Teaching Competencies with respective milestones to provide more meaningful assessment and evaluation of pediatric residency faculty. Methods: A bottom-up approach was used to develop a novel set of seven core Teaching Competencies through literature review and faculty feedback. Respective milestones represent a continuum of faculty performance from a novice/ineffective teacher through expert clinical educator. An IRB-approved study surveyed faculty satisfaction with this new Milestone-based Faculty Evaluation Tool (MBET) as compared to a Likert scale-based evaluation (LSE) before and after implementation. Results: Pre- and post-implementation surveys were completed by 65% and 53% of faculty, respectively. Overall, faculty rated increased satisfaction with the MBET on the overall feedback they receive (74% vs. 61%) and comments from residents (81% vs. 64%), as compared to a LSE. The MBET was more useful to faculty than a LSE in all areas surveyed, including evaluation of their: clinical teaching (71% vs. 54%); supervision of residents (71% vs. 54%); autonomy to residents (65 vs. 54%); interpersonal and communication skills (70% vs. 62%); professionalism (70% vs. 59%); feedback to residents (70% vs. 59%); teaching of evidence-based medicine (63% vs. 40%) and quality improvement (59% vs. 37%). Overall, 65% of faculty felt that a MBET was slightly or much better than a LSE, and 56% of faculty preferred the MBET. Conclusions: We have created a novel set of core Teaching Competencies with associated milestones for use in evaluating pediatric faculty. A survey of pediatric faculty found that milestone-based evaluation provided more useful information and feedback across multiple educational behaviors and was overall preferred by our faculty. Milestones can therefore be used for assessment of clinical faculty.

21. THE NATIONWIDE CHILDREN’S HOSPITAL (NCH) FACULTY CLINICAL TEACHING MILESTONES: EARLY ASSESSMENT OF EFFECTIVENESS (Research Abstract)

Rebecca Wallihan MD, Karyn Kassis MD, Rebecca Matthews MD, Margaret Chase MD, John D. Mahan MD, Nationwide Children’s Hospital/Ohio State University, Columbus, OH

Background: Assessment of faculty teaching has long relied on normative Likert-type evaluations. After positive experiences with resident milestones, we developed faculty teaching milestones based on the Stanford Faculty Clinical Teaching rubric. We proposed that this tool would provide more variable assessments of faculty teaching performance by pediatric and medicine-pediatric residents. Methods: NCH Faculty Clinical Teaching Milestones (NCH FCTM) are composed of 10 items (9 based on the Stanford rubric + 1 professionalism item) as created by a committee of program directors (PDs) and faculty development leaders followed by 4 cycles of review and clarification/revision by other PDs, faculty educators, chief residents, and trainees. Final revisions occurred after a pilot trial (25 resident raters). NCH FCTM were collected from Jul-Sep 2015 and contrasted with faculty evaluations performed by similar level residents from Jul-Sep 2014 using a normative system. Results: The NCH FCTM method was well regarded by trainees (domains better identified faculty teaching performance) compared to the previous traditional faculty evaluation model. They found the NCH FCTM method easy to use; faculty perception was also positive. In these early results, the NCH FCTM method did not provide more variability in overall scores of faculty (see Table) but provided lower mean and median values and thus a more complete range to assess higher and lower performance. Analysis of specific inpatient, ICU and EM faculty demonstrated results similar to the all faculty analysis. For the specific Feedback item SD, COV and QCOD were greater while for Professionalism COV was greater than that seen with the 2014 method. Conclusions: These newly developed Faculty Teaching Milestones provided a better assessment method of faculty teaching performance than a traditional Likert-based normative method. The greater range of milestone determinations and greater dispersion should allow more specific assessments and feedback to help drive improvement in faculty teaching skills.

<table>
<thead>
<tr>
<th>All Faculty: Average Faculty Teaching Scores (1-S scale Likert for 2014; 5 milestones per item for 2015)</th>
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<tr>
<td></td>
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<tr>
<td>Mean</td>
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<td>75th Percentile</td>
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<td>Quartile Coefficient of Dispersion (QCOD)</td>
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22. CORRELATION OF PEDIATRIC RESIDENCY APPLICANT SCORING WITH MEAN PEDIATRIC MILESTONE ASSESSMENT SCORES FOR 2013-14 AND 2014-15 PEDIATRIC INTERNS AT A MEDIUM SIZED PEDIATRIC RESIDENCY PROGRAM (Research Abstract)

Daniel Sklansky MD, Grant Syverson MD, John Frohna MD, Melissa Cercone MD, Kathy Desantes MD, Jens Eickhoff PhD, University of Wisconsin, Madison, WI

**Background:** Evidence is lacking for predictors of resident performance during residency years. USMLE Step 1 and 2 exams may be used to predict graduation rates and pediatric board pass rates, but have not been linked to broader resident performance. Other aspects of residency applications have not been linked to outcomes, nor have outcomes during the residency period been thoroughly studied. **Aims:** We sought to correlate resident applicant scores with future resident performance as measured by aggregate Pediatric Milestone scores. **Methods:** An application scoring tool was designed by the associate program directors to give specific scoring weight to applicant attributes and accomplishments in the areas of scholarly activity, commitment, humanism, and leadership in addition to traditional exam scores and class rank. Scores were compared to weighted means of all 21 required ACGME sub competency milestones that were compiled from end of rotation faculty assessment forms for the 2013 (N=15) and 2014 intern classes (N=15). We used a linear regression model to analyze the relationship of application scores to mean milestone scores in the two most recent intern classes. Multivariate analysis using available demographics was also performed. **Results:** We found a strong correlation between application score and mean milestone score for both classes. USMLE scores were strongly correlated (r=0.82, p<0.001) for the 2013 intern class, but only moderately correlated (r=0.56, p=0.03) at all for the 2014 intern class, with disparate class means. When USMLE test outcomes were removed, the other attributes in the applicant scoring tool showed moderate correlation with mean milestone scores for both intern classes (r=0.6, P<0.02), with no effect from gender or local medical school matriculation. **Conclusion:** Our data show that characteristics and accomplishments of applicants may correlate with performance during internship as measured by mean pediatric milestone assessments.

![Graph showing correlation between application score and mean milestone score](image)

23. ASSESSING ACTING INTERN READINESS FOR RESIDENCY WITH A PAPER OSCE (Descriptive Abstract)

Susan G. Mautone MD, Rutgers New Jersey Medical School, Hackensack, NJ, Christin M. Traba MD, MPH, Rutgers New Jersey Medical School, Newark, NJ

**Background:** The AAMC 2014 publication entitled Core Entrustable Professional Activities for Entering Residency (CEPAER) lists 13 activities a PGY-1 resident should be able to perform without direct supervision on day 1 of residency. **Objectives:** We sought a cost-effective and efficient means to document Acting Intern (AI) competence in arriving at an accurate diagnosis, developing a relevant differential diagnosis and writing orders and prescriptions (now elements of CEPAER 2,3 and 4) by direct faculty observation. **Methods:** All students completing an Acting Internship in Pediatrics at our institution are provided written and online instruction in writing orders and prescriptions at the start of the rotation, and supervised practice is provided throughout the rotation. Students are expected to offer their thoughts on patient diagnosis and differential diagnoses during daily attending rounds, at Morning Report and in their documentation of H&Ps and daily progress notes. Ongoing formative feedback is provided by supervising faculty and senior residents. At the conclusion of the rotation each AI completes a 3-station, open-book paper OSCE. Stations were developed to specifically assess AI competence in the targeted areas. Submitted work is reviewed by the Program Director or Associate Program Director and feedback is provided to students within 24 hours. Students also complete a self-assessment of their perceived level of performance in the 13 CEPAER. **Results:** For the past 10 years, 135 students applying for pediatric residency completed an Acting Internship in Pediatrics and the end-of-rotation paper OSCE. With few exceptions, students demonstrated competence in the targeted CEPAER at the
Conclusion: Students can achieve the expected level of competence in these core EPAs during a rigorous 4-week Acting Internship. A paper OSCE is an inexpensive, time- and cost-effective, reliable tool to assess and document student readiness for residency training in the selected CEPA-ER.

24. MULTI-INSTITUTIONAL DETERMINATION OF THE CORRELATION BETWEEN MILESTONE LEVEL BY ROTATION-SPECIFIC EPA ASSESSMENT AND PRIMARY SUBCOMPETENCY ASSESSMENT (Research Abstract)

Jerry G. Larrabee MD, University of Vermont Medical Center, Burlington, VT, Dewesh Agrawal MD, Children’s National Medical Center, Washington, DC, Franklin Trimm MD, University of South Alabama, Mobile, AL, Mary Ottolini MD, MPH, Children’s National Medical Center, Washington, DC

Background: Entrustable Professional Activities (EPAs) have been suggested to be a link between the theoretical framework of competencies and real world clinical practice. One approach to the assessment of EPAs is based on a scale of entrustment that reflects the level of supervision required for the trainee to perform the activity. There has been no study to look at the reliability of mapping the levels of entrustment directly to the milestone levels of the subcompetencies. Objective: Our primary objective was to determine the correlation of milestone level by parallel and concurrent EPA assessments and primary subcompetency assessments. Methods: Shared rotation-specific EPAs were derived from core rotation objectives using Delphi method across our 3 different and diverse programs. Rotation evaluation data for PICU, NICU, General Inpatient, and Continuity Clinic rotations from the 2014-15 academic year from the 3 institutions were entered into a REDCap database. Multivariate linear regression models were utilized to predict each subcompetency milestone assessment from the predetermined rotation-specific EPAs. Results: A statistically significant proportion of the variance for all subcompetency milestones was predicted by the set of mapped rotation-specific EPAs (Median R² = 0.81). Conclusion: We found a statistically significant degree of correlation between milestone level as determined by rotation-specific EPA assessment using entrustment scales, and corresponding milestone level as determined by primary subcompetency assessment. Our data support the approach of creating evaluation tools where multiple subcompetencies can be mapped and validly assessed by a set of rotation-specific EPAs.

25. IMPLEMENTATION OF A WEEKLY FORMAL FEEDBACK PROTOCOL INCREASED RESIDENT SATISFACTION AND THE PERCEPTION OF INFORMAL FEEDBACK (Descriptive Abstract)

Leia M. Woelkers DO, Crozer-Chester Medical Center, Upland, PA, Jenna Trosko MD, Wilmington, DE, Stephen Higgins MD, Crozer-Chester Medical Center, Kelly Bradley-Dodds MD, Upland, PA

Objective: The purpose of this study was to evaluate and improve feedback given to Pediatric residents during their NICU rotation. The study evaluated the institution of a formal feedback system between Pediatric resident physicians and Neonatology faculty physicians in the NICU, and whether the new system would increase the value and frequency of feedback residents received from their faculty on this rotation. Method: A survey was distributed to residents before and one year following the introduction of a requirement for a weekly feedback session between faculty and residents. The required weekly feedback session was structured with an outline inspired by the Pediatric Milestones which critiques resident performance on daily rounds, procedural skills, relationships with ancillary staff and team members, medical knowledge, hand-offs/safety and patient care procedures. The rubric was designed to facilitate narrative-based feedback grounded in the developmental paradigm of resident education. The study subjects were Pediatric residents of all training levels including PGY-1, PGY-2 and PGY-3. The survey assessed residents’ perception of the frequency, usefulness, and tone of their feedback, as well as their motivation levels after receiving it. Results: With the addition of a formal feedback protocol, the residents reported overall increased frequency and satisfaction of both informally and formally given feedback. After implementation of the feedback protocol, all residents reported at least once weekly feedback with the majority reporting informal feedback more than once weekly. The residents also felt as though the feedback they received was overall of greater quality, more useful, and more constructive after implementing the protocol. Conclusion: With the overwhelming positive response from the resident trainees regarding the new system, the feedback protocol was instituted as a permanent component of the NICU rotation, with future plans to implement a similar protocol on other rotations, to assist in evaluation and continued education of the residents throughout training.

26. STUDENTS AS DIRECT OBSERVERS OF RESIDENTS: A COMPARISON OF MILESTONE-BASED ASSESSMENTS BETWEEN FACULTY AND STUDENTS (Descriptive Abstract)

Carla R. Schwartz MD, Erin McMaster MD, University of Massachusetts, Worcester, MA, Christopher Recklitis PhD, MPH, Boston, MA, Mark Vining MD, University of Massachusetts, Worcester, MA

Background: Milestone-based assessment of resident knowledge, skill, and attitude requires direct observation, yet a resident’s work is often not under direct faculty supervision. Students work alongside residents at times when faculty do not. This project aims to understand if students’ milestone-based evaluation of residents’ communication and professionalism skills provide additional information when compared to faculty evaluations alone. Methods: Over 6 months, medical students...
were oriented to milestone-based assessments during clerkship orientation. Students were asked to anonymously evaluate residents on five sub-competencies (ICS1, ICS2, Prof1, Prof3, Prof5). To determine assessment trends, the highest and lowest milestone scores for each resident, as well as the resident rank order from highest to lowest milestone level, were compared between faculty and students. Results: 46 student evaluations were submitted. 20 residents had milestone assessments from at least one faculty and student evaluator in the same sub-competency which could be paired for analysis (N=62). Students tended to assess residents at higher milestone levels: student’s high scores exceeded faculty high scores 43 times, whereas student’s low scores were lower than faculty low scores only 20 times. Also, differences exist between student and faculty rank order of residents from highest to lowest milestone level for all five sub-competencies, reaching statistical significance for ICS1 (Communication with patients/families, p<0.008) and Prof5 (Trustworthiness, p< 0.001) (Wilcoxon Signed Ranks Test). Conclusions: The differing rank orders of residents by milestone level between students and faculty suggest students may see different skills and attitudes than faculty. Student comments offered different perspectives than we receive on school-administered evaluations which tend to focus on resident teaching skills. Further data collection and analysis is needed to determine if statistically significant differences between faculty and student assessments emerge for the other sub-competencies in addition to ICS1 and Prof5.

27. OVERCOMING MINNESOTA NICE: PROTECTED TIME FOR PEER FEEDBACK (Descriptive Abstract)
Patricia T. Hickey MD, Ellen Christiansen MD, Heather Dahlquist MD, University of Minnesota, Pallavi Kamra MD, Minneapolis, MN

Background: Providing feedback to physicians increases self-awareness and promotes behavioral change, which may result in better patient care. Unfortunately, giving peer-to-peer feedback is often avoided in the workplace due to time constraints and/or discomfort with critiquing colleagues. At our institution, residents received intermittent, anonymous written feedback and only 50% reported satisfaction with this feedback, compared to the national average of 70%. Objective: To increase the frequency and quality of resident peer feedback and improve residents’ comfort engaging in verbal feedback. Methods: Baseline data was obtained from pediatric and internal medicine-pediatric residents at the University of Minnesota with an online survey. Chief residents implemented weekly peer feedback sessions at four inpatient pediatric sites. Time was protected and residents were instructed to share personal improvement goals and provide each other with feedback. A follow up survey was sent at 6 months. Results: Response rates for the baseline and 6 month surveys were 38% and 51% (n=102) respectively. Residents participating in weekly verbal peer feedback increased from 13% to 69%, 78% of residents felt comfortable giving feedback compared to 49% at baseline, while 87% reported comfort receiving feedback compared to 77%. The percentage who felt their peer feedback was useful increased from 74 to 78%. 81% believed that peer feedback had caused a change in their practice compared to 71% at baseline. Conclusion: This qualitative study suggests that chief-facilitated peer feedback sessions increase the frequency of and comfort with peer feedback. This feedback can lead to a perceived change in practice with the goal of improved patient care.

28. ASSESSMENT OF PRIMARY CARE ANTICIPATORY GUIDANCE THROUGH THE USE OF AN OBJECTIVE STRUCTURED CLINICAL EXAMINATION (Descriptive Abstract)
Luke Shieh MD, Allison Rometo MD, Ana Malinow MD, UPMC Medical Education, Pittsburgh, PA

Background: The objective structured clinical examination (OSCE) is a validated tool in medical education that can provide formative evaluation of individual residents and has potential to help standardize education of residents at various clinical sites. Objective: Our project assessed the need for a primary care anticipatory guidance OSCE in pediatric resident education and begins to define an expected competency level for our residents. Methods: All first and third year residents were asked to complete two OSCEs using professional standardized patients. The cases for first-year residents were a 12-month-old well child and acute gastroenteritis. The cases for third-year residents were an 11-year-old well child and functional abdominal pain. We developed a scoring checklist using literature from the American Academy of Pediatrics as well as input from local pediatricians. Post-OSCE surveys assessed resident satisfaction with the project and application of acquired knowledge. Results: Forty seven percent (17/36) of first year residents and forty four percent (14/32) of third year residents completed the OSCE. Mean scores for the 12 month old well child and the acute gastroenteritis cases were 5.5/14 [SD = 2.2] and 8.6/14 [SD = 2.2], respectively. Mean scores for the 11-year old well child and the functional abdominal pain cases were 10.6/14 [SD = 1.3] and 6.5/14 [SD = 2.2], respectively. In the immediate post-OSCE survey, 94% (16/17) first-year residents and 100% (14/14) of third-year residents rated the cases as relevant, very relevant or extremely relevant to their practice. Of those who completed our two month post-OSCE survey, 85% (11/13) of first year residents and 90% (9/10) of third year residents stated they made changes to their clinical practice due to the OSCE. Conclusion: Residents deemed a primary care anticipatory guidance OSCE as clinically relevant and support incorporating it into the educational curriculum. The scores are distributed in a way that will allow us to develop an expected competency level of primary care anticipatory guidance for our residents as more data are collected.
29. ASSESSMENT OF CLINICAL REASONING IN AN ENVIRONMENT OF UNCERTAINTY: A SCRIPT CONCORDANCE TEST FOR NEONATAL-PERINATAL MEDICINE (Research Abstract)

Grant Erickson MD, Kari Wagner, National Capital Consortium, Bethesda, MD, Maribel Morgan, San Antonio Uniformed Services Health Education Consortium, Fort Sam Houston, TX, Jennifer Hepps, Gregory Gorman, National Capital Consortium, Christopher Rouse, Bethesda, MD

Background: While clinical reasoning is a crucial aspect of graduate medical education, there are limited modalities to evaluate development of these skills. The Script Concordance assesses clinical decision making skills in situations of uncertainty. While Script Concordance Tests have been validated for other specialties, no test has been validated for neonatal-perinatal medicine. 

Objective: To design and gather validity evidence for the use of a Neonatology Script Concordance Test. Methods: A 50 question Script Concordance Test was designed using the American Board of Pediatrics general pediatrics content outline. The test was given to 10 staff neonatologists across the country from different training backgrounds to serve as the panel of experts for the basis of scoring. The test was administered to 27 pediatric residents and neonatal-perinatal medicine fellows across all training levels. Results: Pediatric PGY-1s had a median score of 26.12 (range 19.99-30.08), PGY-2s had a median score of 28.50 (range 18.82-32.59), PGY-3s had a median score of 28.68 (range 21.77-31.28), and neonatal-perinatal medicine fellows had a median score of 32.24 (range 30.12-35.51) out of 50 possible points. A Kruskal-Wallis rank-sum test demonstrated a significant difference between all training levels (p=0.02). Wilcoxon rank-sum tests for paired comparison between groups showed a significant difference between PGY-3 and fellows (p=0.047). Conclusion: A Script Concordance Test can determine the progression of clinical decision making skills in neonatology during graduate medical training

30. OPTIMIZING EDUCATIONAL EXPERIENCES THROUGH REAL-TIME CONFERENCE FEEDBACK (Descriptive Abstract)

Matthew W. Zackoff MD, Alisha George MD, Joseph Knadler MD, Ndidi Unaka MD, MEd, Sue Poynter MD, MEd, Javier Gonzalez MD, MEd, Cincinnati Children’s Hospital Medical Center/University of Cincinnati College of Medicine, Cincinnati, OH

Background: While pediatric residents gain valuable knowledge and skills through clinical experiences, formal educational conferences are crucial to ensure adequate preparation for the ABP Certifying Exam. At our institution, which trains over 190 pediatric residents each year, educational conferences were not systematically evaluated and hence feedback was inconsistently provided to presenters. Objective: Our primary objectives were to 1) develop a system for real-time assessment of twice-daily conferences and 2) develop a standardized approach for disseminating actionable feedback to presenters to optimize conference quality. Methods: We developed a brief 6 item survey that was intended to be completed by residents immediately following daily morning and noon conferences. In addition to questions on conference type, date and topic, respondents assessed speaker engagement and topic relevance via a 5 point Likert scale. An additional free text item allowed for comments. A Google form was utilized to administer the survey, allowing repeated use without alteration needed for each conference. A link to the form was disseminated to residents via weekly emails and on the residency website and can be saved on a phone home screen, allowing one-click access following conference. Residents were encouraged to complete the surveys in real-time, allowing feedback to be aggregated and shared via email with the presenters using a standardized form. Resident- or chief resident-generated actionable steps for improvement were offered when indicated. Results: The tool was utilized July-Dec 2015, with 1,020 individual conference evaluations submitted for faculty-delivered conferences. The average response rate per conference was 12. Results were aggregated and sent to presenters with actionable suggestions for improvement within one month of the presentation. Conclusion: Adoption of a brief, reusable, electronic survey generates both real-time conference evaluation and timely, actionable feedback for presenters. Future directions include assessing the impact of the feedback on speaker engagement and educational content of the conferences.

CURRICULUM / EDUCATION

31. AN EPIC PROBLEM IN THE GOPHER STATE: UNIFYING ELECTRONIC HEALTH RECORD ORIENTATION FOR LEARNERS ACROSS MULTIPLE SYSTEMS IN MINNESOTA (Descriptive Abstract)

Michael B. Pitt MD, Marcus Seyward DC, Michael H. Kim MD, University of Minnesota, Minneapolis, MN

Background: The University of Minnesota is one of the largest medical schools in the country with over 900 medical students who rotate across over several medical systems across the state. Most of these systems use Epic for their Electronic Health Record (EHR) with each site requiring its own unique training. Objectives: Determine the time burden spent on EHR orientation by medical students rotating across the sites using Epic and determine feasibility of creating a single orientation across the systems. Methods: We surveyed the Epic educators responsible for training at each site to determine what type of onboarding they required, what they were teaching and how, and the expected time burden for learners. We asked if they were open to a single onboarding, and if so, what core components would be necessary in this curriculum. We then used a Delphi method through conference calls and email to obtain a consensus for course objectives. Results: We identified six programs who host our medical students and use Epic for their EHR. All required individual training ranging from less than two hours (n=2) to greater than four hours (n=1). Three programs used e-learning only, two used in-person training only, and one used both. All programs were eager to create a standardized orientation which could be used across sites, with most (4/6) indicating they would anticipate still requiring a brief (less than 30 minute) orientation to site specific processes. We identified 14 skill
areas where orientation was required at one or more of the institutions (i.e. Entering Orders, Navigating Results Review). We reached agreement on learning objectives for four modules covering the topics Epic Overview, Ordering, Patient Information, and Documentation, and will be implementing the standard orientation beginning in June 2016. **Conclusion:** We were able to develop a model single onboarding curriculum for Epic EHR for multiple systems across the state which we anticipate will greatly decrease time spent by learners repeating material.

### 32. CURRENT EVENTS: TEACHING BEYOND THE LITERATURE (Descriptive Abstract)
*Elizabeth K. Nelsen MD, Winter Berry DO, Steven Blatt MD, Ellen McHugh MD, SUNY Upstate Medical University, Syracuse, NY*

For decades, medical educators have recognized the need to train house staff on how to keep up with the literature and current health information after they graduate. With the exception of Journal Club, few activities have been developed to address this. We have innovated a new way of teaching our learners about current topics in pediatrics. The Division of General Pediatrics provides three one-hour didactic sessions per week for residents rotating in the outpatient clinic. One session is devoted to current events. Four Division faculty participate in these sessions, and present articles from traditional journals as well as mainstream media. Topics are current, including stories identified from the morning paper to articles from journals published that month. During the discussion a faculty member augments source articles with supporting articles or data. After each session the articles and supporting information are emailed to residents. The topics, sources, and articles discussed during these sessions were tracked from January to September 2015, and were analyzed for a variety of qualities. In 36 sessions, a total of 182 articles were used, and only 2 were repeated once each. On average, 5 articles were reviewed during each session (range 2-13). 79 unique sources were accessed, and the 3 most common were Pediatrics, the NY Times, and JAMA Pediatrics. New England Journal of Medicine and other pediatric journals were also used. The three most common topics covered were newborn medicine, infectious disease, and general pediatrics. Other topics included poverty, the anti-vaccine movement, and professionalism. The format of the sessions lends itself to an easy yet well-informed discussion. It gives learners insight into hot topics that patients and families are hearing about, and provides them with evidence so they are prepared when these issues arise. The setup allows for discussion on matters not often found in traditional curricula. The post-session email gives residents the chance to start their own general pediatric library of information. Lastly, these sessions spur the faculty to stay abreast of current information and recent publications.

### 33. A CURRICULUM FOR EDUCATING RESIDENTS TO CARE FOR LGBTQ YOUTH (Research Abstract)
*Brian Lurie, MD, MPH, Atlantic Health Program, Morristown, NJ*

**Background:** Although the majority of adolescents identifying as LGBTQ will grow up to be healthy and resilient, this population faces significant health disparities and lack access to quality health care. Many health care providers find it difficult to care for them because of lack of formal training and few professional resources. Currently, there are no uniform training requirements on LGBTQ health at the graduate medical education level. Recent studies show that in undergraduate medical education the median time dedicated to LGBTQ related content is five hours over four years. Barriers to content inclusion include lack of curricular materials demonstrated to be effective and absence of faculty able to teach relevant content. There is a need for specific evidence-based educational interventions to improve a Pediatric resident’s knowledge, skills, and attitudes to caring for LGBTQ individuals. **Methods:** As per Kern’s six steps of curricular development, needs assessments were conducted. Goals and objectives and educational strategies were developed based on a comprehensive literature review and the needs assessments. Using a single academic center intervention design, participants completed a pre-test based on evidence from the literature, were exposed to the curriculum, and then completed a post-test immediately after and again four to six months post to assess for retained knowledge. The curriculum consisted of a 2 hour interactive didactic session, an on-line module, an article titled, “Office Based Care for Lesbian, Gay, Bisexual, Transgendered, and Questioning Youth”, and an on-line scavenger hunt identifying available resources. The pre and post-test assessed comfort level and consisted of 47 questions: 22 addressing definitions, 8 addressing disparities of care, 8 addressing communication techniques, 5 concerning developmental challenges, and 4 about resources. Using the Wilcoxon Signed Rank Test, scores from the pre test, immediate post test and 6 month post test were compared. **Results:** 29 Pediatric Residents from one institution successfully completed all components of the curriculum (12 PGY-1s, 9 PGY-2s, 8 PGY 3s). From the pre to post-test, there were significant increases in comfort level (p=0.003) and number of correct answers (p<0.001). The median difference was an increase of 8 questions, min -2, max 17 (95% CI 6, 11). In general, there was an increase in scores in all categories (p<0.001), except the developmental challenges. Comparing the immediate post-test to the 4-6 month post-test, there were no significant changes in comfort level or number of correct answers, median -1.5, min -8, max 6 (95% CI -4, 1). **Conclusion:** A curriculum addressing definitions, health disparities, communication techniques, and resources available for sexual minority youth increases a Pediatric resident’s comfort level and knowledge in caring for this population. Knowledge was also retained for a period of time after completing the curriculum.

### 34. CREATIVE WAYS TO IMPLEMENT A PRIMARY CARE CURRICULUM (Descriptive Abstract)
*Daniel A. Nicklas MD, Emily Greenwald MD, Julia Brant MD, Janice Hanson PhD, EdS, University of Colorado, Aurora, CO*

**Background:** In 2006, the Yale pediatric residency switched from free-form review of topics to case-based curriculum for primary care conference and showed an increase in learner satisfaction, participation, and confidence in some areas. The
Discussion: Learning optimal history-taking and presentation skills is a crucial aspect of intern preparedness and fulfilling admission (MI=1) and a follow-up case (MI=0.7). Additionally, interns felt more confident in establishing rapport (MI=0.7), past medical history (MI=0.9), psychosocial history (MI = 1.3), adolescent psychosocial history (MI=1.8), presenting workup. Improvements in confidence, out of 5 Likert points, were in: obtaining the history of present illness (mean improvement level of confidence.

Methods

It included an interactive lecture on the components of a history, techniques for obtaining one and building rapport, practice with obtaining histories and presenting cases (n=11). The workshop was part of an innovative intern bootcamp to aid in preparedness. Improvements in confidence, out of 5 Likert points, were in: obtaining the history of present illness (mean improvement level of confidence.

36. HISTORY TAKING AND PRESENTATION SKILLS REBOOT: A WORKSHOP TO BOOST CONFIDENCE IN INTERNS (Descriptive Abstract)

Sonia Desikan MD, MPH, Brooklyn Hospital Center, Brooklyn, NY

Background: History taking and presentation skills are key components of ACGME patient care milestones. The expectation is that skills are honed in medical school and clinical experiences before residency, providing a foundation to improve gathering, organizing and synthesizing clinical information. Interns may lack the confidence to execute expected baselines at the start of residency. A refresher workshop in history taking and presentation basics could refine skills and boost intern confidence. Design/Methods: Surveys during intern orientation before and after a History and Presentation Skills Workshop measured confidence in obtaining histories and presenting cases (n=11). The workshop was part of an innovative intern bootcamp to aid in preparedness. It included an interactive lecture on the components of a history, techniques for obtaining one and building rapport, practice with comprehensive oral presentations, and evaluating notes. Pre and post-survey Likert-scales, scored 1 through 5, measured intern confidence, out of 5 Likert points, were in: obtaining the history of present illness (mean improvement level of confidence.

Results: Paired t-tests, in Excel, calculated differences in mean intern confidence levels before and after the workshop. Results were statistically significant for all questions with p values < 0.01, demonstrating increased confidence after the workshop. Improvements in confidence, out of 5 Likert points, were in: obtaining the history of present illness (mean improvement (MI)=0.9), past medical history (MI=0.9), psychosocial history (MI = 1.3), adolescent psychosocial history (MI=1.8), presenting an admission (MI=1) and a follow-up case (MI=0.7). Additionally, interns felt more confident in establishing rapport (MI=0.7).

Discussion: Learning optimal history-taking and presentation skills is a crucial aspect of intern preparedness and fulfilling patient care obligations and call schedules and variable attending uptake of the curriculum. Conclusions: Next steps include: Deliver the curriculum in a new digital learning management system to increase access; add podcasts; provide faculty development at continuity clinic sites; tie resident assessment to specific learning objectives in lesson plans.
38. TEACHING PEDIATRIC RESIDENTS TO ASSESS FOR AUTISM SPECTRUM DISORDERS (Descriptive Abstract)

Sonia A. Monteiro MD, Kathryn K. Ostermaier MD, Baylor College of Medicine (Houston), Dinah Godwin MSW, Robert Voigt MD, Baylor College of Medicine (Houston), Houston, TX

Background: The prevalence of autism spectrum disorders (ASD) has increased in primary care practice. There is a scarcity of subspecialty autism diagnostic resources to refer to and long wait lists at tertiary care evaluation centers. Resident confidence and competence in identification and evaluation of children with concerns about ASD is crucial to build a future workforce of primary care providers to serve both children with ASD and neurodevelopmental disorders. Most pediatric residents experience in developmental pediatrics involves only observation. A DBP curriculum where residents perform developmental assessments under the supervision of an experienced faculty member has not been reported. Research investigating the ability of pediatric residents to perform hands-on clinical evaluations for children with ASD and other neurodevelopmental disorders is scarce.

Objectives: To assess the ability of pediatric residents to perform hands-on clinical evaluations of social, behavioral, language, visual problem solving, and motor development of children referred to a tertiary care developmental evaluation center due to concerns about possible ASD. Methods: Pediatric residents on their core Developmental pediatrics rotation between January and March of 2015 were paired with a Developmental Pediatrics faculty member to evaluate children for ASD. Residents obtained medical and developmental histories, performed physical exams and performed developmental testing. Prior to checking out with a faculty member, residents completed a form to document their clinical impression of whether the child had ASD, did not have ASD, or needed further evaluation with a psychologist. Residents also documented the presence or absence of gross motor, fine motor, and language delays. The same form was then completed by the faculty member after checking out the patient, and resident and faculty diagnoses were compared.

Results: 15 residents completed 29 diagnostic forms with each resident completing between 1 and 3 forms. Concordance of resident and faculty ASD diagnoses was 72% (N=21 forms); concurrence of resident and faculty developmental delay diagnoses was 48% (N=14 forms). Agreement on the presence of a language delay was 96% (25 out of 26 children). Gross motor and/or visual problem solving delays were not identified by residents in 31% (N=9) of the evaluations.

Conclusions: Our study provides preliminary evidence on the ability of pediatric residents to clinically evaluate patients for ASD. Allowing residents the opportunity to directly evaluate children for ASD while being supervised by an experienced clinician could strengthen existing ASD curriculums that include case-based educational modules focusing on medical knowledge. Future studies will need to examine whether assessments made by residents over the course of the month improve and if these skills are applied going forward into the 2nd and 3rd years of residency, as well as following completion of pediatric residency, will also need to be examined.
9. AN INTENSIVE CLINICAL ORIENTATION FOR RESIDENTS: INCREASING INTERN PREPAREDNESS (Descriptive Abstract)

Ariel S. Winn MD, Carolyn H. Marcus MD, Theodore C. Sectish MD, Children's Hospital/Boston Medical Center, Boston, MA, Grant C. Smith BA, MSc, Children's Hospital/Boston Medical Center, Jamaica Plain, MA, Irina Gorbounova BSc, Christopher P. Landrigan MD, MPH, Children's Hospital/Boston Medical Center, Boston, MA

**Background:** The AAMC has published a list of core Entrustable Professional Activities (EPAs) that all graduating medical students should be expected to be able to perform on day one of residency without direct supervision. However, most interns start internship with little preparation or training in how to perform these skills. **Methods:** A 3-day Intensive Clinical Orientation for Residents (ICOR) was designed based on targeted needs assessment data and piloted for half of the incoming interns in the Boston Combined Residency Program (N=24) just prior to starting intern year. Participants were assigned to rotate through an inpatient ward; they performed the usual functions of interns, such as participating in handovers, entering orders, admitting patients and calling consults. However, they cared for half the usual number of patients with double the supervision. They received intensive feedback and coaching on the EPAs and participated in workshops focusing on these skills. All supervisors were trained to give feedback to the interns and role model best practices. Participants completed a survey assessing their reactions to the curriculum. At the end of the first block of intern year, a subset of the participating interns (N=10) retrospectively rated their perceived preparedness to start intern year on a 10-point scale. The mean ratings were compared to those of a random subset of control interns who did not participate in the curriculum (N=12). **Results:** 100% of interns thought the curriculum should be offered again next year and rated the educational value as very positive (71%) or positive (29%). 93% of interns reported feeling more confident starting intern year because of the curriculum. Retrospective preparedness to start intern year increased from a mean score of 4 pre-ICOR to 7 post-ICOR (P = 0.004). Intervention interns also retrospectively rated themselves as more prepared to start intern year on day one (mean of 7) as compared to the control group (mean of 5.6) (P = 0.0496). **Conclusion:** The ICOR was felt to be educational and resulted in improved perceptions of confidence and preparedness.

40. MAINTENANCE OF EDUCATION: FOSTERING LIFELONG LEARNING (Descriptive Abstract)

Anne Marie S. Guerrero MD, MA, Sarada S. Panchanathan MD, MS, Emily W. Wong MD, Leslie-Anne J. Dietrich MD, Hany M. Khattab MD, Lydia Rabon MD, Phoenix Children's Hospital, Phoenix, AZ

Lifelong, self-directed learning is essential for physicians. Residents are expected to trade the regimented learning style of medical school for self-directed learning, but this transition is not intuitive. Common concerns of our residents include how to plan study time during residency, as well as how to master the broad foundation of knowledge needed to pass board exams and become adept physicians. In designing our curriculum to foster residents as lifelong, self-directed learners, which we call Maintenance of Education (MOE), we looked to the American Board of Pediatrics Maintenance of Certification (MOC) program. MOC has 4 components following a 10-year cycle: (1) professional standing: maintaining licensure and CME, (2) lifelong learning and self-assessment, (3) examination of knowledge, and (4) QI project. In constructing MOE, we divided the academic year into three 4-month blocks, with each month focusing on a subspecialty. The requirements of MOE parallel MOC with a 4-month cycle for completing components 1, 2, and 3: (1) maintain residency standing by meeting educational requirements: weekly review article reading assignments with required summary questions, (2) lifelong learning and assessment: 25 monthly PREP questions, and (3) examination of knowledge: subject exams covering an outgoing block's 4 subspecialties. Component 4 entails completing a QI project prior to graduation. In January 2015, we introduced MOE to pediatric and med-peds residents, except outgoing seniors. In June 2015, a resident survey revealed that while a handful felt MOE provided too much structure and accountability, the overwhelming response was positive, including from PGY3s who opted to use MOE to help with board preparation. The number of monthly completed PREP questions increased by 2-3 times, and weekly reading increased by 30-60 minutes. Residents reported using their article summaries to guide patient management and facilitate teaching. We are encouraged by these initial positive results. We plan to next investigate MOE's effect on the 2015 In-Training Exam performance on the subspecialty topics covered in this time frame.

41. IMPACT OF TRANSITIONING FROM NOON CONFERENCE TO ACADEMIC HALF DAY ON RESIDENT ATTENDANCE, INTERRUPTIONS, AND PROTECTED EDUCATIONAL TIME (Research Abstract)

Laura E. Zastoupil MD, Leonard Selit MD, University of Colorado, Aurora, CO

**Background:** In 2014 the Pediatric Residency Program at the University of Colorado transitioned from a traditional noon conference (NC) to an academic half day (AHD), in which residents, free of clinical responsibilities, attend one 3.5 hour session per month focused on a specialty theme. Little published data has described this curriculum model. **Objective:** To analyze the impact of AHD on resident attendance, interruptions and perceived protected educational time **Methods:** In this pre-post study design we directly observed 9-12 NCs (Feb-April 2014) and 10 AHDs (Oct 2014-April 2015), gathering data on resident attendance, conference length of stay, and number of interruptions (phone calls/pages). We also compiled resident responses on the annual residency program survey regarding perceived protected educational time. The data were analyzed with either a standard two-variable t-test or chi square test. **Results:** Following implementation of AHD, conference attendance increased from 55% to 94% (P<0.0001) with increased length of stay from 84% to 92% of the conference duration (P<0.0001). Interruptions from pages and phone calls per resident per hour decreased from 0.25 to 0.01 (P<0.0001). For the cohorts of residents that received...
42. RESIDENT IN SCHOOL INITIATIVE: RESIDENT PERFORMANCE (Descriptive Abstract)
Rebecca R. Matthews MD, John D. Mahan MD, Mary Kay Kuzma MD, Melissa Meyers MD, Nationwide Children’s Hospital/Ohio State University, Columbus, OH

Background: Advocacy in pediatric residency education is an ACGME requirement. There is variation among programs in how this requirement is addressed. Since 2003, Nationwide Children’s has used the Resident In School Initiative (RISI) as part of our advocacy standard and as a method to promote better pediatric resident (PR) understanding of underserved children in their social and educational environment. This 3 year longitudinal experience places PR in underserved schools in Columbus to teach curricular objectives in nutrition, injury prevention and science (biology). This study presents the evaluation of PR performance in this experience. Methods: 74 PR were evaluated in 2012-2013. In RISI PR are assigned to the same school during specific rotations to complete 15-18 afternoon sessions during training. PR teach up to 4 classes (30 minute increments) per half day (2nd + 3rd grade students). Lessons include models, posters, and games to enhance engagement and learning. PR are evaluated on proficiency at explaining health and science concepts to elementary school students; actively engaging the students; being prepared to teach the lessons; and keeping to time expectations. Faculty preceptors at each school day directly observe the interactions. RISI program assessment includes feedback from school administrators/teachers and assessment of student engagement and learning. Results: Overall evaluation scores for these 74 PR was mean 4.62 +/- 0.23 (scale 0-5). Performance comments included mostly positive affirmations of PR classroom performance. School administrators and teachers continue to be very positive about RISI and reserve time for our PR teachers each year. Student energy, enthusiasm and learning are consistently rated highly by teachers and faculty preceptors. Conclusions: Most PR achieve competent to role model status on the teaching performance measures. RISI continues to deliver value for the students and the school. The next step in program evaluation is to formally assess resident attitudes towards this unique longitudinal advocacy experience and formally determine teacher/administrator outcomes.

43. EVALUATION OF THE TRANSITION FROM NOON CONFERENCE TO ACADEMIC HALF DAY (Research Abstract)
Amanda McIntosh MD, Jenna Sopfe MD, University of Colorado, L. Barry Seltz MD, Lindsey Lane Bmbch, Janice Hanson PhD, University of Colorado, Aurora, CO

Background: The pediatric residency program at the University of Colorado transitioned from daily noon conferences to an academic half day (AHD) format that includes small groups, case discussions, and lectures. Each resident attends one AHD per month while peers cross-cover. Few studies have described this educational model. Objective: To describe residents’ experiences with AHD. Methods: In this qualitative study, we gathered data from residents using focus groups and interviews during the transition year. We used a semi-structured interview guide, analyzed data using constant comparative methods, and collected data until reaching saturation. We developed codes using an iterative approach and then identified major themes, resolving disagreements by consensus. Results: 32 residents participated in 5 focus groups and 5 individual interviews. The AHD experience was often compared to noon conference. Analysis yielded 6 themes. Attendance/scheduling: Residents experience AHD as engaging and meaningful with improved attendance, length of stay and interruptions all improved following implementation of AHD. Although perceived protected educational time significantly increased overall, additional work on resident schedules and patient care coverage is needed to optimize the experience for PL-2s.

44. SCHOOL HEALTH IN RESIDENCY: IDENTIFYING GAPS IN PEDIATRIC TRAINING (Descriptive Abstract)
Cheryl Yang MD, Lauren Anderson MD, Jillian M. Cotter MD, Barry Seltz MD, University of Colorado, Aurora, CO

With the rise of chronic childhood disease, the urgency for integration between the health and education systems is growing. School health (SH) refers to the partnership between medical providers and schools, which provides students with accessible assistance in managing acute and chronic illness. As budding pediatricians, residents should understand SH and learn how to
build school alliances. Prior studies suggest that while residents desire further involvement in schools, they lack the necessary skills and confidence to do so. The goal of this project was to identify current gaps in SH training and perceived usefulness of developing a SH curriculum for pediatric residents at a large academic children’s hospital. We designed and conducted an electronic questionnaire of current pediatric residents and faculty at the Children’s Hospital of Colorado asking about SH experience, knowledge and education needs. The survey was trialed on a small cohort and revised based on feedback prior to distribution. 52 of 84 residents (62%) completed surveys, including 21 PL1s, 16 PL2s and 15 PL3s, with varying career interests (13% primary care, 13% hospitalist, 54% sub-specialist). The survey was sent electronically to a large faculty list-serve and 32 members participated (55% primary care, 23% hospitalists and 23% sub-specialists). While 86% of residents had exposure to SH, the majority only had limited experiences through a half-day at school-based clinics or discussion with another provider. 56% of residents had contacted a school on a patient’s behalf, but 92% reported feeling not very comfortable contacting a school. Although most (71%) residents have tried to explain school accommodations to a family, only 38% were familiar with SH terminology (IDEA, ADA, IEP and 504) or how to obtain school services for special needs children. 63% of residents viewed SH education as a medium to large priority. 82% of faculty reported interfacing with a school in the past 12 months, with a quarter actively involved. Few (3%) had a lot of SH training in residency. The majority (91%) thought additional SH education would be somewhat to very useful for residency training. In summary, pediatric residents and faculty commonly serve as liaisons between patients and schools, yet most are poorly prepared to function in this role. A SH curriculum is needed in residency programs to better enable pediatricians to advocate for their patients in the school system.

45. IMPROVING ATTENDANCE RECORDING: ELECTRONIC BADGING VERSUS TRADITIONAL SIGN IN SHEET (QI Abstract)

Drew T. Louden MD, Jaime W. Peterson MD, Valerie Gribben MD, Stanford University, Michelle R. Brooks, Palo Alto, CA

Background At Lucile Packard Children’s Hospital Stanford, pediatric residents used a traditional sign-in sheet to record attendance at Morning and Noon Conferences. Recorded attendance at these conferences was lower than expected and observed. Morning and Noon Conference average recorded attendance for the 2014-2015 academic year were 5.4 and 7.5, respectively. In addition, residency coordinators were spending significant time entering the data into Medhub for tracking purposes. Aim Statement Increase recorded conference attendance by 100% in 2015 during 3 month period when compared to the same time period in 2014. Interventions Chief Residents and Residency Coordinators at Stanford evaluated multiple different methods of recording attendance at conferences. Electronic badging was chosen for ease of use and compatibility with MedHub for direct uploading of attendance into MedHub. Each resident was given a specific Quick Response Code placed on their hospital ID that was linked to MedHub. An iPad was loaded with codeReadr software and was placed at the door for each morning and noon conference. Residents scanned their code, which automatically recorded attendance in MedHub. The scanner would prevent anyone from recording attendance if they arrived more than 50% of the way through the conference. Conference attendance data was recorded four days a week for three months (Sept 5-15-Dec 15) and compared to the previous three months (Jun 15-Sept 5) before the intervention and to the same time period the previous academic year (Sept 5- Dec 14). Measures Measures include number of recorded attendees at each conference and average conference attendance. Results After the intervention, average Morning Conference recorded attendance increased by 43% (p-value <0.005), and Noon Conference recorded attendance increased by 16% (0.02). When comparing the average recorded conference attendance from the same time period in the 2014 versus 2015 academic year, Morning Conference attendance increased by 9.7 residents a 287% increase(<0.005) and Noon Conference increased by 7.2 a 115% increase(<0.005). Conclusions and Next Steps There was a significant increase in recorded attendance at both Morning and Noon Conference after implementation of electronic attendance tracking. Manually entering attendance data into MedHub was also eliminated from a coordinator’s tasks. More data needs to be collected to measure sustainability of increase and expansion to all conferences.
46. AUGMENTING EDUCATIONAL EXPERIENCES ON OFF-SITE ROTATIONS THROUGH LOW-COST VIDEO CONFERENCING TECHNOLOGY (Descriptive Abstract)

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Background: Many academic hospitals have created satellite locations to meet needs of growing communities. Video conferencing or telemedicine has increasingly been used to address challenges of growth such as increasing subspecialty consultation demands. Similar limitations exist in providing core resident education at these locations. Conference series may not easily be reproduced for small numbers of off-site residents, leading to either abandonment of traditional conferences when off-site or replacement with alternative experiences. Objective: To pilot the use of low-cost video conferencing technology to allow remote participation in educational conferences by pediatric residents rotating at satellite locations. Methods: We sought a system with the ability for off-site residents to 1) view and hear real-time conferences presented at our main campus to maintain the same protected educational time and 2) participate actively in conferences. Through our Information Services (IS) Department, we purchased equipment to allow transmission of content to remote sites through the Skype for Business platform. This low-cost system that is integrated into our Outlook calendar software permits remote users on any device to access conference invitations and participate without the need for additional equipment. Results: Since implementation in Oct-Dec 2015, teleconferencing of didactics has occurred twice daily to a remote site, allowing six off-site residents the opportunity to participate in 120+ conferences. While attendance has not been a hurdle, there have been intermittent site-specific technology issues. The lack of an IS specialist at the remote site has limited our ability to troubleshoot acutely. We have since developed a streamlined approach for contacting IS to resolve issues prior to the next scheduled conference. Conclusion: By leveraging the platform Skype for Business with moderate upgrades to our AV technology, we can now provide interactive educational experiences for our residents at any off-site location with internet connectivity and ensure standardization of core educational content.

47. TRAINEE-LED DEVELOPMENT OF A PEDIATRIC LEADERSHIP CURRICULUM (Descriptive Abstract)

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Background: A societal expectation exists that pediatricians are effective leaders and advocates for children and communities. Given the historic changes occurring in healthcare, there is a great need for physicians to be highly skilled in transformational leadership throughout their career. The ACCME recognizes this and requires that pediatric residents be trained as effective leaders. Access to formal leadership training in medical education is variable. Needs assessment of the 14,000 members of the AAP Section on Medical Students, Residents, and Fellowship Trainees (SOMSRFT) have consistently prioritized increased leadership training. In its 2014 strategic plan, SOMSRFT established an objective to meet this important need. Methods: The Learning and Growth Workgroup developed a pilot curriculum customized for trainees that was unveiled for their executive committee. The evidence-based framework of Kouzes and Posner was used as its foundation. This training included personality-type identification to enhance self-awareness, didactics to identify leadership behaviors, and case-based small group discussions of leadership challenges and changes. After this pilot launch, participants were surveyed. Based on feedback the leadership training module was improved and presented through two delivery pathways: A session for the membership of the SOMSRFT at the 2015 AAP National Conference and Exhibition; and a streamlined module that trainees could present to colleagues in their home institution. Results: The trainee-led workgroup developed and disseminated a presentation with pediatric trainee-based cases at the AAP National Conference and Exhibition. Conclusion: Pediatric trainees desire more leadership training, and our brief, pediatric-specific presentation appears to help meet that need. Attributes of leadership training that appear to be most critical for success include: opportunity for self-reflection, peer-mentoring, utilizing real-life challenges as cases; and using evidence-based models for content and skill development.

48. TEN TIPS FOR FELLOWS TEACHING RESIDENTS (Descriptive Abstract)

Aadil Kakajiwala MBBS, Nicole Hames MD, Adam Dziorny MD, PhD, Laura Rubinos MD, Stephanie Deutsch MD, Dorene Balmer PhD, Gail Slap MD, MS, Children’s Hospital of Philadelphia, Philadelphia, PA

Background: Fellows play a prominent role in the learning and daily work life of pediatric residents in institutions with subspecialty training programs. Despite the prevalence and apparent importance of resident-fellow interactions, resident perceptions of fellow teaching and suggestions for how to improve it are poorly understood. Objective: To understand and enhance the near-peer teaching and learning interactions of pediatric residents and fellows. Methods: Pediatric chief residents at The Children’s Hospital of Philadelphia (CHOP) asked pediatric level 1-3 residents to name via an anonymous web-based survey those pediatric subspecialty fellows at CHOP who were particularly effective teachers and to describe behaviors that contributed to their effectiveness. Four fellows identified by the residents as particularly effective teachers were asked to lead a panel discussion attended by residents and fellows on their use of explicit teaching strategies when interacting with residents in clinical settings. Panelists used themes from the survey to structure the discussion. Two chief residents and one faculty independently recorded key strategies for effective resident-fellow teaching discussed during the session.
Results: Fifteen of 138 residents completed the survey. Of the 18 fellows identified by resident responders as particularly effective teachers, the four fellows who were named by at least two residents led the one-hour panel discussion attended by 12 residents and fellows and 1 faculty. Strategies for effective resident-fellow teaching interactions emerging from the survey and discussion were condensed into a Ten Tips bullet list of actionable pearls. The list was distributed by email to residents, fellows, program directors and division chiefs and was posted in resident and fellow work rooms. Discussion: Ten Tips for Fellows Teaching Residents provides a concise list of actionable strategies perceived by pediatric residents and fellows at one institution to enhance the near-peer teaching and learning experience. The Ten Tips handout will be included in the orientation packets for incoming residents and fellows, and an annual panel discussion on resident-fellow interaction will be added to the institution’s core seminar series for fellows.

49. DEVELOPMENT OF A VIRTUAL REALITY CURRICULUM FOR PEDIATRIC RESIDENTS ON ADDRESSING INFLUENZA VACCINE HESITANCY IN THE PRIMARY CARE SETTING (Descriptive Abstract)
Francis J. Real MD, Nick DeBlasio MD, MEd, Daniel McLinden EdD, David Davis, Bradley Crane, Zeina Samaan MD, Nicholas J. Olerding PhD, Andrew F. Beck MD, MPH, Melissa Klein MD, MEd, Cincinnati Children’s Hospital Medical Center/University of Cincinnati College of Medicine, Cincinnati, OH

Background: Influenza vaccine hesitancy is common in the primary care setting. Though physicians have a significant influence on caregiver attitudes regarding vaccination, few studies have targeted physician-patient communication training as a means to decrease vaccination refusal. This is despite evidence that physicians express uneasiness interacting with caregivers who exhibit vaccine hesitancy. Virtual reality (VR), a type of simulation-based education, has been rarely utilized in pediatrics though may be an effective means to train residents regarding communication in cases of vaccine hesitancy.

Objective: Design and implement a VR curriculum for pediatric residents addressing the topic of influenza vaccine hesitancy in the primary care setting. Design/Methods: A VR curriculum was designed based on Kern’s approach to curriculum development. A focus group of attending physicians was conducted to identify the most common reasons for influenza vaccine refusal at our institution. A survey was administered to residents to assess previous experiences addressing influenza vaccine hesitancy. Virtual reality simulations were designed based on the identified reasons for vaccine hesitancy, and demonstration of best-practice communication skills was incorporated into simulation algorithms for resident education. VR environment was designed based on typical patient rooms at our institution, and graphical characters were created based on caregiver demographics seen at our clinic. Results: A focus group identified the most common reasons for vaccine refusal as family perceptions of the vaccine as ineffective or injurious. One hundred percent (46/46) of eligible residents completed the pre-curriculum survey. Nearly 60% (27/46) of these residents reported experiencing influenza vaccine hesitancy during more than half of primary care visits. Almost 70% (32/46) of residents reported that in the majority of cases they were unable to persuade families who expressed initial vaccine hesitancy to have their child vaccinated. The VR curriculum was implemented in November 2015. Assessment of the impact of the curriculum on rates of influenza vaccine refusal is ongoing. Conclusion: Virtual reality experiences such as this curriculum may be an effective method to educate residents on communication strategies to address difficult topics such as vaccine hesitancy.

50. HIGH VALUE, COST-CONSCIOUS CARE: PERSPECTIVE OF PEDIATRIC FACULTY AND RESIDENTS (Research Abstract)
Brian C. King MD, Erika Abramson MD, MPH, Jennifer DiPace MD, Linda Gerber PhD, Hoda Hammad MS, MPH, New York Presbyterian Hospital (Cornell Campus), New York City, NY, Monique Naifeh MD, University of Oklahoma Health Sciences Center, Oklahoma City, OK

High and rising US healthcare costs are unsustainable. The American College of Physicians has defined the term “high value, cost-conscious care” (HVCC) as care that promotes optimal patient outcomes while reducing unnecessary cost. Teaching around HVCC is essential to promote this practice, yet little educational research has assessed the perspective of pediatric
51. A FLIPPED CLASSROOM MODEL: TEACHING INTERNS CLINICAL GUIDELINES (Research Abstract)

Drew T. Louden MD, Jaime W. Peterson MD, Valerie Gribben MD, Rebecca L. Blankenburg MD, MPH, Stanford University, Palo Alto, CA

**Background:** The American Academy of Pediatrics (AAP) publishes core pediatric clinical practice guidelines advising pediatricians on evidence-based management of common diagnoses. However, multiple studies demonstrate poor guideline compliance by pediatricians. There is no published curriculum on how to teach these guidelines, and on a national survey we conducted of pediatric residency training programs, only two indicated they had a formal curriculum for teaching the guidelines. **Objective:** To evaluate pediatric intern knowledge, confidence, and attitudes before and after an innovative flipped classroom approach to teaching the clinical guidelines. **Methods:** We taught guidelines for Acute Otitis Media (AOM), Obstructive Sleep Apnea Syndrome (OSAS), and Attention Deficit Hyperactivity Disorder (ADHD). All 28 pediatric interns took a de-identified 32 question pre/post-test to assess knowledge, confidence, and attitudes. The intervention group received weekly, half-hour flipped classroom lessons for three guidelines (N=9 for OSAS, 10 for AOM and ADHD), and the control group had no formal education about guidelines (N=19). The tests were graded with a scoring rubric. Descriptive statistics and unpaired, two-tailed t-test were used (p<0.05) for analysis. **Results:** The interns had an average knowledge score of 44% on the pretest; by guideline: OSAS (45%), AOM (11%), ADHD (79%). Intervention interns had a statistically significant increase in knowledge 21% vs. 10% for OSAS (p=0.03); 16% vs. 4% for AOM (p=0.009); and 21% vs. -5% for ADHD (p=0.005). There was a statistically significant increase in intern use of guidelines post-intervention, but no difference between intervention and control groups. 96% (28/29) of interns think it is very important for a pediatrician to know and use clinical practice guidelines. **Conclusions:** Creating a dedicated curriculum to teach clinical practice guidelines to interns resulted in a statistically significant improvement in residents’ knowledge, confidence, and attitudes of using guidelines. Our data suggests the flipped classroom model allows for self-driven interactive learning. Next steps include lesson development for all 10 guidelines and national dissemination to increase adherence of guidelines by all residents in training.

52. PEDIATRIC SLOT MACHINE: A CASE-GENERATING MEDICAL EDUCATION GAME THAT CAN BE PREPARED IN MINUTES (Descriptive Abstract)

Pallavi Kamra MBBS, University of Minnesota, Michael B. Pitt MD, Minneapolis, MN

**Background:** Academic pediatricians are often expected to facilitate case-based learning sessions. Lack of time, difficulty remembering details of cases, and/or anticipating useful learning points may pose challenges in preparing these discussions. **Objectives:** Create an easy to implement educational game-based learning tool that can be used for facilitating impromptu case-based learning sessions. **Methods:** We created a case-generating game called the Pediatric Slot Machine. Three stacks of index cards are used: Stack A has combinations of a patient age and sex; Stack B a chief complaint (i.e. bloody nose, red urine); and Stack C, an abnormal laboratory/imaging result (i.e. abnormal electrolytes, abnormal chest X ray). A learner picks cards from stacks A and B to create a scenario such as 14 year old male with red urine. The learners discuss a differential diagnosis for this scenario. A card is then picked from Stack C, mimicking the real world scenario with an abnormal result narrowing the differential (for example, this patient has an abnormal chest X-ray). Learners now discuss how this new information changes the differential. For example, one might say that the red urine is blood, and the CXR was consistent with Goodpasture Syndrome, while another might say the CXR will reveal a pneumonia, and the patient is on cefdinir which discolors the urine red/orange. **Results:** The cards can be made to tailor specific learning objectives. For example, Stack B could be all gastrointestinal complaints, or a stack can be added with gestational ages for use in a NICU setting. We will have stacks with examples available at the APPD meeting. We are in the process of gathering data on resident and medical student perception of learning obtained from a game based session as compared to a traditional morning report. **Conclusions:** This game has proven to be powerful at eliciting creative discussions, allowing for a safe place for residents and medical students to suggest ideas without the fear of being wrong. It takes minimal preparation and provides a launching pad for dynamic, team-based problem solving.
33. IMPROVING EVIDENCE BASED MEDICINE SKILLS (Descriptive Abstract)
   Elise N. Bream MD, Keith Ponitz MD, Ross Myers MD, Case Western Reserve University/University Hospital Case Medical Center/Rainbow Babies, Cleveland, OH

   Background: ACGME Requirements for Graduate Medical Education in Pediatrics state that residents must locate, appraise, & assimilate evidence from scientific studies related to their patients health problems. Our curriculum for evidence based medicine (EBM) included an online course, and residents were required to attend & critically appraise 5 journal club articles.

   Objective: To improve the educational value of our EBM curriculum related to doing a literature search, critical appraisal of articles, & application to clinical practice. Methods: Residents were sent a survey to assess use of EBM with the current curriculum whether they subscribed to a journal blast, how often & proficient they were with literature searches, & how often they prepared for journal club. Then, we revised the curriculum to incorporate the online course into a chief led discussion at journal club for articles about diagnosis, therapy, prognosis, systematic review, clinical guidelines, & clinical decision rule.

   We began a conference where residents do a literature search with the assistance of the librarian to answer a clinical question followed by a discussion of the articles found. Residents were also required to register for a journal blast. We plan to do a 6 month follow-up survey & have the data available for the APPD meeting. Results: Forty-three (51%) residents responded: 32% PGY1, 40% PGY2, 28% PGY3. Only 23% were receiving a journal blast. Over the 6 months prior, 28% accessed journal articles >10 times/month, 30% 5-10 times/month, 42% 0-5 times/month. Of the journal club conferences attended, 40% reported being unprepared >50% of the time. Barriers included not receiving the article early enough, already having completed their requirements, or forgetting. Of the respondents, only half felt comfortable performing a literature search, & in their last inpatient block 15% performed a real time literature search for a clinical question >10 times, 21% 5-10 times, & 65% <5 times.

   Conclusion: EBM is a critical skill for residents to learn. Based on survey results, an online course coupled with traditional journal clubs is not sufficient for teaching these skills.

34. CHIEF ROUNDS: DIDACTICS FOR MILLENNIALS (Descriptive Abstract)
   Beth A. Papas MD, Catherine A. Polak MD, Luke A. Shieh MD, UPMC Medical Education, Pittsburgh, PA

   Background: Resident educational needs are evolving with the growing use of personal electronic devices. Though these devices are used daily to access medical resources, we have not used them in formal teaching sessions. Additionally, though research indicates that resident learners prefer more interactive educational sessions, our current curriculum consists of slide-show based presentations with limited resident participation. With these ideas in mind, we reevaluated our approach to resident education. Objective: To improve learner engagement, satisfaction and proficiency in critically appraising electronic resources via development of an electronic problem-based learning noon conference designed for residents to work through clinical vignettes developed from ABP content specifications. Methods: The session starts with a case presentation driven by ABP content specifications, followed by a short discussion of diagnosis and work-up. Topics to date have included nephrotic syndrome, premature adrenarche, Fragile X, anticholinergic toxicity, and ITP. The residents then worked in small groups to answer management or diagnostic questions specific to the topic, using evidence based medicine from trusted medical sources. A subspecialty fellow serving as our content expert reviewed responses for accuracy and subsequently shared key resources and additional teaching points. Results: The residents completed Likert scale evaluations (1 = Not a good conference to 5 = One of the best conferences) for these sessions, and 25-40 residents evaluated each session. The average score of Chief Rounds was 4.46/5 [SD = 0.1] while the average score of lecture sessions was 4.07/5 [SD = 0.2] with a p-value < 0.05. Text comments on evaluations identified its interactive design, small group format, and case-based learning as strengths.

   Conclusion: We developed an interactive noon conference session that engaged residents in reviewing board specific content using available electronic medical resources, which improved learner satisfaction when compared to prior conferences in our curriculum. We are encouraging our current lecturers to use this format to improve our resident didactics.

35. IT'S ON THE APP: USING TECHNOLOGY FOR COMMUNICATION AND EDUCATION (Descriptive Abstract)
   Lydia M. Rabon MD, Sarada Panchanathan MD, Phoenix Children’s Hospital, Phoenix, AZ

   Background: With increased smart phone use by residents for personal and clinical purposes, fewer residents are carrying handbooks or textbooks. In addition, residents may have difficulty accessing secure servers from remote sites. Phoenix Children's Hospital (PCH) has traditionally released a Resident Handbook both in print and on a secure server. However, utilization of the handbook has dwindled in recent years. Currently, on the App Store, there are only two searchable residency specific apps available. Both were designed for specific residency programs and are not available for widespread use. Objective: The primary objective was to disseminate searchable residency and clinical information that would be used more frequently by the residents than the current modalities and be adaptable to other programs. Methods: An app was created that housed the resident handbook and contained vital information within the residency program such as contact numbers, the conference calendar, announcements, links to important websites, and the ability to watch video conferences. Residents were surveyed on their use of the resident handbook prior to downloading the resident app and access to the app was restricted to those who completed the pre-survey. Patterns of usage were recorded from the app itself and compared with the pre-app surveys. Results: The app was downloaded by 88% of PGY1s, 60% of PGY2s and 53% of PGY3s. Handbook utilization increased by 147%. Overall app utilization averaged 3.2 accesses/resident/week, with PGY1s using the app 4 times/week, PGY2s 3 times/week and PGY3s 3.5 times/week. Residents were most likely to use the app from 8 to 8AM (prior to rounds) and 11am to 12pm (prior to conference). Conclusion: The app was downloaded by 88% of PGY1s, 60% of PGY2s and 53% of PGY3s. Handbook utilization increased by 147%. Overall app utilization averaged 3.2 accesses/resident/week, with PGY1s using the app 4 times/week, PGY2s 3 times/week and PGY3s 3.5 times/week. Residents were most likely to use the app from 8 to 8AM (prior to rounds) and 11am to 12pm (prior to conference).
56. INCORPORATION OF LITERATURE REVIEW INTO RESIDENT MORNING REPORT TO ENHANCE TRAINING IN EVIDENCE-BASED MEDICINE (Descriptive Abstract)

Nathan R. Stehouwer MD, Diana Yan MD, Elise Bream MD, Gina Poslusny MD, Ross Myers MD, Keith Ponitz MD, Case Western Reserve University/University Hospital Case Medical Center/Rainbow Babies, Cleveland, OH

**Background:** Training in Evidence-Based Medicine (EBM) is an ACGME-mandated component of resident education. Residency programs face the challenge of training young physicians to translate clinical questions into effective literature searches, thereby generating answers which can be taken back to the bedside. Intervention: Residents presenting at weekly morning report were instructed to identify a question for a Critically Appraised Topic (CAT) at the end of their presentation. Residents were provided with a template for CATs instructing them in the Patient, Intervention, Comparison, Outcome (PICO) model. The resident searched the literature and identified a relevant source. The pediatric librarian attended all sessions and was available for assistance. The resident prepared a brief report including the question, search methods, assessment of the evidence, and clinical bottom line of how the evidence would impact future care. These summaries were sent to all residents at the end of each week. **Outcomes:** In the 6 months since implementation of this model, 48 CATs have been generated by residents from morning reports. The most common categories of questions selected were treatment (31%), epidemiology (28%), clinical prediction (21%), and diagnostics (10%). The most common topics were Infectious Diseases (27%), Neurology (15%), and Rheumatology (8%). Sources identified by resident searches included retrospective cohort studies (25%), systematic reviews with or without meta-analyses (22%), randomized controlled trials (15%), and prospective cohort studies (10%). This model has met with approval from residents and the resident advisory committee. **Conclusions:** Incorporation of CATs into morning report generated literature searches on a wide variety of topical areas and question types. This model has the potential to improve curricula in EBM and train residents to incorporate EBM into routine clinical care. Further study is needed to demonstrate educational effectiveness of this model.

57. A CORE FELLOWSHIP CURRICULUM: PERCEIVED IMPORTANCE AND INTEREST (Descriptive Abstract)

Stephanie A. Deutsch MD, MS, Aadil Kakajiwala MD, Laura Rubinos MD, Anne Ades MD, MSEd, Don Boyer MD, MSEd, Dorene Balmer PHD, Gail Slap MD, MS, Children’s Hospital of Philadelphia, Philadelphia, PA

**Background:** The ACGME mandates didactic sessions as part of the curriculum for accredited fellowship programs. Across these programs there is considerable overlap in required topics such as fatigue management and quality improvement. For large sponsoring institution (SI), a centralized curriculum may facilitate educational efficiency and adherence to the ACGME requirement. However, fellow and program director (PD) interest in the centralization of required and elective topics remain poorly described. **Objective:** To assess and compare fellow and PD awareness of an existing centralized curriculum at a large SI, perceived importance of required topics, interest in elective topics, and preferred modes of didactic delivery. **Methods:** Fellows and PDs in both ACGME-accredited and non-accredited programs at one SI were asked to complete an anonymous online survey from Dec 2015 through Jan 2016. One dichotomous item assessed awareness of an existing curriculum; one Likert-type item assessed preferred modes of delivery. Respondents distributed 100 points related to importance across required topics and 100 points related to interest across 10 elective topics. **Results:** Of 264 fellows and 39 PDs, 72 (27%) and 20 (52%), respectively, completed the survey. Awareness of the centralized curriculum was noted by 68 (94%) fellows and 17 (85%) PDs. The topics fellows ranked as highest importance were career planning, feedback, and work-life balance. In contrast, PDs ranked feedback, professionalism, and teamwork as most important for inclusion in a centralized curriculum. Elective topics of highest interest were transition after fellowship, contract negotiations, and financial planning for fellows and transition after fellowship, mentorship, and effective presentations for PDs. Although PDs thought fellows preferred online delivery, fellows selected live didactic sessions as preferential. **Conclusion:** Fellows and PDs differ in perceptions of importance of required topics, interest in elective topics, and preferred mode of delivery. Better understanding of these issues may help guide content, format, and ultimately effectiveness of centralized didactic curricula.

58. USING FACEBOOK TO FACILITATE CONTINUITY CURRICULUM IS NOT WELL LIKED (Descriptive Abstract)

Kristen Samaddar MD, Katy Mullens MD, Jennifer Farbaugh BS, Phoenix Children’s Hospital, Phoenix, AZ

**Background:** Social networking sites are increasingly used by medical professionals for patient education and have begun to be employed in medical education. There is a lack of conclusive evidence of its educational effectiveness for post graduate learners. **Objective:** Our objective was to determine if a social networking site would be an effective tool for improving pediatric residents confidence in giving evidence based advice for common outpatient conditions. **Methods:** Weekly discussion questions and evidence-based summaries were posted on a closed Facebook group. The number of views and comments were monitored over time. Residents completed anonymous surveys prior to implementation and six months after
introduction of the curriculum. Learners rated (on a 5 point Likert scale) their confidence for providing advice on 10 topics and scores were compared over the six month period. Results: Seventy-five percent of residents reported using Facebook at least weekly. Confidence in giving advice increased for all outpatient topics over time, including topics not discussed on the site. The average number of views for questions decreased from 60 views per week to 35 over 6 months. Many residents stated not being on the site and wanting to keep work and personal life separate were barriers to utilizing the curriculum. Conclusions: Though most residents use Facebook, there were unexpected barriers to the success of this curriculum. Many residents desire to keep their work and private life separate and were not interested in participating. Learners preferred shorter, poll-like questions for online learning and in person discussions. In response to this, the curriculum has been taken off-line with questions posted on slides that run during clinics and brief discussions at the start of morning report. We will continue to monitor resident feedback.

59. AUGMENTING NOON CONFERENCE LEARNING WITH ONLINE MATERIALS: A FEASIBILITY STUDY (Descriptive Abstract)
Stacey Engster MD, Mario Cruz MD, Nicholas Kuzma MD, St. Christopher’s Hospital for Children, Philadelphia, PA
Background: Regular and timely attendance at noon conference has become a widely recognized problem across residency programs. Augmenting a noon conference curriculum with online materials has potential to enhance resident learning.
Purpose/Objectives: Our goal was to assess the feasibility and usefulness of augmenting our noon conference curriculum with online materials (articles, lecture slides, quizzes) using the Blackboard website. The primary objectives were to increase pediatric resident utilization of and satisfaction with online materials, while identifying and reducing barriers to accessing Blackboard. Design/Methods: In September of 2015, educational materials complementary to our noon lectures were placed online through Blackboard, with multiple reminders provided to residents. Prior to the intervention, a 6-item online survey was distributed to all 75 pediatric residents. Follow-up surveys were distributed at 2 and 4 months. Surveys assessed resident satisfaction with online materials, as well as barriers to accessing the materials. Utilization of the online resources was measured using the content usage statistic feature on Blackboard. Results: Completion rates by pediatric residents for the initial, mid-point and final surveys were 68%, 37% and 34%. 18 of 75 residents accessed the online materials. Over the four month study period, there was an increase in resident satisfaction with online resources (20% to 87%) and utilization of online materials (28 to 68 site visits). The most frequently cited barriers to accessing online materials included inadequate network connection, conflicting priorities and forgetting to access the website. The perception of these barriers decreased over time.
Discussion/Conclusion: While most residents did not access the online materials, a subset reported that online materials augmented their learning. Several barriers to accessing online materials were identified. A follow-up quality improvement project to assess the process by which residents access online noon conference materials is warranted.

60. USING AMERICAN BOARD OF PEDIATRICS CONTENT SPECIFICATIONS AS A WAY TO MEASURE RESIDENT EDUCATIONAL EXPOSURE (Descriptive Abstract)
Corinne L. Schmidt MD, Nataly I. Vadasz MD, Leslie-Anne J. Dietrich MD, Anne Marie S. Guerrero MD, MA, Sarada S. Panchanathan MD, MS, Phoenix Children’s Hospital, Phoenix, AZ
We modeled our academic curriculum, Maintenance of Education (MOE), after the American Board of Pediatrics’ (ABP) Maintenance of Certification (MOC). MOE requirements parallel MOC: (1) weekly review article reading assignments with summary questions, (2) 25 monthly PREP questions, (3) quarterly exams, and (4) a QI project. MOE was designed with these components in order to provide residents with a structured method of study during residency and to ease transition into MOC activities post-residency. To monitor for gaps in our curriculum, we mapped MOE content to the ABP Content Outline’s (CO) content specifications (CS). The questions for MOE part 1 are written by senior residents who are assigned an article, a link to the CO, and instructions to write 4-5 questions. Residents are encouraged to use the CO for guidance, but may propose additional questions not covered in the CO. When questions are proposed that do not correspond to a content specification, the resident provides a brief defense stating why it should be included. To assess MOE part 1, evaluators compared MOE article questions with the 2015 CO, matching questions with the CO following a predetermined protocol. The 2015 CO had 2233 individual content specifications. Within 1 year, as part of MOE part 1, residents completed questions covering 295 content specifications. For MOE part 2, each PREP question corresponds to at least 1 or more content specifications, exposing residents to a minimum of 300 content specifications a year. Combining parts 1 and 2, our residents were exposed to 595 content specifications within the year, with some duplication. Extrapolating out over 3 years, residents could be exposed to up to 1785 of the 2233 content specifications, or 80% of the ABP Content Outline. MOE not only provides residents with structure to hone their learning skills and broaden their knowledge base, it does so within the structure of the current MOC program.

61. AN INCLUSIVE MORNING REPORT (Descriptive Abstract)
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Background: Morning report, an educational session at most institutions, is a case-based discussion between residents and faculty. The style and goals vary between institutions and across specialties, with interns and medical students variably included. Previously at our institution, a chief resident presented a formal case and residents were called on to answer questions. Faculty often overtook the discussion to share their expertise, which was challenging for junior learners. The
residents asked for a more inclusive and discussion-based morning report so that all learners could actively engage without intimidation. Aim: To create a morning report that encourages active participation and collaboration among all levels of learners using a bottom up hierarchy. Methods: Chief residents trialed several modifications of our traditional morning report to meet these objectives. Results: Several morning report approaches were developed. In our primary morning report students, residents and faculty split into small groups. The chief resident begins by presenting the case one-liner followed by small group discussion of aspects of the case. The junior-most table member is responsible for sharing the group’s ideas with the larger audience. For example, the chief may ask groups to discuss key questions to be considered about the patient’s history. The groups discuss the topic, with junior team members offering their input first, facilitated by senior residents with faculty guidance. In similar fashion, the groups may then discuss the physical exam, differential diagnosis or management, depending on educational objectives. The chief and faculty conclude with teaching points. Every other week, the night float residents guide the discussion of a fresh case. We have also created senior-only and intern-only morning reports with cases and teaching points presented by the residents. A chief resident and 1 or 2 faculty members facilitate. Conclusion: We have created a morning report that encourages active participation and collaboration among all levels of learners, and promotes the development of the learners’ clinical reasoning skills while benefiting from faculty expertise.

62. CARE OF THE CHILD WITH MEDICAL COMPLEXITY: A MULTIMEDIA CURRICULUM FOR RESIDENTS ACROSS NORTH AMERICA (Research Abstract)
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Background: Providing safe, high quality care to CMC requires that residents receive relevant education as part of their training. However, competing educational priorities, time limitations, variable exposure and lack of adequate resources may impact the individual program’s ability to incorporate this training. Objective: To evaluate resident satisfaction, knowledge impact and behavior change after participating in an online curriculum focused on care of CMC composed of multimedia learning modules and virtual simulation compared to the more traditional format of print media. Methods: This is an ongoing prospective, randomized, controlled study of residents across North America supported by the APPD 2014 Special Project Grant. The curriculum is composed of 6 self-paced multimedia modules and topic-specific literature. Participants were randomized to 1 of 2 groups; each group was asked to complete 3 modules and 3 sets of readings that are mutually exclusive on the following topics: dysautonomia, spasticity, ventriculoperitoneal shunts, tracheostomy tubes, enteric feeding tubes, and pressure ulcers. In addition, to assess behavior change each participant reviewed the medical record of a fictional CMC, recorded a verbal handoff of that patient and responded to a device-related emergency in a virtual simulation exercise prior to and after curriculum completion. Assessments included knowledge based pre- and post-tests, satisfaction survey and performance on virtual simulation activities. Results: To date, 84 residents have completed the curriculum and associated assessments. With respect to knowledge impact, Group A and B participants had significantly higher post-test scores (p<0.0001). Overall there was high satisfaction with the curriculum content and method of delivery. Of note, participants were more likely to express comfort with the topics that they were randomly assigned to modules for compared to readings; this finding was statistically significant for 4 of the 6 topics (table). We anticipate data collection and analysis to be complete in 1/2016. Conclusion: Participants in this study were highly satisfied with the curriculum. There was significant improvement in knowledge and residents expressed significantly higher comfort with caring for patients with the diagnoses/devices for which they received module training as opposed to topic-specific readings.
63. THE PICU PASSPORT: AN INNOVATIVE APPROACH TO STREAMLINING PEDIATRIC RESIDENT LEARNING IN THE PICU (Descriptive Abstract)

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Introduction: Upon completion of training, pediatric residents are expected to be able to recognize and provide initial stabilization for critically ill children. Given the relative rarity of critically ill children outside of the pediatric intensive care unit (PICU), pediatric residents receive most of their exposure to critical care during their PICU rotations. However, due to seasonal variations in disease presentations and the ebbs and flow of patient care, residents' experiences during their PICU rotation vary even within the same institution. This may lead to differential learning opportunities, with some residents receiving little to no exposure to certain important topics during their PICU rotation.

Methods: The authors reviewed both the Accreditation Council for Graduate Medical Education program requirements for graduate medical education in pediatrics as well as the content outline published by the American Board of Pediatrics for the General Pediatrics certification examination. Considering resident exposures during other rotations, 21 topics were chosen as being most important to be taught by PICU faculty. Of the 21 topics, 13 were designated core topics and the other 8 were designated supplementary topics. These topics were presented in the form of a “PICU Passport”, which also included certain basic reference information for residents to use as a resource during their PICU rotation.

Results: Residents were provided a “PICU Passport” at the beginning of their 4-week PICU rotation, during which each resident was expected to hear about 10/13 core topics and 4/8 supplementary topics from a PICU faculty member. Completed Passports were due back to the pediatric chief residents. PICU faculty members were provided learning objectives for each topic, and were asked to cover requested topics either during rounds, small group discussions, or in 1-on-1 discussions. Feedback will be sought from residents via pre and postrotation surveys, as well as from faculty 6 months after implementation.

Conclusions: The PICU Passport targets specific topics to be covered during the PICU rotation, helping pediatric residents achieve a standard and baseline exposure to certain high yield topics. The Passport also assists PICU faculty streamline teaching time to individual residents’ learning needs.

64. PILOT OF A FACULTY DEVELOPMENT CURRICULUM (Descriptive Abstract)

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Background: The ACGME requires teaching faculty participate in programs to enhance their skills as educators. A needs assessment at our institution suggested that current faculty development (FD) offerings did not meet need. Objective: During 2014/15, we piloted a multimodal FD program, with goals of meeting needs for topic and mode of delivery.

Methods: A needs assessment of our 74 pediatric faculty queried baseline FD activity, topics of interest, preferred delivery methods, and participation barriers. Using these data, a pilot FD curriculum was created with 4 units, including “Milestones,” “Feedback,” “Learners in Difficulty,” and “Generational Learning Differences.” Each unit was available for 2 months as an online module (the preferred delivery method) and also offered by 1 in-person method (Grand Rounds lecture, lunchtime mini-workshop, after-hours workshop, or “snippet” during a Department meeting). Participants evaluated sessions, and participation was tracked. An end-of-course assessment was conducted.

Results: Faculty participated in each of the online modules and in 3 of 4 in-person sessions; those 3 in-person sessions had better participation than any online module. No pediatric faculty attended the after-hours workshop. In the year prior to the pilot, fewer faculty reported participation in any FD pertinent to teaching than during the pilot year (8% vs. 80%). Total time in FD increased: 31% of faculty reported at least 3 hours of FD in the year prior to the pilot, and 60% in the year after. Before the course, 75% agreed local FD opportunities were adequate; afterward 90% agreed. Time was consistently identified as the largest participation barrier. Faculty who participated in any FD offering reported increased knowledge and comfort regarding the topic covered.

Conclusion: A needs-based FD curriculum increased participation and reported knowledge and comfort of core topics. Time constraints remain a major barrier. While faculty reported online modules as the preferred mode of FD, in-person FD during routine faculty activities had the most uptake. Next steps include making online modules permanently available and developing additional topics.

65. PEDIATRIC CHIEF RESIDENT EXCHANGE PROGRAM (Descriptive Abstract)

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Background: Pediatric residency programs have many conferences and activities to meet the educational needs of their residents. The development of a specific experience to share the best practices in education amongst programs would be beneficial to pediatric training programs and residents. Objective: To implement and evaluate an exchange program where pediatric chief residents visit another residency program to experience a sample of the educational offerings of another institution.

Methods: Chief residents from two pediatric residency programs in Northeast Ohio visited the other institution for a day. The chief residents participated in various activities including educational conferences, multi-disciplinary rounds, meetings with program directors, and discussions with faculty. The activities were directed by the individual educational interests of the chief resident. A survey was administered to all participating chief residents approximately one month after their visit to the other program to assess their experience. This instrument included questions to determine what each chief resident experienced during the visit, assessments and areas of improvement of the exchange program, and to determine if
Objective: Through intra- and inter-institutional collaboration at and between BCM and TCH, researchers collaborated and strategized identification of essential training concepts to foster long term success of pediatric trainees with a passion to conduct research and provide excellence in clinical care. Results: All residents commit to the American Board of Pediatrics Integrated (rather than Accelerated) Research Pathway. The PSTDP formally began in 2014 and has completed its first resident match. One objective of the PSTDP was to increase the number of MD-PhD graduates in residency training at BCM/TCH and the first match provided 4 from leading US medical schools. The PSTDP has three core components: the Parallel Education Program (PEP), Mentoring, and Academic Advancement Activities. The PEP aims to provide the knowledge and perspective necessary for a seamless career flow through the academic pipeline. In addition to regular lunch and learn seminars, grand rounds, and an annual program retreat, there are two concrete monthly opportunities -- the Pediatrician-Scientist Forum (PSF) and the Didactic Noon Conference (DNC) -- for junior trainees to engage with and learn from successful senior faculty. The mentoring component fosters an environment of inquiry and scholarship, which includes an active research component. Each program must allocate adequate educational resources to facilitate resident involvement in scholarly activity. Objective: Our primary objective is to describe the successful implementation of a scholarly work mentorship committee at our training site. Methods: Core program faculty created goals and objectives for a Scholarly Work Advisory Group (SWAG). The goal of this committee is to allow residents to work in an area of specific interest to them, while learning about aspects of medicine and scholarly activity that are outside of the clinical setting. The committee provides oversight to their projects and makes final determinations as to which projects meet graduation requirements for participation in scholarly work as outlined by the ACGME. The SWAG convenes twice monthly: the first meeting is specifically for faculty to discuss research ideas and seek peer mentorship, while the second meeting is for residents to present progress reports to the group and seek feedback on their projects. Results: Implementation of the Scholarly Work Advisory Group (SWAG) at the Naval Medical Center, San Diego, has increased academic productivity among pediatric residents and faculty. Since SWAG was initiated two years ago, 100% of graduating residents have met requirements for participation in scholarly work and exposure to basic research principles. Conclusion: The development of a Scholarly Work Advisory Group increases academic productivity for both faculty and staff, and provides invaluable opportunities for collaboration and mentorship within a pediatric residency training program.
68. TEACHING AND LEARNING COMMUNITIES: IMPLEMENTATION OF A NOVEL PEER GROUP BASED MENTORING INITIATIVE (Descriptive Abstract)

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**Background:** Our annual program evaluation survey revealed a need for improved mentorship. Residents’ agreement with the statement “The residency program’s approach to mentorship helps me to meet my professional goals” averaged 3.2 (neutral), 95% CI [3.0, 3.6] on a scale of 1 (strongly disagree) to 5 (strongly agree). On the same scale, residents rated the mentoring relationships they had formed as helpful to their professional development with an average rating of 4.2, 95% CI [4.0, 4.5]. In addition, residents noted that peer mentoring was helpful with an average rating of 4.1, 95% CI [3.8, 4.3] but that there was no system in place to foster peer-mentoring relationships. **Objective:** Provide structured opportunities for mentorship based on career interest. Residents will have access to expanded opportunities for mentoring and career guidance from faculty and each other. **Methods:** Residents are allowed to self-select a group based on their career interest: primary care, hospital medicine, ED/NICU/PICU, or subspecialty. Residents can also sample different groups over time to explore multiple career paths. Faculty members were recruited by e-mail to serve as mentors; 65 faculty members signed up to participate in the first cohort. Groups will meet six times per year during a portion of our protected bi-weekly academic half-day sessions. **Results:** Initial feedback from both residents and faculty mentors has been overwhelmingly positive. On a 5-point agreement scale, residents rated the statement, “These Teaching and Learning Community sessions will be a useful addition to my professional development and career planning,” at a mean of 4.3, 95% CI [4.0, 4.6]. On the same scale, they rated “I found it helpful to connect with peers with similar career interests” at a mean of 4.1, 95% CI [3.8, 4.5]. Faculty also rated the initial session highly, with a mean of 4.1, 95% CI [3.3, 4.9] in response to the statement, “The TLC session was a meaningful experience for me.” **Conclusion:** Peer group-based, specialty-focused mentorship holds promise as a method for enhancing the mentorship offered during residency.

69. THE RAP: IMPROVING EFFECTIVENESS OF THE RESIDENT/ADVISOR RELATIONSHIP THROUGH JOINT PROFESSIONAL DEVELOPMENT AND GROUP MENTORSHIP (Descriptive Abstract)

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Mentoring is an essential part of medical education and plays an important role in physician development. The ACGME expects each pediatric resident receive faculty mentorship without delineating the structure of the relationship. Feedback from resident/advisor dyads at our institution revealed wide variability in the effectiveness of the relationship. Our objective was to enhance our resident advisor program (RAP) to provide mentorship skills training and connect dyads to needed resources. As a result we created two RAP branches July 2014: MyRAP, which connects each resident with a faculty advisor and provides joint professional development sessions on topics like introduction to mentorship, and social and emotional intelligence; and GroupRAP, led by faculty in two oversight committees which provide career path-specific group mentorship through workshops and portfolio review. The committees offer regular meetings with residents committed to a career path and assist with career preparation.

We administered anonymous pre- and post-implementation surveys to assess mentorship skills using a 4 point Likert scale; responses were compared using percent change. All residents and advisors reported low confidence with mentorship skills including recruiting a mentor and guiding the mentoring relationship on the Fall 2013 pre-surveys. Post-survey results of PGY3s Spring 2015 revealed >20% change for all questions on mentor recruitment and >18.8% change in 4 of 5 questions on guiding the mentor relationship. RAP evaluation data in Spring 2015 revealed 100% of residents and 64.6% of advisors found RAP addressed their need for professional development, 92.9% of residents found RAP resources assisted in solidifying their career choice, and 100% of advisors saw RAP enhanced their ability to be an effective mentor. Joint professional development and career-based group mentorship can increase satisfaction with the resident/advisor relationship and improve confidence with mentorship skills. Next steps include addressing the need for mentorship in the arena of scholarly activity.

70. NATIONAL FACULTY DEVELOPMENT PROGRAM SHOWS PROMISE IN HELPING CLINICIANS DEVELOP CLINICAL TEACHING SKILLS (Descriptive Abstract)

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**Background:** Many institutions struggle with how to best train faculty how to be effective clinical teachers. The Advancing Pediatric Educator eXcellence (APEX) Teaching Program was designed to bridge this gap. **Objective:** To evaluate a national blended clinical teaching skills curriculum for pediatric hospitalists. **Design/Methods:** The 12-month AAP and APA sponsored curriculum consists of program-specific and elective workshops, asynchronous interactive web-based assignments, reflections, facilitated discussions, and observations of clinical teaching by local/regional mentors. Half-day courses at two consecutive Pediatric Hospital Medicine annual meetings focus on the learning environment, teaching strategies, feedback, and learners in difficulty. Program evaluation included satisfaction, knowledge, and self-efficacy data. Participants evaluated individual workshops and program as a whole. Learning and self-efficacy were measured through retrospective pre/post content area knowledge and efficacy self-assessments. Results were analyzed using t-tests and descriptive statistics. **Results:** 14/16 participants graduated from the APEX program in the first year. 14/14
graduates completed the program assessment. In aggregate, the cohort shows statistically significant growth across all self-reported knowledge and self-efficacy domains. Participants rate the curriculum highly (with overall module ratings of 4.2-4.7, on a 5 point Likert scale). Unexpected benefits of the program were noted to include the networking/cohort development and recognition as an educator by their institutions and others. 93% (13/14) graduates said they would make the decision to do it again (1 was unsure). Three workshops are being developed by the 2015 Cohort for submission to PAS and PHM. Conclusions: The APEX Teaching Program is an innovative multimodal curriculum to enhance the clinical teaching skills of a national cohort of clinical educators. APEX not only shows promise for developing individual clinician educators, but also those they teach through leading faculty development locally and nationally.

71. MENTORING RESEARCH AS A PATHWAY TO INCREASING ACADEMIC PRODUCTIVITY: A UNIQUE THEME FOR A FACULTY DEVELOPMENT PROGRAM (Descriptive Abstract)

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Background: Lack of time is a barrier to research productivity per faculty in academic residency centers. Residents and fellows help overcome this barrier, but require faculty mentoring skills in research methodology. We used the forum of Faculty Learning Community (FLC) to provide faculty development on mentoring research aimed at increasing faculty academic productivity. Methods: Educational leaders at Phoenix Children’s Hospital partnered with the Office of Research at University of Arizona College of Medicine - Phoenix, to create a curriculum for a monthly, 1-hour session over 2 years. The formal curriculum was organized into the framework of: Prepare (question, literature, mentoring plan), Perform (study design, IRB submission, data analysis) and Present (abstract, manuscript preparation/review). Sessions included faculty career development, statistical support, grant writing, and funding by internal and external guests. Faculty-learner dyads presented research projects in various stages from preliminary concepts, designs, to data analysis and manuscript drafts, followed by interactive peer review with experienced researchers. Results: About 15 faculty attended each session. 98% of participants ranked FLC as relevant and an opportunity to improve current practice (learning how to mentor). 92% of respondents felt that FLC provided opportunities to create/revise protocols, policies and procedures. Eleven presentations by faculty and their learners, focused on nascent projects and actively discussed strengths, weaknesses and process improvement. All eleven completed scientific and regulatory review by institutional committees, nine were accepted at national meetings as posters and six have been submitted to peer review journals. 100% faculty felt satisfaction, mentoring and collegiality within a motivating FLC environment. Participants identified structured peer mentorship of faculty/learner research studies as most valuable. Conclusion: FLC on mentoring research was well-received with significant future potential to enhance faculty and learner academic accomplishments.

72. PEDIATRIC AND MED-PEDS RESIDENTS EMOTIONAL INTELLIGENCE SUB-SCORES VARY BY TRAINING YEAR (Descriptive Abstract)

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Purpose: A physician’s level of emotional intelligence (EI) positively correlates with patients’ trust, better patient follow-up, better doctor-patient relationships and increased patient satisfaction. Recent studies have begun assessing the level of EI demonstrated by resident physicians in various specialties. While most of these studies have focused on surgical specialties, fewer studies have included Pediatric and Medicine-Pediatric residents. The purpose of this study was (1) to determine the baseline EI scores of Pediatric and Med-Peds residents and (2) to compare EI scores between Pediatric and Med-Peds residents. Methods: Residents from Pediatrics and Med-Peds residency programs at a university-based training program volunteered to complete an online self-report EI survey (EQ-i 2.0) in May 2015. A summary EI score report was generated for each resident by a consulting firm. De-identified score reports were compared between programs and by year of training. Results: All pediatric and med-peds residents completed the survey (N=47). The median score for the group as a whole for overall emotional intelligence was higher than the national average and considered to be in the high range (110). The highest median subcomponent scores were in Impulse Control (114) and Empathy (113) and the lowest subcomponent scores were in Independece (101) and Assertiveness (102). No difference was seen between pediatric residents and medicine-pediatric residents in their total EI scores or the various components. Residents in their early years of training (PGY 1-2) compared to later years of training (PGY 3-4) showed significant differences in the component of Assertiveness (100 vs 109, p=0.002) and Empathy (115.5 vs 110, p=0.03). Conclusion: As a group, Pediatric and Med-Peds residents scored lowest in areas of independence and assertiveness. While assertiveness scores did go up with added years of training, empathy scores decreased. Educational interventions to improve resident EI scores should focus on the areas of independence, assertiveness, and empathy.

73. RESIDENT FOCUSED WELLNESS SERIES (Descriptive Abstract)

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Background: Resident physician health and wellness are critical components of postgraduate education and training. Residency training can evoke a variety of challenges including physical and emotional burnout, lowered mood, feelings of...
inefficacy and social disconnection. As residents spend a majority of their time in the clinical setting, residency naturally creates a community which can be a major sponsor of wellness. **Methods:** We surveyed the residents to obtain a baseline understanding of resident wellness behaviors including their physical, mental, spiritual, and emotional wellness. We used the standardized Perceived Stress Scale from the American Sociological Association to measure the residents’ perception of their own stress. Based on resident interest and response, we plan on offering wellness activities including walking groups, guided meditation, yoga, group volunteering, joint resident and faculty events, art therapy, and reading groups among others. Workshops will be offered to discuss trainee depression recognition and available counselling services, sleep behaviors, time management, as well as financial guidance and counselling. A post-survey will be given to the residents later in the academic year to measure changes in their wellness habits and stress level. **Results:** 41 out of our 62 Pediatric and Combined Internal Medicine-Pediatric Residents returned the full survey. On average, they estimate that they participate in the daily wellness behaviors surveyed as follows: physical activity 2 days/week, eat at least 5 servings of fruits and vegetables 2.7d/wk, prayer 2.4d/wk, wake feeling rested 1.5d/wk, and get at least 7 hours of sleep 2.5d/wk. They feel fatigued 3d/wk, irritable or angry 1.9d/wk, lack interest/motivation 1.7d/wk, and skip a meal 3d/wk. They had an average Perceived Stress Score of 16.4, above a standardized average of 14.2 in a national poll of respondents age 18-29. **Conclusions:** Pending results of post-survey.

74. THE RESIDENCY LEADERSHIP'S ROLE IN RESIDENT SUPPORT AND WELL-BEING (Research Abstract)
**Kate Perkins MD, PhD, Los Angeles, CA, Su-Ting Li MD, University of California (Davis) Health System, Sacramento, CA**
**Background:** While program directors and the program leadership team are charged with the responsibility for promoting well-being and monitoring stress amongst residents, little is known about the extent to which the program leadership team is involved in providing support to residents or the effect that providing resident support has on the leadership team. **Methods:** We performed a national cross-sectional web-based survey of pediatric program directors (PD), associate program directors (APD), and coordinators (PC) in June 2015, on their experience supporting resident well-being (WB). **Results:** 44% (364/821) of participants responded. All (100%) PD and APD, as well as 91% PC strongly agreed that supporting resident WB is an important part of their role. The majority of PD and APD (68-95%), and less frequently PC (26%-88.4%), reported that they have supported residents experiencing grief, burnout, health challenges, and other stressors at least annually, and in some cases weekly, with a majority (72%) spending over 10% of their time on resident WB. In addition, 45% of PD supported residents who experience domestic abuse, discrimination, or sexual harassment semi-annually. Respondents reported mixed feelings related to supporting resident WB at least some of the time. While almost all (>90%) felt both valued and fulfilled, many felt stressed (67%) in the role. Negative feelings related to supporting WB were more likely to impact PD than APD or PC; for example, PD were more likely to feel unable to take time off work (PD 68%, APD 49%, PC 45%, p<0.05). The majority of respondents agreed that they needed additional training in their roles supporting resident WB, including for resident burnout (70%), patient grief (67%) and mental health (65%). **Conclusions:** Residency program leadership spends a significant amount of their time supporting resident well-being. While they feel that supporting resident well-being is an important part of their job, it is also a significant source of stress and there are opportunities to improve preparedness and training in providing support to residents.

75. AN INNOVATIVE APPROACH TO TEACHING PERSONAL AND PROFESSIONAL DEVELOPMENT AND RESILIENCY DURING PEDIATRICS RESIDENCY (Descriptive Abstract)
**Amy E. Sass MD, MPH, Adam A. Rosenberg MD, University of Colorado, J. Lindsey Lane BM BCh, Janice L. Hanson PhD, Eds, University of Colorado, Aurora, CO**
**Background:** The Pediatric Milestone Project’s Personal and Professional Development (PPD) competency encompasses milestones that are integral to individual professional formation and resiliency. Clinical training during residency is largely experiential and PPD milestones are often not addressed explicitly. Reflection and deliberate practice can be used to promote development in these areas. **Objectives:** To develop, implement and evaluate a curriculum utilizing self-reflection and deliberate practice to promote PPD and resiliency during residency. **Methods:** A longitudinal curriculum for the 2014-15 academic year was developed with five 3 hour, protected sessions focused on topics pertaining to the PPD milestones. Each session included a large group (LG) activity followed by a small group (SG) discussion. 84 residents were divided into 8 SGs composed of PL1s, PL2s and PL3s and 2 faculty facilitators. The LG topics were used in the SGs as triggers for reflection and discussion of issues pertaining to their practice, PPD and resiliency. Residents completed worksheets summarizing meaningful points from the session and described application strategies to improve their practice and resiliency. Residents reported back...
and described their efforts and outcomes at subsequent SGs. Residents provided verbal feedback and completed written evaluations at the end of each session. Results: Residents agreed that the topics were relevant to their experience as trainees. They enjoyed the LGs but favored the SG setting, describing it as a safe environment that was conducive to reflection and sharing and fostered inter-class collegiality and peer mentoring. They described sharing their experiences as normalizing and validating and although their efforts at deliberate practice were variable, they expressed learning from each other’s reports of application strategies and outcomes. Conclusions: This curriculum provided a learning environment that built collegiality, fostered peer mentoring and facilitated direct application of personal strategies to improve PPD and resiliency.

76. EVALUATING THE FEASIBILITY AND IMPACT OF A NEW MINDFULNESS CURRICULUM IN A LARGE PEDIATRIC RESIDENCY PROGRAM (Research Abstract)
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Background: Burnout affects physician well-being and patient care and safety. Mindfulness is the quality of being fully present in the moment during everyday activities. Mindfulness curricula can reduce physician burnout and improve their wellness and empathy. Objectives: We designed, implemented, and evaluated a new mindfulness curriculum to improve resident wellness and decrease burnout. Methods: We performed a needs assessment to assess the rate of burnout and the acceptability of a curriculum to address burnout. The curriculum objectives were that participants will: 1) understand what mindfulness is 2) report a positive attitude towards mindfulness 3) feel confident discussing mindfulness 4) demonstrate awareness of evidence for mindfulness 5) understand the link between mindfulness and burnout 6) use mindfulness techniques more often 7) report decreased rates of burnout. The curriculum was led by two residents with mindfulness practices and included five sessions each with a mindfulness exercise and discussion about the use of mindfulness at work. We implemented a longitudinal study design with pre- and post-surveys to measure change in residents’ knowledge, attitudes, and behaviors. Data were analyzed using chi-square tests. Results: A needs assessment found that 64% of residents reported experiencing burnout within the prior 12 months or since starting residency. Only 17% of residents did not believe a curriculum aimed at preventing burnout would be beneficial. 60 residents completed pre-tests, 49 completed post-tests. After the curriculum, a higher proportion of residents: 1) felt they could define mindfulness (p<0.0005) 2) felt that burnout had impaired their patient care (p=0.035) 3) planned to use mindfulness techniques to prevent burnout (p=0.02). Conclusions: Burnout is common among pediatric residents, many of whom believe that curricula to prevent burnout could be beneficial. A new mindfulness curriculum implemented in a large residency program increased resident awareness of the impact of burnout on patient care and intention to use mindfulness techniques to prevent burnout.

77. WELLNESS WEDNESDAYS (DESCRIPTIVE ABSTRACT)
Amanda D. Lee MD, Jennie E. Lee MD, Nuzhat Shaikh MD, Kaiser Permanente Medical Group (Northern California), Oakland, CA, Rebecca Chasnovitz MD, Kaiser Permanente Medical Group (Northern California), Oakland, CA

Background: The ACGME acknowledges that the demanding nature of residency can lead to fatigue, emotional exhaustion, and burnout. In our program, residents took initiative to create a wellness curriculum in order to help one another personally thrive as well as to benefit patient care. Vision: We aim to promote the physical, social, emotional, and spiritual health of all residents by reflecting on the challenges we all face, by fostering resiliency, and by harnessing our inner child through creativity, movement, and play. Learning Activities: Wellness Wednesdays take place weekly during our 30-minute afternoon report. Each session focuses on rotating themes of Creativity, Patient Bonding, Movement, and Humanism. Residents or faculty facilitate each session, and all residents attend. Each session begins and ends with a one-minute meditation. Sessions are all activity-based and interactive. Creativity sessions have included creating a My Life Wheel and coloring. Movement has included Tahitian, Bollywood dancing, and Yoga. During Patient Bonding, residents spend time with one of their patients focused on an activity unrelated to medicine, such as reading, doing crafts, or walking the hallways. Humanism sessions are case discussions designed to spark conversation on common challenges residents face. Assessment: We collected baseline Maslach scores and conducted a needs assessment. Ongoing assessment at 3 and 6 months includes focus groups, Maslach scores, and formal course evaluations. Preliminary data from the 3 month Maslach inventory show a decrease in emotional exhaustion scores, stable depersonalization scores, and a slight decrease in personal accomplishment scores. 92% of residents felt that dedicating 30 minutes weekly toward wellness is an appropriate amount of time. The majority appreciate Creativity, Movement, Humanism, and one-minute meditation sessions. Challenges of Patient Bonding sessions include bonding with patients who have short stays and patient availability. Conclusion: Residents find dedicated time for wellness to be helpful in improving their overall well-being and were able to identify strengths of the curriculum and areas for improvement.

78. FACTORS CONTRIBUTING TO STRESS DURING RESIDENCY TRAINING AT HARLEM HOSPITAL: A PILOT STUDY (Research Abstract)
Priyanka Shekhwat MD, Sundari Periasamy MD, Harlem Hospital Center, New York, NY

Background: Stress is a common human experience which negatively affects health, and impairs the professional abilities of a person. Residency is considered a rigorous period of training. 68% of residents report stress and a high prevalence of mental health problems. Despite the ACGME’s recommendation of a minimum of 1 hour per week for wellness opportunities, there is limited literature on the feasibility and impact of a formal wellness curriculum. Objectives: To describe a pilot curriculum for improving resident wellness at a large hospital residency program and to evaluate its impact on wellness. Methods: We conducted a needs assessment and qualitative interviews to design a new wellness curriculum. We implemented monthly Wellness Wednesdays, focusing on rotating themes of Creativity, Patient Bonding, Movement, and Humanism. Sessions included activities such as yoga, painting, and walking the halls. Each session began and ended with a one-minute meditation. Results: Residents agreed that the topics were relevant to their experience as trainees. They enjoyed the LGs but favored the SG setting, describing it as a safe environment that was conducive to reflection and sharing and fostered inter-class collegiality and peer mentoring. They described sharing their experiences as normalizing and validating and although their efforts at deliberate practice were variable, they expressed learning from each other’s reports of application strategies and outcomes. Conclusions: This curriculum provided a learning environment that built collegiality, fostered peer mentoring and facilitated direct application of personal strategies to improve mental health and wellness and decrease burnout.

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problems (17-33%) have been found among trainees. Recent suicides of two newly minted residents in NYC raised major concerns for burnout, depression and suicidality. Currently there is a lack of understanding of factors related to stress, coping strategies and available resources among residents, and our study aims to address this problem. 

Method: A total of 100 resident surveys were studied, consisting of 49 females and 51 males across pediatrics, psychiatry, surgery and internal medicine programs. Results: We analyzed the data using SPSS software via ANOVA test and observed that there was stress reported by residents across all four programs but there was no statistical difference between them (p=0.93). Mean PSS-4 scores for the PGY levels tended to be elevated for interns and senior years except for surgery which continued to increase till the final year(Fig). Most residents reported clinical status of patients as the major factor contributing to stress. Maximum residents reported co-residents (60%) as their first line of support during times of stress. Lack of resources (70%), fear of the negative image that seeking help would lead to in the program (28%) and no time to seek help (58%) were identified as the most important barriers. If suspecting that a co resident is experiencing difficult times, most residents (85%) chose not to escalate the matter. 

Conclusion: Stress is an existing issue among residents at all levels across all programs. Greater emphasis is needed to ensure that residents feel comfortable coming forward in times of stress and escalating to higher authorities if experiencing stress or suspecting stress in a co-resident. QI projects should focus on the factors identified in this study to improve residency experience and patient safety. Future studies with higher sample size are needed to validate results of our pilot study. 

79. HELPING RESIDENTS PROCESS THE STRESS OF THE ICU (Descriptive Abstract)
Jason E. Vargus MD, Donna Holland MD, Frederick Willyerd MD, Phoenix Children’s Hospital, Phoenix, AZ

The shared opinion among most Pediatric residents is that the Critical Care rotation is the most emotionally trying rotation during residency. In an attempt to find a solution to help preserve mental health a survey was provided to the resident staff at a tertiary children’s hospital about their PICU experience. Of the 22 respondents, 76% said that they felt a PICU debriefing session at the end of their rotation would be beneficial for their mental health. We addressed this need by enlisting the services of an ICU social worker, trained in debriefing, to lead a resident only debrief on the last Friday of every month. During these sessions, the residents were granted an hour, free of duties, to discuss feelings of being overwhelmed, sadness, joy, personal experiences and frustrations. Physician staff were not included so residents could express their feelings openly and without omissions. After 6 months, residents were reevaluated to determine if debriefing sessions had any benefit. Of the 49 residents who experienced a debriefing, 36 completed the survey. Of the 36 respondents, 75% agreed that sessions were beneficial to their mental health. 89% agreed that the sessions were necessary to process the events encountered and were helpful when led by a social worker trained in debriefing. 94% felt that along with a social worker, there should be someone present that could relay the administrative concerns that were encountered. Lastly, almost 70% of residents felt that 1 hour was sufficient time to discuss the month, while approximately 20% felt that either more time or more sessions were needed to completely deal with the emotional overload. The survey results indicate that a one-hour debriefing intervention is effective and allows most residents to maintain better mental and emotional balance during the rigors of the ICU experience. We advocate that such a program be incorporated into the critical care rotation curriculum in order to maintain emotional wellbeing for residents. In the future we plan on exploring the added benefit of increased debriefing frequency by having better structured break-out sessions immediately after adverse events.

80. WELLNESS WEEK: AN INTENSIFIED APPROACH FOR ADDRESSING RESIDENT BURNOUT (Descriptive Abstract)

Background: Physician burnout is associated with decreased job satisfaction, increased medical errors and mental health issues. Rates of burnout among pediatric trainees have been reported up to 80-70%. We designed and implemented a Wellness Week (WW) to raise awareness and enhance our existing wellness curriculum. Objective: Create a one-week curriculum consisting of evidence-based and conceptual, individual and group-level strategies for mitigating burnout. Methods: During WW, residents were
invited to participate in educational and experiential activities intended to impact both individual wellness (lectures, massage, exercise, reflective writing, mindfulness) and a community culture of wellness (interactive group cooking, therapy animals, peer positive affirmations). Events occurred both during scheduled conferences and night shifts. We surveyed residents before and after WW about their definitions of wellness, personal wellness practices and barriers to wellness in residency. Results 38% (44/113) of residents responded to the pre-survey. 98% agreed or somewhat agreed that mindfulness can be useful for physician well-being, and that it could be a useful tool for their patients. More challenging areas of wellness to achieve were exercise (64%), work/life balance (57%) and ownership over time (43%). The most cited contributions to wellness were spending time with friends/family (85%), fitness/sports (84%) and mindfulness practice (41%). 38% (40/113) of residents completed the post-survey. 39% noted adopting new mindfulness practices, including use of a smart-phone mindfulness app and journaling. Positive themes from feedback included appreciation for the variety of activities offered and time for socializing. The main area for improvement identified was increasing activities for residents working nights and off-site. Conclusion Evidence-based and conceptual strategies for enhancing personal and community wellness can be offered in a condensed format, and may change self-reported behavior in some residents. Further studies are needed to identify which interventions are most effective to prevent resident burnout.

81. FORMAL EMPATHY TRAINING DURING A TWO-WEEK PATIENT EXPERIENCE ROTATION FOR RESIDENTS (Descriptive Abstract)

Nicholas A. Jabre MD, MS, Bob Dudas MD, Raquel Hernandez MD, MPH, All Children’s Hospital/Johns Hopkins Medicine, Saint Petersburg, FL

Background: Provider empathy influences patient satisfaction and can lead to better health outcomes. Teaching empathy skills to residents is challenging given the time constraints of training. Implementation of an empathy curriculum during a focused patient experience rotation for residents is feasible and could lead to heightened perceptions of empathy in our clinic. Aim: To determine if patient satisfaction, perceived empathy, and resident use of empathy skills can be enhanced using a formal empathy-training program. Methods: We integrated an evidence-based empathy curriculum (The Language of Caring®) into a 2-week rotation for residents focused on understanding patient perspectives in the hospital. There were 7 modules consisting of educational videos and role-play. Pre and post-assessment surveys were given to the residents to assess confidence level with empathic communication and frequency of skill utilization. Two validated surveys, the Jefferson Scale of Patient Perceptions of Physician Empathy (JSPPPE) and the Scale of Patient Overall Satisfaction with Primary Care Physicians (SPOSPCP), were administered to general pediatric patients to assess changes in perceived empathy and overall satisfaction with care. Results: The modules were administered to 10 second-year pediatric residents with an 80% completion rate of the post-assessment. Resident confidence improved by a mean of 0.2 and resident skill use improved by a mean of 0.3 on a 5-point scale. JSPPPE and SPOSPCP scores were unchanged, although high pre-assessment scores were noted for each survey. Feedback indicated the program was well received by residents with a mean module rating of 5.1 on a 7-point scale. Conclusion: Formal empathy training was successfully integrated into our residency curriculum and led to increased comfort with empathic communication and frequency of skill utilization. Improvements in perceived physician empathy and patient satisfaction remain to be seen, however a second phase of this study will consider the high initial JSPPPE and SPOSPCP scores, the possibility of survey fatigue, and the small number of providers.

82. CRITICAL CARE ROTATION IMPACT ON PEDIATRIC RESIDENT MENTAL HEALTH AND BURNOUT (Research Abstract)

Katie K. Wolfe MD, Sharon Unti MD, McGaw Medical Center of Northwestern University, Chicago, IL

Background: 50-75% of residents will experience significant burnout during their training. Depressive symptoms and burnout are frequently coincident (in 50-90% of those residents meeting criteria for burnout). In addition to the personal impact burnout and depression has on residents, evidence suggests that burnout can negatively impact patient care. The Pediatric Intensive Care Unit (PICU) rotation is an important, yet challenging, educational experience during a pediatric resident’s training. The high patient volume and acuity, ethical dilemmas, long hours, and other demands inherent to the rotation can result in a significant amount of stress on trainees. Attending physicians in the ICU experience high rates of burnout and depression which may impact those trainees whom they teach. Hypothesis: Residents experience increased frequency of depression and burnout at the end of their critical care rotation compared to the beginning. Methods: IRB-approved, prospective study included all second-year pediatric residents at Ann & Robert H. Lurie Children’s Hospital of Chicago who consented to participate over a 12 month period starting December 2014 and ending December 2015. Residents were surveyed just prior to and immediately following one of their PICU rotations. Surveys included the Center for Epidemiologic Studies Depression Scale and the Maslach Burnout Inventory (scored in 3 domains); both previously researched and validated. A short insitution-specific survey was also completed to identify positive and negative aspects of the experience. Results/Conclusions: Complete data analysis is ongoing. 24 pre-rotation assessments and 17 post-rotation assessments were completed. Prevalence of at least mild depression increased from 4% to 43.7% over the 4 week period. Analysis of 17 paired surveys indicate an average increase in depression scale scores by 6.3 points over the course of the rotation. Scores are higher on the post-rotation burnout surveys in the emotional exhaustion domain (by average of 5.7 points) and unchanged in the depersonalization domain. Residents overall rate the PICU rotation as a positive experience (82.3% in the post-rotation survey) and almost universally identify patient acuity, education and nursing-integrated rounding as positive aspects. Residents most commonly cite a lack of autonomy and lack of opportunity to do procedures as negative aspects. Further analysis comparing pre- and post- rotation surveys is ongoing.
83. UNMET MENTAL HEALTH NEEDS AMONG PEDIATRIC RESIDENTS (Descriptive Abstract)

Sara A. Hasan MD, St. Christopher’s Hospital for Children, Philadelphia, PA, Angela MD, Jodi Schaffer MSW, Courtney Wein DO, Mario Cruz MD, St. Christopher’s Hospital for Children, Philadelphia, PA

**Background:** The graduate medical education community has become increasingly aware of the mental health problems among the resident workforce. In 2013 our residency program implemented a multifaceted resident wellness committee, in part to destigmatize mental health issues and raise awareness of local mental health resources. **Objective(s):** To assess the prevalence of and contributors to unmet mental health needs among pediatric residents at a medium-sized residency program. **Methods:** In December of 2015 we distributed a 12-item, web-based, anonymous survey to all 78 pediatric residents at our program. The survey addressed resident interest in mental health services, prevalence of unmet mental health needs, and barriers to obtaining mental health services. **Results:** 35% of residents completed the survey. Respondents were disproportionately female (93%) but equally distributed among residency class and relationship status. **Conclusions:** Despite the efforts of our wellness committee, a subset of residents at our program reported an unmet mental health need, primarily due to time, scheduling conflicts, lack of knowledge on how to access care, and stigma. Richer qualitative data through focus groups is needed to better understand and address these resident perceptions. National surveys of pediatric and non-pediatrics residents should be performed to identify best practices in addressing resident mental health.

84. PRODUCTIVE PUMPING! HELPING TRAINEES INCREASE CLINICAL TIME (Descriptive Abstract)

Ana L. Creo MD, Heather N. Anderson MD, Jay H. Honne MD, Mayo Clinic College of Medicine (Rochester), Rochester, MN

**Background:** Many residents and medical students choose to start families during training. Much is known about the benefits of breastfeeding, and many trainees desire to exclusively breastfeed. However, conflicting lactation at work while balancing service and educational demands can be challenging. While literature exists on improving the efficiency of lactation using higher frequency cycles and two phase expression in lactating women, no studies have specifically examined trainee lactation and compared methods of milk extraction. **Objective:** Our goal is to measure and improve the efficiency of lactation by providing trainees with a quiet, hospital grade pump (HGP) compared to a portable double-electric pump (PP). **Design/Methods:** A quiet, HGP was purchased for trainee use only and stored in a designated room with computer, phone, and dictation system. Lactating trainees compared pumping time as well as production using their own PP and the HGP. Mothers were asked to provide the time to complete pumping and ounces produced based upon the first pump of the morning averaged over the first month back from maternity leave. Data was reported and analyzed with a paired t test. **Results:** A total of six trainees provided data. Lactation time with PP averaged 24 minutes (range 15 to 40 minutes). Lactation time with HGP averaged 15.5 minutes (range 10-32 minutes), resulting in an average reducing total lactation time by 8.5 minutes (p=0.045 95% CI 3.8-12.2). Production volume also increased from 6.0 ounces (range 3.5-8.5 ounces) with PP to 8.8 ounces (range 8-11 ounces) with HGP, averaging 2.8 ounces (p=0.06 95% CI 1.2-4.3) despite decreased lactation time. Trainees also commented that the noise was reduced allowing them to return pages, dictate, and even listen to lectures. **Conclusions:** Purchasing a HGP for trainee use significantly decreased time to complete lactation while increasing milk supply. In addition to having more time for clinical tasks, the quietness of the pump increased the amount of clinical and educational tasks that could be accomplished while pumping. Providing a HGP may be one way training programs can help residents sustain breastfeeding and decrease the burden of lactation on patient care and education tasks.

See also Poster 133 in Fellows topic area.

85. INTERDISCIPLINARY TRANSPORT MEDICAL CONTROL TRAINING: A PILOT CURRICULUM (Descriptive Abstract)

Samantha W. Gee MD, Michael J. Stoner MD, Nationwide Children’s Hospital/Ohio State University, Columbus, OH

**Background:** Injured or ill pediatric patients often present to the nearest hospital. Some are found to be critically ill and require transfer to a pediatric tertiary care center. This interfacility transport frequently involves the use of a hospital-based transport team and requires a medical control physician (MCP) should escalation of care be necessary en route. The role of MCP is usually served by emergency medicine (EM) and critical care (CC) fellows. Traditionally, this skill is taught informally on-the-job. Development of advanced communication skills and competency for fellows who are trained by this traditional pathway, however, may not be optimized. We sought to close this curriculum gap by developing a formalized MCP training program that immerses EM and CC fellows together with transport team members to manage a sick patient in real-time, incorporating high-fidelity simulation. Fellows are exposed to the transfer process, while given an opportunity to practice their communication and critical thinking skills in a safe environment. **Methods:** Pilot study involving 1st year EM and CC fellows. In teams between disciplines, fellows observe each other in the role as MCP. A case-based patient scenario is initially presented to the fellow with a phone call for transfer by a referring facility, scripted by a faculty member. The fellow is to then provide the transport team with pertinent information and...
86. PEDIATRIC BUDDY PROGRAM: OPPORTUNITY FOR QUALITY IMPROVEMENT AND POSITIVE COLLABORATIVE RELATIONSHIP BUILDING THROUGH NURSE-INTERN EDUCATIONAL PARTNERSHIP

(Descriptive Abstract)

Haneme Idrizi MD, Beth Payne MAEd, C-TAGME, Michelle Arandes MD, University of Texas Health Science Center School of Medicine at San Antonio, San Antonio, TX

Background: Healthcare and Graduate Medical Education (GME) are placing increasing emphasis on multidisciplinary clinical teams as critical components of medical education and superior patient care. The Clinical Learning Environment Review (CLER) program by the Accreditation Council for Graduate Medical Education (ACGME) further highlights the role of teamwork in healthcare. Although residencies have traditionally included quality and patient safety initiatives, few have formally introduced a multifaceted approach beyond bedside care. The Department of Pediatrics at the University of Texas Health Science Center at San Antonio created an innovative venture, the Pediatric Buddy Program, which pairs Pediatric interns with Pediatric nurses. The program has graduated Cohort 1 and Cohort 2 is enrolled. Methods: Cohort One (2014-2015) successfully completed the program and Cohort Two (2015-2016) is currently enrolled. All components of the program promote a multidisciplinary team approach: -10 Pediatric nurses were selected to voluntarily participate. -12 pediatric interns were paired with 10 nurses based on personality test results. Cohort 1 participant feedback and leadership self-reflection were used to make adjustments in team size and the formation process for Cohort 2. -Nurse-Intern teams were formally introduced during intern orientation and participated in team building activities over a 2 day period. Activities included a scavenger hunt, scripted dialogues in the TeamSTEPPS format, and simulation cases. - Nurse-Intern teams participated in quarterly didactics focusing on topics relative to team-building such as QI, CLER and healthcare generational differences. - Nurse-Intern teams developed and implemented QI projects. Results: - Cohort 1 successfully paired and graduated 10 nurse-Intern teams. - A 12% improvement in Nurse-Intern collaborative attitudes was demonstrated on pre and post-program surveys. - Nurses and interns obtained knowledge of QI methodology resulting in the creation of 10 QI projects. - 6 months of reflective journaling by participants based on prompts related to nurse-physician relationships were gathered. - All CLER assessment areas were addressed. - Based on anecdotal feedback from current pediatric nursing staff, a positive influence in interprofessional work relationships has resulted as a result of the Pediatric Buddy Program. Conclusions: The benefits of Interprofessional Education (IPE) are numerous and theoretical models have been proposed discussing how high-quality relationships within primary care settings may contribute to improved quality of care. The Pediatric Buddy Program is designed to investigate how interdisciplinary work relationships improve as a result of IPE partnership programs. Participants will walk away with not only the confidence and QI skills needed to change healthcare, but also a strong foundation in collaborative teamwork that will influence future, interdisciplinary interactions.

87. RESIDENT INCLUSION INTO IN-SITU INTERPROFESSIONAL SIMULATION CURRICULUM

(Descriptive Abstract)

Gene Hobbs, Chapel Hill, NC, Ashey Kellish DNP RN CCNS, Children’s Hospital/Boston Medical Center, Boston, MA, Sarah Hassing RN BSN CCRN, AfSANeH PiRzaDeH MD, Benny L. Joyner MD MPH, Sofia Aliaga MD, Kenya A. McNeal-Trice MD, University of North Carolina Hospitals, Chapel Hill, NC

Background: Dedicated recertification in resuscitation skills (ie. PALS and NRP) is required every two years in most hospital settings. Retention of emergency skills is poor with this training only (Hamilton 2005). Cardio-respiratory emergencies at North Carolina Children’s Hospital have become high risk/low volume events due to implementation of a successful Rapid Response System. In response to this decrease in out-of-ICU codes, weekly in-situ simulations with interprofessional teams began in 2013 to practice emergency skills. In 2014, the simulations increased to occur twice a week and residents were incorporated into the curriculum to practice teamwork training in 2015. Objective: Establish a successful interprofessional simulation curriculum involving pediatric nurses and residents focused on improving communication and teamwork skills. Methods: Training is held on inpatient units with scenarios based on recent events or lectures. All staff attends as to develop interprofessional teams, improve communication and practice resuscitation skills. The simulations require scheduling four residents each week to participate. The nursing team begins by evaluating the simulated patient then paging the resident team (intern and senior) to the bedside. Sessions are 20-30 minutes and the interprofessional team is debriefed by members of the Children’s Hospital Simulation Committee using a TeamSTEPPS (Strategies and Tools to Enhance Performance and Patient Safety) approach. TeamSTEPPS is an evidence-based teamwork system aimed at optimizing patient care by improving communication and teamwork skills among health care professionals. Results: To date, there have been 54 simulation opportunities and 98 residents exposed. Retention of resident teamwork and communication skills will be measured as residents participate in subsequent simulations throughout training. Discussion: Additional simulation training opportunities were requested by our residents in a 2014 survey. Both residents and staff are extremely enthusiastic about the program and have welcomed the opportunity for systems improvement (Barbeito 2015).
88. SHARED DECISION MAKING: A MULTI-SITE EDUCATIONAL BUNDLE IMPROVES PATIENT ENGAGEMENT AND COMMUNICATION DURING INPATIENT ROUNDS (Research Abstract)
Rebecca Blankenburg MD, MPH, Stanford University, Palo Alto, CA, Patrick Yuan BS, University of California (San Francisco), San Francisco, CA, Stephanie Harman MD, Stanford University, Stanford, CA, Brad Monash MD, University of California (San Francisco), San Francisco, CA, Debbie Sak MD, Stanford University, Ian Chua MD, Children's National Medical Center, Palo Alto, CA, Poornam Hosamani MD, Stanford University, Stanford, CA, Adeena Khan MD, MPH, University of California (San Francisco), San Francisco, CA, San Francisco, CA, Lisa Shieh MD, Lijia Xie MD, Stanford University, Eric Huynh BS, Stanford, CA, Joan Hilton PhD, Jason Saterfield PhD, Stephanie Rennke MD, University of California (San Francisco), San Francisco, CA

Background: Shared decision-making (SDM) has been shown to be an important tool for improving patient engagement and health care outcomes. Despite the demonstrated value of SDM across disciplines, little is known about how to increase SDM occurring in general inpatient settings. Objective: To evaluate the effectiveness of an educational bundle on inpatient resident teams abilities to do shared decision-making during morning rounds. Design and methods: We completed an IRB-approved pre/post intervention study of SDM on inpatient ward rounds on pediatrics and internal medicine services at two large university-based hospitals. Twelve observers trained to use a validated, 9-item observation tool, the Rochester Participatory Decision-Making Scale (RPAD) and observed the occurrence of SDM behaviors on inpatient rounds. Data was collected for 12 weeks prior and 12 weeks after an educational bundle (including interactive 90-120 min workshop with role-plays, mnemonic for remembering the under-utilized SDM tools, direct observation and oral feedback on actual rounds, customized written feedback, posters, screensavers, email reminders, and pocketcards). Mean scores across all RPAD items were calculated, and performance across pediatrics and internal medicine services was compared using ANOVA. Results: In total, 33 teams, 95 ward rounds, and 268 unique patient encounters were observed pre-intervention. 34 teams, 100 ward rounds, and 391 unique patient encounters were observed post-intervention. Both pre- and post- groups were split approximately evenly between pediatrics and internal medicine. All sites improved, with a 1.8 mean improvement in RPAD total score on a 9-point scale (pre: 4.0 mean, post: 5.8 mean, improvement range: 0.5 to 2.8, p<0.05). Conclusions/discussion: A robust, multimodal intervention launched over an 8-week period was effective in improving shared decision-making skills in inpatient resident teams across all 4 observed services. Future studies should evaluate the relative effectiveness of each educational bundle component as well as dose response.

89. HEARING OUR PATIENTS’ VOICES IN PEDIATRIC EDUCATION: A MULTI-INSTITUTION RESIDENT SELF-ASSESSMENT OF COMMUNICATION SKILLS WITH PATIENTS (Research Abstract)
Elisa M. Phillips BS, BA, University of Arizona, Tucson, AZ, Vasudha L. Bhavaraju MD FAAP, Phoenix Children’s Hospital, Phoenix, AZ, Becky Blankenburg MD, MPH, Alyssa L. Bogetz MSW, Stanford University, Palo Alto, CA, Katherine Killmon, Atherton, CA, David Mahoney BS, Stanford University, Stanford, CA, Alisa McQueen MD, Nicola Orlov MD, MPH, University of Chicago, Chicago, IL, Caroline Rassbach MD, Stanford University, Stanford, CA

Background: The ACGME encourages milestone assessments that incorporate the patient voice. Pediatric resident attitudes toward and confidence in patient communication have not yet been published. The Communication Assessment Tool (CAT) is a validated measure of physician-patient communication that may be useful in evaluating residents on the milestones. Objective: Use a modified CAT to evaluate resident confidence in communication and attitudes toward patient/guardian feedback (PGF) by PGY level. Methods: In a multi-institution cross-sectional IRB-approved study, residents at 3 institutions completed an anonymous modified CAT with 5-point Likert-scale items measuring confidence in communication and attitudes toward PGF by PGY level. We found a general increase in confidence by PGY level but no statistically significant differences (PGY1: 3.62, PGY2: 3.68, PGY3: 3.76, p=0.09). Conclusions/discussion: Residents’ confidence in communication skills does not change significantly during residency, while attitudes decline. Next steps include exploring reasons for this decline and correlating resident and patient assessments of resident communication skills.
90. COMMUNICATION IS KEY: USING THE OUTPATIENT ELECTRONIC MEDICAL RECORD (OEMR) MESSAGING SYSTEM TO COMMUNICATE ABOUT PATIENT CARE (QI Abstract)
Mahesh Shrestha MD, Sonia Desikan MD, Lewis Krata MD, Emmanuel Unachukwu MD, Guiqing Huang MD, Kimberly J. Matthews MD, Mebratu Daba MD, Sasikumar Cheruvettara MD, Vahid Khajoee MD, Brooklyn Hospital Center, Brooklyn, NY

Background: Continuity of care is a primary objective of general pediatrics and reflects quality patient care. For every patient admitted to the pediatric floor, the admitting resident's responsibility is to contact the patient's pediatrician (PMD) to inform about the admission and management plan. For patients with PMD's from our continuity clinic, a brief message is sent using the OEMR messaging system. This allows for simple in-house communication which, in turn, contributes to effective continuity of care. Our baseline data showed that messaging to the PMD was less than 20% at the onset of the Quality Improvement (QI) Project. Aim Statement: We planned to increase OEMR messaging about inpatient admissions to the patient's PMD to 90% over 10 months.

Interventions: The 1st intervention was an email sent to all residents informing about the OEMR messaging system. The 2nd intervention was a discussion with all residents working on the pediatric floor about how to use the OEMR messaging system. The 3rd intervention included reminder notes about messaging the PMD on all computers on the pediatric floor.

Measures: Every month, the message section was checked in the OEMR for each admitted clinic patient to see if a message was sent to the PMD. We measured the % of PMD's notified of patient admissions at two-week intervals and made a run chart (shown below). Results: Starting from a baseline of 20% OEMR messaging in July 2015, our next data point increased to 43% but dropped to 0% by the 2nd week of September. We initiated our 1st intervention then and saw improvement to 46%, followed by a dip before increasing again to 88% in December, 2015. We then started our 2nd intervention, but we saw a drop to 38%. We made the 3rd intervention the 2nd week of January and then saw a gradual improvement to 100% before leveling off to 75% at the conclusion of the QI project.

Conclusions and Next Steps: Our QI project highlighted that teamwork, identifying problems early and intervening consistently can bring progressive improvement in communication about patient care. A barrier was that there is a separate inpatient and outpatient EMR, requiring consistent prompting to use the messaging system. Making it part of the admission checklist may help with consistency of messaging in the future.

Table 1: Resident attitudes toward patient/guardian feedback (PGF)

<table>
<thead>
<tr>
<th>Attitudes regarding PGF</th>
<th>PGY1</th>
<th>PGY2</th>
<th>PGY3</th>
<th>p-value</th>
</tr>
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<tbody>
<tr>
<td>Receiving PGF is important to my professional development</td>
<td>4.57</td>
<td>4.39</td>
<td>4.43</td>
<td>0.12</td>
</tr>
<tr>
<td>Communication with patients/guardians is important to quality patient care</td>
<td>4.95</td>
<td>4.83</td>
<td>4.77</td>
<td>&lt;0.01</td>
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<tr>
<td>I ask patients/guardians for feedback on my communication skills</td>
<td>2.49</td>
<td>2.67</td>
<td>2.86</td>
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<tr>
<td>PGF increases my confidence in my communication skills</td>
<td>3.93</td>
<td>3.86</td>
<td>3.85</td>
<td>0.77</td>
</tr>
<tr>
<td>PGF changes the way I communicate with other patients/guardians</td>
<td>4.16</td>
<td>4.01</td>
<td>4.17</td>
<td>0.27</td>
</tr>
</tbody>
</table>
91. DESIGN AND IMPLEMENTATION OF A CURRICULUM TO TEACH COMMUNICATION SKILLS TO PEDIATRIC CRITICAL CARE FELLOWS (Descriptive Abstract)
Erin Powell MD, Jessica Turnbull MD, MA, Vanderbilt University, Nashville, TN

Background: Good communication is an essential skill for all physicians. Poor communication was cited as one of the primary root causes of all sentinel events by the Joint Commission from 2004-2014. Fellows in pediatric subspecialties are required by the ACGME Core Competencies and the Pediatric Milestones Project to demonstrate competency in communication skills. Little formal training exists for teaching communication at the graduate medical education level. There is a growing body of literature that demonstrates curricula can improve communication skills based on trainee confidence and perception. Few studies have demonstrated the effect of such a curriculum on trainee performance or family satisfaction. Objective: The aim of this project is to design and implement a curriculum to improve confidence and communication skills among pediatric critical care fellows while improving family satisfaction. Methods: This study examines the effect of a curricular intervention on observed, standardized communication skills among trainees. The prospective design targets current pediatric critical care medicine (intervention) and neonatal intensive care fellows (control) at MCJCHV. The intervention consists of a longitudinal curriculum designed to teach communication skills in the care of critically ill pediatric patients. Its design includes 6 didactic sessions and 3 practice simulation sessions with standardized family members in which communication skills can be practiced in a safe environment. The curriculum covers topics such as advanced communication skills, emotionally challenging conversations, cultural competence, end-of-life discussions, leading team meetings and negotiating professional disagreements. Results: Per difference-in-differences design, all participants complete a pre- and post-curriculum standardized assessment of communication skills. This assessment utilizes a standardized encounter with simulated patient families and faculty observation using a communication performance evaluation checklist. Additionally, pre- and post-curriculum surveys assessing participant confidence in communication skills are used for comparative analysis of subjective improvement. Skill acquisition is also assessed by actual family evaluation of communication skills utilizing a standardized communication tool pre- and post-intervention. Feedback from trainees regarding the curriculum thus far has been positive citing it as a “formative,” “effective,” and “realistic” experience.

Winner - APPD 2016 Trainee Research Award

92. TAKING THE HEAT: TEACHING PEDIATRIC RESIDENTS TO COMMUNICATE WITH EMOTIONALLY CHARGED FAMILIES (Research Abstract)
Nicolas J. Delacruz MD Candidate, Suzanne M. Reed MD, John D. Mahan MD, Ansley Splinter MD, Amy Brown MD, Stacy Flowers PsyD, Nicole Verbeck MPH, Nationwide Children’s Hospital/Ohio State University, Columbus, OH

Background: Effective communication skills are essential for physicians to deliver high quality, patient-centered care. Effective communication has been shown to positively impact healthcare outcomes, including patient safety, compliance, and satisfaction. Communication with angry families can be challenging, and resident physicians often do not receive specific training on this skill. There is little literature examining this communication skill in pediatric trainees and if performance can be improved with an education intervention. Objective: Our objective was to evaluate the effectiveness of an educational workshop based on the Take the HEAT communication strategy. We also aimed to create and validate a novel tool to evaluate resident’s skills in communicating with angry families. Methods: 34 first-year pediatric and internal medicine-pediatrics residents participated in our study. The workshop used the Take the HEAT (Hear, Empathize, Apologize, Take action) strategy of communication. Communication skills were assessed through standardized patient encounters at two time points, baseline and post-workshop. Encounters were scored using a locally created and validated assessment tool. Results: After Take the HEAT training, residents’ overall communication performance significantly improved from baseline total mean score 23.15(SD 2.283, range 19-27) to total mean score 25.36(SD 2.655, range 21-31,p-value <0.001). In 2/4 components, residents showed significant improvement after the intervention, while in Apology there was a significant decline in performance, baseline 2.87(SD 1.137) to post-intervention 1.70(SD 1.159). Residents scored lowest on Empathy skills. Intraclass Correlation Coefficient 2.1 demonstrated substantial agreement (0.60 and 0.61) among raters using our novel tool. Conclusion: Performance of first-year pediatric trainees in communication with emotionally charged families improved with education focused on the Take the HEAT strategy, demonstrating this as a teachable skill. The poor performance by first year residents in demonstrating empathy should be more thoroughly explored.

93. IMPROVING HOSPITAL COMMUNICATION THROUGH STANDARDIZATION OF PAGING PRACTICES (QI Abstract)
Rachel M. Weigert MD, Medical College of Wisconsin Affiliated Hospitals, Milwaukee, WI, Anna Schmitz MD, Medical College of Wisconsin Affiliated Hospitals, Wauwatosa, WI

Background: Paging is a primary mode of communication in hospitals, though it is asynchronous and often inconsistent. Children’s Hospital of Wisconsin (CHW) does not have a standardized paging format with variation in practice leading to staff dissatisfaction as well as roughly 6 reported patient care incidents per year resulting from pager related communication errors. Aim Statement Our Primary Aims were 1) create a standardized format designed to increase pages containing sender’s full name, call-back number, patient name, room number, and urgency wording to a goal of 90% for each element, and 2)
improve provider ratings of the quality of paging communication with 80% of respondents rating paging satisfaction as excellent by January 2017. Interventions Interventions to date have included verbal announcements presented hospital-wide to residents and nursing staff, orientation material on paging etiquette, and posting of informational flyers were posted hospital between October and December 2015. Measures Outcome Measures for this project include percent of pages containing each key element, rating of provider satisfaction with paging communication, and the frequency of patient safety events related to paging tracked over time. Process measures include ratings of timeliness and appropriateness of response to pages measured via survey, and frequency of pages including 5-6/6 critical elements. Balancing measures include measure of number of pages sent per day and paging satisfaction. Results Preliminary analysis revealed that respondents sent an average of 5-15 pages per day and rated paging communication as intermediate/good (3.3/5 point scale). There was an improvement in frequency of inclusion of 6/6 critical elements and inclusion of patient’s room number. Evaluation of other critical elements demonstrates stable or declining inclusion to date. Conclusions and Next Steps After initial interventions aimed at improving the quality of paging communication in our hospital using a standardized format there are some early signs of improvement. Reaching the goal of widespread use of a standardized paging format will likely require multiple targeted interventions to reach all providers involved and achieve sustainable culture change. With further interventions and data collection, we hope to show standardized paging etiquette improves the clarity of communication and thereby both provider satisfaction and patient care.

94. IPASS: OUR JOURNEY THROUGH TIME (Descriptive Abstract)
Vanessa A. Orrego MD, Sara Tarolli MD, SUNY Upstate Medical University; Jennifer Nead MD, FAAP, Elizabeth Nelsen MD, FAAP, Paula Rosenbaum PhD, SUNY Upstate Medical University, Olamide Ajagbe MD, FAAP, Syracuse, NY
Objective: IPASS is a nationally recognized model used to standardize physician communication during transitions in patient care. Our residency program implemented IPASS in 2013 and found it did not fully meet the needs and culture of our program. From 2013-2015, we elicited resident feedback, adapted the IPASS format to better serve our residents, and assessed the effectiveness of these changes. Methods: We surveyed residents at 3 separate points: prior to implementation in 2013, 3 months after, and 24 months later in 2015. Using identical surveys, we assessed 3 distinct areas: quality of resident signout, efficiency of signout, and patient safety. We analyzed data using Pearson’s Chi-Square test and Linear-by-Linear Association. Results: At 3 months, there was improvement (p=0.004) in quality of verbal handoffs, but no difference for overall or written quality. At 24 months, we found improvement in verbal and overall quality of signout (p=0.01 and 0.005, respectively). Comparison of verbal quality from 3 months to 24 months post-application did not differ. Regarding efficiency, residents felt duration of signout was longer than necessary prior to and after IPASS. At 24 months, opinions reversed to shorter than necessary (p=0.001). When analyzed by level of training, the majority of those responses were PGY-1s (86.7%). Additionally, in 2015 we added a new question about internal and external factors affecting efficiency. Residents stated that internal factors (irrelevant tangents and insufficient information reported) occurred often at 28.1% and 9.4%, respectively, whereas external factors (resident punctuality and interruptions) occurred often at 87.6% and 90.6%, respectively. We evaluated understanding of hospital course, overall plan, severity of illness, and awareness of potential complications to assess patient safety. Compared to 3 months, at 24 months there was better understanding of the overall plan (p=0.044). Conclusions: Changes to the IPASS format can improve understanding of overall plan and resident adherence to handoffs without affecting overall quality or compromise patient safety. External factors are an ongoing issue and will be the next area of focus for quality improvement.

95. IMPROVING RESIDENT AND NURSING WORKING RELATIONSHIPS (Descriptive Abstract)
Jessica Z. Berenson MD, Callie E. Hansen MD, Inova Fairfax Medical Campus/Inova Children’s Hospital, Falls Church, VA
We endeavored to improve frontline patient care by strengthening nursing and resident relationships. In order to achieve this...
Poster Abstracts

Task, we designed two surveys: one survey was given to our residents and one survey to all of our floor nurses. These surveys touched on major hot button topics in nursing and resident relationships that were identified by focus group discussions with nurse and residents. We completed four PDSA cycles. PDSA Cycle #1: We presented the data to the residents and asked them to pick an area to improve. They choose update the nurses with changes to the plan. We reminded them frequently via email and at meetings. We saw little improvement after PDSA Cycle #1. PDSA Cycle #2: We worked with the residents to establish specific times when they would check in with nurses about new orders (after rounds, before signout etc). We saw significant increase in scores during this cycle with a positive response increase from 66% (before PDSA Cycle #1)? 74% (Before PDSA Cycle #2)? 86% after PDSA Cycle #2. For PDSA Cycle #3, we choose to work on updating nurses at night. Our residents agreed to try and check in with nursing after evening signout and before morning signout. We did not see much improvement between PDSA Cycle #3 and PDSA Cycle #4 39%-42% positive responses. For PDSA Cycle #4 we have instituted a meeting at 5 AM with our bed placement leader who oversees all the nurses on the floor in an attempt to communicate information about patients and disposition. Future directions for this project will include maintaining the survey for periodic “temperature checks” of attitudes between nursing and residents and continuing to focus on ways to improve relationships. We have also fostered a community of inclusiveness and interdisciplinary work. We are hosting a two day diversity workshop and it is designed to be interdisciplinary. We will bring together nurses, child life specialists, technicians and physicians to discuss issues of diversity in our hospital. We believe that through seeking nursing input on front line care and creating a community of inclusiveness we will improve nurse resident relations and ultimately patient care.

Winner - APPD 2016 QI Project Award

96. WATCHER INITIATIVE DECREASES UNSAFE TRANSFERS TO A HIGHER LEVEL OF CARE (QI Abstract)
Melanie M. Smith DO, Maryanne M. Chumpia MD, Lindsey A. Wargo MD, Mark Bugnitz MD, University of Tennessee, Memphis, TN

Background: Unrecognized clinical deterioration is a serious safety issue, and inability of care teams to promptly identify decompensating patients often leads to preventable undesirable outcomes. In an effort to reduce the number of poor clinical outcomes, we referenced an existing model at Cincinnati Children’s Hospital where huddles were used to identify “watchers” and prevent “unrecognized situation awareness failure events” (UNSAFE). We modified their system to fit our hospital’s floor-based inpatient setting. UNSAFE transfers include patients who required intubation, vasopressors, or >/= 3 fluid boluses either before or within one hour after transfer to a higher level of care. Aim Statement: Our goal was to decrease the number of UNSAFE transfers from the targeted inpatient floor(s) to an ICU setting by 50% over a 6-month period. Interventions: In May 2015, we asked residents and nurses to identify “watchers” based on defined criteria. This was reported in a daily safety brief. In July, we piloted twice daily huddles on an inpatient floor and have been implementing them on the remaining floors since that time. These huddles include a nursing patient care coordinator, supervising resident(s), and respiratory therapist. The huddles occur twice daily to communicate a plan for intervention and expected outcome within a designated time frame. This information is then disseminated to the bedside nurse and intern, who follow up on the outcome. Measures: We evaluated the number of UNSAFE transfers, as well as deaths on the floor, compared to the total number of transfers to an ICU setting. Results: Prior to starting the daily safety brief in May, the percentage of UNSAFE transfers to a higher level of care was 14% over the previous 16 months. Our first intervention resulted in a 61% decrease in UNSAFE transfers. After our second intervention, the percentage of UNSAFE transfers was 3.7%, which is a total reduction of 74% from baseline. Conclusions and Next Steps: By ensuring that all members of the care team are aware of an at-risk patient’s clinical status, watcher huddles incorporated into the daily inpatient routine can significantly decrease the number of UNSAFE transfers to a higher level of care.
97. IMPROVING PATIENT SAFETY: STANDARDIZING PHYSICIAN NOTIFICATION OF PATIENT ARRIVAL
(QI Abstract)
Lindsey A. Wargo MD, University of Tennessee, Maryanne Chumpia MD, Melanie M. Smith DO, Elisha McCoy MD, University of Tennessee, Memphis, TN

Background: Le Bonheur Children's Hospital is a 255-bed stand-alone children's hospital in Memphis, Tennessee. The pediatric residents admit the majority of general pediatric and subspecialty patients. Upon the patient's arrival to the floor, the admitting team is to be notified. There was a patient safety event related to a breakdown in communication to the admitting team which resulted in a review of the notification process. We discovered there was not a uniform notification process amongst the different units once the patient arrived to the floor. Aim Statement: The aim was to create a standardized notification process and ultimately reduce the percentage of times that the physician was not notified of a patient's arrival to the floor to 5% three months after the new process was implemented.

Interventions: We used a model for improvement effort with PDSA cycles on a pilot floor to improve the physician notification of patient arrival process. We chose a pilot floor based on the lowest percentage of “no calls.” A “no call” was any time that the physician was not notified of a patient's arrival to the floor. Upon looking at the notification process for the pilot floor, we discovered that there were different processes for each floor. Based on pre-intervention data, we established our goal at 5%. In July 2015, we initiated the new notification process on the pilot floor; once sustainable success was achieved, we spread the initiative hospital-wide in November 2015.

Measures: Our outcome measure was the percentage of “no calls.” There were no process or balancing measures.

Results: The baseline total “no call” rate was 17.3%. With the intervention, the total “no call” rate dropped to 3.7% for an overall decrease of 78.6%.

Conclusions and Next Steps: The implementation of a standardized notification process improved communication and ultimately benefited patient safety.

98. CULTURAL AND LANGUAGE GAPS: OVERCOMING COMMUNICATION BARRIERS ON THE PEDIATRIC WARD (Descriptive Abstract)
Neeru P. Narla MD, Children's Hospital/Boston Medical Center, Zeena Audi MD, Catherine Distler Michelson MD, Alan M. Leichtner MD, Children’s Hospital/Boston Medical Center, Boston, MA

Background: Patients with limited English proficiency are more likely to suffer adverse events. Residents consistently report a lack of preparation in caring for an increasingly diverse US population. While certain cultural competence-promoting educational interventions have been met with success, limited data exists on their effectiveness and application to pediatric trainees and populations.

Objectives: 1. Improve the quality of care delivered on a pediatric inpatient ward by creating and implementing a new cultural communication curriculum for residents that leverages interpreters as key stakeholders. 2. Evaluate impact of direct real-time interpreter feedback on resident learning and performance.

Methods: After surveying the residents and interpreters, communication barriers were identified and explored using interpreter focus groups. Through this, 10 tips to overcome communication barriers with multicultural patients and 10 tips to overcome barriers with interpreters were identified (10 and 10). We then performed a needs assessment of existing interventions aimed at improving multicultural communication. Using this knowledge, we designed and implemented the intervention below.

Results: Before Curriculum Implementation: A group of interpreters were trained as “Interpreters-as-Teachers” (IAT). Training centered on their role as educators, characteristics of effective feedback, reviewing the 10 and 10, and the new resident curriculum. Trained interpreters were preferentially assigned to work on the pediatric ward. A rubric was created for the IAT to provide real-time feedback to the residents following patient encounters. The rubric was pretested with multiple interpreters and residents. The Resident Curriculum: The Primer. In the first week of the rotation, residents are instructed to have at least one multicultural patient interaction evaluated by a trained interpreter, to describe areas of strength and improvement in each resident's communication. The Flipped Classroom and Simulation. In the second week, residents are asked to complete a brief interactive online module which was developed using generative learning and flipped classroom theory to optimize retention of the 10 and 10. They then undergo a one hour simulation session run by physicians and interpreters, followed by time for debrief and review of the 10 and 10.
99. IMPROVING RESIDENT COMMUNICATION SKILLS WITH PATIENTS OF DIVERSE BACKGROUNDS
(Descriptive Abstract)
Ruchika Mohla MD MS, Paul Schwartzberg DO, Neptune, NJ

Setting: Residents often do not receive formal education in communication skills in the setting of cultural competency. The objectives of this new strategy were: 1. To assess resident understanding of cultural competency and comfort level with patients of diverse backgrounds 2. To determine if simulated patients can be useful in teaching and evaluating communication skills and cultural competency. Intervention: Five first-year pediatric residents in our program participated in a case-based session using local high school theater students simulating patients with diverse cultural and religious backgrounds. To evaluate each resident, we developed a pre-/post resident survey and a “cultural competency” communication checklist. Additionally, each participating resident received feedback from us, other first-year residents, specialists from our Office of Cultural Diversity, and the theater students following a medical interviewing protocol created by the Children's Hospital of Pittsburgh. Preliminary Outcomes: Our preliminary data suggest that patient-based simulation exercises may be an effective tool in teaching culturally competent communication and improving resident comfort in interacting with individuals of diverse backgrounds. Additionally, we were able to complete the session in less than two hours, the exercise itself required no cost and the medical interviewing protocol provided an effective structure for the activity. We are currently expanding this project to include residents from our Department of Internal Medicine and second-year pediatric residents (data to be included for the session) as well as creating a new longitudinal Cultural Competency Curriculum including lectures, a “Cultural Competency Day,” and workshops from our Office of Cultural Diversity.

100. INTERPROFESSIONAL COLLABORATION: A FORWARD-LOOKING APPROACH TO TEAM-BASED HEALTHCARE (Descriptive Abstract)
Carol Fries MD, Karla Suter MD, Karol Hyjek MD, Rachel Diamond MD, University of Rochester, Rochester, NY

Background: Interdisciplinary collaboration is necessary to achieve best-practice care delivery. Nurses, residents, and all healthcare personnel (HCP) are vital to the team and must work together to optimize patient care. Aims: 1. To improve interprofessional communication, 2. To educate HCP about effective teamwork strategies, 3. To sustain tangible, interdisciplinary, team-building efforts. Methods: Representatives from each discipline formed our Interprofessional Collaboration Committee. A five-point Likert Scale surveyed hospital-wide perceptions of interprofessional relations to identify targets for intervention. Respondents, regardless of discipline, are 40% less likely to report feeling very comfortable communicating with those outside their discipline compared to within (48% vs. 88%), despite agreeing that other discipline input is very (83.7%) or somewhat (13.3%) important. Only 51.5% perceived quality of interdisciplinary communication as anything above adequate. We brainstormed ways to bridge these communication gaps and disseminated techniques for enhancing interprofessional interactions. Results: A resident workshop reviewed strategies for approaching difficult conversations between HCP. We are sharing similar education via hospital-wide newsletter while working to incorporate these communication techniques into daily nursing huddles. We have successfully advocated for resident swipe-access to nurse lounges as well as clear-paneled doors on provider workrooms to promote shared environments. Efforts to obtain hand-held phones for provider teams are anticipated to increase communication and to improve the coordination of entire-team bedside rounds. Resident access to an EHR nursing documentation tool is also improving collaborative patient-care. Conclusions: With practical interventions, we can strengthen the culture shift toward team-oriented care. A uniform team approach is becoming increasingly needed, and formal collaboratives promoting interprofessionalism make this a realistic possibility.

101. MIND THE GAP: INFORMING A CULTURAL COMPETENCY CURRICULUM FOR PEDIATRIC RESIDENTS (Research Abstract)
Zeena Audi MD, Neeru P. Narla MD, Alan M. Leichtner MD, Elida Acuna-Martinez, Children’s Hospital/Boston Medical Center, Boston, MA, Daniel M. Schumacher MD, MEd, Cincinnati Children’s Hospital Medical Center/University of Cincinnati College of Medicine, Cincinnati, OH

Background: Cultural competence education for healthcare professionals has been proposed as a key strategy to address health care disparities between patients of different linguistic and ethnic backgrounds. However, limited data exists regarding application of these curricula to a pediatric setting, particularly in regard to their content. Objective: To inform the creation of a new cultural communication curriculum in the Boston Combined Residency Program in Pediatrics (BCRP) through exploring gaps in communication between pediatric resident physicians and linguistically and ethnically diverse patients from the perspective of residents and interpreters. Methods: A needs assessment was performed by administering surveys to second and third year BCRP residents and all interpreters at Boston Medical Center (BMC). Surveys included open-ended
questions and 5-point Likert scales. Results were coded, and emergent themes were analyzed to identify perceived gaps in communication with non-English speaking and multicultural patients. To further explore and qualify these themes, an interpreter focus group instrument was developed. Two focus groups were then held with interpreters at BMC representing 8 different cultures; focus groups were audio-recorded and transcribed. Gaps in cultural knowledge and interpreter interactions were identified using qualitative thematic analysis with standard coding methods of the de-identified transcripts performed by 2 blinded investigators. Results: Needs Assessment: 87% (20/23) of responding second and third year pediatric residents reported working with an interpreter 1-10 times/week. 65% (15/23) reported having had unfavorable interactions with a family attributed to cultural differences/misunderstandings. Barriers in communication secondary to cultural differences included discrepancies in patient and physician understanding of: the role of healthcare encounters, gender roles and family dynamics, perceptions of offensive behavior, and appropriate traditions and greetings. Barriers in communication secondary to working with interpreters included: physician fear of misinterpretation, inappropriate use of medical terminology and pace of speech, and difficulty building and maintaining rapport between physician and family. Focus Groups: Interpreters across cultures perceived similar gaps in communication between physicians and patients, especially in regard to: how to gain trust, the role of primary care, acknowledging different cultural backgrounds, appropriate use of idiomatic phrases, traditions, adolescence, comfort with medical uncertainty, and ways to effectively work with interpreters in a clinical setting. Conclusion: Pediatric residents and interpreters agree that there is a need for targeted resident training in overcoming cultural and communication barriers while working with non-English speaking and multicultural patients. Potential ways in which to overcome these barriers seem to be shared across cultures and are not ethnicity-specific.

102. DID YOU CHECK YOUR EMAIL?: CAN DAILY COMMUNICATION IN A RESIDENCY PROGRAM BE IMPROVED? (Descriptive Abstract)
Thomas J. Duggan MD, Keyur Mehta MD, Hussam Alharash MD, Marguerite Orsi-Canter MD, Henry Schaeffer MD, SUNY Health Science Center at Brooklyn, Brooklyn, NY
Background: Pediatrics residency programs throughout the United States are comprised of many residents, fellows, attendings and staff. Using a combination of paging, texting, phones, voicemails, and e-mails to communicate on a daily basis, few programs have a unified approach. This fractured, opaque system often creates a chaotic communication environment that stifles efficiency. Some hospitals, at cost, have implemented hospital-wide communication platforms to unify communication. Slack is a rising proprietary communication platform that is used in the non-medical industry to facilitate daily, real-time communication, among employees. Objective: To implement a smartphone and web-based platform for program-wide communications. Key features include decreased reliance on the need for cellular access, the connection of all residents/staff without the use of personal phone numbers, flexibility to create private/subgroup contexts, accessibility, and a relatively easy learning curve. Slack was chosen as it possesses all of the above qualities, is secure for non-HIPAA purposes and is free of charge. Methods: A Slack account was established; groups/channels corresponding with teams/rotations/services/departments were created; residents were trained on how to utilize Slack. A survey was sent to all residents one month following its implementation to evaluate their perception of changes in communication. Results: 49 (60%) residents replied to the survey. Of those who replied, 72% felt communication has improved among the residents, 62% felt communication improved with staff and faculty, and 60% felt the benefit of slack outweighed the annoyance of using slack. Conclusions: The implementation of a customizable communication platform with wi-fi capability improved the quality of daily communication for residents within a large training program. Alternative solutions for communication should be explored if hospital-wide solutions are not already in place.

ADVOCACY

103. RAISING HUMAN TRAFFICKING AWARENESS AND EDUCATION AMONG MEDICAL RESIDENTS (Descriptive Abstract)
Kim B. Hoang MD, Christine Nelson MD, Baylor College of Medicine (Houston), Houston, TX
Background: Human trafficking has surpassed the international drug trade to become the most rapid growing criminal enterprise in the world. Houston is recognized by the U.S. Department of State as one of the largest hubs in the country for human trafficking. One study reported that 50% of trafficking victims have sought medical care while in captivity. Another study showed that less than 10% of doctors recognize trafficking victims and less than 3% have received training in recognition and action. In 2004, Texas Human Trafficking Prevention Task Force was created to combat trafficking and in 2013, a bill was enacted that called for health care professionals be trained on how to identify victims of trafficking. Objectives: Our goal was to create a curriculum to educate local medical residents about the scope of trafficking in Houston and to train them how to identify red flags of victims of trafficking and provide the appropriate resources available for these individuals. Method: A one-hour training session was created that includes a lecture and practice case studies discussing human trafficking in the healthcare setting. Sessions where given to different residency programs including Emergency Medicine, Psychiatry, OB/GYN, Pediatrics, and Family Medicine; a total of 84 residents received the training. Pre and post surveys were given to assess attendees’ knowledge, attitude, behavior, and experience with human trafficking before and after the training. Results: The assessment score of the surveys demonstrated that there was an overall 35% improvement on all knowledge assessment questions. 96% of individuals ranked physician training to identify victims of trafficking as very important to extremely
important and 100% were aware of Houston area resources and appropriate actions after attending our training. Since the implementation of our training this past year, our attendees have reportedly identified 8 new trafficking victims. **Conclusions:** There is a lack of awareness about human trafficking among medical residents in the Houston area. Most have never received training or education on how to identify human trafficking victims and few know the appropriate resources and actions to take with these victims. Our future direction includes expanding our curriculum to hospitals, urgent cares, and medical clinics in high-risk areas of Houston, follow our attendees long term to see how many victims are then identified, and creating a standardized protocol for all health care providers in Houston on what to do when they identify a victim of trafficking.

**104. IMPLEMENTING A SELF-DEVELOPED CULTURAL COMPETENCY WORKSHOP IN PEDIATRIC RESIDENCY AND ASSESSING OUTCOMES (Descriptive Abstract)**

Karolina Maksimowski MD, Danielle Massarella MD, Abdulla Gholi MD, Henry Ng MD, Maria I. Herran MD, Ronald Magiola MD, Robert Needlman MD, Mammen M. Puliyel MD, Case Western Reserve University (MetroHealth), Cleveland, OH

**Background and Significance:** The United States is becoming more culturally and linguistically diverse. Our trainees’ cultural backgrounds do not always reflect the same mix of diversity. There is an increasing need for providing our trainees with the education and tools to provide culturally and linguistically appropriate health care. **Objective:** Implementing a self-developed cultural competency workshop in pediatric residency and assessing outcomes. **Instructional Methods:** We developed a 4 hour workshop with 2 hours of didactic teaching, video-debriefing and small group sessions aimed at becoming aware of their own cultural context and to reflect on it, presenting data on patterns of health care disparities and the quality of health care, to recognize their own potential for bias and stereotyping and how that may affect clinical care and describe strategies for reducing the effects of these biases. The next 2 hours was used to conduct standardized Objective Structured Clinical Encounters (OSCE) in a high fidelity simulation center, with video recording and standardized observation feedback tools to provide immediate feedback. The examples of cases included: 2 year old infant of Chinese descent presenting in acute liver failure later found to be a result of traditional herbal remedy administered by grandmother 3 day old with hyperbilirubinemia requiring exchange transfusion, parents are Jehovah s Witness 7 year old boy with severe persistent asthma whose family has Spanish speaking, recently immigrated from Puerto Rico and speaks only Spanish and reportedly non adherent to asthma medications. These cases were used to elicit the patient’s (Kleinman’s Explanatory) model of illness, demonstrate the use of shared negotiating skills and discuss common health beliefs and identify questions about health practices and beliefs that may be important in a local community and to demonstrate competent use of medical interpreter services effectively to overcome the language barrier in communicating with patients. We also incorporated the use of cultural brokers (Jehovah’s Witness ministers) to give feedback after the OSCE and also speak to the residents about their beliefs. **Results:** Before the workshop we used a standardized cultural medicine questionnaires to assess the faculty perception of cultural competence teaching and what the residents report that they are practicing including the use of shared negotiation at least once a week (p<0.01) and, Incorporating the patient’s health beliefs in treatment plans (p<0.05). The survey conducted 6 months after the workshop failed to show a significant change in the resident’s use of above mentioned skills. **Conclusion:** There is a wide gap between the gap between the faculty perceptions of cultural teaching, and what the residents report that they are practicing while providing care to patients. A workshop with educational strategies aimed at different learning styles failed to show sustained change in pediatric trainees practice behaviors. Longitudinal efforts may be more effective in reinforcing and achieving sustained change.

**105. AN INNOVATIVE MODEL OF INTEGRATED BEHAVIORAL HEALTH (IBH): SCHOOL PSYCHOLOGISTS IN CONTINUITY CLINIC (Descriptive Abstract)**

Sharon Dabrow MD, Carolyn Adams PhD, University of South Dakota, Jennifer Takagishi MD, Carol Lilly MD, Sara Hinojosa, Kathy Armstrong PhD, University of South Florida Morsani, Tampa, FL

**Introduction:** Up to 20% of youth experience a mental, emotional, or behavioral disorder that interferes with daily functioning but 70% do not receive mental health (MH) services. An inter-professional, inter-system approach across settings that includes medical, mental health, and education has been proposed to increase access and collaboration across systems. Training efforts are imperative to support these collaborative efforts. **Methods:** 2 school psychologists (1 student/1 staff) were placed in 2 continuity clinics (CC) 1 day/week. A referral process was established. Services were provided through 81 hands off and co-appointments. They evaluated need for triage, psychoeducation (i.e. IEP/504 plan development), collaboration with schools, parent behavior training, ongoing therapy, medication monitoring, etc. Diagnoses included: ADHD, SLD, DD, Depression, Anxiety, ASD, sleep problems. **Results:** There were 494 visits: 178 therapy (coping, social skills, family communication), 146 parent interventions, 56 triage assessments, 47 triage with intervention, 24 diagnostic psychoeducation, 16 specific diagnostic assessment (SLD, DD, ASD), 13 meeting with other agency (IEP/504 plan), 7 medical monitoring, 5 academic interventions, 4 crisis intervention. Caregivers reported that care was helpful and improved their child’s outcome. All would recommend. 94% of CC residents were involved with the program. 80% referred a patient every 1-3 clinics. 74% had 6 patients involved. Referral diagnoses, in decreasing frequency, included ADHD, behavior/school problems, anxiety and depression. Assistance provided included parent behavior intervention, psychoeducational intervention and assistance with making a diagnosis. Benefits to residents included access to resources, improved workflow, education, and assistance with school issues. **Conclusion:** IBH can work effectively in CCs to provide patient care, resident education and collaboration with school...
and home. Benefits include easy access for families to MH, early intervention/prevention, reliable communication between providers with little stigma. Residents get access to MH provider for patient care and education, improved productivity, workflow, skills and confidence. The psychologist can serve as a liaison between primary care, medical home and school to improve behavioral outcomes, decrease symptoms and health concerns.

106. LETTERS TO THE EDITOR: AN INNOVATIVE STRATEGY IN CHILD ADVOCACY TRAINING (Descriptive Abstract)
Laura M. Plencner MD, Molly K. Krager MD, Stephanie Seger MA, MSW, Jane Knapp MD, Children’s Mercy Hospital, Kansas City, MO

Background: The ACGME requires advocacy education as a component of pediatric training. Pediatricians have powerful voices and communicating a message to legislatures and media is a vital skill in promoting child health. Objective: Our objective was to train residents in developing skills necessary to communicate a concise pediatric public health message. Methods: A collaborative partnership was formed with the hospital government relations team (GRT), including education on the legislative process, pediatricians’ impact on policy, and crafting a message to legislators or media. Residents wrote an evidence-based letter to the editor of the Kansas City Star newspaper (weekday circulation >200,000) on a pediatric public health topic. Based on the Star guidelines letters were limited to 200 words. The GRT served as mentors and reviewers for the letters with a 24 hour turnaround for submission. Results: From 7/2014 to 9/2015 33 Pediatric and Internal Medicine/ Pediatrics Residents participated in the training and submitted letters to the editor of the Kansas City Star. 12/33 (36%) were published. A broad range of topics were represented including safe sleep, choking hazards, car seat safety, pool safety, heat stroke, tobacco exposure, carbon monoxide poisoning, bullying, discipline, vaccine refusal, transition of care, poverty, trust between parents and doctors, and reliable health information sources for parents. Some articles were very timely such as a letter about preventing heat stroke following the death of a child in a hot car. The activity was highly rated by the residents with > 95% in the first year recommending that the activity be repeated for future residents. Resident comments included “fun and interesting” and “...not as intimidating as I thought it would be!” This project also helped to increase the profile of residency program as each letter was also published on the hospital intranet. Conclusion: Letters to the editor are an objective way to build advocacy skills that reach media and produce a tangible work product. Partnering with hospital GRTs is a valuable component of an advocacy training program.

107. HOW DO U.S. PEDIATRIC RESIDENCY PROGRAMS TEACH AND EVALUATE COMMUNITY PEDIATRICS & ADVOCACY TRAINING? (RESEARCH ABSTRACT)
Cara Lichtenstein MD, MPH, Children’s National Medical Center, Washington, DC, Benjamin Hoffman MD, Oregon Health and Science University, Portland, OR, Rachel Y. Moon MD, University of Virginia, Charlottesville, VA

Background: The AAP released its first policy statement on community pediatrics in 1999. There has since been increased emphasis on community pediatrics and advocacy (CP&A) training in residency. The most recent study of CP&A teaching was published in 2005, prior to a program requirement for CP&A teaching. Objective: Determine how CP&A is being taught and evaluated in US Pediatric Residency programs and if there is variability by program location or size. Methods: A web-based, APPD-approved survey sent through the Program Directors listserv in September 2014 asked about teaching and evaluation of 10 community pediatrics topics. Results: Of 85 programs (43% response rate), 30% offer a separate training track and/or 6-Block Individualized Curriculum in community pediatrics or advocacy. More than 75% require all residents to learn about 7/10 CP&A topics queried, with provision of culturally effective care being the most common topic required for all residents (92.94%). Public speaking on behalf of children’s health, collection of population level data and community-based research are required of all residents in <1/3 of programs and are not taught at all in ~20% of programs. Respondents in urban settings were significantly more likely to teach care of special populations (p=0.018) and public speaking (p=0.002). Larger programs were more likely to teach (p=0.048) and evaluate (p=0.041) community-based research. Experiential learning and classroom-based didactics were the most common teaching methodologies reported. Many programs used multiple teaching methodologies for all topics. Observation was the most common evaluation technique used; portfolio review and written reflection were also commonly reported. Conclusion: There is a continued strong emphasis on CP&A training among pediatric residency programs in the US, with >75% of programs requiring all their residents to learn about 7/10 community pediatrics topics. Although respondents report a variety of teaching and evaluation methods, there are few statistically significant differences between programs.

108. IMPACT OF AN ACADEMIC PEDIATRICS ENRICHMENT EXPERIENCE FOR FOURTH YEAR MEDICAL STUDENTS FROM MINORITIES UNDERREPRESENTED IN MEDICINE (Descriptive Abstract)
Alexandra M. Sims MD, Terry Kind MD, Gabrina Dixon MD, Craig DeWolfe MD, Aisha Davis MD, Children’s National Medical Center, Washington, DC

Physician workforce diversity is important for quality medical education, culturally competent care, and research to address the needs of the increasingly diverse population of US children. Previous studies comparing race and ethnicity of US children (URM) is particularly poor in academic pediatrics. Mentoring, professional exposure, social supports, and financial support
enhance the success of URM medical students. Senior URM medical students (Hispanic/ Latino, Black/ African-American, Native American, Alaska Native, Native Hawaiian, Pacific Islander) were invited to apply for a visiting elective. Eleven of the 38 applicants were selected. A stipend to participants helped to offset their travel/housing costs. The experience consisted of a clinical rotation, resident and faculty mentors, networking, and career development sessions in an academic setting. A program evaluation was distributed to all students via RedCap, a secure, web-based survey application designed to support data capture for research studies, hosted at our institution. Retrospective and qualitative questions aimed to understand the impact of the program on career. All participants completed the survey. Pre- and post-program participation data were as follows: 63 vs 90% of students were interested in academic pediatrics as a career choice, 45 vs 81% were interested in residency at a large program, and 90 vs 100% were interested in training at a free-standing children’s hospital. Participants provided in-depth descriptions of the positive impact of professional exposure and supportive mentors. Our findings suggest that an enrichment visiting rotation at an academic pediatric program impact the career trajectories of URM medical students through increasing interest in academic pediatrics and their ability to envision themselves as residents in a similar program. Further outcomes will be evaluated including residency match data and 5-year career follow up.

109. ADVOCACY BUS TOUR: A NOVEL APPROACH TO EDUCATING RESIDENTS ABOUT SOCIAL DETERMINANTS OF HEALTH AND COMMUNITY RESOURCES (Descriptive Abstract)
Michelle J. Ro MD, Valerie Zolezzi-Wynham JD, Beverly Nazarian MD, University of Massachusetts, Mark Vining MD, Worcester, MA

Background: Residents are not often exposed to the challenges families face outside of the hospital setting or to the community resources available to help alleviate those challenges. Creating effective educational methods is essential in helping them advocate for their patients. Methods: During orientation, the intern class of 2014 was taken on a continuous 3 hour bus tour led by an attorney from Community Legal Aid of Central Massachusetts who provided commentary on the challenges and resources in each of the neighborhoods. Based on the 2014 intern class survey Results, the advocacy bus tour for 2015 was changed from a continuous tour to 4 distinct stops with commentary: a local housing project, a community health center, an elementary school known for advocacy, and a middle school in a low-income neighborhood. The interns were given a survey immediately after the tour to assess the impact of visiting specific sites on understanding the social determinants of health and resources in the community. The survey also asked if the bus tour should be repeated, and if the delivery of information in tour format as opposed to conference was more useful. Results: After the advocacy bus tour in 2014, 66% of the interns felt the bus tour should be repeated. In 2015, this figure increased to 100%. All respondents felt the tour format provided was a better delivery of information than a conference format. Comments from interns included: “eye-opening to the needs of many families in Worcester”, and “helpful in getting to know the challenges facing Worcester and its residents”. Conclusion: Our Advocacy bus tour provides a novel experiential learning opportunity that introduces residents to their community and educates them about the social determinants of health that impact the children of Central Massachusetts. The tour remains enthusiastically received. In an effort to apply CQI techniques, we will continue to survey residents yearly and make changes to the tour based on feedback.

110. PEDIATRICIANS “EDUCATING KIDS ABOUT GUN VIOLENCE” - PREVENTING INNER CITY YOUTH VIOLENCE THROUGH COMMUNITY COLLABORATION AND OUTREACH (Descriptive Abstract)
Pei-Yuan (Pearl) Tsou MD, Michelle Barnes, University of Illinois College of Medicine at Chicago, Chicago, IL

Background: Gun violence is a substantial public health problem, and it poses significant threat to the well-being of children, especially inner city youth. Although most pediatricians agree that they play an important role in gun violence prevention, one third of pediatric residency programs offer formal firearm safety counseling training and few pediatricians thought they had sufficient training in this topic. The Educating Kids about Gun Violence (EKG) program, utilizing a community multidisciplinary approach, was initially developed at the Indiana University and had shown positive impact on youth’s knowledge and attitude towards gun violence. Objective: Our objective was to educate youth about the medical and legal ramifications of gun violence through the EKG program, to increase the number of pediatric residents involved by incorporating the program and specific tools for addressing gun violence into the UIC pediatric residency curriculum, and to promote sustainable collaboration between community pediatricians, Illinois States’ Attorneys, and Chicago police department. Methods: Along with Illinois States’ Attorneys, and the Chicago Police Departments, UIC Pediatric residents rotating through community and advocacy electives presented the EKG program to students in the Chicago public schools on a monthly basis. The program incorporates different cases scenarios and encourages interactive discussion of the consequences of gun violence and help students explore safer alternatives of conflict resolution. Results: The EKG programed had positive short-term impacts on youth’s knowledge of legal and medical consequences and attitudes towards gun violence. By incorporating the EKG program in the UIC pediatric residency curriculum, residents were more equipped to address gun violence. The program also promoted sustainable community collaboration, essential for community outreach efforts. Conclusion We were able to establish a sustainable community collaboration to address the issue of gun violence and improve the pediatric training curriculum at UIC through the EKG program. This program can be expanded to other pediatric residency programs as a mean to impact youth gun violence.
GLOBAL HEALTH

111. CREATION OF E-LEARNING MODULES FOR SHORT MEDICAL STUDENT COURSE IN ZIMBABWE (Descriptive Abstract)

Background: There is a concerted effort to increase the health care workforce throughout Africa that has resulted in increasing numbers of students admitted to medical school. This poses significant challenges including shortages of faculty to educate the increasing student body while preserving quality of training. In this environment of limited faculty, e-Learning provides the opportunity to extend faculty availability. One of the challenges to e-learning in LMIC (low middle income countries) is internet accessibility. SMILE plug (Stanford Mobile Inquiry-Based Learning Environment) offers a solution to the challenges of internet accessibility. It creates a portable Wi-Fi access point, gateway, and content server with which users can access SMILE global from any device (PC, laptop, PDA). The SMILE plug was utilized to download course content for a 2-week short course for medical students currently enrolled at University of Zimbabwe College of Health Sciences (UZCHS). This flipped classroom medical education approach should allow for greater engagement by both students and faculty and encourage critical thinking skills among students. Objective: To transition short rotations within the UZCHS medical school curriculum to an e-Learning format and explore challenges to e-Learning within UZCHS. Design/Methods: Sample population: 28 medical students enrolled in the two-week anesthesia course at UZCHS March-July 2015. Content creation: Content consisted of powerpoint presentations with overlying lecturer recordings that were developed through the Camtasia program. Delivery of Content: Course content was available to students through a content management system (WordPress) and through the SMILEplug. Pre-and post-course surveys were administered to assess e-Learning readiness among students and faculty (Kerr et al). Results: e-Learning was implemented for the anesthesia course at UZCHS. 21 of 28 students accessed the content. 100% of participants completed e-learning readiness survey. Challenges faced during implementation included: faculty availability and participation, SMILEplug technical difficulties, and dissemination of access to SMILEplug to medical students and faculty in a time-efficient manner. Conclusion: Successful implementation of e-Learning requires faculty support, personnel to solve technical problems, and student enthusiasm.

112. IMPACT OF A PREPARATION CURRICULUM FOR GLOBAL ELECTIVES (Descriptive Abstract)
Jacquelyn C. Kuzinski MD, Nicole St Clair MD, Tiffany Frazer MPH, Medical College of Wisconsin Affiliated Hospitals, Milwaukee, WI

Purpose: The Medical College of Wisconsin (MCW) developed a combined undergraduate and graduate medical education (UME and GME) pre-departure curriculum for global health (GH) electives in 2012. Preliminary data regarding trainee feedback about the curriculum was reported at APPD in 2014. Additional efforts were made to measure the impact of the curriculum by performing post-GH elective surveys, which is summarized in this abstract. STRUCTURE: An interdisciplinary group of MCW faculty determined the essentials of pre-departure preparation for UME/GME trainees based on a literature review, discussion with national colleagues and local expert consensus. A total of 2.5 hours of training materials were developed: 1) Two 20 minute on-line preparation modules on health and safety; 2) a Guide for Global Engagement; and 3) an in-person 1.5 hour seminar on the ethics of short-term GH electives. The curriculum was piloted, modified, and then integrated into required pre-departure training for GH electives. In order to ensure the curriculum was achieving its target of cultural and ethical pre-departure training, data was gathered through annual pre- and post-elective surveys (2013-2015) to assess whether the mandatory curriculum adequately prepared MCW trainees for their GH electives. Results Nineteen of the 48 trainees who participated in the pre-departure preparation training responded to the post-elective questionnaire. Nearly half of respondents (9/19) felt they had encountered ethical situations while on their GH elective. The majority (18/19) felt they had adequate preparation to deal with ethical situations if they arose. More than half of respondents (13/19) felt they had encountered ethical situations while on their GH elective. All respondents felt they were adequately prepared for their GH elective and the cultural diversity they encountered. Using a five point Likert scale with a high score of 5, the elements of the curriculum that were rated the highest by learners were the in-person ethics seminar (3.89/5), the Guide for Global Engagement (3.79/5) and the on-line modules (3.79/5). Conclusion: An interdisciplinary curriculum can be used to prepare trainees in differing stages of their career for ethical and cultural scenarios pertinent to global training experiences. Based on learner feedback, a successful curriculum should include both in-person and on-line modules as well as a resource guide.

113. CHARACTERIZATION OF ONLINE RESOURCES FOR GLOBAL HEALTH SELF-EDUCATION (Descriptive Abstract)
Kathryn A. Spectorsky MD, Jennifer Watts MD, MPH, Children’s Mercy Hospital, Kansas City, MO

Background: Interest in global health (GH) among residents has had an unprecedented surge of attention and growth. However, in 2013, only 25% of pediatric residency programs self-identified as offering a formal GH training program. Online resources provide a possible solution to this gap of interest versus availability. This study sought to compile, categorize and describe the current online GH educational offerings. Methods: Online searches were conducted using Google from January to September 2015 with terms Global Health OR International Health AND Residency OR Module OR Free OR Education.
In addition, expert recommendations were solicited from Global Health educators. Inclusion criteria required resources to be (1) available to US learners, (2) less than $300, (3) targeted at medical learners interested in GH, and (4) completed at your own pace. Resources were then characterized by sponsoring body, cost, time, number of modules offered, audience, and opportunity to obtain certificate or proof of completion. **Results:** Using the predetermined criteria, 30 resources were identified and compiled in a table with characteristics listed. Academic centers accounted for 47% of the sponsoring institutions and non-profits 30%. One third were large educational offerings, such as open courseware or Massive Online Open Courses, with broader offerings than just GH that require the learner to search for applicable material. Courses ranged from 30 minutes to over 30 hours. Nearly half of the resources offered proof of completion. Over 83% were offered for free, and 17% required a small fee for some or all of the materials. Only 3 resources were specifically devoted to pediatric GH, and an additional 10 had pediatric modules or courses embedded within. **Conclusions:** There is a clear gap between the number of residents interested in GH education and the number of programs offering formal education. Online resources can provide a relatively cheap, self-paced alternative for residents seeking further education in GH.

114. CREATING SUSTAINABLE MODELS FOR SHORT-TERM VOLUNTEERS THROUGH THE GLOBAL HEALTH SERVICE PARTNERSHIP (Descriptive Abstract)

**Kiran Mitha MD, UCLA Medical Center, Los Angeles, CA, Elizabeth Hutchinson MD, University of Washington, Margot Anderson MD, Tulane University, Libby Cunningham MPH, Sadath Sayeed MD, JD, Vanessa Kerry MD, MSc, Massachusetts General Hospital, Boston, MA**

Many countries in sub-Saharan Africa (SSA) have critical shortages of pediatricians who serve as both clinicians and educators. Many African medical schools increase student enrollment to address these shortages; they must also increase faculty. There is an opportunity to assist with faculty placement by tapping into a growing effort by US academic institutions to establish meaningful global health experiences for residents and faculty. Pediatric training is a key focus of the Global Health Service Partnership (GHSP). Between 2013-2015, GHSP placed 15 pediatric educators in medical/nursing schools in SSA for a one-year assignment. These educators taught 41 courses to 1600 trainees, assisted with curriculum development, worked on quality improvement projects, and enhanced teaching methods. Building on this program, a strategy to improve global health experiences is to create partnerships between US academic institutions and GHSP partner sites, where residents and faculty could rotate for shorter periods and be paired with GHSP educators embedded in the local institution. GHSP educators would serve as liaisons and supervisors, have an understanding of sites needs and challenges, and identify educational projects without overburdening local faculty. One model, between University of Washington (UW) and University of Malawi College of Medicine (CoM), demonstrated success. UW family medicine residents rotated at CoM monthly under the supervision of a Malawi-based US educator. Residents completing the rotation oriented their incoming peers and handed over ongoing educational projects. This partnership improved host provider satisfaction, established continuing professional development and quality improvement, and reduced patient referrals to the national hospital. Two UW residents chose to volunteer with GHSP after residency, creating a pipeline of volunteer faculty for the host institution. Similar partnerships between US academic institutions and GHSP could create meaningful and sustainable ways of enabling residents and faculty to serve in resource-limited settings.

115. SEVERE ACUTE MALNUTRITION AND FOOD INSECURITY: A MODEL FOR MAKING GLOBAL HEALTH EDUCATION RELEVANT LOCALLY (Descriptive Abstract)

**Pallavi Kamra MBBS, University of Minnesota, Cynthia Howard MD, Diana Cutts MD, University of Minnesota, Minneapolis, MN, Sarah J. Schwarzenberg MD, Emily Borman-Shoap MD, Michael B. Pitt MD, University of Minnesota, Minneapolis, MN**

**Background:** We provide six, 3.5 hour global health sessions over the course of 3 years during block education that all residents attend. Though the feedback for these sessions has been largely positive, we have noted a growing request to put GH topics in a local context for those who don’t anticipate future work in an international setting. **Objective:** Pilot and evaluate a GH health session that emphasizes both global and local contexts, using the theme of food insecurity. **Methods:** Severe acute malnutrition and food insecurity were identified as topics that could bridge the global/local context. Initial focus was on the burden, diagnosis and management of severe acute malnutrition (global) using an interactive team-based learning assessment. This was followed by a moderated brainstorm on the social determinants of access to food, globally and locally (glocal). We then defined food insecurity, addressing the local burden, screening methods, and highlighting clinical tools available to pediatricians (local). Finally, we assessed the role of pediatricians in advocacy and policy writing using the recent food insecurity AAP policy as an example (national). Resident feedback was obtained using the standard post block education evaluation tool that includes both qualitative and quantitative components, and compared the results to all sessions from the current academic year. **Results:** The session received an average score of 4.68 for learning and 4.75 for interaction (on a scale of 1-5, with 1 being least effective and 5 being most effective). By comparison, previous block ed session evaluations from this academic year (n=7) have received an average of 3.97 (3.3-4.4) for learning and 3.8 (2.1-4.6) for interaction. **Conclusion:** We were able to meet resident demand for putting GH education into a local context, demonstrate improved participant evaluation scores, and provide a model for future sessions. The session is available as open-source for other programs via this link (http://tinyurl.com/ghlumn) which includes learning objectives, team-based learning assessment, slides, and resources.
116. RELIABILITY OF A TOOL TO MEASURE CULTURE SHOCK IN MEDICAL TRAINEES - PROJECT PRIME (PSYCHOSOCIAL RESPONSE TO INTERNATIONAL MEDICAL ELECTIVES) PILOT STUDY
(Research Abstract)
Vanessa C. McFadden MD, PhD, Sabrina Butteris MD, Tiffany Frazer MPH, Ashley Hines, Zahra Ismail, Jacquelyn Kuzminki MD, Melodee Nugent MA, Pippa Simpson PhD, Samantha Wilson PhD, Nicole E. St Clair MD, Medical College of Wisconsin Affiliated Hospitals, Milwaukee, WI
Background: Trainees with global health (GH) interests often participate in a GH elective, a clinical experience in an international setting. Such electives occur within markedly different cultural, ethical, economic and clinical paradigms, resulting in intense immersion experiences. There is minimal data pertaining to how medical trainees experience culture shock during GH electives; however, GH educators have anecdotally noted culture shock as a frequent experience for medical trainees, with varying degrees of negative impact on the training experience. Improved understanding of trainee culture shock would inform pre-travel preparation and on-site support, would maximize the benefit of trainee participation during the elective and, ideally, would enhance their desire to address health disparities throughout their career through a positive global training experience. Our objective was to assess the reliability of the Culture Shock Profile (CSP) (Zapf, Social Work, 1993) to quantify the degree of culture shock experienced by medical trainees during a one month GH elective. Methods: Three residents and 9 medical students participated in a pilot study. Participants completed a pre-travel survey including demographic information and Resilience Assessment (CD-RISC 10). Participants were then prompted to complete the CSP Questionnaire every 4 days during their GH elective. Results: The Resilience Assessments and CSP Scores demonstrated good-to-excellent reliability as assessment tools. Pearson correlations showed a significant inverse relationship between resilience and culture shock for days 6 (R=0.77) and 22 (R=0.83). Conclusions: The pilot study demonstrated good reliability and feasibility of the assessment tools and supported an inverse relationship between trainee resilience and culture shock severity. A larger study using this assessment tool is warranted and will allow the delineation of culture shock patterns, along with identification of factors that influence the severity of culture shock experienced by medical trainees during a GH elective.

See also Poster 117 in Skills / Procedures topic area.

117. PEARLS: PROCEDURAL EDUCATION FOR ADAPTION TO RESOURCE-LIMITED SETTINGS - A SUGAR SPIN-OFF CURRICULUM (Descriptive Abstract)
Rachel S. Bensman MD, Cincinnati Children’s Hospital Medical Center/University of Cincinnati College of Medicine, Cincinnati, OH, Michael B. Pitt MD, University of Minnesota, Plymouth, MN, Tina M. Slusher MD, University of Minnesota, Minneapolis, MN, Sabrina M. Butteris MD, Lisa Umprehy MD, University of Wisconsin, Madison, WI, Amy R. Rule MD, On Behalf of the SUGAR PEARLS Investigators, Cincinnati Children’s Hospital Medical Center/University of Cincinnati College of Medicine, Cincinnati, OH
Background: Residents are increasingly participating in global health rotations in resource-limited settings. Often they do not have access to the supplies they are accustomed to using to perform procedures. SUGAR (Simulation Use for Global Away Rotations) is a standardized simulation curriculum developed by a multi-institutional consortium to prepare learners for the emotional challenges of working in resource-limited settings, yet it does not provide skill training for performing procedures in these settings. Methods: We polled the pediatric global health educators in the seven-institution consortium who developed, piloted, and disseminated the original SUGAR curriculum to determine common procedures residents may be asked to perform while on a global health elective. We used a modified Delphi method to reach consensus on a list of core procedures. Using existing literature and clinical expertise of those with extensive work abroad, we determined the most valuable strategies to address resource limitations and make modifications to perform each procedure. Results: Ten core procedures were identified: IV and IO access, administration of IV infusions, application of nasal cannula oxygen, bag-valve-mask ventilation, application of bubble CPAP, administration of nebulized and inhaled medications, burns and wound care, lumbar puncture, thoracentesis and tube thoracostomy, and routine neonatal care. Investigators have selected procedures within their expertise and are developing consortium-reviewed procedural instruction modified for resource-limited settings. Investigators will produce short videos of instruction, each corresponding to a core procedure, along with an introductory video to explain the goals and limitations of the PEARLS curriculum. Conclusions: These PEARLS videos will supplement the SUGAR curriculum and will be available on the sugarprep.org website for free for global health educators and trainees to use. As SUGAR is already in use at dozens of institutions, we hope the addition of easily accessible training videos will be a valuable addition to the curriculum.

118. A MULTIDISCIPLINARY SIMULATION CURRICULUM IMPROVES RESIDENT PREPAREDNESS ON ACGME PROCEDURAL SKILLS (QI Abstract)
Patricia M. Notario MD, Advocate Christ Medical Center, Oak Lawn, IL, Corrie Fletcher DO, University of Washington, Seattle, WA, Cheryl Lefaire RN, PhD, Mark M. Butterly MD, Advocate Christ Medical Center, Oak Lawn, IL
Background: Pediatric residents have less exposure to performing clinical procedures as a result of duty hour restrictions. In 2013, the Accreditation Council for Graduate Medical Education (ACGME) Resident Survey included a novel set of questions...
for graduating pediatric residents on their level of preparedness to perform 13 procedural skills without supervision. Baseline ACGME May 2013 data from our graduating PGY-3s revealed 100% reported feeling confident performing major ACGME procedures (ex. endotracheal intubation). However, the survey showed that over 50% of our PGY-3s reported they were not comfortable performing minor procedures (ex. splinting). Aim Statement Our objective was to create a simulation-based curriculum with the aim to have all residents report confidence in performing ACGME procedures independently by the time of their graduation. Interventions Starting Fall 2013, we created 5 skills workshops throughout each academic year focusing on procedural training in areas of weakness based on ACGME survey data. Using a rotating schedule of workshops in an existing weekly lecture block, residents received small group learner-directed teaching from multidisciplinary experts. Further iterations of curricular development were implemented through subsequent PDSA cycles based on workshop evaluations. Process changes included increasing length and modality of sessions with low levels of resident confidence, and changing specific procedural facilitators. Measures All residents were anonymously surveyed before the workshops and at the end of each academic year using questions identical to the PGY3 ACGME survey. Yearly PGY3 ACGME survey results were compared to internal survey results using percent change. Results Baseline survey results of our 36 residents Fall 2013 mirrored the 2013 PGY3 ACGME survey results. Internal survey responses of agree or strongly agree for procedural skills and summary scores showed yearly improvements from 2013 to 2015. These internal results reflected the change seen in our ACGME scores from baseline: 2013 (mean 4.08), 2014 (mean 4.15, 2% change) and 2015 (mean 4.30, 5% change). Conclusions and Next Steps A multidisciplinary, simulation based procedure curriculum outside of unit-specific clinical and simulator training resulted in overall improvement in self-efficacy ratings for most reportable ACGME procedures. Next steps include improving specific simulation models used based on resident and trainer feedback.

119. POSTER WITHDRAWN

120. PROCEDURE DOCUMENTATION AND CHECKLISTS IN THE PALM OF YOUR HAND (Descriptive Abstract)

Kris A. Rooney, MD, APD Richard Mazzaccaro, MD, PhD, PD Liborio Larussa, MD Katherine Adams, Program Coordinator Pediatric Residency Program Lehigh Valley Health Network Allentown PA

Background: Timely and accurate logging of procedures is a challenge for residents, leading to under-reporting of procedures. Moreover, when procedure checklist logging is used to establish competence, inaccurate resident logs can affect a program’s ability to establish procedural competency, as required by the ACGME. The most commonly reported barrier noted during resident reviews was the lack of convenient access to the procedure logging website and checklist sheets at the actual time of the procedure. Purpose: To develop and implement a novel method of procedure documentation that would allow residents to easily log procedures and for faculty to complete procedure checklists in real-time using a portable electronic platform. Methods & Results: A portable web-based program was developed that allows residents to instantly access procedure checklists on their hand-held devices from any location. The device is then handed to their supervisor to complete the log and competence checklist in real-time as resident performs the procedure. The checklist and log is automatically emailed to the supervisor who confirms the procedure by simply clicking reply and send, thus generating an automated email to the program coordinator for tracking in a procedure database. Additionally, with this program, each resident’s successful procedures and qualification of independent competence are readily available to all faculty via the website on any device. A systematic review of numbers of checklists and total procedures performed is currently being tracked for one year prior and one year following implementation and data collection is ongoing. Conclusions: We have created a novel, easily accessible, handheld, web-based program that allows residents and supervising faculty to perform procedure logging and competency checklist completion in real-time with a goal of improved reported procedural competence.
121. TEACHING RESUSCITATION SKILLS TO PEDIATRIC RESIDENTS THROUGH SIMULATION

(Descriptive Abstract)
Diana H. Van MD, Ingrid M. Anderson MD, Monika Bhola MD, Ann M. Bacevice MD, Monyulona Y. James EMS P, Case Western Reserve University/University Hospital Case Medical Center/Rainbow Babies, Cleveland, OH

Background: All pediatric residents must learn to identify and resuscitate acutely ill patients. Work hour restrictions and the infrequency of these high-acuity events hinder residents mastering these skills. Multiple studies show simulation is an effective tool to teach resuscitation, improve confidence and procedural proficiency. Objective: To create a simulation curriculum that fosters a learning environment for pediatric residents to gain confidence in performing resuscitations. We emphasize closed-loop communication and appropriate management per Neonatal Resuscitation Program (NRP), Pediatric Advanced Life Support (PALS) and Advanced Trauma Life Support (ATLS) resuscitation guidelines. Methods: We developed a curriculum that systematically reviews NRP, PALS and ATLS guidelines through monthly mock codes. The 12 pediatric conferences are divided among neonatal, pediatric and trauma resuscitations. Expert faculty highlight learning objectives crafted for each case and facilitate a debriefing session. Participants complete a written evaluation after each session. Feedback is incorporated into the next mock code conference in a continuous ongoing quality improvement. Results: To date, we held 8 sessions involving 129 pediatric residents. 96% of trainees report improved confidence. 100% agreed or strongly agreed these skills were relevant to medical practice. 96% of trainees believe this activity will play a valuable role in improving the care they provide their patients. There were no disagree or strongly disagree responses to any of our survey questions. Conclusions: Our curriculum improves trainee confidence to resuscitate acutely ill patients. Our survey results show that trainees value this simulation activity. The residents comments help us improve our curriculum continuously and enhance their education in resuscitation and code-team leadership. References: 1. ACGME Program Requirements for Graduate Medical Education in Pediatrics. Approved: 9/20/2012, Effective 7/1/2013 2. Mills DM, et al. Hospital Pediatrics.2013;3:167-176. 3. Friedman D, et al. Pediatric Emergency Care.2010;26:490-494.

122. A CURRICULUM FOR SIMULATION IN PEDIATRIC EMERGENCY SITUATIONS: IMPROVING PEDIATRIC RESIDENTS SKILLS AND SELF CONFIDENCE (Descriptive Abstract)
Price S. Ward MD, Daphna Barbeau MD, University of Florida, Gainesville, FL, Nora Colman MD, Emory University, Atlanta, GA

Management of cardiopulmonary events in children can be a challenge for pediatric residents due to the rarity of events and lack of skills training during residency. Literature suggests that residents have deficits not only in procedural skills, but also in the confidence and communication proficiency to successfully run a code. At the University of Florida, aside from PALS certification, there was no formal curriculum devoted to learning and maintaining code skills or enhancing self-confidence in these situations. We developed a year-long curriculum for our pediatric residents using simulation training and mock codes to reinforce these skills and develop resident self-confidence and communication during code scenarios, with the ultimate goal of improving patient outcomes. The simulation training curriculum breaks down the PALS guidelines into 8 modules: (1) Patient Assessment & Team Roles, (2) Airway Management & Respiratory Failure, (3) Compressions & Circulation, (4) Rhythm Recognition, (5) IV/IO Access & Medications, (6) Shock, (7) Putting it all together. Residents are divided into groups of 5-8 and attend 30 minute training sessions which occur once weekly from 8:00-8:30 to review each module separately. Each module takes between 4-6 weeks to complete with the last module focusing on using the skills obtained throughout the year and running various patient scenarios. In addition, throughout the year, we hold 2-4 multidisciplinary mock codes per month which allow the residents an additional opportunity to practice and maintain their resuscitation skills. After a year of running the curriculum, pre and post surveys showed a significant percent improvement in all of the following categories: confidence with bag-mask ventilation (19%), performing chest compressions (18%), ability to intubate (12%), knowledge of PALS algorithms (28%), recognizing cardiac rhythms (26%), being a team leader (44%) and ability to resuscitate a pediatric patient without supervision (56%). Although low on the Kirkpatrick’s Hierarchy for Health Professional Education Evaluation (but arguably will still have a positive effect on patient care), the feedback and confidence improvement suggests that there is a need for this education during pediatric residency training.

123. AN INNOVATIVE, LONGITUDINAL PROCEDURE CURRICULUM FOR PEDIATRIC RESIDENTS (Descriptive Abstract)
Robert J. Casey MD, Laura Sartori MD, Rebecca Swan MD, Tyler Reimschisel MD, Erin Powell MD, Whitney Browning MD, Vanderbilt University, Nashville, TN

Background: The ACGME requires all pediatric residents to achieve competency in 11 core procedures. During resident training, hands-on procedural experience is frequently challenging. It is therefore incumbent on programs to devise new strategies for meaningful trainee exposure to these procedures. With this in mind, we developed an innovative, longitudinal curriculum involving simulation. Objective: Our primary objective was to increase pediatric resident comfort level performing procedures required by the ACGME. Methods: Over the course of one academic year, residents received instruction on each ACGME-required procedure by attending monthly hour-long procedure labs. These labs were held during routine conference time and led by an inter-professional team of experts, including physicians, nurse practitioners, respiratory therapists and nurses. Teaching methods included case discussions, simulated procedures, and mock codes. Results of the ACGME post-graduate survey before (2014) and after (2015) the implementation of the procedure curriculum were used to measure resident comfort level. Results: In the surveys completed by 79% of graduating residents, the number of residents who strongly agreed that they were comfortable with a given procedure increased in 8 of the 11 ACGME-required procedures.
The rates of strongly agree more than doubled with bag-valve mask ventilation, umbilical catheter placement, and splinting of fractures. Administration of immunizations, neonatal endotracheal intubation and simple dislocation reduction increased from 0% to 5.3%, 15.8% and 5.3%, respectively. **Conclusions and Future Directions:** We were able to show that participation in our curriculum over one academic year greatly increased comfort level for most of the ACGME-required procedures. We hypothesize that these rates will continue to increase with repeat exposure to the labs over the course of residency training as a supplement to clinical experiences. We believe this approach can easily be replicated at institutions of varying sizes, resulting in improved competency in procedures across training programs.

**124. RESIDENT PERSPECTIVES OF VIRTUAL SIMULATION IN AN ONLINE COMPLEX CARE CURRICULUM (Research Abstract)**

Keri Toner MD, Dewesh Agrawal MD, Priti Bhansali MD, Neha Shah MD, Children’s National Medical Center, Washington, DC

**Background:** There are a growing number of children with medical complexity (CMC). These children may be dependent on devices such as G tubes, VP shunts, or tracheostomies and have unique needs. Resident physicians are involved in the care of these patients but may have less exposure to these devices. CMC serve as a special population for which virtual simulation (VS) may serve a beneficial role in pediatric residency medical education. While simulation is a widely recognized training tool in graduate medical education, VS is relatively unique in this context. **Objective:** To ascertain resident perceptions toward the use of VS for learning to care for CMC with a medical device-related emergency. **Design/Methods:** This was a cross-sectional survey of pediatric residents enrolled in a national randomized study evaluating an online curriculum on CMC. Pediatric residents were asked to complete the curriculum and associated assessments, which included VS. Each participant was asked to complete one of three VS scenarios of an emergency related to medical device malfunction. In the VS scenario, participants were provided with scenes where information was presented with audio and video inputs, prompting actions to address the acute problem. Survey outcomes included assessment of resident experience and perceptions toward VS, and confidence in addressing medical device malfunction after participating in the VS. **Results:** 86 pediatric or medicine-pediatric residents from 20 pediatric residency programs across the nation completed the survey. Of the respondents, 77% have participated in live simulations in residency. However, only 42% have participated in VS. 93% agree or strongly agree that simulation enhances learning methods in residency, and 94% agree or strongly agree that VS would be a useful supplement to live simulations. Regarding CMC, 88% agree or strongly agree that VS would be helpful to learn about children with medical devices. **Conclusions:** While live simulations are an integrated part of pediatric residency education, less than half of resident participants have utilized VS. VS provides a reality-based, safe learning environment, without the resources and personnel required of live simulation. The majority of participants in this study believe that VS is particularly helpful in learning about the growing population of CMC with medical devices.

**125. IMPROVING GRADUATING RESIDENT PROCEDURAL COMPETENCE: A SIMULATION-BASED SENIOR RESIDENT BOOT CAMP (Descriptive Abstract)**

Michelle C. Starr MD MPH, University of Washington, Maya Jones MD MPH, Taylor Sawyer DO MEd, Maneeh Batra MD MPH, Heather McPhillips MD MPH, University of Washington, Seattle, WA

**Background:** The Accreditation Council for Graduate Medical Education (ACGME) mandates that pediatric residents demonstrate procedural competence, though multiple studies report that residents lack many of these skills. We designed and implemented a procedural boot-camp for PGY3 residents in our program to improve perceived competence with intraosseous placement (IO), emergency umbilical vein catheter placement (eUVC), peripheral intravenous catheter placement (PIV), neonatal airway management (NAM), and pediatric airway management (PAM). **Objective:** To improve residents’ perceived competence with procedures by implementing a simulation-based intervention, and measure perceptions of the usefulness of simulation-based training. **Methods:** We anonymously surveyed all PGY3 residents before and after a 4-hour procedure boot-camp regarding their experience with and perceived competence of selected procedures. Additionally, we evaluated the utility of this procedure curriculum. Descriptive statistics were used to analyze results. **Results:** 88% (30/34) of PGY3s attended the boot-camp. 100% (30/30) responded to the pre and post surveys. 97% (29 of 30) of residents reported having performed both PAM and NAM during their residency, with mean attempts of 1.0 and 2.7, respectively. The procedural skills session increased residents self-reported competence with NAM from 18% to 47%, PIV from 36% to 63%, PAM from 7% to 30%, IO from 18% to 73%, and eUVC from 28% to 67%. No residents felt they had done too many procedural simulations and most reported that more frequent and earlier experience to similar sessions would be helpful in achieving competence. **Conclusion:** Residents report few opportunities to attempt procedures on patients during residency. A simulation boot camp for PGY3s increased self-perceived competence with ACGME required procedures. Residents found the boot-camp to be useful, however the long term impact of this intervention has yet to be evaluated, and the translation of skills learned through simulation to the clinical environment requires further investigation.
126. EFFECTIVENESS OF PEDIATRIC FUNDAMENTALS OF CRITICAL CARE SUPPORT (PFCCS) IN ENHANCING RESIDENT SELF-EFFICACY AND SKILLS (Descriptive Abstract)
Andrew L. Rodenbarger MD, Tensing Maa MD, Margaret Chase MD, Markita Suttle MD, Maria Estrada DO, John D. Mahan MD, Nationwide Children’s Hospital/Ohio State University, Columbus, OH

Objective Ensuring residents acquire the skills necessary to care for unstable pediatric patients is a difficult process. PFCCS is designed to educate practitioners to recognize and manage these patients. This study aims to evaluate PFCCS effectiveness in enhancing pediatric resident self-efficacy and clinical skills. We present initial data from the first half of this 12 month study.

Methods All second year (PL2) residents completed the PFCCS course in July and August 2015. Assessments of the PL2 and third year (PL3) residents included 1) multiple choice knowledge test 2) self-efficacy in critical care skills 3) resident milestone-based clinical skills as assessed by faculty during their Pediatric Critical Care (PICU) rotation and 4) post-acute event assessments of clinical decision making by residents caring for unstable children in non-PICU settings. Paired and non-paired nonparametric tests were used to determine the impact of PFCCS on these measures.

Results All PL2 s (n=47) passed the knowledge assessment post-course. Post-PFCCS, self-efficacy significantly improved in all areas (mean improvement 0.52 on 5-point Likert scale), greatest in knowledge and procedural competence; these categories showed no statistical difference between PL2 s and PL3 s (n=53; p Value 0.53 and 0.07). While PL2 self-efficacy declined by their PICU rotations, corresponding faculty evaluations rated residents significantly higher than their own self-efficacy. The effect of PFCCS on procedural competency was significantly higher than that seen from PICU rotations in PL2 s. Post-event data (n=25 PL2) show a positive impact of PFCCS, with most residents stating PFCCS improved their clinical performance.

Conclusion PFCCS improved resident preparedness for care of unstable children as defined by improved self-efficacy and faculty rating of performance. Further, PL2 residents indicated PFCCS positively impacted their performance during specific acute patient care events. Our early results indicate that PFCCS offers meaningful benefits for early 2nd year pediatric residents and their patients.

127. NATIONAL TRENDS IN PROCEDURAL TRAINING IN PEDIATRIC RESIDENCY (Research Abstract)
Allison M. Whalen, Catherine D. Michelson MD, Children’s Hospital/Boston Medical Center, Boston, MA

Background The Accreditation Council for Graduate Medical Education mandates procedural training in pediatric residency. Over the years, there have been decreases in the number of procedures performed by residents. Simulation has augmented residents’ exposure to procedures, but resident experience, even within the same program, remains variable. There is also little known about methods being used to deliver and assess procedural training across residency programs.

Objective Describe national trends in procedural training across pediatric residency programs.

Methods Pediatric program directors completed anonymous surveys about procedure curricula and assessment methods used in their programs, their own perceptions about the importance of specific procedures, and the level of supervision residents from their program attained prior to graduation. Descriptive statistics were used to analyze results.

Results 128 pediatric program directors completed the survey; 22% represented small programs (<30 residents) and 27% represented large programs (>60 residents). 98% of respondents reported using computerized logs to track resident procedures. Assessment by real-time verbal feedback was used by 85% of programs while only 25% used a written assessment tool. 72% of programs discussed progress towards procedural training in milestone meetings. The perceived importance of training was procedure-specific, with 87% of respondents believing bag mask ventilation was important for all pediatric residents and only 1.3% believing that arterial line placement was important for all residents. There was also variability in level of supervision attained by graduating residents with fewer than 1% of graduating residents able to perform thoracentesis and 90% able to perform lumbar puncture without supervision.

Conclusions While the majority of pediatric residency programs are consistently tracking residents’ procedural experience, few programs have established methods for assessing competency. Furthermore, there exist procedure-based differences in program director s perceptions of importance and level of supervision attained at the time of graduation.

128. USE OF A CRITICAL CARE SIMULATION CURRICULUM TO ASSESS PEDIATRIC RESIDENTS ON ACGME DEVELOPMENTAL MILESTONES (Descriptive Abstract)
Joshua D. Patterson MD, San Antonio Uniformed Services Health Education Consortium, Renee I. Matos MD, Matthew A. Borgman MD, Heather M. Delaney MD, San Antonio Uniformed Services Health Education Consortium, Fort Sam Houston, TX

Background The ACGME has put forth 21 milestones to better assess pediatric residents. Many of these milestones require the subjective assessment of residents, which can vary based on the acuity and volume of patients, as well as the degree of visibility of the rater. Our program had wide variance in assessments among faculty with difficulty scoring the evaluations.

Objectives In order to standardize learning and assessments, we created high fidelity simulated scenarios with objective, quantifiable assessment tools that synchronized with the PICU curriculum and aided with milestone calculations.

Methods We created four scenarios utilizing high-fidelity simulation: Procedural sedation (S1), Pulseless electrical activity (S2), asthmatic respiratory failure (S3), traumatic brain injury and seizures (S4). Objective assessment forms were created for each. Prior to the sim, the rotating resident was given a standardized didactic lecture set correlating with the sim material. All residents were certified in PALS prior to training.

Results From Jan 2013 to Nov 2015, 39 PGY2 residents received training. Simulation scores contributed to milestone scores. The scores informed the following ACGME milestones: Decision Making (PC4), carrying out management plans (PC5), identifying strengths, deficiencies and limits in one’s knowledge (PBLI1), communication skills...
(ICS2), demonstrating respect for others (Prof1), and coordinating patient care (SBP1). **Conclusions** We have created an integrated lecture and sim-based curriculum for residents that aids in informing ACGME milestone assessments. This helped us identify residents who required remediation and gave opportunities to evaluate them in crisis scenarios that they wouldn’t have otherwise been experienced. We identified consistent difficulty with basic PALS knowledge, resulting in added sim exposure during ward block. We also identified the need to improve assessments by weighting tasks differently based on their clinical importance in the scenario, as well as identifying skills and actions that more closely unify with the ACGME milestones.

**FELLOWS**

**129. FELLOW ONBOARDING (Descriptive Abstract)**

YoungNa J. Lee-Kim MD, YoungNa J. Lee-Kim MD, Ernest D. Frugé PhD, Teri L. Turner MD MPH MEd, Baylor College of Medicine (Houston), Michael E. Scheuer PhD MPH, Charles P. Steuber MD, Baylor College of Medicine (Houston), Houston, TX

**Background:** Onboarding is the process by which new employees acquire knowledge, skills, and behaviors necessary to be productive and successful. The CoPS Fellowship Readiness Action Team identified areas for improvement for Pediatric residents entering subspecialty training, including independent decision-making, familiarity with principles of research, procedural proficiency, and mentorship. The Pediatric Hematology-Oncology (PHO) Fellowship Program at Baylor College of Medicine has an onboarding curriculum to address these components of transition from residency to fellowship. **Objective:** Evaluate the effectiveness of our onboarding curriculum for first year PHO fellows **METHOD:** All new fellows participate in an 8 hour/day, month-long onboarding curriculum which includes didactic lectures, sessions on consent process and protocols, sessions with the Chief Fellow and program directors, simulated patient encounters, procedural experience, and shadowing on clinical rotations. They are assigned to a fellow/faculty mentor and invited to social events. To assess the effectiveness of our curriculum, we used a 15 item retrospective pre/post (1= no ability to 9= very high ability) questionnaire at the end of the month, focused on skills in evaluating new patients, managing overnight calls, understanding consent processes and protocols, navigating the hospital system, accessing online resources, leading difficult conversations, performing procedures, and seeking assistance. **Results:** Paired t-test data (n=16) showed significant improvement in every area (p<0.002). Most helpful were shadowing, procedure days, general PHO topics, practical sessions (eg, writing chemotherapy) and team-building. Greatest improvement was in the ability to access online resources, more so in fellows who completed their residency at another institution (p=0.05). Least useful were very detailed didactic lectures on specific research protocols and pathology. **Conclusions:** Onboarding is important to fellowship training and provides a framework for effectiveness and success. We plan to implement follow-up surveys later in fellowship training to evaluate the long-term impact of the onboarding curriculum.

**130. CREATION OF A PEDIATRIC SUBSPECIALTY EDUCATIONAL RESEARCH NETWORK (Descriptive Abstract)**

Richard B. Mink MD, MACM, Los Angeles County-Harbor UCLA Medical Center, Torrance, CA, Carol L. Carraccio MD, MA, American Board of Pediatrics, Chapel Hill, NC, Alan Schwartz PhD, University of Illinois College of Medicine at Chicago, Chicago, IL, Christiane E. Dammann MD, Tufts Medical Center, Boston, MA, Pamela C. High MD, Brown University, Providence, RI, Kathleen A. McGann MD, Duke University Hospital, Durham, NC, Bruce E. Herman MD, University of Utah, For the Subspecialty Pediatrics Investigators Network, Salt Lake City, UT

**Introduction:** A challenge to meaningful research in medical education is the need for large sample sizes so that innovative approaches can be adequately assessed. Furthermore, trainees need to be evaluated in different educational settings to understand what functions well in which environment and why or why not. The Subspecialty Pediatrics Investigators Network (SPIN) was created to meet these needs. **Methods:** SPIN was conceived as a collaborative effort of CoPS, APPD LEARN, the ABP and the APPD Fellowship Committee taking advantage of the expertise of each group. CoPS’ role was to coordinate the efforts of the subspecialties whereas APPD LEARN assisted with IRB submission and data management/analysis and supplied a data warehouse. All stakeholders provided input into study design. Each subspecialty identified up to 2 representatives who were responsible for recruitment and communication within their subspecialty. These individuals, along with the organizational leaders, serve as the SPIN Steering Committee. In its initial project, the Network conducted a study evaluating entrustment decisions for the common pediatric subspecialty Entrustable Professional Activities. **Results:** 209 pediatric subspecialty programs (27% of ACGME approved fellowships) submitted data involving 1069 fellows. IRB approval was obtained from 79 different institutions and all 14 subspecialties with ABP certification contributed data. Neonatology (n=33) and Critical Care (n=24) had the highest number of programs participating. However, Developmental-Behavioral Pediatrics enrolled the greatest percentage of programs (46%) followed by Child Abuse Pediatrics (40%) and Critical Care (38%). Twelve of 14 (86%) subspecialties met the prescribed participation rate of 20%. **Conclusions:** A subspecialty educational network, SPIN, representing all ABP-certified pediatric subspecialties, was successfully created and utilized. This Network provides a critical infrastructure for evaluating the education of fellows and also provides a repository for data that can be utilized in further studies. Supported by the ABP Foundation. Thanks to Alma Ramirez, BS
131. DO FELLOWSHIP PROGRAM DIRECTORS (FPD) AND CLINICAL COMPETENCY COMMITTEES (CCC) AGREE IN FELLOW ENTRUSTMENT DECISIONS? (Research Abstract)

Richard B. Mink MD, MACM, Los Angeles County-Harbor UCLA Medical Center, Torrance, CA, Carol L. Carraccio MD, MA, American Board of Pediatrics, Chapel Hill, NC, Bruce E. Herman MD, University of Utah, Salt Lake City, UT, Tandy Aye MD, Stanford University, Stanford, CA, Jeanne M. Baffa MD, Jefferson Medical College/duPont Hospital for Children, Wilmington, DE, Patricia R. Chess MD, University of Rochester, Rochester, NY, Jill F. Russell MD, University of Arkansas for Medical Sciences, Little Rock, AR, Cary G. Sauer MD, MSc, Emory University, Atlanta, GA, Diane E. Stafford MD, Boston Children’s Hospital, Boston, MA, Pnina Weiss MD, Yale-New Haven Medical Center, New Haven, CT, Alan Schwartz PhD, University of Illinois College of Medicine at Chicago, For the Subspecialty Pediatrics Investigators Network, Chicago, IL

Introduction: Throughout fellowship, FPDs assess fellow performance, including their required level of supervision. However, CCCs now also evaluate fellow progress. We examined the association of the entrustment levels determined by the FPD with that of the CCC for 6 common pediatric subspecialty Entrustable Professional Activities (EPAs). Since both groups evaluate fellows longitudinally, we hypothesized that there would be a strong correlation and minimal bias between their judgments.

Methods: The Subspecialty Pediatrics Investigators Network (SPIN) conducted a multi-subspecialty study in which FPDs and CCCs were asked to separately assign a level of supervision to each of their fellows for 6 common pediatric subspecialty EPAs. A supervision scale specific to these EPAs was created and assessments were made in 2014 (fall) and 2015 (spring). FPDs were asked to complete the evaluations 1 week before the CCC meeting and to indicate if they were a CCC member. For each EPA, the correlation between FPD and CCC assessments was analyzed with Spearman rho and bias was calculated as FPD-CCC values.

Results: 209 programs from 14 pediatric subspecialties participated. For the fall and spring, there were 598 and 513 FPDs who were CCC members and 433 and 399 FPDs who were not, respectively. In both periods and for each EPA, there was a strong correlation between the FPD entrustment level and that of the CCC (p<0.001; table). In both the fall and spring, the correlation was slightly lower (p<0.001) when the FPD was not a CCC member compared with when the FPD was. Irrespective of whether the FPD was a CCC member, mean biases in the fall and spring were similar (p>0.05; table) and the differences between the FPD and CCC assignments were small.

Conclusions: There is a strong correlation between FPD and CCC assignment of entrustment levels. Although the association is slightly weaker when the FPD is not a CCC member, since the bias is very small, this is unlikely to be important in determining fellow level of entrustment. Supported by ABP Foundation.

Thanks to Alma Ramirez, BS

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132. TEACHING HIGH VALUE CARE ACROSS THE SUBSPECIALTIES (Descriptive Abstract)

Jerri A. Rose MD, Nancy Bass MD, Brendan J. Kilbane MD, Anne Stormorken MD, Katherine Mason MD, Case Western Reserve University/University Hospital Case Medical Center/Rainbow Babies, Cleveland, OH

Background: With the growing emphasis on unsustainable costs and inefficiencies throughout healthcare, physicians must be well-trained to practice high-value care (HVC). While the ACGME requires that pediatric specialists learn to incorporate considerations of cost awareness and risk-benefit analysis into patient care, there is little consensus regarding how such training should be integrated into fellowships’ curricula. Objectives: We implemented a workshop into a core curriculum to educate pediatric fellows in HVC concepts. Objectives included preparing learners to: (1) appreciate the importance of HVC; (2) describe a simple HVC delivery model; (3) describe barriers to HVC practice; (4) articulate strategies for incorporating HVC into practice; and (5) effectively communicate about HVC. Methods: Our workshop included three segments: (1) introduction to HVC concepts and a delivery model; (2) communicating HVC; and (3) incorporating HVC throughout clinical
service lines. Faculty role-played an HVC-related clinical scenario to open the workshop. Within small groups, participants collaborated to identify and discuss barriers to HVC practice, shared examples of conflicts encountered when communicating HVC-based recommendations, and proposed potential negotiation strategies. HVC-related resources were provided for future self-directed learning. OUTCOMES: Participants included 31 fellows representing ten subspecialties. Self-reported knowledge/comfort levels related to various HVC elements were assessed pre-workshop using audience response technology. An identical questionnaire was distributed three months post-workshop; six of 31 participants (19%) responded. Five respondents (83%) reported changing at least one aspect of their clinical practice as a result of workshop participation. Nine of 31 (29%) participants rated usefulness of the workshop’s content through an electronic survey, with most (75, 67, and 71%) rating each of the three segments as “very” or extremely” useful. DISCUSSION: An interactive workshop proved to be a practical strategy for training fellows in core HVC principles across subspecialties. While less than twenty percent of participants completed our follow-up questionnaire, those responding indicated that the workshop led them to make changes in clinical practice related to HVC.

133. ASSESSING BURNOUT AND PROFESSIONAL FULFILLMENT AMONG PEDIATRIC SUBSPECIALTY FELLOWS (Research Abstract)
Caroline Okorie MD, MPH, Mickey Trockel MD, Sumit Bhargava MD, Stanford University, Palo Alto, CA

Introduction: Despite extensive data about physician wellness and burnout, there is a paucity of literature evaluating wellness and burnout among fellow physician trainees. Objectives: 1) To assess the degree of Professional Fulfillment and Burnout among pediatric subspecialty fellows at an academic institution 2) To assess determinants of Professional Fulfillment and Burnout 3) To assess post-fellowship career plans and to determine if either Professional Fulfillment or Burnout affects these plans. Methods: We adapted a Faculty Wellness survey already employed at our institution. The survey was administrated electronically to each of the 95 pediatric subspecialty fellows. Results: The survey had a 65% response rate (n=62) and demonstrated that 80% of fellows reported at least moderate levels of Professional Fulfillment. Also, 60% of fellows reported one or more symptoms of burnout using the single-item burnout self-assessment scale. This is significantly higher compared to the 28% of faculty at the same institution. Linear regression model predictors of higher Professional Fulfillment included: sleep-related impairment (p=0.01, β=-0.35), mindfulness (p<0.001, β=0.47), low focus (p=0.003, β=-0.41), perceived appreciation (p<0.001, β=0.62), and peer support (p<0.001, β=0.63). Logistic regression model predictors of Burnout included sleep-related impairment (p=0.01, OR=31.3) and low focus (p<0.001, OR=7.3). Mindfulness (p<0.001, OR=0.03), and perceived appreciation (p<0.001, OR=0.27) were protective against Burnout. There was no statistically significant association between a fellow's intent to pursue a career in academics and level of Professional Fulfillment or Burnout. Conclusion: This study revealed a high rate of Burnout among pediatric fellows at a large academic institution. It also demonstrated identifiable predictors of both Professional Fulfillment and Burnout, with the relationship between sleep-related impairment and Burnout especially striking. The data identifies clear areas for intervention, specifically, targeting ways to increase mindfulness and reduce sleep-related impairment to reduce Burnout and increase Professional Fulfillment. Studies have shown how mindfulness can have a positive effective on sleep. Interventions and courses on mindfulness should be deliberately initiated for fellows. Participants identified additional potential interventions, including: structured mentorship, appreciation events, and wellness workshops. Next steps would include assessment of fellows at other institutions and in other specialties and a repeat evaluation to assess for intervention effectiveness.
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