APPD 2017
Annual Spring Meeting
April 5-8, 2017

Adventures in Pediatric Medical Education: Small World, Big Impact

MPPDA Annual Meeting
April 4-5, 2017

Anaheim, California
Hilton Anaheim

*This activity has been approved for AMA PRA Category 1 Credit™*
Welcome to the APPD 2017 Annual Spring Meeting in Anaheim!!

I am thrilled to welcome you to Southern California as we gather to advance pediatric medical education to ensure the health and well-being of children. I look forward to lots of learning and lots of fun at this meeting. APPD’s membership and the children and families we serve are as diverse as the children represented in the classic Disney ride, It’s a Small World. Our meeting is a collaborative effort among Board members, Program Committee members, Executive Committees, Task Force Chairs and members, Pediatric Educational Group (PEG) leaders and members, regionally focused organizations, and a diverse group of APPD members – all of whom I wish to 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.

I hope that you take full advantage of the learning and interaction opportunities from our meeting activities that represent the diversity of our membership.

- Pre-meeting workshop on training future pediatrics to provide for the mental health needs of children
- Outstanding medical education research by our members in platform and poster sessions
- Highly interactive and practical workshops
- Task Force, Pediatric Education Group, Grassroots, and “small program” meetings in which colleagues with similar interests gather to work and learn
- Regional meetings where topics of geographical interest are discussed
- Update to the APPD Strategic Plan: Vision 2020 that charts a course for our organization into the future and is engaging members at multiple levels.

I am so pleased you are attending this annual meeting. It is truly an opportunity to learn, share and celebrate with our colleagues and friends at APPD! I look forward to experiencing my own “Big Impact” from this meeting and learning of yours.

In Memoriam

Cynthia L. Ferrell, M.D., M.S.Ed.
(1966-2017)
APPD 2017 Annual Meeting Program Chair
Pediatric Residency Program Director & Associate Professor of Pediatrics
Oregon Health & Science University (OHSU)
### Schedule-At-A-Glance

**APPD 2017 Annual Spring Meeting**  
April 5-8, 2017  
Program Details begin on page 12

**MPPDA 2017 Annual Meeting**  
April 4-5, 2017  
Program Details begin on page 35

Anaheim, California

#### Tuesday, April 4, 2017

<table>
<thead>
<tr>
<th>Time</th>
<th>Event</th>
<th>Location</th>
</tr>
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<tbody>
<tr>
<td>7:30am-5:00pm</td>
<td>APPD LEAD* Meeting <em>(LEAD Cohort Only)</em></td>
<td>Carmel</td>
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<tr>
<td></td>
<td>APPD Board of Directors Meeting</td>
<td>Executive Boardroom</td>
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<tr>
<td>8:00am-5:30pm</td>
<td>MPPDA Annual Meeting <em>(details on pages 35-37)</em></td>
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<tr>
<td>6:30pm-9:30pm</td>
<td>MPPDA 50th Anniversary Dinner and Celebration <em>(additional fee required)</em></td>
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#### Wednesday, April 5, 2017

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<th>Time</th>
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<tbody>
<tr>
<td>8:00am-11:30am</td>
<td>APPD LEAD* Meeting <em>(LEAD Cohort Only)</em></td>
<td>Carmel</td>
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<tr>
<td>8:00am-4:30pm</td>
<td>MPPDA Annual Meeting <em>(details on pages 37-38)</em></td>
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<tr>
<td>8:00am-5:30pm</td>
<td>APPD Forum for Chief Residents</td>
<td>California Ballroom C</td>
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<tr>
<td>8:30am-3:00pm</td>
<td>APPD Pre-Meeting Workshop/ “The Mental Health Crisis: Preparing Future Pediatricians to Meet the Challenge” <em>(sponsored / presented by ABP and APPD)</em></td>
<td>Pacific Ballroom D</td>
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<tr>
<td>9:00am-5:30pm</td>
<td>APPD Coordinators’ Session</td>
<td>Pacific Ballroom B</td>
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<tr>
<td>3:30pm-5:30pm</td>
<td>APPD Grassroots Forum for PDs</td>
<td>Pacific Ballroom C</td>
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<td>APPD Grassroots Forum for FPDs</td>
<td>Malibu</td>
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<td></td>
<td>APPD Grassroots Forum for APDs</td>
<td>Pacific Ballroom D</td>
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<tr>
<td>5:45pm-6:00pm</td>
<td>APPD Meet and Greet <em>[Brief Orientation for Attendees at their first APPD Meeting]</em></td>
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<tr>
<td>6:00pm-7:00pm</td>
<td>APPD Networking Reception</td>
<td>California Ballroom D</td>
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#### Thursday, April 6, 2017

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<tr>
<th>Time</th>
<th>Event</th>
<th>Location</th>
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<tbody>
<tr>
<td>7:00am-8:15am</td>
<td>APPD Members Meeting: Awards and Annual Reports with Continental Breakfast</td>
<td>Pacific Ballroom</td>
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<tr>
<td>8:30am-10:00am</td>
<td>Task Force Meetings <em>(details on page 16)</em></td>
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<tr>
<td>10:15am-11:45am</td>
<td>Workshop Session 1 <em>(choice of 9, details on pages 16-19)</em></td>
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<tr>
<td>12:00pm-1:30pm</td>
<td>Lunch On Your Own</td>
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<td>Vision 2020: Strategic Plan Project Teams Meeting <em>(Project Team Members Only)</em></td>
<td>Pacific Ballroom</td>
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2017 Annual Meeting  April 5-8  Anaheim, California  www.APPD.org
1:40pm-3:00pm  Key Stakeholders Session  Pacific Ballroom
3:15pm-4:45pm  Workshop Session 2 (choice of 9, details on pages 20-23)
5:00pm-6:30pm  Forum for Directors of Small Programs and Affiliate Chairs  Pacific Ballroom B

APPD Speed Mentoring Session for Faculty (pre-registration required / limited number accepted)  Pacific Ballroom A
6:30pm-7:30pm  APPD LEAD Graduates Reunion (LEAD Graduates and Council only)  Manhattan

Friday, April 7, 2017
7:00am-8:30am  Regional Breakfast Meetings (details on page 23)
9:15am-11:15am  Workshop Session 3 (choose one of eight, 2-hour or two, 1-hour workshops, details on pages 23-26)
11:30am-1:00pm  Lunch On Your Own

Council of Regional Chairs Lunch Meeting  Oceanside
Council of Task Force Chairs Lunch Meeting  San Clemente
1:15pm-3:15pm  Workshop Session 4 (choose one of eight, 2-hour or two, 1-hour workshops, details on pages 27-29)
3:30pm-5:30pm  Poster Session (posters displayed throughout the day)  Pacific Ballroom CD

Saturday, April 8, 2017
7:00am-8:30am  Continental Breakfast/PEG Meetings (details on page 30)
8:45am-10:15am  Platform Presentations of Top Research/QI/Descriptive Abstracts  Pacific Ballroom A
10:30am-12:00pm  Special Interest Symposia (choice of 8 sessions presented by APPD Task Forces and PEGs, details on pages 32-33)

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)**
- Laura Degnon, CAE
- Franklin Trimm, MD
- Marsha Anderson, MD
- Susan Bostwick, MD

**APPD Sponsor ($500-$999)**
- Sean P. Elliott, MD
- Teri L. Turner, MD, MPH, MEd
- Linda Waggoner-Fountain, MD, MEd
- Ketan Kansagra, MD
- Gail A. McGuinness, MD

**APPD Supporter ($250-$499)**
- Kimberly Boland, MD
- W. Michael Southgate, MD
- Charlene Larson Rotandi, AB, AA
- Daniel L. Schumacher, MD, MEd

**APPD Friend (up to $249)**
- Charlene Larson Rotandi, AB, AA
- Daniel L. Schumacher, MD, MEd
**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, Association of Pediatric Program Directors (APPD) and the Medicine-Pediatrics Program Directors Association (MPPDA). 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 25.25 (MPPDA sessions only for a maximum of 9.0, and APPD sessions only for a maximum of 21.25) AMA PRA Category 1 Credits™. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

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### APPD Session Time | Session Title | Credit Hours
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**Wednesday, April 5 - 7 hours**
8:30am-3:00pm | APPD Pre-Meeting Workshop / “The Mental Health Crisis” | 5.0
3:30pm-5:30pm | APPD Grassroots Forum for PDs, APDs or FPDs | 2.0
**Thursday, April 6 - 5.75 hours**
10:15am-11:45am | APPD Workshop Session 1 | 1.5
1:40pm-3:00pm | APPD Key Stakeholders Session | 1.25
3:15pm-4:45pm | APPD Workshop Session 2 | 1.5
5:00pm-6:30pm | APPD Forum for Directors of Small Programs and Affiliate Chairs | 1.5

**Friday, April 7 – 4.0 hours**
9:15am-11:15am | Workshop Session 3 | 2.0
1:15pm-3:15pm | Workshop Session 4 | 2.0

**Saturday, April 8 – 4.5 hours**
7:00am-8:30am | APPD Pediatric Education Group Meetings | 1.5
8:45am-10:15am | APPD Platform Presentations from Top Research/QI/Descriptive Abstracts | 1.5
10:30am-12:00pm | APPD Special Interest Symposia | 1.5

**TOTAL** 21.25

### MPPDA Session Time | Session Title | Credit Hours
---|---|---
**Tuesday, April 4 - 4.0 hours**
8:30 am - 9:30am | MPPDA Plenary Session 1: MedPeds 50 Years | 1.0
9:40am - 10:40am | MPPDA Workshop Session: Leadership and MedPeds | 1.0
10:50am-11:50am | MPPDA Plenary Session II: Looking Within | 1.0
11:00am-12:15pm | MPPDA Group Activity | 1.0

**Wednesday, April 5 - 5.0 hours**
8:00am-8:30am | MPPDA Presidential Address | .5
8:30am-9:30am | MPPDA Plenary Session III: Looking Forward | 1.0
9:45am-10:45am | MPPDA Breakout Sessions: Nuts & Bolts | 1.0
11:00am-12:15pm | MPPDA Keynote Address | 1.25
1:45pm-3:00pm | MPPDA Plenary Session IV: Regulatory Updates | 1.25

**TOTAL** 9.00
APPD Leadership

President
Franklin Trimm, MD (2016-2018)
University of South Alabama

President-Elect
Javier Gonzalez del Rey, MD, MEd (2016 - 2018)
Cincinnati Children’s Hospital Medical Center

Secretary-Treasurer
John Mahan, MD (2016-2019)
Nationwide Children’s Hospital/Ohio State University

Past-President
Dena Hofkosh, MD, MEd (2016 - 2018)
Children’s Hospital of Pittsburgh of UPMC

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

Board of Directors - At Large Members
Rebecca Blankenburg, MD, MPH (2016-2019)
Stanford University, Lucile Packard Children’s Hospital

Pamela Carpenter, BA, C-TAGME
Chair-Elect (2016 - 2017) / Chair (2017-2018)
University of Utah

Grace Caputo, MD, MPH (2015-2018)
Phoenix Children’s Hospital

Duke University Medical Center

Nomination Committee
Dena Hofkosh, MD, MEd, Chair
Children’s Hospital of Pittsburgh of UPMC

University of North Carolina

Duke University Medical Center

Coordinators’ Executive Committee
Charlene Larson Rotandi, AB, AA, C-TAGME
Chair (2016-2017)
Stanford University

Pamela Carpenter, BA, C-TAGME
Chair-Elect (2016 - 2017) / Chair (2017-2018)
University of Utah

Teresa Beacham, MBA, C-TAGME
Immediate Past Chair (2016-2017)
University of Kansas School of Medicine

Michelle Brooks, C-TAGME (2015-2018)
Stanford University

Amy Gaug, BA (2016-2019)
University of Minnesota

Rachel Laws, MBA (2016-2017)
Children’s Mercy Hospital

Associate Program Directors’ Executive Committee
Glenn Rosenbluth, MD
Chair (2016-2017)
University of California, San Francisco

Megan Aylor, MD
Chair-Elect (2016-2017) / Chair (2017-2018)
Oregon Health and Science University

Maneesh Batra, MD, MPH
Immediate Past Chair (2016 - 2017)
University of Washington/Seattle Children’s

Goryeb Children’s Hospital Atlantic Health

Sara Multerer, MD (2015-2018)
University of Louisville School of Medicine

Sydney Primis, MD (2016-2017)
Carolinas Medical Center

Fellowship Program Directors’ Executive Committee
Angela Myers, MD, MPH, Chair (2016-2017)
Children’s Mercy Hospital

Pnina Weiss, MD, Chair-Elect (2016-2017) / Chair (2017-2018)
Yale University School of Medicine

Geoffrey Fleming, MD, Immediate Past Chair (2016-2017)
Vanderbilt University School of Medicine

Jennifer Kesselheim MD, MEd, MBE (2016-2019)
Dana Farber Cancer Institute

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

Kathleen McGann, MD (2013-2017)
Duke University Medical Center
APPD 2017 Annual Meeting Program Committee

Executive Planning Committee

Cynthia Ferrell, MD, MSEd, Program Chair  
Oregon Health and Science University

Andrea Asnes, MD, Program Co-Chair  
Yale School of Medicine

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

Katherine Mason, MD  
Rainbow Babies & Children’s Hospital

Suzanne McLaughlin, MD  
Brown University / Rhode Island Hospital

Megan Aylor, MD  
Oregon Health and Science University

Teresa Beacham, MBA, C-TAGME  
University of Kansas School of Medicine

Program Committee Members

Michelle Barnes, MD  
University of Illinois at Chicago

Brooke Bokor, MD, MPH  
Children’s National Medical Center

Kimberly Boland, MD  
University of Louisville School of Medicine

Heather Burrows, MD, PhD  
University of Michigan

Savanna Carson, MS  
UCLA Pediatric Residency Program

Tania Condurache, MD, MSc  
University of Louisville School of Medicine

Paul Darden, MD  
OU Health Sciences Center

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

Kimberly Gifford, MD  
Dartmouth-Hitchcock Medical Center

James Hagadorn, MD  
Connecticut Children’s Medical Center

Grace Haymes, BA  
St. Christopher’s Hospital for Children

Carrie Johnson  
Lucile Packard Children’s Hospital/Stanford University

Melissa Klein, MD, MEd  
Cincinnati Children’s Hospital Medical Center

Fernanda Kupferman-Meik, MD  
The Brookdale Hospital & Medical Center

Richard Mazzaccaro, MD, PhD  
Lehigh Valley Health Network/University of South Florida College of Medicine

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

Renuka Mehta, MBBS  
Medical College of Georgia/ Augusta University

Catherine Michelson, MD  
Boston Medical Center

Sara Multerer, MD  
University of Louisville School of Medicine

Sue Poynter, MD  
Cincinnati Children’s Hospital Medical Center

Aarti Raghavan, MD  
University of Illinois at Chicago

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

Caroline Rassbach, MD  
Stanford University Pediatric Residency Program

Jerri Rose, MD  
Rainbow Babies & Children’s Hospital

Charlene Rotandi, AB, AA, C-TAGME  
Stanford University School of Medicine

Christiana Russ, MD  
Children’s Hospital of Boston

Heidi Sallee, MD  
St. Louis University/SSM Cardinal Glennon Children’s Hospital

Daniel Sklansky, MD  
University of Wisconsin

Sharon Smith, MD  
Connecticut Children’s Medical Center

Omolara Uwemedimo, MD  
Cohen Children’s Medical Center

Mark Vining, MD  
University of Massachusetts Memorial Medical Center

Suzanne McLaughlin, MD  
Brown University / Rhode Island Hospital
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 23 for location of your region’s meeting).

www.appd.org/activities/regions.cfm

APPD Regions

Midwest Region
Jason Homme, MD (2013 - 2016)
Program Director, Mayo School of Graduate Medical Education
homme.jason@mayo.edu

Eyad Hanna, MD, MME (2015-2018)
Associate Program Director
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Eyad-hanna@uiowa.edu

Sarah Braet, MBA, C-TAGME (2016-2019)
Visiting Learning Coordinator
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Heidi M. Sallee, MD
Program Director Chair-Elect (2017-2020)
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SSM Cardinal Glennon Children’s Hospital
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New England Region
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Pediatric Residency Program Coordinator
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New York Region
Program Director
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Yakhira Encarnacion-Patterson, MPH (2014 - 2017)
Education Program Coordinator
Maimonides Infants & Children’s Hospital of Brooklyn
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Southwest Region
Kenya McNeal-Trice, MD (2016-2019)
Director, Pediatric Residency Training Program, UNC Pediatrics
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Jennifer Crotty, MD, FAAP (2016-2019)
Associate Program Director, Vidant Medical Center/East Carolina University
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Southeast Region
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Mid-Atlantic Region
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Sue Poynter Wong, MD (2015 - 2018)
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Mid-Atlantic Region
Dewesh Agrawal, MD (2014 - 2017)
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Coordinator, Pediatric Residency Program
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Meredith Carter, MD (2014 - 2017)
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New York Region
Joyce Soprano, MD (2015-2017)
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joyce.soprano@hsc.utah.edu

Sylvia Yeh, MD (2015-2017)
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Western Region
Sean P. Elliott, MD (2015-2017)
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Lynne C. Huffman, MD (2015-2017)
Associate Fellowship Program Director,
Stanford University
lynne.huffman@stanford.edu

APPD Council of Regional Chairs

Chair, Council of Regional Chairs
Program Director, Albert Einstein College of Medicine,
Jacobi Medical Center
Auxford.burks@einstein.yu.edu

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

APPD Council of Regional Chairs

Southwest Region
Tammy Camp MD (2014 - 2017)
Pediatric Residency Program Director
Texas Tech University Health Sciences Center
tammy.camp@ttuhsc.edu

Assistant Professor, University of Texas Medical School at Houston
cindy.jon@uth.tmc.edu

Mary Matus (2016-2019)
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UT Austin Dell Medical School Pediatrics
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Western Region
Sean P. Elliott, MD (2015-2017)
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Lynne C. Huffman, MD (2015-2017)
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Stanford University
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Joyce Soprano, MD (2015-2017)
Program Director, University of Utah,
Division of Pediatric Emergency Medicine
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Sylvia Yeh, MD (2015-2017)
Program Director, Los Angeles County-Harbor UCLA Medical Center
syeh@uclacvr.labiomed.org

Jaime Bruse, C-TAGME (2016-2017)
University of Utah
jaime.bruse@hsc.utah.edu
Join an APPD Task Force!

Task Force meetings will be held on Thursday, April 6 from 8:30-10:00am. Come and see what the task forces are all about (see page 16 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
Rebecca Blankenburg, MD, MPH
Chair, Council of Task Force Chairs
Stanford University, Lucile Packard Children’s Hospital

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

Curriculum Task Force:
Helen Barrett Fromme, MD, MHPE, Chair (2016-2018)
University of Chicago
Nicole Paradise Black, MD, MEd, Vice Chair (2016-2018)
University of Florida

Faculty and Professional Development Task Force:
Marsha Anderson, MD, Chair (2015-2017)
University of Colorado
Erin Giudice, MD, Vice Chair (2015-2017)
University of Maryland

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 8 from 7:00am-8:30am. See page 30 for room locations.

**PEDIATRIC GLOBAL HEALTH EDUCATORS 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.
  - Christiana Russ, MD, Co-Leader (2016-2018)

**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.

**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.
  - Patricia Poitevien, MD, MSc, Co-Leader (2014-2017)

**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.
  - Ariel Frey-Vogel, MD, Co-Leader (2016-2018)
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

Alan Chin, MD
Share Warehouse Team Leader
University of California-Los Angeles

Emily Borman-Shoap, MD
University of Minnesota

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

Ashweena Gonuguntla, MD
Hurley Medical Center / Michigan State University

Robert Lee, DO, MS
Winthrop University Hospital

Tara McKinley, MA
University of Louisville

Michelle Miner, MD
Southern Illinois University

Sydney Primis, MD
Carolina Medical Center - Levine Children’s Hospital

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

APPD Share Warehouse

General Information
Quick Links
Submit Materials
My Profile: Recent Posted Resources
Browse By: Author, Institution, Submission Date, TOPICS AND KEYWORDS
Program Administration and Policies
Curriculum
Assessment Tools
Faculty Development
Handbooks
Fellow Protocols
Orientation Info
Policies
Year in the Program
Handbooks
Clinical
Competencies
Quality Improvement
Wellness
EPPs
Evaluation
COPD Documents/Tools
Medicine
Podiatric
Leadership
Worshops
Career Advancement
Professional Development
Teaching Tools

What’s New in Share Warehouse:

Faculty Wellness & Survival
Tara McNulty
University of Louisville School of Medicine
03/15/2019

Pediatrics: Chief International Exchange Program
Rice Myers
Rainier Babies & Children’s Hospital
05/31/2018

CSEAR based on the iFly Initiative by Emily Brennan-Shoap
University of Minnesota
06/23/2016

Financial Tips for New Interns
James Law
APPD & Resident Medical News
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 6 is underway. The deadline for applications for this group is April 21, 2017. Visit www.appd.org/ed_res/LEAD.cfm for details. For more information about LEAD, look for the “Ask Me About APPD LEAD” buttons worn by attendees, APPD LEAD information near the registration area, and on page 95 of this program.

LEAD Council Members / Faculty
- Su-Ting Li, MD, MPH, Chair
  University of California (Davis) Health System
- Marsha Anderson, MD
  University of Colorado
- Susan Bostwick, MD, MBA
  New York Presbyterian Hospital/Cornell Campus
- John Frohna, MD, MPH
  University of Wisconsin
- Hilary Haftel, MD, MHPE
  University of Michigan
- Richard Shugerman, MD
  Seattle Childrens’ Hospital / University of Washington
- Rebecca Swan, MD
  Vanderbilt University School of Medicine
- Linda Waggoner-Fountain, MD, MEd
  University of Virginia
- Robert Vinci, MD
  Boston Medical Center

The fifth APPD LEAD Cohort (see list below) was selected from among a highly qualified group of applicants. This fifth 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 their name and institution.

Robert Brooker, MD
St. Louis University School of Medicine
Assessment of Resident Performance of Patient Care During Night Float Rotations

Jessica DeBord, MD, MPH
Tulane University School of Medicine
A WILD Approach to Didactics: Comparing pediatric resident knowledge acquisition and retention following Weekly Interactive Learning half-Day conferences and daily noon conference

Angela Etzenhouser, MD
Children’s Mercy Kansas City
Creating a Culture of Feedback: Use of Informal Feedback Sessions with Pediatric Residents to Increase Quality and Quantity of Feedback for Faculty

Lindsay C. Johnston, MD, MEd
Yale School of Medicine
The Impact of Attending Coverage Models on Perceptions of Pediatric Critical Care Subspecialty Fellow Autonomy

YoungNa J. Lee-Kim, MD
Baylor College of Medicine/Texas Children’s Hospital
Shadowing Curriculum for First-Year Pediatric Hematology-Oncology Fellows

Megan E. McCabe, MD
The Children’s Hospital at Montefiore
Palliative Care 101: A Curriculum for Fellows

Jon McGreevy, MD, MSPH
Phoenix Children’s Hospital
E-Delphi Survey to Identify Faculty Motivations to Participate in Academic Endeavors
Mary Moffatt, MD  
Children’s Mercy Hospital Kansas City  
Resiliency Skills for Fellows Curriculum

Jennifer A. Rama, MD, MEd  
Baylor College of Medicine/Texas Children’s Hospital  
Life After Fellowship: The Use of Appreciative Inquiry to Inform Program Evaluation

Amy Sass; MD, MPH  
University of Colorado  
Using Small Group Learning and Peer Mentoring to Foster Personal and Professional Development and Build Resiliency During Pediatrics Residency

Daniel J. Sklansky, MD  
University of Wisconsin School of Medicine and Public Health  
Correlation between Attending Physician and Peer Mean Milestones-Based Assessment Scores of Pediatric Residents

David Stewart, MD  
University of Michigan  
Assessment of a Pediatric Residency EBM Curriculum on Residents’ Comfort, Practice, and Knowledge of EBM

Lynn Thoreson, DO  
The University of Texas at Austin Dell Medical School  
iPath: A Qualitative Approach to Developing a Graduated Individualized Learning Plan Tool to Support Individualized Learning Goals in Residency Training

Meredith van der Velden, MD  
Boston Children’s Hospital  
An Integrated Clinical and Educational Model for Pediatric Critical Care and Pediatric Surgical Critical Care

Suzanne Wright, MD  
Marshfield Clinic  
Perception vs. Reality: Comparison of Resident Inpatient Caseload at Small vs. Large Pediatric Training Programs in Wisconsin

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 subspecialities (with the Council of Pediatric Subspecialties, the American Board of Pediatrics, and the new Subspecialty Pediatrics Investigator Network) and in general Pediatrics (with the American Board of Pediatrics). Please visit with us during the meeting to learn more about your educational research network and how you can become involved!

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

APPD LEARN has its own web site at http://learn.appd.org
APPD 2017 Annual Meeting • April 5–8
Anaheim, California

Adventures in Pediatric Medical Education: Small World, Big Impact

APPD Meeting Schedule

Tuesday, April 4

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

APPD Board of Directors Meeting
Executive Board Room

MPPDA Meeting (see pages 35-37 for details)

Wednesday, April 5

7:00am  Registration Opens
Pacific Registration Desk

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

8:00am-4:30pm  MPPDA Meeting (see pages 37-38 for details)

8:00am - 5:30pm  Forum for Chief Residents (breakfast and lunch will be included)
California Ballroom C

Coordinated by Blair Dickinson, MD, MS, Associate Residency Program Director, St. Christopher’s Hospital for Children, Jay Homme, MD, Residency Program Director, Mayo Clinic, Edwin L. Zalneraitis, MD, Pediatric Residency Program Director, University of Connecticut, and the Chief Resident Forum Planning Committee (Megan Aylor, MD, Associate Program Director, Oregon Health Sciences University, Erin Giudice, MD, Residency Program Director, University of Maryland Children’s Hospital, Sophia Goslings, MD, Associate Residency Program Director, University of South Alabama, Alan Meltzer, MD, Residency Program Director, Goryeb Children’s Hospital, Ross Myers, MD, Associate Residency Program Director, UH Rainbow Babies & Children’s Hospital, Lisa Pomeroy, MD, Associate Program Director, Texas Tech University Health Sciences Center, Maria Ramundo, MD, Pediatric Residency Program Director, Akron Children’s Hospital, Glenn Rosenbluth, MD, Associate Director, Pediatric Residency Training Programs, University of California, San Francisco, Maha Al-Chafry, MD, Chief Resident, University of South Alabama, Abby Basaley, MD, Chief Resident, Cohen Children’s Medical Center, Lisa Miyatake, DO, Chief Resident, Akron Children’s Hospital, Grant Morris, MD, Chief Resident, Janet Weis Children’s Hospital at Geisinger Medical Center, David Gonzalez-Villamizar, MD, Chief Resident, University of Illinois at Chicago, Megan Griffiths, MD, Chief Resident, University of Connecticut, Erin Hanft, MD, Chief Resident, Cohen Children’s Medical Center, Heather Haverkamp, MD, Akron Children’s Hospital, Peter Holmberg, MD, Chief Resident, Mayo Clinic, Adam Kasper, MD, Chief Resident, Baystate Children’s Hospital, John Kotula, MD, St. Christopher’s Hospital for Children, Lisa Miyatake, DO, Akron Children’s Hospital, Grant Morris, MD, Chief Resident, Janet Weis Children’s Hospital at Geisinger Medical Center, Cara Tillotson, DO, Chief Resident, Carilion Clinic-Virginia Tech Carilion School of Medicine, and Bethany Williams, MD, Chief Resident, Texas Tech University Health Sciences Center).
**Sponsored by the APPD Faculty and Professional Development Task Force.**

3:30-5:30 Table Talks
7:30-8:00 Breakfast
8:00-8:15 Welcome and Introductions
Blair Dickinson, MD, MS, Jay Homme, MD, Co-Chairs, Chief Resident Forum Planning Committee
8:15-9:00 The Chief Handoff
Chief Residents: Jennifer Ezirike, MD, David Gonzalez-Villamizar, MD, Taumoha Ghosh, MD
Faculty: Jay Homme, MD
9:00-9:45 Chief Resident Crisis Management
Chief Residents: Taumoha Ghosh, MD, Bethany Williams, MD
Faculty: Sophia Goslings, MD, Ed Zalneraitis, MD
9:45-10:00 Break
10:00-12:00 Speed Chiefing
Chief Residents: Jennifer Diep, MD, Kendra Elwood, MD, Jennifer Ezirike, MD, David Gonzalez-Villamizar, MD, Peter Holmberg, MD, Adam Kasper, MD, Grant Morris, MD
Faculty: Ross Myers, MD
12:00-1:15 Lunch with “Show Your Best” Graduating Chief Resident Presentations

**Abbreviated Platform Presentations**

“An Innovative Curriculum Teaching Pediatric Residents How to Advocate for Their Patients on an Individual, Community and Legislative Level”
Yonit Lax, MD, Social Pediatrics Chief Resident, The Children’s Hospital of Montefiore

“Use of an Objective Structured Clinical Examination (OSCE) to Increase Peer-to-Peer Feedback”
Marina V. Martínez Garri, MD and Rosa L. Haddock de Jesús, MD, Jefes de Residentes, Universidad de Puerto Rico, Recinto de Ciencias Médicas

“Improving Pediatric Acute Care Through (IMPACT) Simulation”
Abby Basalely, MD, Meghan Craven, MD, and Erin Hanft, MD, Chief Residents, Cohen Children’s Medical Center

**Platform Presentations**

“Resident Driven Clinical Pathways”
Kim Hoang, MD, Chief Resident, Baylor College of Medicine, Children’s Hospital of San Antonio

“Simulation Curriculum Associated with Improved Resident Confidence”
Cailyn Rood, MD, Chief Resident, Medical College of Wisconsin

“Four-Fold Approach to Assess and Improve Resident Wellbeing”
Krista Whitney, MD, Chief Resident, Children’s Medical Center Dallas, University of Texas Southwestern Pediatrics Residency

1:15-3:30 Breakout Sessions

**RISING CHIEF RESIDENT TRACK**
California Ballroom C
1:15-2:30 Not Your Typical Morning Report
Chief Residents: Abby Basalely, MD, Meghan Craven, MD, Emmanuelle Favilla, MD, Erin Hanft, MD, John Kotula, MD
Faculty: Blair Dickinson, MD, MS

2:30-2:45 Break
2:45-3:30 Planning the Chief Resident Year
Chief Residents: Crista Cerrone, MD, Kendra Elwood, MD, Megan Griffiths, MD, Adam Kasper, MD, Cara Tillotson, DO
Faculty: Sophia Goslings, MD, Ed Zalneraitis, MD

**GRADUATING CHIEF RESIDENT TRACK**
Huntington ABC
1:15-2:15 Debriefing the Chief Year
Faculty: Jay Homme, MD, Ross Myers, MD, Glenn Rosenbluth, MD

2:15-2:30 Break
2:30-3:30 Professional Development Planning and Mentoring
Chief Residents: Heather Haverkamp, MD, Lisa Miyatake, DO
Faculty: Megan Aylor, MD, Maria Ramundo, MD

3:30 – 3:45 Break
3:45-4:30 Meeting of the Minds  
**Chief Residents: Maha Al-Ghafry, MD, Kendra Elwood, MD**  
Faculty: Sophia Goslings, MD, Ed Zalneraitis, MD

4:30-4:45 Top 10 Great Things About Chief Year  
**Faculty: Ross Myers, MD**

4:45-5:00 Wrap-Up and Evaluations  
**Blair Dickinson, MD, MS, Jay Homme, MD**

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8:30am-3:00pm Pre-Conference Workshop / The Mental Health Crisis (lunch included)  
(sponsored by the American Board of Pediatrics and the APPD)

**Pacific Ballroom D**

Special Guest Speaker: Lawrence Wissow, MD, Professor, Division of Child and Adolescent Psychiatry, Johns Hopkins School of Medicine; Director, Center for Mental Health in Pediatric Primary Care, Johns Hopkins Bloomberg School of Public Health

Speaker: Cori Green, MD, Weill Cornell Medical College

Panelists: Lynn Garfunkel, MD, University of Rochester School of Medicine; Janet Serwint, MD, Johns Hopkins School of Medicine; Molly Broder, MD, Albert Einstein College of Medicine; Keith Pontz, MD, Case Western Reserve University; Nathan Blum, MD, Perelman School of Medicine, University of Pennsylvania; Laura Richardson, MD, University of Washington; John Duby, MD, Wright State University Boonshoft School of Medicine

Leaders and moderators: Laurel Leslie, MD, MPH, Tufts University School of Medicine and The American Board of Pediatrics; Marshall Land, Jr., MD, University of Vermont, Julia A. McMillan, MD, Johns Hopkins School of Medicine

“The Mental Health Crisis: Preparing Future Pediatricians to Meet the Challenge,” is intended to help residency and fellowship programs understand what will be needed to provide the faculty and training environment to meet the expectations of EPA 

#9, “Assess and manage patients with common behavior/mental health problems.” Appropriate and effective care for infants, children, and adolescents includes promotion of behavioral health and competence in preventing behavioral and mental health problems, identifying risk factors, recognizing common mental health problems, and assessing and managing or co-managing patients with these problems. The meeting day will include information on existing educational resources, panels that will

describe methods for integrating behavioral and mental health training into your program, and a special guest speaker, Dr. Larry Wissow, a pediatrician and child psychiatrist who studies and promotes innovative models for integrating mental health into pediatric primary care. Dr. Wissow will also discuss common factors, an evidence-based approach to improving mental health care in the primary care setting that has been incorporated into the AAP’s residency curriculum.

All attendees must have preregistered to attend. There will be no breakfast available prior to the meeting, but lunch will be available on site.

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9:00am-5:30pm Coordinators’ Session (lunch included)

**Pacific Ballroom B**

**9:00-10:00 Welcome and Opening Remarks**

**10:00-11:30 Workshop CS1: MESSY DESK, CLEAN DESK: A TALE OF TWO TIME MANAGEMENT THEORIES**  
*Carrie M. Johnson, Michelle R. Brooks, Stanford University, Palo Alto, CA*

There are numerous time management tools in existence and a hundred ways to organize your office, however no one tool or strategy will work for every person. How do we choose strategies and practices that best complement how we think? How do we use our strengths to guide our daily practices? Through self-assessment, group work and best practice sharing, this workshop will help attendees identify whether or not they are a Judger or Perceiver (according to the Myers-Briggs inventory) and provide skills for both types of organizers to take back to their programs.

**11:30-11:45 Coordinators’ Group Photo**

The tradition continues...

**11:45-1:00 Mentorship groups/luncheon**

**1:15-2:05 Workshop CS2: FORGET MENTORSHIP: FIND SPONSORSHIP**  
*Ambrosya Amlong, Janene Bondie, University of Michigan, Ann Arbor, MI*

Who's pulling for you? Who's got your back? Odds are this person is not a mentor, but a sponsor. Mentors can help build your self-esteem and provide a sounding board, but they’re not your ticket to the top. If you’re interested in fast-tracking your career, you need a sponsor: a senior-level champion who believes in your potential and is willing to advocate for you as you pursue that next raise or promotion. Sponsors are a proven link to success. Sponsorship is a two-way street, creating a strong and mutually beneficial alliance. This session will lay out a seven-step map to chart your course toward your greatest goals and will mix solid data with real-life narratives.

**2:05-2:15 Wellness Break**
2:15-3:15  Workshop CS3: THRIVE OR SURVIVE? ORGANIZATIONAL TIPS TO ENHANCE RESIDENT WELLNESS
Jean Segall, MA, Corinne O’Day, BA, Stony Brook Medicine/University Hospital, Stony Brook, NY
Coordinators play a pivotal role in the life of a resident and can significantly impact wellness. We are their first contact with the residency program; their “go to” person throughout training; and are often called a “life saver” for providing the information they need to meet certain professional responsibilities. Technically, coordinators don’t influence a resident’s clinical training, but we can help reduce stress and enhance their emotional well-being by bringing organization and structure to their lives. Maintaining resident organization also helps to reduce the coordinator’s stress level. During this session, we will share ways to keep residents informed about the mounting ACGME requirements and remain up-to-date with program and institutional tasks. Participants will discuss the obstacles of keeping up with administrative tasks, learn new ways to track resident’s professional responsibilities and monitor their progress. All attendees will learn to create a vision board, which can be used to teach residents to set goals that will enhance individual wellness. Through small group activities, participants will complete a needs assessment and begin to develop organizational templates that will meet the needs of their own programs.

3:15-3:30  Wellness Break
3:30-5:30  Table Talks

3:30pm-5:30pm  Grassroots Forum for Associate Program Directors
Pacific Ballroom D
The Forum for Associate Program Directors will review timely and important topics of interest to the APPD and will discuss organizational and career development needs specific to our group. As in previous years, the highlight of our session will be peer-reviewed presentations from Associate Program Directors around the country on innovative projects that they are working on currently in their programs. We invite you to bring your ideas and questions to this energetic group session to add to our discussion. Leaders: Michelle Barnes (University of Illinois-Chicago), Rhett Lieberman (UPMC Medical Education), Nicola Orlov (University of Chicago Medicine), and Dan Sklansky (University of Wisconsin School of Medicine and Public Health).

Grassroots Forum for Fellowship Program Directors
Malibu
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 / Angela Myers, MD, MPH, Geoffrey Fleming, MD, Kathleen McGann, MD, Pnina Weiss, MD, Kathy Mason, MD, and Jennifer Kesselheim, MD, MEd, MBE.

Grassroots Forum for Program Directors
Pacific Ballroom C
The Grassroots Forum for Program Directors will focus on timely topics of interest to Program Directors. This year’s facilitators will be Drs. Casey Hester (Oklahoma University Health Sciences Center), Jennifer DiPace (New York Presbyterian Hospital/Cornell Campus) and Vasu Bhavaraju (Phoenix Children’s Hospital/Maricopa Medical Center).

5:45pm-6:00pm  Meet and Greet – Brief Orientation for Attendees at their first APPD Meeting
First Time Attendees should remain in the session/room where they are at 5:30pm and await further instruction. Welcome!

6:00pm - 7:00pm  Networking Reception
California Ballroom D
Thursday, April 6

7:00am-8:30am  APPD Members’ Meeting: Awards and Annual Reports
(includes Continental Breakfast)
Pacific Ballroom
7:00-7:05  APPD Welcome and Introduction - Franklin Trimm, MD, APPD President
7:05-7:08  APPD Financial Update - John Mahan, APPD Secretary / Treasurer
7:08-7:15  APPD LEARN - Alan Schwartz, PhD, APPD LEARN Director
7:15-7:20  APPD Special Projects - Rebecca Blankenburg, MD, MPH, Chair, APPD Council of Task Force Chairs
7:20-7:30  APPD Berkowitz, Holm, Tunnessen Awards - Dena Hofkosh, MD, MEd, APPD Past President
7:30-7:33  APPD Research, QI and Trainee Research Awards - Lynn Garfunkel, MD, APPD 2017 Past Program Chair (see page 39 for location of award winning abstracts)
7:33-7:35  APPD Global Health Scholarships – Mike Pitt, MD and Christiana Russ, MD, Co-Leaders, APPD Pediatric Global Health Educators PEG (see page 94 for more information on scholarship recipients)
7:35-7:42  Recognition of Outgoing APPD Leaders - Franklin Trimm, MD
7:42-7:45  APPD Election Results - Dena Hofkosh, MD, MEd
7:45-8:05  APPD Hot Topics/Strategic Plan - Franklin Trimm, MD
8:05-8:15  APPD LEAD Graduation - Su-Ting Li, MD, MPH, APPD LEAD Chair

8:30am-10:00am  Task Force Meetings
(visit www.appd.org/activities/taskforce.cfm for Task Force descriptions)
Assessment Task Force  Capistrano AB
Curriculum Task Force  Huntington ABC
Faculty and Professional Development Task Force  Avila AB
Learning Technology Task Force  Palos Verdes AB
Research and Scholarship Task Force  Oceanside

10:15am-11:45am  Workshop Session 1 (choice of 9)
WORKSHOP 1. BUILDING RECOGNITION THROUGH ACRONYMS, NETWORKING, AND DESIGN (BRAND):
TURNING YOUR IDEAS (AND YOURSELF) INTO A MOVEMENT THROUGH BRANDING
Michael B. Pitt, MD, Emily Borman-Shoap, MD, University of Minnesota, Minneapolis, MN, Nicole St. Clair, MD, Medical College of Wisconsin Affiliated Hospitals, Milwaukee, WI, Su-Ting Li, MD, MPh, University of California, Davis, Glenn Rosenbluth, MD, University of California (San Francisco), San Francisco, CA, Susan C. Pitt, BS, University of Minnesota, Minneapolis, MN
El Capitan AB
Building a brand is Marketing 101. Successful companies know that creating an emotional story around a practical product builds a connection essential to elevating that product from merely a good idea to a hot commodity. Most of the techniques used to create awareness around a brand - notably naming, logo, design, story, and intentional dissemination plan - can be leveraged in academics to help make an idea into a tangible polished product which generates excitement and encourages participation. I-PASS, CLIPP, PREP, and SUGAR are recent examples of successful multi-institutional medical education projects that have more in common than just having a catchy name (though that’s part of it!); each went beyond the traditional dissemination paradigm, developed their own logos, web presence, and story, and ultimately became recognizable brands. This workshop will help pediatric educators apply the marketing principles of branding to their own scholarly projects AND career advancement by employing the BRAND Concept (Building Recognition through Acronyms, Networking, and Design). Participants will receive an introduction to the core concepts behind branding, facilitated by a marketing executive who has served as Brand Manager and Strategic Consultant for several Fortune 500 companies including General Mills, Coca-Cola, and Procter & Gamble. The facilitators, pediatric educators who have had success with multi-institutional projects employing these techniques, will then discuss the key steps from their processes and share readily available resources educators can begin using to do the same. Participants will work in moderated small groups to apply these techniques to one of their existing projects or ideas by developing a brand strategy, logo, and plan for collaboration and study. Groups will then discuss how applying this paradigm to their academic career as a whole can be a powerful tool in supporting academic advancement by considering, themselves as a brand and approaching projects and undertakings through the lens of building or detracting from that brand.
WORKSHOP 1. RESOLVING CONFLICT: IMPARTING SKILLS TO CURRICULUM DEVELOPERS

**Capistrano AB**

As Helen Keller said, “Alone we can do so little, together we can do so much.” The Program Director/Associate Program Director relationship is central to the success of a program and contributes immensely to the personal and professional wellbeing of each party. On a daily basis, PDs and APDs work together closely to offer leadership, mentorship, education, and conflict resolution. Successfully navigating this relationship, providing a unified front, and ensuring professional growth for each person can sometimes prove challenging and require well-developed skills from all involved parties. Through both large and small group discussion, self-reflection, and role playing, this workshop will explore ways to identify leadership styles, provide mentorship, develop succession plans, and overcome conflict. Participants will be provided with essential tools to bring back to their programs to help maximize the PD/APD relationship.

WORKSHOP 2. THERE IS NO I IN TEAM, BUT THERE IS SUCCESS IN SUCCESSION: MAXIMIZING THE PROGRAM DIRECTOR / ASSOCIATE PROGRAM DIRECTOR RELATIONSHIP

Sydney P. Primis, MD, Carolinas Medical Center, Charlotte, NC, Brian Lurie, MD, MPH, Atlantic Health Program, Morristown, NJ, Casey Hester, MD, University of Oklahoma Health Sciences Center, Oklahoma City, OK, Sara Multerer, MD, University of Louisville, Louisville, KY

**Capistrano AB**

As Helen Keller said, “Alone we can do so little, together we can do so much.” The Program Director/Associate Program Director relationship is central to the success of a program and contributes immensely to the personal and professional wellbeing of each party. On a daily basis, PDs and APDs work together closely to offer leadership, mentorship, education, and conflict resolution. Successfully navigating this relationship, providing a unified front, and ensuring professional growth for each person can sometimes prove challenging and require well-developed skills from all involved parties. Through both large and small group discussion, self-reflection, and role playing, this workshop will explore ways to identify leadership styles, provide mentorship, develop succession plans, and overcome conflict. Participants will be provided with essential tools to bring back to their programs to help maximize the PD/APD relationship.

WORKSHOP 3. PROMOTING DIVERSITY IN THE PIPELINE OF PHYSICIANS: RECRUITING AND MENTORING OF UNDER-REPRESENTED MINORITY PHYSICIANS

Alda Maria Gonzaga, MD, MS, Stephanie Dewar, MD, UPMC Medical Education, Pittsburgh, PA, Patricia Poitevien, MD, MSc, New York University School of Medicine, New York, NY

**Palos Verdes AB**

In this workshop, the presenters will review strategies for recruiting a group of diverse residents, especially under-represented minority (URM) candidates and for evaluating and rating high quality students’ residency applications. Small and large group discussions and activities, led by the presenters, will engage participants with each other throughout the workshop. Brief didactics will be interspersed to highlight the need for a more diverse physician workforce in all specialties and to describe nationally available resources and tools for holistic application review and mentorship of URM trainees. Through small group case review, participants will learn how to integrate leadership and personal experiences, and unique attributes into existing metrics for application evaluation. We will review mentoring strategies to maximize the success of all your residents, especially those of URM resident physicians. Strategies to ensure all residents thrive with appropriate mentorship will be highlighted through small and large group discussions. We will highlight how residency programs and their directors can peripherally lead institutions to fully realize how a diverse physician workforce will result in excellence in the tri-fold mission of academic institutions, by increasing access to high-quality patient care, shaping the education of all trainees, and broadening the research agenda. Participants will complete a worksheet that allows them to assess current state of training programs with respect to diversity and identify areas for improvement as well as discuss barriers to increasing diversity at their institution. Participants will leave with a detailed toolkit of strategies for attracting URM applicants, appropriately and fairly reviewing their applications materials, and fully supporting their professional development and success through mentorship activities. This toolkit will include a worksheet for evaluating applications and a slide set to be used for faculty development around recruitment of URM candidates.

WORKSHOP 4. TEACHING CONFLICT RESOLUTION ON THE ROAD TO MILESTONE ATTAINMENT: LESSONS FROM BUSINESS, DIPLOMACY, AND THEATRE

Adam D. Wolfe, MD, PhD, Kim B. Hoang, MD, Sarah F. Denniston, MD, Baylor College of Medicine (San Antonio), San Antonio, TX

**Avila AB**

In his 2016 APPD Annual Spring Meeting address, Dr. David Nichols, President of the American Board of Pediatrics, reported that the parent stakeholders within ABP demand improved communication skills among pediatricians. Likewise, communication skills are prevalent throughout the ACGME pediatric milestones. Conflict resolution offers an opportunity to address many of these subcompetency skills in a single topic. As educators, we recognize that disagreement and conflict are inevitable in the medical setting and among all members of the care team, including physicians, staff, patients, and families. However, the best practices for conflict resolution have not been established in a clinical setting. This workshop is adapted from the Conflict Resolution component of our Advanced Communication Skills longitudinal curriculum at The Children’s Hospital of San Antonio. The content has been refined following feedback from two years of resident training and feedback from educators and fellows at two national meetings in 2016. The workshop utilizes lessons from the business world: understanding team dynamics, establishing priorities at times of disagreement, and employing a structured, hierarchical approach to conflict resolution that preserves interpersonal relationships. We will also use lessons from international diplomacy and improvisational theatre to understand the non-verbal cues that can guide us to communicate most effectively during times of conflict. Using multiple interactive activities and brief didactics, we will demonstrate techniques to teach conflict resolution skills that can be incorporated into curricula at home institutions. We will emphasize how the content of each exercise reflects the language of ACGME milestones in 8 of the 21 subcompetencies: SBP1, SBP3, PBL4, PROF1, PROF2, PROF3, ICS1, and ICS2. We will conclude with an opportunity for participants to share their own tools and experiences in conflict resolution. Participants will leave the workshop with experience in these exercises and customizable tools to teach conflict resolution skills at their home institutions.
WORKSHOP 5. MIND MAKEOVER: CULTIVATING A GROWTH MINDSET

Teri L. Turner, MD, MPH, MEd, Lauren Hess, MD, Dana Foradori, MD, Baylor College of Medicine (Houston), Houston, TX, Rachel Boykan, MD, Stony Brook Medicine/University Hospital, Stony Brook, NY, Monique Naileh, MD, University of Oklahoma Health Sciences Center, Oklahoma City, OK

San Simeon AB

Helping learners become reflective, competent physicians is an enormous and daunting task. As learners progress across the medical education continuum, they should increasingly become more responsible for their own growth as professionals. However viewing one's abilities as “fixed” or “innate” limits this potential for growth. The performance target for these trainees is perfection and doing those tasks they already do well. One’s mindset also affects whether we choose to seek feedback and ultimately how we act upon this feedback. The goal of this session is to help program directors and other faculty identify and use techniques which can help facilitate a shift from a fixed to a growth mindset. In essence creating a mind makeover to enable continuous professional development and success in our trainees. This session will use the principles outlined in “Mindset: The New Psychology of Success” by Carol Dweck, PhD. Participants will be challenged to shift their own thinking about intelligence as well as practice using teaching strategies, such as focusing on effort instead of praise to promote success. During the session, attendees will participate in small and large group activities and will practice coaching for improvement using the R2C2 facilitated reflective performance feedback model. Activities include crafting interview questions to identify a growth mindset and editing feedback phrases to move from praise to growth. The R2C2 model is an evidence-based model developed by Sargeant et al. and is composed of four components; 1) introduction and relationship building, 2) exploring reactions to and perceptions of the data/report, 3) exploring understanding of the content of the data/report and 4) coaching for performance change. Attendees will gain valuable insights and tools to identify and enhance the performance of all trainees regardless of their mindset.

WORKSHOP 6. SOCIAL SCREENING AND BEYOND: HOW TO CREATE A SCREENING PROGRAM THAT EMPOWERS RESIDENTS TO TAKE ACTION

Francis J. Real, MD, Cincinnati Children’s Hospital Medical Center/University of Cincinnati College of Medicine, Cincinnati, OH, Christine Cheston, MD, Children’s Hospital/Boston Medical Center, Boston, MA, Meredith Merkley, DO, Nationwide Children’s Hospital/Ohio State University, Columbus, OH, Alex Rakowsky, MD, Nationwide Children’s Hospital/Ohio State University, Columbus, OH, Melissa D. Klein, MD, MEd, Cincinnati Children’s Hospital Medical Center/University of Cincinnati College of Medicine, Cincinnati, OH

Malibu

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 life course. Additionally, poverty concentrates in certain neighborhoods often in close proximity to academic medical centers. Still, those who work in the medical center including residents may have a limited understanding of the health-related risks and assets present within their patients’ home neighborhoods and may therefore not appropriately screen or intervene for social risk factors during routine clinical care. The American Academy of Pediatrics (AAP) recently released a policy statement recommending screening for the social determinants of health (SDH) and collaborating with community organizations to help families address unmet needs. The Academic Pediatric Association (APA) Taskforce on Childhood Poverty has taken on this charge to create an agenda to lift children out of poverty. However, in busy clinical settings, social screening and action can be difficult to implement. As such, in this highly interactive workshop, participants will be provided a framework on the importance of social screening. Participants will reflect on their institution’s current strategies related to social screening and identify key stakeholders and barriers at their clinical sites. Participants will identify critical questions and will discuss a variety of strategies for developing interventions around positive social screens. After selecting a critical question and an intervention strategy, participants will create a plan to implement their own social risk screening process that encourages resident action during routine clinical care. By the conclusion of the session, participants will have created a blueprint to guide implementation of a social risk screening program and leave with a toolbox of resources that residents might use when families with social risks are identified.

WORKSHOP 7. COACHING STRATEGIES TO HELP TRAINEES’ CLINICAL SKILL DEVELOPMENT


Huntington ABC

Medical educators are responsible for helping trainees develop their clinical and life-long learning skills. Learners have varying degrees of clinical skill, motivation, and self-direction to reflect and learn from prior experiences, and thus faculty’s teaching strategies must adapt to individual learner needs. Specifically, faculty must assess how best to help trainees learn from and process their clinical experiences. This interactive workshop will begin with a think-pair-share discussion and report-out about the characteristics of an effective coach. We will then have a brief introduction to coaching, including when it can be used, its purpose and benefits. Facilitators will then do a skit for the audience with two scenarios: the first in which the faculty Coach gives feedback without asking for the learner’s reflection and goals, and the second in which the faculty Coach asks for the learner’s reflection and goals, and gives targeted feedback. Following each skit, workshop participants will discuss the role-plays and describe what the faculty Coach did that was effective or ineffective in each case. Facilitators will then introduce tools for coaching including: 1) methods for building a safe learning climate, 2) a coaching framework, 3) tools for direct observation, and 4) scripts and questions...
for use in coaching. In small groups, participants will practice using these tools in skills practice scenarios that represent a range of common situations. In each scenario, one member from each group will play the role of Faculty Coach while other members play the role of Trainee or Observer. Coaches will use coaching skills to help the trainee reflect on a clinical encounter, provide feedback, and promote goal-setting. Observers will coach the Coach by providing feedback at the end of each scenario. The large group will then reconvene to debrief the exercises and to discuss common challenges in coaching and their potential solutions. We will briefly introduce two models of coaching in residency education from Stanford and Seattle Children’s programs which were created to develop learners’ clinical skills through direct observation, facilitated reflection, feedback and goal-setting and participants will have the opportunity to ask questions. At the conclusion of the workshop, the facilitators will share a toolkit of additional strategies that coaches can use to engage trainees in coaching and build upon their strengths.

WORKSHOP 8. INCORPORATING SPIRITUAL HUMILITY IN THE PRACTICE OF MEDICINE: UNDERSTANDING HOW SPIRITUAL PRACTICES OF PATIENTS AND FAMILIES RELATE TO OUR PRACTICE OF MEDICINE

Amanda D. Osta, MD, University of Illinois College of Medicine at Chicago, Chicago, IL, Ann E. Burke, MD, Wright State University, Dayton, OH, Annamaria Church, MD, Naval Medical Center (Portsmouth), Portsmouth, VA, Albina Gogo, MD, University of California (Davis) Health System, Sacramento, CA, Dena Hofkosh, MD, UPMC Medical Education, Pittsburgh, PA, Megan E. McCabe, MD, Montefiore Medical Center/Albert Einstein College of Medicine, Bronx, NY, Janet R. Servint, MD, Johns Hopkins All Children’s Hospital, Baltimore, MD

Santa Monica

Spiritual beliefs serve as a comfort to many of our patients and their families at the time of serious illness. Up to 90% of the US population practices spiritual or religious traditions. It is impossible to fully understand all there is to know about another individual’s beliefs, but it is the role of the healthcare provider to connect with patients to communicate and deliver care effectively. Spiritual humility acknowledges that we do not know everything about another’s religious or spiritual life, but we seek to understand. Religion and spirituality are topics that have historically not been well covered in medical education. As a result, physicians often feel uncomfortable discussing spirituality and faith with patients and families. To address this deficiency, members of AAP, APA, APPD, and COMSEP collaboratively developed and published a novel curriculum focused on promoting resilience across the pediatric training continuum. Spiritual humility is part of this larger curriculum. The purpose of this interactive workshop utilizing components of the AAP Resilience curriculum is two-fold: (1) to convey the critical importance of spirituality in comprehensive patient-centered care, and (2) to give the learner the tools to practice spiritual humility and skillfully discuss spirituality with patients and families. We will use journaling, small group exercises and discussion to enhance knowledge and skills in practicing spiritual humility and incorporating patient spiritual beliefs into patient care. In the train the trainer model, participants will be comfortable with obtaining a spiritual history, applying that knowledge to the care of their patients and teaching learned skills to others. We will share links to online resources that will allow workshop participants to disseminate knowledge and skills gained from this workshop within their own training programs.

WORKSHOP 9. WHO ARE YOU? PERSONAL VISION, MISSION AND VALUES

Susan B. Hathaway, PhD, Jill Edwards, MBA, C-TAGME, Children’s Mercy Hospital, Kansas City, MO

Laguna AB

Good strategic plans can help organizations prioritize their resources and energy. These processes always start with a vision, mission and values and then lead to action plans with measurable outcomes. The same thought goes into well-conceived curriculum in education. Individuals, however, are not as good at doing the foundational work to identify the core concepts that should drive all their own personal actions, their choices at work and their careers. This workshop is designed for the Program Coordinator who wants to more clearly see how his/her role fits with the overall mission and goals of the institution. This reflective workshop will challenge participants to clarify identity and values and set a direction for where you want to go and what you enjoy doing so you can be a better, more effective leader in medical education.

12:00pm-1:30pm Lunch On Your Own

Vision 2020: Strategic Plan Project Teams Meeting (Project Team Members Only)
Pacific Ballroom

1:40pm-3:00pm Key Stakeholders’ Session
Pacific Ballroom

1:40-1:45 Intro – Franklin Trimm, MD, APPD President
1:45-2:05 ACGME/ Pediatrics RC Update: Suzanne Woods, MD, FAAP, FACP, Chair RC for Pediatrics; Caroline Fischer, Executive Director, Review Committees for Pediatrics and Physical Medicine and Rehabilitation, ACGME
2:05-2:25 American Board of Pediatrics/ABP Update: Gail McGuinness, MD, Executive Vice President, American Board of Pediatrics
2:25-2:45 News from Pediatric Milestones Assessment Collaborative / PMAC: Patricia Hicks, MD, MHPE, PMAC Director
2:45-3:00 Q&A
Workshop Session 2 (choice of 9)

- **WORKSHOP 10. CODES, CONCEPTS AND CATEGORIES, OH MY! BUILDING YOUR SKILLS IN QUALITATIVE DATA ANALYSIS**
  - Alyssa L. Bogetz, MSW, Stanford University, Palo Alto, CA
  - Erika Abramson, MD, MS, New York Presbyterian Hospital (Cornell Campus), New York, NY
  - Su-Ting Li, MD, MPH, University of California (Davis) Health System, Sacramento, CA
  - Catherine Distler, MD, Children’s Hospital/Boston Medical Center, Boston, MA
  - Arabella Simpkin, MD, MA, Massachusetts General Hospital, Boston, MA
  - Hilary Haftel, MD, MHPE, University of Michigan, Ann Arbor, MI
  - Melissa Klein, MD, MEd, Cincinnati Children’s Hospital Medical Center/University of Cincinnati College of Medicine, Cleveland, OH

**Palos Verdes AB**

- Medical educators are increasingly looking to qualitative research methods to understand complex educational challenges and address questions not easily studied through traditional quantitative measures. With interest in qualitative research at a tipping point, there is a critical need to build qualitative research skills and elucidate the principles of rigorous data analysis.
- In this highly interactive workshop, participants will be introduced to three approaches to qualitative analysis and will work in expert-facilitated small groups to practice analyzing data using one of the three approaches. Through brief didactics, small group activities, and large group discussions, participants will be able to compare the approaches, discuss when to use each, analyze results, and select the best strategy to display their findings. By the end of the workshop, all participants will have an introductory knowledge of qualitative analysis principles that can be applied to their own research questions.

**Workshop 11. TEACHING RESIDENTS TO MITIGATE PREJUDICE (TRMP): ROLE PLAY WITH SIMULATED PARENTS TO ADDRESS PREJUDICE IN THE WORKPLACE**
- Stephanie B. Dewar, MD, Christine A. March, MD, Sylvia Choi, MD, Regina L. Toto, MD, Lorne W. Walker, MD, PhD, UPMC Medical Education, Pittsburgh, PA

**Santa Monica**

- The American Academy of Pediatrics supports culturally effective care, cultivating optimal health outcomes through an appreciation of diverse backgrounds. An environment that bolsters diversity and inclusion and resists intolerance is vital to promoting culturally effective care. Clinicians may encounter discriminatory comments or behaviors when caring for patients and families. Many residents feel ill-equipped to respond in such situations. Conflict between the medical team and the patient and family may have adverse consequences for patient care and physician well-being. Furthermore, disregard or minimization of intolerant behavior suggests tacit acceptance.
- We have developed a course for pediatric residents focused on the skills needed to address expressions of prejudice. This two-hour session employs scenarios set during Family Centered Rounds with simulated parents. We teach residents techniques to use when presented with discriminatory statements including how to practice empathy and redirect the conversation towards shared decision making. Simulated encounters are facilitated by faculty and incorporate self-reflection, discussion among peers, and feedback from the simulator. Simulated parents are trained actors who can provide valuable feedback about the residents’ communication skills. We encourage residents to reflect on their experience and foster awareness of internal obstacles in addressing emotionally-charged scenarios. During this interactive workshop we will share the details of our TRMP course, present resident survey data, and describe how to create similar courses at other institutions. We will explain and demonstrate The Primary Teaching Method of guided facilitation and self-reflection. Training of faculty facilitators, creating a safe learning environment for role play, and acquiring essential resources will be reviewed. We will share the specific scenarios for TRMP skill practice. Participants will have the opportunity to practice facilitation of these scenarios using role plays so they can receive real-time feedback from the course directors.

**Workshop 12. GOING GLOBAL IN FELLOWSHIP - HOW TO INTEGRATE GLOBAL HEALTH (GH) IN POST-RESIDENCY TRAINING**
- Jennifer Watts, MD, MPH, Children’s Mercy Hospital, Kansas City, MO
  - Tania Condurache, MD, MSc, University of Louisville, Louisville, KY
  - Christiana M. Russ, MD, DTMH, Children’s Hospital/Boston Medical Center, Boston, MA
  - Maneesh Batra, MD MPH, University of Washington, Seattle, WA
  - Charles Schubert, MD, Cincinnati Children’s Hospital Medical Center/University of Cincinnati College of Medicine, Cincinnati, OH
  - Heather L. Crouse, MD, Baylor College of Medicine (Houston), Houston, TX
  - Patricia McQuilkin, MD, University of Massachusetts, Worcester, MA

**El Capitan AB**

- Concurrent with a groundswell of political momentum prioritizing child GH, there has been rising interest in GH experiences among medical trainees in the United States. Responding to the demand by trainees and faculty, GH electives are now offered by many medical schools and residencies and formal Global Health Tracks are offered by 25% of pediatric residencies. Trainees with early interest and exposure to GH bring their passion for improving child health globally with them into their fellowship and faculty careers. Training programs are now responding to the demand for post-residency opportunities by creating GH training pathways in both sub-specialty and general pediatric fellowships. This multidisciplinary, interactive workshop will be led by a multi-institution group of GH educators who are participating in designing and coordinating GH opportunities for fellows. This workshop will equip participants with the tools and knowledge needed to provide meaningful GH educational opportunities at all different levels during fellowship. Participants will work in small groups depending on the stage of development of their own GH opportunities for fellowship training, from early brainstorming to developing an elective rotation to even designing a GH fellowship or track. Participants will apply resources to design a GH opportunity tailored for their own institution with feedback and discussion about solutions to obstacles provided by the small groups. We will conclude with a panel discussion of expert GH educators where challenges faced by participants can be addressed and solutions offered. Participants will leave with an individualized plan as well as educational materials specific to global health training in fellowship.
bias in the United States. Building upon the expertise and experiences of those in the room, we will explore challenges to implicit bias on patient care. Yet the emotionally, socially, and politically charged nature of implicit bias presents a challenge that we automatically and unconsciously exercise. Both quantitative and qualitative evidence highlight the profound impact of cultural competency programs may not adequately address implicit bias: the learned stereotypes and prejudices generally focus on caring for patients of diverse backgrounds and understanding the impact of cultural beliefs on patient care.

Numerous opportunities exist within medical education to learn about cultural competency. Educational efforts in an examination of their own training program, hands-on practice utilizing the CHAMP mapping tool, and effective methods have shown a statistically significant increase in understanding, confidence, and competencies in all course topic areas. Qualitative findings emphasized residents gaining a better understanding of the scope and practice of advocacy at all levels from the individual, to large systems, including policy change. This fun and practical workshop will engage participants in an examination of their own training program, hands-on practice utilizing the CHAMP mapping tool, and effective methods and tools to increase active learning, practical engagement and capacity of residents. By transforming curricula, we can help create transformed learners, who can transform the world!

WORKSHOP 15. MAKING THE IMPLICIT EXPLICIT: DESIGNING AND IMPLEMENTING A CURRICULUM ON IMPLICIT BIAS, CULTURAL HUMILITY AND RACISM FOR PEDIATRIC RESIDENTS, FACULTY AND INTERDISCIPLINARY CARE TEAMS
Heather Hsu, MD, MPh, Children’s Hospital/Boston Medical Center, Boston, MA, Kathleen Bartlett, MD, Duke University Hospital, Durham, NC, Stephanie L. Donatelli, MD, Catherine Michelson, MD, MMSc, Katherine A. Nash, MD, Joanna E. Perdomo, MD, Children’s Hospital/Boston Medical Center, Boston, MA, Betty Staples, MD, Duke University Hospital, Durham, NC, Robert J. Vinci, MD, Children’s Hospital/Boston Medical Center, Boston, MA

Capistrano AB
Numerous opportunities exist within medical education to learn about cultural competency. These educational efforts generally focus on caring for patients of diverse backgrounds and understanding the impact of cultural beliefs on patient care. However, cultural competency programs may not adequately address implicit bias: the learned stereotypes and prejudices that we automatically and unconsciously exercise. Both quantitative and qualitative evidence highlight the profound impact of implicit bias on patient care. Yet the emotionally, socially, and politically charged nature of implicit bias presents a challenge for educational leaders desiring to incorporate implicit bias training into medical education. In this highly interactive workshop, we will discuss implicit bias, its impact on patient care, and the historical underpinnings of racially based implicit bias in the United States. Building upon the expertise and experiences of those in the room, we will explore challenges to incorporating implicit bias training in medical education and appraise existing resources and tools to facilitate training. We will briefly share the experiences of two case-based and patient-centered novel interdisciplinary forums that have been used.
at our institutions to foster a reflective, blame-free environment and promote change in personal and institutional practices. Participants in this workshop will have an opportunity to build an action plan for their own curricula and will leave the workshop with materials including slide sets and evaluation forms, as well as tips on how to facilitate and authenticate difficult conversations on implicit bias at their own institutions.

**WORKSHOP 16. MAXIMIZING THE VALUE OF THE ACGME SELF-STUDY PROCESS FOR YOUR PROGRAM: CREATING AIMS THAT DRIVE PROGRAM SUCCESS!**

Priya S. Garg, MD, Tufts Medical Center, Boston, MA, Kimberly A. Gifford, MD, Dartmouth-Hitchcock Medical Center, Lebanon, NH, John G. Frohna, MD, MPH, University of Wisconsin, Madison, WI, Alexander Rakowsky, MD, MPH, Nationwide Children’s Hospital/Ohio State University, Columbus, OH, Susan Guralnick, MD, Winthrop-University Hospital, Mineola, NY

Avila AB

One main component of the Next Accreditation System process is the Self Study (SS). The ACGME began to pilot the program SS, along with optional formative SS Site Visits 2 years ago; yet for many programs these processes remain a mystery. As programs which have each completed the self study pilot, the process of developing AIMS was valuable and continues to play a large role in our programs today. The primary goal of this workshop is to enable participants to see the SS process not as a chore, but as a valuable opportunity. Participants will: (1) develop AIMS and a shared vision for their program, (2) learn how to use AIMS to improve their program and (3) use AIMS to expand the presence of the program, both in enhancing the program’s recruitment process and in discussions with academic and community leaders regarding program support. The session will start with a brief overview of the rationale for the self-study and the basics of the SS process. Facilitators will then share tools they have used to inform their AIMS and identify and engage key stakeholders in the process. In small groups, participants will discuss important themes for their program AIMS and the stakeholders who should be engaged in the process. Next, facilitators will share how they have used program AIMS to inform their curricula, annual program evaluations, and continuous improvement processes in their programs. To better understand the value of AIMS, each group will review their own AIMS and be asked to think about how these could be mapped to a pediatric residency curriculum and provide opportunities for innovative curriculum development. Facilitators will share how they have used their AIMS to enhance their residency recruitment process. Small groups will then revisit their table’s AIMS and brainstorm how these could be utilized during residency recruitment and to engage local institutional and community leaders. Finally, in an interactive large group, participants will discuss other potential opportunities to use AIMS in residency education. Facilitators will share with workshop participants lessons learned from experiences at their diverse institutions and across disciplines and the tools they have created to develop aims, monitor program improvement, improve recruitment and engage local academic and community leaders.

**WORKSHOP 17. COMBATING BURNOUT WITH RESILIENCE: DEVELOPING A CULTURE OF FACULTY WELLNESS**

Megan E. McCabe, MD, Montefiore Medical Center/Albert Einstein College of Medicine, Bronx, NY, Susan Bostwick, MD, MBA, New York Presbyterian Hospital (Cornell Campus), New York, NY, Ann Burke, MD, Wright State University, Dayton, OH, Annamarie Church, MD, Naval Medical Center (Portsmouth), Portsmouth, VA, Albina Gogo, MD, University of California (Davis) Health System, Sacramento, CA, Dena Hofkosh, MD, UPMC Medical Education, Pittsburgh, PA, Amanda Osta, MD, University of Illinois College of Medicine at Chicago, Chicago, IL, Janet R. Serwint, MD, Johns Hopkins University, Baltimore, MD

San Simeon AB

Resilience is crucial in preventing burnout, depersonalization, major depression, medical errors, and dissatisfaction with career choice. Resilience education is especially important for faculty who serve as role models for trainees. However, the topic has historically not been addressed in medical education. To address this deficiency, members of the AAP, APA, APPD, and COMSEP collaboratively developed and published a novel curriculum focused on promoting resilience in the face of grief and loss across the pediatric training continuum. In this interactive workshop we will use a train-the-trainer model to introduce components of the curriculum focused on in-the-moment, after-the-moment, and long-term wellness strategies. We will discuss work stressors unique to faculty and techniques to recognize and prevent burnout in ourselves, our colleagues, and trainees. Using small and large group discussion we will identify resilience techniques, and participants will then choose an individual technique (meditation, mindfulness, individual wellness plan, office exercise) to practice and enhance their skills. We will then review and discuss the role of peer support in faculty wellness, both how to provide it and how to get it. Participants will leave the workshop ready to implement wellness strategies in their own practice and within their programs and institutions.

**WORKSHOP 18. FROM PADAWAN TO JEDI MASTER: CONQUERING THE DARK SIDE OF PROFESSIONALISM**

Meghan Stawitcke, BA, Charlene Larson Rotandi, AB, AA, Susan Marie Freeman Ike, BS, Michelle Brooks, Emily Johnson, Carrie M. Johnson, Megan K. Christofferson, BA, Stanford University, Palo Alto, CA

Laguna AB

The Pediatric Milestone Project notes in its analysis of the professionalism competency that “there are no well-structured published sequences for the professional development of physicians,” though some components of professionalism are surely learned throughout childhood and others need to be taught or role modeled during medical education and training. Further, an article introducing the new professionalism section of the Journal of the American Medical Association noted that “there is inherent subjectivity to identifying what is appropriate professional behavior and also what the best approach might be for addressing what is perceived as unprofessional behavior in a specific context or setting.” Professionalism may be context dependent across cultures, generations, institutions, specialties, situations, and individual personal interactions; the differing context can dictate how professionalism is modeled and how lapses in professionalism should be addressed. This session aims to demonstrate the role the coordinator can play in assessment of trainees, particularly with respect to the professional conduct...
milestone. Coordinators will be led through small and large group discussions on how to address lapses of professionalism amongst trainees. Background will be given in how professionalism can differ across the aforementioned contexts, and coordinators will be presented with ideas on how to set professionalism standards for their trainees.

5:00pm-6:30pm  Forum for Directors of Small Programs and Affiliate Chairs

Pacific Ballroom B

Keith Mather, MD, University of Oklahoma School of Community Medicine (Tulsa), Joseph Zenel, MD (Sanford School of Medicine) and Brian Youth, MD (Maine Medical Center)

“Small programs” have traditionally been defined as having 10 or less residents per year. However, many programs consider themselves “small” as compared to other larger programs in their vicinity. 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.

APPD Speed Mentoring Session for Faculty

Pacific Ballroom A

APPD Speed Mentoring Session for Faculty

(Pre-registration required as this session requires advance preparation)  APPD Mentoring Leadership Committee of the Faculty and Professional Development Task Force - Drs. Megan Aylor, Aditee Narayan, Erika Abramson, Michelle Barnes, Kimberly Gifford, Bruce Herman, Lauren Nassetta, and Marsha Anderson

We are excited to offer a speed mentoring session for faculty attendees. Prior to the meeting, mentors and mentees will review each other’s CVs. Mentees are asked to bring specific questions to the session. During the session, participants will be grouped in tables of five mentors and mentees, based on topic of interest. Mentees will spend ten minutes with each of the five various experienced APPD mentors for one-on-one interactions.

Friday, April 7

7:30am – 9:00am  Regional Breakfast Meetings

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

9:15am-11:15am  Workshop Session 3 (choose one of eight, 2-hour or two, 1-hour workshops)

WORKSHOP 19. ADDRESSING WHAT’S MISSING FROM OUR CONVERSATIONS ABOUT RESILIENCE: HOW COGNITIVE BIASES INTERFERE WITH OUR ABILITY TO COPE, ADAPT TO STRESSFUL EVENTS, AND ACHIEVE OUR HIGHEST POTENTIAL AS PHYSICIANS AND TRAINEES

Alyssa L. Bogetz, MSW, Stanford University, Palo Alto, CA, Janet Serwint, MD, Johns Hopkins University, Baltimore, MD, Albina Gogo, MD, University of California (Davis) Health System, Sacramento, CA, Caroline Buckway, MD, Stanford University, Stanford, CA, Sarah Hilgenberg, MD, Caroline Rassbach, MD, Stanford University, Palo Alto, CA, Lahia Yemane, MD, Stanford University, Stanford, CA, Whitney Chadwick, MD, Carmin Powell, MD, Walter (Charlie) Wickremasinghe, MD, Rebecca Blankenburg, MD, MPH, Stanford University, Palo Alto, CA

Huntington ABC

The development of resilience is essential in preventing burnout, depression, career dissatisfaction and medical errors. Despite the attention the topic has received, the specific pathways that lead to resilience and long-term coping strategies remain difficult to teach and even harder to implement - and our learners continue to struggle. Cognitive biases are automatic, irrational thought patterns that reinforce negative emotions, undermine confidence, and interfere with our ability to cope. In this highly interactive workshop, participants will be introduced to the concept of cognitive biases and will learn about the critical role they play in the development of resilience. After learning about a range of cognitive biases through real-life examples, participants will use reflection and pair-share to identify the cognitive biases they are most vulnerable to and how they undermine their well-being. Participants will also learn specific strategies to overcome cognitive biases and will work in small groups to apply a series of communication and coaching techniques to address these with trainees. By the end of the workshop, all participants will be able to recognize how cognitive biases operate in their lives - and in the lives of their trainees - and will be able to implement a range of strategies to conquer these, strengthen their coping skills and build resilience.
Chalk talks - where the teacher is equipped solely with a writing utensil and writing surface - have been used for centuries, yet little has been presented regarding strategies for their use in medical education. Structured education proximal to patient encounters (during rounds, at the bedside, or in between patients in clinic) maximizes the opportunities for clinical learning. This workshop presents a strategy to bring 1-3 minute mini-chalk talks (MCTs) to the bedside as a practical way to provide relevant clinical teaching by visually framing teachable moments. Built upon the success of this workshop at last year’s meeting (tinyurl.com/APPDChalk), facilitators will aim to empower educators to revive the art of the chalk talk 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 an MCT when an appropriate topic is triggered in any in-patient or out-patient clinical setting. 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 implement these techniques honing their skills and receiving immediate feedback. Participants will leave with a tool-kit of chalk talk strategies that they can immediately utilize when the next teachable moment presents itself.

WORKSHOP 22. SILENCE IS NOT THE ANSWER: ADDRESSING MODERN DAY SOCIAL INJUSTICE IN YOUR GRADUATE MEDICAL EDUCATION CURRICULUM.
Brian Lurie, MD, MPH, Atlantic Health Program, Morristown, NJ, Megan Aylor, MD, Oregon Health and Science University, Portland, OR, Patricia Poitevien, MD, MSC, PAAP, New York University School of Medicine, New York, NY, Amanda Osta, MD, University of Illinois College of Medicine at Chicago, Chicago, IL, Michelle Brooks, Stanford University, Palo Alto, CA

As Dr. Martin Luther King Jr. said, “Our lives begin to end the day we become silent about the things that matter.” Recently, we have witnessed horrific events on our own soil, clear acts of racism, homophobia, and transphobia. These events raise questions for our trainees, for ourselves, and for our profession. As program directors and advisors, we care for patients and teach trainees who are deeply affected by these horrific events. Despite this, we lack a formal framework and the language to address racism, homophobia and transphobia with our trainees. Structural bias (defined as a confluence of institutions, culture, history, ideology, and codified practices) towards underrepresented populations contribute to and perpetuate health inequities and poorer health outcomes. The US Department of Health and Human Services has made clear that health equity and addressing social determinants of health is critical in maintaining the overall health of our nation. Healthy People 2020 highlights the importance of this and stresses that we should “create social and physical environments that promote good health for all” as one of the four overarching goals for the decade. Despite this we continue to train our residents to treat the consequences of the social determinants, rather than address them. Addressing health care disparities is one of the primary reasons for inclusion of structural bias / social justice curricula in pediatric residency programs. In this highly interactive workshop, participants will enhance their own knowledge and develop the necessary tools to enable them to teach pediatric trainees the knowledge, skills, and attitudes needed to provide equitable care. After starting with a group activity to help all understand the impact of racism, homophobia, and transphobia, participants will watch a brief movie and pair share aspects of their identities that define them. Following a brief didactic illustrating the historical roots of contemporary health disparities,
leaders will provide overarching goals and objectives for a social justice curricula based off existing medical school curricula. In small groups, participants will then begin to modify medical school curriculum geared to help understand the impact of racism, homophobia, and transphobia on health outcomes for implantation in a pediatric residency. We will wrap-up the workshop with a Gallery Walk where participants from all groups will view the “in progress” ideas from other participants and provide feedback and make a commitment to continue their small group work for contribution to a formalized curriculum which can be instituted at their home institution.

WORKSHOP 23. STRENGTH IN NUMBERS: STATE COLLABORATIVES FOR ADVOCACY EDUCATION
Sarah K. Garwood, MD, Washington University/B-JH/SLCH Consortium, St Louis, MO, Leora Mogilner, MD, Mount Sinai School of Medicine (Jersey City), New York, NY, Sara Bode, MD, Nationwide Children’s Hospital/Doctors Hospital, Columbus, OH, Sara del Campo de Gonzalez, MD, University of New Mexico, Albequerque, NM

Santa Monica
Collaboratives are an exciting strategy to strengthen child health advocacy and community pediatrics education for pediatric trainees. In addition to enabling member institutions to share curricula and educational resources, collaboratives can facilitate the creation of statewide advocacy networks that work collectively on behalf of child health. By creating a network through the academic institutions in a region, pediatric residents can engage in advocacy on issues in their region as a part of their training. Collaboratives are also a way for faculty leaders to work together on projects and grants that improve child health, academic scholarship and faculty development in a peer-mentoring model. There are many benefits of this emerging model and only a handful of states across the country are in the process of creating collaboratives. This workshop is led by physicians who are Directors of their training program’s Advocacy/Community Pediatrics rotations and each is also the leader of a collaborative in their state/region. Dr. Garwood is an APD. This workshop will explore the participants’ current strengths and difficulties with their advocacy curricula, identifying common challenges. We will discuss the participants’ advocacy work through their state AAP chapters or other outlets. A brief didactic presentation will provide an overview of the benefits of collaboratives. The experience of the California Collaborative as the oldest and most established example will be highlighted. We will then describe the experiences at the diverse programs we represent, including Arizona, Missouri, New Mexico, and New York, acknowledging challenges, keys to success, and champions. Participants will then work through a Collaborative Readiness Assessment to help them identify key players and partners for collaborative creation. The participants will also be given a roadmap/guide for creating collaboratives at the end of the session. The roadmap was first presented at AAP Community Pediatrics Training Initiative meeting at PAS in 2015. Other useful resources and planning for future networking among participants will be discussed.

WORKSHOP 24. ENSURING MEANINGFUL FEEDBACK: “THAT’S YOUR JOB, NOT MINE!”
Ndidi Unaka, MD, MEd, Sue Poynter Wong, MD, MEd, Cincinnati Children’s Hospital Medical Center/University of Cincinnati College of Medicine, Daniel Schumacher, MD, MEd, Javier Gonzalez del Rey, MD, MEd, Cincinnati Children’s Hospital Medical Center/University of Cincinnati College of Medicine, Cincinnati, OH

El Capitan AB
The traditional framework for the assessment of trainees in residency and fellowship is based on the observation of performed tasks followed by feedback from peers and supervisors. The feedback literature suggests the frequency and depth of this feedback is often suboptimal. New frameworks for assessment (milestones, EPAs, etc) provide an opportunity to renew efforts of frequent, meaningful, and specific feedback that learners desire. But, whose job is it to ensure this happens? Trainees often place this responsibility on their supervisors and training program. However, should trainees truly be passive recipients of information given by supervisors? Lifelong learning is an important competency for 21st century physicians, and central to this is owning and driving one’s own learning. Thus, should learners own some responsibility for seeking their own feedback? The literature would suggest that perhaps they should, using terms like “self-directed assessment seeking” and “external information seeking”. However, most trainees may be inadequately prepared to do this well. Moreover, learners often train in systems that place the onus of feedback on their supervisors. In this interactive workshop, we will discuss generational differences influencing the feedback process. Participants will develop a systematic educational approach to prepare their trainees to seek and obtain learner-centered feedback that can drive improvement. Important concepts integral to the effective seeking and receiving of feedback including principles of lifelong learning, generational communication, time management, and conflict resolution will be discussed in small and large group formats.

WORKSHOP 25. SAFE ZONE: CREATING A WELCOMING ENVIRONMENT TO IMPROVE CARE FOR PATIENTS IN THE LGBT COMMUNITY
Stephanie Brown, MBBS, Christopher Jones, MD, Marie Clark, MD, MPH, Case Western Reserve University/University Hospital Case Medical Center/Rainbow Babies, Cleveland, OH

Malibu
The goal of this workshop is to provide participants practical tools to empower trainees and colleagues to create a welcoming and supportive environment for youth who identify as LGBT. We will review current AAP and GLMA (Health Professionals Advancing LGBT Equality) recommendations for caring for patients who identify as LGBT, as well as relevant current policy issues. Next, we will present an overview of the “Safe Zone” training curriculum designed by The Safe Zone Project, an open-access online curriculum which prepares participants to identify as an “Ally” for the LGBT population. Participants will participate in an example exercise from the curriculum, “Privilege for Sale.” Small group discussions will focus on implementation of the curriculum and solutions to potential barriers. Participants will also consider how to evaluate the curriculum’s efficacy in addressing implicit bias and attitudes related to gender and sexual identity and how to utilize the curriculum to measure traditionally difficult-to-elicit trainee core competencies. The workshop will conclude with guidance.
and a dialogue on collaboration with potential community partners and outreach to leverage change to support the LGBT community and to move forward LGBT-friendly policies and programming in participants' local programs and communities. Participants will receive electronic files of the curriculum materials, sample evaluations and guidance for implementation.

WORKSHOP 26. HAVING YOUR CAKE AND EATING IT TOO: SUCCEEDING PROFESSIONALLY AND PERSONALLY IN MEDICINE
Jennifer E. Crotty, MD, Vidant Medical Center/East Carolina University, Greenville, NC, Jennifer K. O'Toole, MD, MEd, Cincinnati Children's Hospital Medical Center/University of Cincinnati College of Medicine, Cincinnati, OH, Sara Mulerer, MD, University of Louisville, Louisville, KY, Rachel Boykan, MD, Stony Brook Medicine/University Hospital, Stony Brook, NY

Palos Verdes AB
Physicians often struggle with balancing the demands of both their personal and professional lives, feeling they must sacrifice achieving their full potential in one arena in order to succeed in another. This workshop will provide attendees with an opportunity to identify what constitutes “success” in both the professional and personal arenas. An interactive brief didactic will introduce the attendees to the literature around career success and satisfaction in medicine. Attendees will outline an “individualized life plan” that will define not only long and short-term goals in the personal and professional arenas, but also detailed steps on how to achieve those goals. Next, participants will identify their current personal and professional activities and how much time they dedicate to each activity. Attendees will then participate in a critical appraisal activity during which they will examine the alignment of each activity with their individualized life plan. Additionally, they will identify activities and individuals that they must move toward to improve attainment of success. Attendees will acquire techniques for asserting and defending their key interests, even if it means saying “no,” and will work through scenarios to practice these new skills. Finally, attendees will work in small groups to identify additional strategies around the topics of work, home, and personal success and wellness. These strategies will be shared with the group and then collated by the presenters into a “success strategy toolbox” to be shared with attendees upon their return home.

9:15am-10:15am
WORKSHOP 27A. HOW TO ADD A LITTLE FRIENDLY COMPETITION INTO YOUR PROGRAM TO GET THINGS DONE!
Amy Gaug, University of Minnesota, Minneapolis, MN

Pacific Ballroom A
We'd like to address one area that can be connected to coordinator burnout - necessary administrative tasks that feel uninspiring and what we did about it! Why not add a little fun into the day to day operations of your program? This can make both your time and the trainees' time feel much more engaging and inspiring. We took a few initiatives this academic year in our residency program to add some levity into areas that we wanted to improve. We have worked on increasing resident engagement in the program with some friendly competition that has led to an increase in the completion of certain administrative tasks by our trainees. We have also delivered content in a game based format to increase the retention of information. We’ll show you what we focused on, how we did it and prove that it worked! You should come away from this presentation inspired and with ideas that you can bring to your own program.

10:15am-11:15am
WORKSHOP 27B. QUALITY IMPROVEMENT: NO MORE “BRICK & MORTAR”...HELLO TECHNOLOGY
Donna J. Williams, MA, University of Texas Southwestern Medical School, Dallas, TX

Pacific Ballroom A
Program coordinators are crucial players in reviewing and updating educational curriculum for the program. They are involved with every step in the entire process and, as a result, can identify opportunities to ease the burden for all those involved. The key focus areas where coordinators have immediate impact are resident learning process, data collection and faculty development. By addressing these areas, coordinators reduce the number of issues leading to fewer meetings and provide a meaningful education experience for residents. This session will illustrate how transitioning to a LMS system will allow new and experienced coordinators to become leaders in identifying curriculum issues and refine processes, thus feeling comfortable knowing that trainees are receiving a meaningful educational experience. Additionally, this process creates opportunities for faculty development and buy-in, an improved tracking system and, finally, help coordinators to gain a better understanding of how to help trainees in their professional development.

11:30am - 1:00pm
Lunch on your own
Council of Regional Chairs Lunch Meeting
Oceanside
Council of Task Force Chairs Lunch Meeting
San Clemente

Remember that Posters are open in Pacific Ballroom CD from 10:00am-5:30pm!
WORKSHOP 28. IS DAILY NOON CONFERENCE OLD SCHOOL? DEVELOPING A SUCCESSFUL ACADEMIC HALF DAY CURRICULUM FOR PEDIATRIC RESIDENCY PROGRAMS
Barry Seltz, MD, University of Colorado, Aurora, CO, Priya Garg, MD, Tufts Medical Center, Boston, MA, Laura Zastoupil, MD, University of Colorado, Aurora, CO, Charles Hannum, MD, Emily Hsieh, MD, Tufts Medical Center, Boston, MA

Pacific Ballroom B
The Accreditation Council for Graduate Medical Education requires residency programs to provide regularly scheduled didactic sessions, traditionally accomplished with daily noon conferences. However, noon conference is affected by poor resident attendance, interruptions due to clinical responsibilities, compressed time with duty hour restrictions, and misalignment with adult learning principles. An alternative to daily noon conference is an Academic Half Day (AHD), in which educational sessions are condensed into one half-day block per week. Core principles of AHD include: protecting time and space for learning, nurturing active learning, deliberate selection of curriculum content, developing faculty, and employing a continuous improvement approach to curriculum development and evaluation. This interactive workshop will be conducted by program directors and Chief Residents from two different pediatric residency programs that have transitioned from daily noon conference to AHD. The target audience will include program directors, chief residents, program coordinators, and any faculty/fellows/residents interested in medical education. Learning activities will include using Poll Everywhere, interactive large group sessions, small group activities, and World Café. We will provide a brief overview of the literature on AHD and describe AHD models at our respective pediatric residency programs. Workshop participants will focus on designing 1) a needs assessment, 2) process for developing an AHD longitudinal schedule; 3) an AHD learning session; and 4) strategies for overcoming potential institutional barriers to implementation. After completion of small group activities, participants will walk through each station to discuss finished products (World Café), and leave with strategies to implement an AHD at their home programs.

WORKSHOP 29. WAR STORIES: TALES FROM THE TRENCHES- ENHANCING PROGRAM RESILIENCE IN THE FACE OF CRISIS BEFORE THE UNTHINKABLE HAPPENS
Michelle D. Barajaz, MD, Baylor College of Medicine (San Antonio), San Antonio, TX, Mark Ward, MD, Baylor College of Medicine (Houston), Mark Hormann, MD, University of Texas Health Science Center at Houston, Houston, TX, Bonnie Deselle, MD, Louisiana State University, New Orleans, LA

Capistrano AB
When a group of program directors gets together for any length of time, the discussion often will turn to the sharing of war stories from their programs: crisis situations that no one ever dreamed they would face. Whether it be natural disasters, criminal acts, or health and well-being emergencies among our residents, the telling of these stories can serve a purpose greater than catharsis. We can learn from each other’s experience and develop preventative plans to enhance program resilience in the face of events that could have the potential to seriously damage or derail both our residents and our residencies or fellowships. In this workshop, we will share lessons learned from seasoned veterans and help you actively work towards the development of an emergency preparedness toolkit for your program. This will include the building of a framework for emergency response and crisis management through case studies and group discussion, as well as the development of personalized tools which will prove to be powerful ammunition in the trenches.

WORKSHOP 30. DE-ESCALATING ANGRY CAREGivers: A NOVEL COMMUNICATION FRAMEWORK AND TOOLKIT FOR PEDIATRICiANS
Sarah L. Hilgenberg, MD, Stanford University, Stanford, CA, Alyssa Bogetz, MSW, Kevin Chi, MD, Rebecca Blankenburg, MD, MPH, Stanford University, Palo Alto, CA

Palos Verdes AB
A practitioner’s ability to communicate successfully with patients and families is of utmost importance, particularly in difficult encounters. For this reason, the Accreditation Council for Graduate Medical Education has identified interpersonal and communication skills as a competency equal in importance to clinical skill and medical knowledge for pediatric residents. Physicians identify 1 in 6 outpatient encounters, including those involving angry patients and caregivers* (*defined as a parent, guardian, or other adult in a similar role), as difficult. As such, communication with angry caregivers has emerged nationally as an area of need for trainee and faculty development. In this highly interactive workshop, we will discuss both evidence-based fundamental communication skills for caregiver interactions and our novel nine-step communication framework and associated skills for de-escalating angry caregivers. Participants will reflect on prior experiences and challenges in facilitated small-group exercises and large group discussions. Participants will then apply the framework in three role-play scenarios. All participants will leave the session with practical tools and curricular materials to improve their own practice and to teach trainees and faculty how to work with angry caregivers.

WORKSHOP 31. REVISITING GUN VIOLENCE PREVENTION: MOBILIZING PEDIATRICiANS TO REDUCE GUN INJURY AND DEATH
Lauren E. Brown, MD, MPH, Jennifer Fiore, MD, Lauren Veit, MD, Elyse Portillo, MD, MPH, Katherine Nash, MD, Eric Fleegler, MD, MPH, Children’s Hospital/Boston Medical Center, Boston, MA

Santa Monica
The BCPR (Boston Combined Residency Program) Response to Gun Violence is a group of pediatricians from both Boston Children’s Hospital and Boston Medical Center, who have felt an urgent need to respond to the gun violence that affects...
children in our communities. As a group we have lost our primary care patients to gun violence, and see the impact of this violence daily in our clinics and emergency departments. As pediatricians, we believe that we have an important role in curbing this public and pediatric health crisis. This workshop will focus on building skills around gun safety education and advocacy among pediatric residents. The workshop will consist of a brief overview of the current state of gun violence in the United States, followed by a brief review of a series of interventions enacted by the BCRP to enhance resident education around gun violence prevention and advocacy. The remainder of the workshop will consist of highly interactive break-out sessions focused on three aspects of gun safety advocacy which are particularly relevant to residency programs: resident education on gun safety screening and counseling, interventions to create a culture of safety in resident clinics, and legislative advocacy. Each workshop will be lead by a BCRP resident or chief resident, and will focus on encouraging a dialogue around gun safety advocacy, while also building tangible skills related to gun violence prevention. The overarching goal of this workshop is to mobilize pediatric residents across the nation around gun safety.

WORKSHOP 32. NOT JUST AT THE BEDSIDE: HARNESSING THE POWER OF THE PATIENT AND FAMILY VOICE IN PEDIATRIC EDUCATIONAL ACTIVITIES OUTSIDE OF THE CLINICAL CARE ENVIRONMENT
Shannon E. Scott-Vernaglia, MD, Massachusetts General Hospital, Boston, MA, Blyth T. Lord, EdM, Courageous Parents Network, Newton, MA, Sandra Clancy, PhD, Susan R. Hata, MD, Patricia J. O’Malley, MD, Mary P. Alexander, MD, Massachusetts General Hospital, Boston, MA

Malibu
Understanding the patient and family perspective and communicating effectively with families underlie many of the pediatric milestones and sub-competencies within interpersonal and communication skills, professionalism and systems-based practice, and are integral to the practice of pediatrics. Training programs are, in fact, tasked by the ACGME with ensuring that trainees “communicate effectively with patients, families, and the public, as appropriate, across a broad range of socioeconomic and cultural backgrounds” and “demonstrate the insight and understanding into emotion and human response to emotion that allows one to appropriately develop and manage human interactions.” With a growing national focus on Patient-Centered Care and the Patient-Centered Medical Home, residents and fellows are actively engaged in communicating and partnering with patients and families. A golden opportunity for trainees to learn from patient families outside of the clinical care delivery system exists that is often underutilized. Utilizing the voices, stories and experiences of patients and families as catalysts for learning can be incredibly powerful for adult learners. Telling their stories also allows families to create meaning of the child’s illness, since, as Charon writes, “much of the telling of self is critical, formative and transformative”. In this workshop, participants will first identify barriers to involving patient families as educators, and then work to identify ways to overcome these barriers. There are many ways that patients can be involved in educational experiences, and examples of using the patient family voice through written narrative, formal presentations, shared patient-caregiver events, patient-provider co-facilitation and videos will be discussed. We will then work in small groups to create outlines for implementing patient family educational opportunities in your home institutions.

WORKSHOP 33. TURNING YOUR EDUCATIONAL INNOVATION INTO SCHOLARSHIP
Melissa Klein, MD, MEd, Cincinnati Children’s Hospital Medical Center/University of Cincinnati College of Medicine, Cincinnati, OH, Su-Ting Li, MD, MPH, University of California (Davis) Health System, Sacramento, CA, Robert Vinci, MD, Children’s Hospital/Boston Medical Center, Boston, MA

Laguna AB
Have you ever had trouble converting your educational innovation into scholarship? If you are interested in learning what is needed from Academic Pediatrics’ education editors, this is the workshop to attend. During this highly interactive workshop, participants will learn how to develop educational projects using a scholarly approach. First, in small groups, utilizing case scenarios, participants will discover the importance of the “so wht?” in making the case for the importance of their scholarship. Next, participants will discuss the importance of using conceptual frameworks to develop research questions in medical education. Participants will then practice developing research questions through the lens of one conceptual framework. Then, small groups will develop evaluation metrics and corresponding activities for the research question identified in the prior activity. Finally, dissemination options including journals with an interest in educational innovation and MedEdPortal will be introduced. By the conclusion of this workshop participants will leave with a toolkit to assist them in turning their educational innovation into scholarship.

WORKSHOP 34. MEDICINE AND THE SEMICOLON PROJECT: MENTAL ILLNESS AS A PAUSE, NOT AN ENDING
Sydney P. Primis, MD, Carolinas Medical Center, Charlotte, NC, Michelle Brooks, Stanford University, Palo Alto, CA, Adam Hill, MD, Indiana University School of Medicine, Indianapolis, IN

El Capitan AB
As physicians and medical educators we care for the sick and support the well. We care for patients with mental health and substance abuse conditions with empathy and without judgment. Yet, medical conditions, such as depression, anxiety, substance abuse, and suicidal ideation often are not met with the same compassion and empathy when it affects our colleagues and/or us personally. This failure is multifactorial in nature, ranging from poor self-awareness or self-preservation to a culture of shame/stigmatization and a fear of repercussions. Over the last few years, great strides have been made in the arenas of physician wellness and self-care, however more dramatic steps must be taken to ensure the creation of cultures of acceptance. A culture change movement is underway utilizing the power of human connection, human empathy and professional unity. This movement relies on the grassroots voices of those willing to be vulnerable and self-compassionate. These voices serve as a catalyst for the conversations of destigmatization and acceptance of individuals living with these conditions in our profession. This workshop uses first person story-telling narratives of professionals working successfully in our profession with their own stories of mental health and substance abuse conditions. Additionally, we will attempt to open up spaces for processing and
self-reflection, in both large and small group discussions. The overall goal is to create a spark of vulnerability. With this spark, we hope to create spaces for individuals to share their own experiences and foster environments, in their own institutions, accepting of individuals who share their own journeys with mental health conditions. In the true essence of a grassroots movement, person by person, we aim to spark a change that will spread across institutions and our profession as a whole.

WORKSHOP 35. HELPING THE EAGLET TO SOAR: HOW TO PREPARE YOUR TRAINEES FOR LIFE AFTER RESIDENCY

Meredith Monaco-Brown, MD, Kelley Pike, BA, Albany Medical Center, Albany, NY; Mackenzie Frost, MD, University of Texas Southwestern Medical School, Dallas, TX; Blair Dickenson, MD, Sharon Calaman, MD, St. Christopher’s Hospital for Children, Philadelphia, PA

Huntington ABC

Residents often muddle through their transition to the next step after residency, whether they are entering practice or fellowship. Often times this transition relies on word of mouth and the resident's luck in finding an effective mentor rather than any formal education. Residents are often unaware of how to successfully interview, negotiate, or deal with financial planning, among other decisions. In this workshop, we will guide participants through the development of a curriculum geared at helping residents make this transition. We will utilize small group activities, role play, and individual planning time to achieve this. A curriculum designed to launch our residents successfully should include: “Guiding residents through the nitty gritty of license applications, contract negotiations, malpractice insurance, maintenance of certification, etc.”; incorporating mock interviews into your program”; and “helping residents structure their research/extracurriculars to align with future goals.” With some basic education and guidance, as well as an up to date and accurate set of resources, program directors can equip residents with a set of practical skills to use moving forward, and also improve alumni success and potentially career satisfaction.

1:15pm-2:15pm

WORKSHOP 36A. CCC-CCC: COORDINATOR CLAIMING CONTROL - CLINICAL COMPETENCY COMMITTEE

Ambrosya Amlong, Janene Bondie, University of Michigan, Ann Arbor, MI

Pacific Ballroom A

To ensure the most efficient and effective execution of the clinical competency committee the program coordinator must assume a leadership role. The program coordinator serves a vital role in development of innovative tracking systems, thorough and accurate data mining, and clearly identifying current milestones attainment. This session will help attendees identify how to execute an efficient clinical competency committee, allowing efficient review of multiple data points; milestones, procedures, duty hours, timely documentation.

2:15pm-3:15pm

WORKSHOP 36B. JUGGLING ALL ASPECTS OF A COORDINATOR’S DAY!!!

Cassandra D. Shorter, BS, Baylor College of Medicine (San Antonio), San Antonio, TX

Pacific Ballroom A

As Coordinators we have to juggle many tasks and, as a new coordinator, sometimes it is difficult to find where to place things on your to-do-list. Often times we tend to put off those things that challenge us the most and work on the simple things. When doing this we get into a time crunch because we take more time to do the challenging things and we are constantly being interrupted by Residents, PDs, Faculty, urgent emails, and phone calls. Depending on the season, we are constantly interrupted with Applicants calling, etc. Prioritizing your day doesn’t start the day before, it starts when you step in the office and what you planned to work on yesterday may not be what you have the opportunity to work on today. There will be an unavoidable situation that will take you off task. How will you handle that and still get the important priorities completed in a timely manner? The goal of this workshop is to give some helpful tools to new coordinators on prioritizing their day. New Coordinators tend to get overwhelmed with all of the items that are placed before them. These tools can help them to organize their day and assist them with what’s important. This session will also provide techniques to help them to communicate with Faculty, Residents and PDs. For the Seasoned Coordinators, it will allow them to refocus and help to relieve the stress level. We will discuss the common problems that every coordinator faces, such as not knowing how to say “I am unable to do that at this time” for fear of feeling like we are inadequate, or that we have failed as a coordinator if we can’t “do it all”.

3:30pm-5:30pm  Poster Session (posters displayed throughout the day, beginning at 10:00am)

Pacific Ballroom CD
BURNOUT IN PEDIATRIC RESIDENTS: A NATIONAL SURVEY TO INFORM FUTURE INTERVENTIONS

Maneesh Batra MD MPH, University of Washington, Seattle, WA, Kathi J. Kemper MD MPH, Nationwide Children's Hospital/Ohio State University, Blacklick, OH, Janet R. Serwint MD, Johns Hopkins University, Baltimore, MD, Alan Schwartz PhD, University of Illinois College of Medicine at Chicago, Chicago, IL, Paria M. Wilson MD, MEd, Cincinnati Children's Hospital Medical Center/University of Cincinnati College of Medicine, Cincinnati, OH, Betty B. Staples MD, Duke University Hospital, Durham, NC, Charles Schubert MD, Cincinnati Children's Hospital Medical Center/University of Cincinnati College of Medicine, Cincinnati, OH, Hilary McClafferty MD, University of Arizona, Tucson, AZ, John D. Mahan MD, Nationwide Children's Hospital/Ohio State University, Columbus, OH, Pediatric Residency Burnout and Resilience Consortium, Seattle, WA

Background: Resident burnout is associated with poor personal health and poor patient care. Previous studies of pediatric resident burnout have involved small samples, and gaps remain in understanding predictive factors to inform future interventions. Objective: Determine the prevalence of burnout among pediatric (PED) and medicine-pediatrics (MEDPED) residents in a national sample and characterize potential personal and programmatic risk and protective factors. Methods: The Pediatric Residency Burnout & Resilience Consortium (PRBRC), involving 34 nationally representative residency programs, conducted an anonymous online survey of residents in April-June of 2016 via APPD LEARN. The survey tool included demographic characteristics, debt, year of training, recent experiences (eg, overnight call, patient death), and standard measures of burnout, stress, mindfulness, self-compassion, empathy, sleepiness, and resilience. Rates of burnout were calculated by residency year. Predictive factors for burnout were assessed by logistic regression. Results: Overall response rate was 62% (1693/2723 eligible residents), and overall rate of burnout was 56%. Among PED, prevalence of burnout was 59% as PGY1s and decreased to 48% as PGY3s. Among MEDPED, prevalence was 73% as PGY1s, and decreased to 49% as PGY4s. Burned out residents had similar demographic characteristics, debt, and physical health to those who were not burned out. Burned out residents reported significantly increased stress, poorer mental health, and decreased: empathy, mindfulness, resilience, self-compassion, and confidence in providing compassionate care. Protective programmatic factors included current rotation (ambulatory/elective/research), decreased sleepiness, temporal relationship to vacation or weekend off, and lack of recent involvement in a medical error. Conclusions: In this national sample of pediatric residents, prevalence of burnout was high and varied by program type and training year. Several personal and programmatic characteristics were identified as potential targets for future interventions to prevent and/or reduce resident burnout.

SATISFACTION AND CHALLENGES OF PEDIATRIC PROGRAM DIRECTORS: A NATIONAL SURVEY

Adam Pallant MDPHD, Brown University, Providence, RI, Eyal Ben-Isaac MD, Children’s Hospital of Los Angeles, Los Angeles, CA

Background: Pediatric Program Directors (PDs) provide the educational foundation supporting the transition of recent medical graduates to independent practitioners. PDs are responsible for the outcomes of their residencies, the competence of their trainees, and the ongoing accreditation of their training programs. Little is known about factors that contribute to the success, well-being, satisfaction, or challenges of PDs in America. Objectives: Describe the demographics of PDs in America in the year 2016, identify factors that impact their work and success, and describe features that contribute to career challenges, success, and longevity. Methods: A survey requesting demographic, academic, salary, and personal career satisfaction information was sent to all categorical Pediatric Directors (PD) that were active members of the Association of Pediatric Program Directors (APPD) beginning in July, 2016. We used descriptive statistics to provide a national analysis of PD experience in the workplace, as well as activities and duties contributing to PD career challenge and satisfaction. Results: 147 PDs responded to the survey yielding a response rate of 73%. The majority of American PDs are mid-career academic physicians of the age 40-59 (67%), at the Associate Professor level (49%), although few are hired on a tenure track (13%). There is a slight predominance of women holding the position of PD (56%), with a major predominance of PDs self-described as white (79%). The majority of PDs have been in their position for 10 years or less (71%). Women have a slightly lower salary range than men, however are also somewhat younger and on a lower academic level of appointment. Of all PDs,
19% have not received any pay raise in the prior five years while 48% have received 1 or 2 raises, and 32% have had raises three or more times over the prior 5 years. Fewer than half of current PDs view their current position as a final career goal, 35% of respondents viewing PD as their final career step, 16% indicating that the PD position was a stepping stone, and 50% marking not sure. PDs rank order Relationship with Residents, Role as an Educator, Relationship with Chair, and Career as a Program Director (in that order) as the four features that bring greatest job satisfaction. In contrast, PDs rank order Administrative Workload, Managing Accreditation and ACGME Expectations, Resources, and Work/Life Balance (in that order) as the four features that are most associated with job dissatisfaction. **Conclusions:** Categorical Pediatric Program Directors are generally mid-career academics that value their role in education, forming relationships with residents and colleagues, and highly regard their position as a training director. Nonetheless, only one-third view the position of PD as their long-term career goal, and many feel that the administrative duties and work/life balance of the position contribute to significant dissatisfaction with their current careers.

Platform Presentation 3

**RESIDENT EXPERIENCES WITH THE INDIVIDUALIZED CURRICULUM: CURRENT STATE AND FUTURE OPPORTUNITIES**

**Daniel J. Schumacher MD, MEd, Cincinnati Children’s Hospital Medical Center/University of Cincinnati College of Medicine, Cincinnati, OH, Mary Pat Frintner MSPH, William Cull PhD, Elk Grove Village, IL**

**Background:** 2016 residency graduates are the first cohort to complete training since establishment of the ACGME requirement for an individualized curriculum (IC); Little is known about residents’ experiences across programs for these six months. **Objective:** Determine graduating pediatric resident experiences with the IC. **Methods:** National, random survey sample of 1000 graduating pediatric residents in 2016. Residents were asked if they defined their IC experiences (resident-defined, chosen from program options, assigned by program) and how important the IC was in preparing them for the next steps in their career (extremely important, important, moderately important, somewhat important, not very important). They were also asked to provide the focus of the IC (they found most valuable (free text)). **Results:** 53% of residents responded (n=535). Approximately half (50.6%) reported they defined at least part of their IC. Almost all (96.4%) reported choosing IC options from a list provided by the program. Finally, a majority of residents (60.7%) reported they were assigned at least part of their IC experiences by the program. Residents with subspecialty career goals were more likely (compared to primary care or hospitalist goals) to have IC experiences defined by themselves, p<0.05. Most residents (81.1%) found their IC experiences to be extremely important/important to next steps in their careers. Residents who chose at least part of their IC experiences (both self-defined and from a program list) were more likely to report their IC experiences were extremely important or important to the next steps in their career, p<0.01 for both. Among residents who answered the question about the most valuable focus of the IC (n=381), specialty experiences, something related to future career, and primary care experiences were most commonly described. **Conclusion:** Program defined IC experiences are more common than resident defined IC experiences. With residents considering self-chosen experiences to be an important component of their IC experiences, future efforts should focus on maximizing these beneficial opportunities.

Platform Presentation 4

**SAFETY IN NUMBERS: DATA FROM THE DUKE PEDIATRIC RESIDENCY SAFETY COUNCIL**

**Ashley E. Hanlon MD, Jennifer Ladd MD, Ann Szefferly MD, Sophie Shaikh MD, Colby Feeney MD, Victoria E. Parente MD, Duke University Hospital, Durham, NC**

**Background:** The ACGME Clinical Learning Environment Review focuses on six areas of trainee working and learning environments, including safety and quality improvement (QI). Recent graduates report dissatisfaction with exposure in these areas, with most training didactic rather than practical. We describe a resident-run safety council as a means to engage residents as active drivers of safety and QI. **Purpose:** The Duke Pediatric Residency Safety Council (PRSC) fosters a culture of safety at Duke Children’s Hospital. In this resident-driven model, trainees identify safety issues and receive hands-on training in systematically reviewing errors and using QI methodology to address concerns. **Description:** Established in 2013, the PRSC is supported by chief residents and faculty mentors. The PRSC organizes multidisciplinary morbidity and mortality (M&M) conferences using an open-format, standardized template. Participants use Learning from Defects to identify systems issues. Participants also use written patient safety event reports to generate further action items. The PRSC has organized over 35 M&M conferences to date, covering topics such as transitions of patient care and cognitive biases in diagnosis. Over 40 action items have been completed, leading to sustained advancements in patient safety, such as implementation of a hospital-wide program to prevent inadvertent discontinuation of home medications during in-patient stays. Resident surveys demonstrate significant improvement in resident perception of Duke Children’s culture of safety since inception of the PRSC. **Conclusion:** The PRSC models successful involvement of trainees in system-based patient safety and QI, fostering growth of a robust patient safety culture within Duke Children’s. Such involvement can help to satisfy ACGME core competencies and develop leaders in the area of patient safety and QI.

Platform Presentation 5

**PRIME: INAUGURAL YEARS & IMPACT OF A RESIDENT-LED MEDICAL EDUCATION INTEREST GROUP**

**Regina L. Toto MD, Christine March MD, Liny John MD, Hilary Michel MD, Benjamin Miller MD, UPMC Medical Education, Pittsburgh, PA**

**Background:** Teaching is a vital skill for all residents; yet, resident teaching curricula are highly variable. In 2014, we conducted a needs assessment on the teaching curriculum of the Children’s Hospital of Pittsburgh of UPMC (pediatric residency program.
All responders (100%) agreed that learning to be an effective teacher was important; however, less than 30% agreed that the current teaching curriculum met their educational needs. **Objective:** We founded a group called Pediatric Residents Interested in Medical Education (PRIME), aiming to enhance CHP’s teaching curriculum and inspire residents to participate in educational scholarship. **Methods:** In Fall 2014, residents applied to join PRIME; Dr. Miller selected 17 inaugural members. Faculty and PRIME leaders led interactive sessions open to the entire residency. Topics included Adult Learning Theory, Medical Decision Making, Cognitive Bias, and Small Group Teaching. These sessions addressed the gap in medical education while also allowing PRIME members to hone their teaching skills. We evaluated all residents’ familiarity with medical education scholarship and satisfaction with the medical education curriculum prior to the institution of PRIME workshops and one year later. The study was IRB-exempt.

**Results:** Enrollment in PRIME increased by 76% from 17 to 30 residents following its first year. PRIME increased awareness of medical educational scholarship for both members and the entire residency program. Of the 33 members of the graduating class of 2016, nine (28%) completed medical education-related scholarly projects, compared to a total of eight projects in the previous four years combined. Finally, following PRIME’s creation, residents responses to the question, “The Medical Educational Curriculum meets my educational needs “ rose significantly from 27.9% to 53.8% (P<0.05). **Conclusion:** PRIME has addressed an unmet need by greatly enriching the residency’s teaching curriculum and increasing participation in education-related scholarly work. PRIME’s application could be replicated in another medium to large residency program.

**Winner – APPD 2017 QI Project Award**

Platform Presentation 6

**IMPROVING RESIDENT-NURSE COMMUNICATION WITH COLLABORATIVE QUALITY IMPROVEMENT**

**Allison Rose MD, Nichole McCollum MD, Laura Wilson MD, Monica Vielkind MD, Nguyet Tyler RN, BSN, Emory University, Atlanta, GA**

**Background:** Medical errors occur frequently, and miscommunication is the leading cause of inadvertent patient harm. In a teaching hospital, resident-nurse communication is a basic, yet crucial interaction that can facilitate safer and better quality healthcare delivery. In our institution, nurses and residents inconsistently round together during general pediatric bedside rounds. **Aim Statement:** The aim is to increase nursing participation on bedside rounds from 25% to 70% by March 2017 for general pediatrics patients on one inpatient unit. **Interventions:** This is a collaborative quality improvement study using the Model for Improvement and iterative Plan, Do, Study Act (PDSA) cycles. Pediatric residents and nurses completed surveys to assess barriers to nurse presence on bedside rounds. Ideas for tests of change were developed from collaborative meetings with residents, nurses and nurse managers and the surveys. PDSA cycles were implemented, including the addition of nurse phone numbers to resident reports (PDSA 1), training residents on an in-room communication system (PDSA 2), and daily nurse huddle announcements (PDSA 3). Baseline and post-intervention data on communication methods and joint presence on rounds were collected. **Measures:** Descriptive statistics and run charts were used to analyze data. **Results:** Barriers to collaborative bedside rounds included the needs of other patients, nurses not aware of rounds, multiple teams rounding simultaneously, residents not wanting to interrupt the pace of rounds, residents not wanting to bother nurses. Baseline data revealed residents notified nurses of rounds in 34% of instances, and nurses were present in 24%. PDSA 1 increased nursing contact to 73% and nursing presence to 66%. PDSA cycles 2 and 3 showed sustained improvement. Finding nurses in person or calling directly were the primary methods for communication. **Conclusions and Next Steps:** Baseline data confirmed that nursing presence on rounds occurs infrequently. Simple measures that align with current team and system processes can improve resident-nurse collaborative bedside rounds and thus potentially improve patient care. PDSA cycles 2 and 3 sustained improvement but did not add to it.

10:30am-12:00pm Special Interest Symposia (choice of 8 sessions)

**Redondo**

The APPD Assessment Task Force will host a 3rd 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.

2. Curriculum Task Force Mini-Posters

**Pacific Ballroom B**

The APPD Curriculum Task Force, hosting a mini poster symposium for the fourth year, will focus on curricular needs identified by the membership, specifically (1) advocacy; (2) patient safety and interprofessional teamwork; or (3) value-based care. Presentations will include a description of the curriculum, including goals and objectives, educational activities, assessment and evaluation.

3. Faculty & Professional Development Task Force Professional Development Symposium

**Manhattan**

The Faculty & Professional Development Task Force will hold a professional development symposium during this time slot entitled “Reframing Careers for Academic Success: Aligning Identity and Scholarly Activity”. This symposium will be of value to APDs/FDs/PDs/Chief residents who are trying to formulate a more intentional professional development pathway towards their career goals. Space will be limited to those persons that register. At the end of this session, learners will be able to:

1. Describe a variety of identities of scholars, and identity-related tasks and scholarly activities.
2. Identify a range of scholarly activities, across broad categories of scholarship, in which individuals might engage as part of their academic career development.
3. Develop a personal action plan for scholarly pursuit and academic success.

4. Global Health PEG Abstract Symposium

   **Laguna AB**
   The APPD Pediatric Global Health Educators Group (GH PEG) invites you to the 3rd Annual APPD GH PEG Abstract Symposium. The theme for this session is Global Pediatric Education: Innovations, Partnerships & Exchanges and include global health education research, quality improvement, or descriptive reports of curricula in global health. Top submissions will be invited to provide brief oral podium presentations during the GH PEG meeting (Saturday 4/8/17, 7-8:30 am). Additional submissions will be presented during this mini-poster session and compiled into an abstract pamphlet, to allow for sharing of global health educational innovations via other global health educator networks.

5. Healthcare Simulation in Pediatrics PEG Mini-Posters

   **San Clemente**
   The Simulation PEG will host a Mini-Poster Symposium, “Innovative Work in Simulation.” Invited abstracts will highlight an innovative and unique way in which simulation is being used to uniquely solve a problem that a residency or fellowship program has faced. Each presenter will have 6 minutes to present their mini poster to the larger group and then will have 5 minutes for questions. We will reserve time at the end of the session for networking and further discussion of ideas amongst the participants.


   **Palos Verdes AB**
   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.

7. Research & Scholarship Task Force Works-in-Progress Symposium

   **Oceanside**
   There are times for every educational researcher when their project just gets ‘stuck.’ We run into issues with project design, implementation, data analysis, dissemination and many other road blocks along the way. Successful researchers have learned to reach out and collaborate when these obstacles arise. The APPD Research and Scholarship Task Force has designed a resource for those who are facing those dead-ends with our Works-In-Progress Symposium.

   Participants will join in an active step-back peer mentoring process to help overcome the barriers which are preventing research from being brought to fruition. Each accepted project will benefit from individual discussion and collaboration to help it advance to the next phase of development. Presenters will hone their presentation skills and their ability to accept and incorporate feedback as well. Attendees will learn strategies which can be applied to their own research questions, current or future, improve their mentoring skills, and learn about some of the exciting educational research being undertaken by our APPD membership.

   At the wrap up to the symposium, the entire group will then examine and synthesize recurrent themes in research difficulty and the tactics which teams used to overcome them. Our task force believes that this will be a unique and powerful directed mentorship opportunity to help guide the advancement of APPD educational research as a whole.

8. Under-Represented Minorities in Pediatric GME PEG Mini-Posters

   **Huntington ABC**
   The Underrepresented Minorities (URM) in Pediatric Graduate Medical Education PEG is excited to host a 2nd annual Mini Poster Symposium. Invited presenters will share curricular and program enhancements targeting four areas: (1) unique recruiting practices to enhance diversity; (2) innovative approaches to support inclusion and mentorship of URMM residents, (3) curricula or faculty development focused on bias; or (4) curricula focused on health equity and social justice for historically disadvantaged groups. Each presenter will have 15 minutes to present their poster and field questions/ foster discussion regarding their project from all perspectives.
Meeting Memories
MPPDA 2017 National Meeting
50 Years of MedPeds: Looking Back, Looking In and Looking Forward

Tuesday, April 4, 2017

7:00am  Registration Opens  
Pacific Registration Desk

7:00am - 8:00am  Continental Breakfast  
Pacific Foyer A

8:00am - 8:30am  Welcome and Introductions  
Pacific Ballroom A
Suzanne McLaughlin, MD, MPPDA President-Elect, Director, Med-Peds Program, Brown University / Rhode Island Hospital

8:30am - 9:30am  Plenary Session I: MedPeds 50 Years – Looking Back  
Pacific Ballroom A
Allen Friedland, MD, FACP, FAAP, Professor of Medicine and Pediatrics, Program Director Med-Peds Program, Christiana Care Health System; Dale A. Newton, MD, FAAP, Professor Emeritus, Brody School of Medicine, East Carolina University

9:30am - 9:40am  Break

9:40am - 10:40am  Workshop Session 1: Leadership and MedPeds (choose one of three)

1. Steering from the Sidecar: Cultivating your Leadership Skills as an APD  
El Capitan A
Benjamin Kinnear, MD, Assistant Professor of Medicine and Pediatrics, University of Cincinnati College of Medicine; Jennifer K. O’Toole, MD, MEd, Associate Professor of Pediatrics and Internal Medicine, Associate Director, Internal Medicine-Pediatrics Residency Program, Medical Director of Education & Adult Care, Division of Hospital Medicine, Cincinnati Children’s Hospital Medical Center/UC College of Medicine; Alda Maria Gonzaga, MD, MS, FAAP, FACP, Associate Professor of Medicine and Pediatrics, Program Director, UPMC Combined Internal Medicine-Pediatrics Residency Program, Visiting Associate Professor, Pediatrics and Internal Medicine, SUNY at Stony Brook Medicine

2. MPPDA Regional Meetings: Supporting and Innovating Together  
Malibu
Jennifer McDonnell, MD, Assistant Professor of Pediatrics, Rush University Medical Center; Benjamin R. Doolittle, MD, M Div, FAAP, FACP, Associate Professor, Internal Medicine & Pediatrics, Yale University; Molly Rose Elkins-Ryan, BA, Senior Program Coordinator, Med-Peds Residency Program, Rush University; Alice A Kuo, MD, PhD, Professor, Internal Medicine and Pediatrics, Chief, University of California Los Angeles Medicine-Pediatrics; John M Solomonides, MD, Associate Professor of Internal Medicine and Pediatrics, Med/Peds Residency Program Director, University of Massachusetts Medical School; Pavan K Srivastava, MD, Assistant Professor of Clinical Medicine and Pediatrics, Program Director, MedPeds Residency Program, University of Illinois at Chicago - College of Medicine
3. Cultivating Med-Peds Interest: Interest group development, Expansion and Innovation

**San Simeon AB**
Allison Rossetti, MD, Assistant Clinical Professor Division of Hospital Medicine, Assistant Program Director Internal Medicine-Pediatrics Residency, The Ohio State University Wexner Medical Center & Nationwide Children’s Hospital; Allen Friedland, MD, FACP, FAAP, Professor of Medicine, Professor of Pediatrics, Program Director Med-Peds Program Christiana Care Health System; Ivelisse Ann Verrico, MD, FACP, FAAP, Assistant Professor of Internal Medicine - Pediatrics Program Director, Internal Medicine - Pediatrics Residency Program, Albany Medical College

10:50am - 11:50am  
**Plenary Session II: Looking In: Addressing Loss and Wellness in our Programs as Educational Leaders, Personally and Professionally**  
**Pacific Ballroom A**
Mary Ciccarelli, MD, Vice Chair for Pediatric Education, Professor of Clinical Medicine-Pediatrics, Indiana University School of Medicine  
Objectives – Participants will
1. Explore experiences and reactions to death and loss in one’s professional world.
2. Consider tools to address the range of self-care needs of oneself and your varied trainees when experiencing loss.
3. Create plans for proactive wellness rather than reactive care for self and trainees.

11:50am – 12:50pm  
**Plenary Session II continues with group activity: Gaudeamus Igatur Reflective Exercise**  
**Pacific Ballroom A**
Benjamin R. Doolittle, MD, M Div, FAAP, FACP, MPPDA President, Associate Professor, Internal Medicine & Pediatrics, Yale University; Antonia Eyssallenne, MD, PhD, Jackson Memorial Hospital/ University of Miami Med Peds Program Director, Assistant Professor; Jonathan Tolentino, MD, FAAP, FACP, Program Director, Combined Internal Medicine-Pediatrics Residency Program, Visiting Associate Professor, Pediatrics and Internal Medicine, SUNY at Stony Brook Medicine; Lori Wan, MD, Clinical Professor of Medicine and Pediatrics, University of California San Diego (UCSD) Health Sciences

12:50pm – 1:50pm  
**MPPDA Awards Lunch**  
**Pacific Ballroom A**

1:30pm – 4:00pm  
**AMPPA Breakout Session**  
**Santa Monica**

1:50pm – 2:00pm  
Break

2:00pm – 3:30pm  
**Committee Meetings**
- Accreditation Committee .......................................................... **Capistrano AB**
  Jane Trinh, Chair
- Curriculum Committee ............................................................ **Palos Verdes AB**
  Mike Aylward, Chair
- Recruitment Committee ......................................................... **Avila AB**
  Allen Friedland and Ron Magliola, Chairs
- Research Committee ............................................................... **Malibu**
  Anoop Agrawal, Chair
- Transition Committee ............................................................ **San Simeon AB**
  Alice Kuo, Chair

3:30pm – 4:00pm  
Break
4:00pm – 5:30pm  
Poster Session/Welcome Reception  
*J.T. Tolentino and Ben Doolittle, Co-Chairs*
  
**Huntington ABC**

6:30pm – 9:30pm  
50th Anniversary Celebration and Social Event  
*Allen Friedland, Ivelisse Ann Verrico, Stephanie Zia, Event Co-Chairs*
  
**In Downtown Disney @ Ralph Brennan’s Jazz Kitchen**  
(1590 South Disneyland Drive, Anaheim, CA 92802 P: 714-563-7261 F: 714-999-2123  
http://www.rbjazzkitchen.com/)

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**Wednesday, April 5, 2017**

7:00am – 8:00am  
Continental Breakfast  
**Pacific Foyer A**

8:00am - 8:30am  
Presidential Address  
**Pacific Ballroom A**  
*Benjamin R. Doolittle, MD, M Div, FAAP, FACP, MPPDA President, Associate Professor, Internal Medicine & Pediatrics, Yale University*

8:30am – 9:30am  
Plenary Session III (Looking forward): GME Finance reform, the IOM and the future of GME Funding: How to avoid a hunger games for MedPeds Training  
**Pacific Ballroom A**  
*Richard M. Wardrop III, MD, PhD, FAAP, FACP, Program Director, Internal Medicine and Pediatrics Residency, Associate Professor of Medicine and Pediatrics, University of North Carolina School of Medicine; John Donnelly, MD, FACP, FAAP, Internal Medicine Program Director, Christina Care Health System, Clinical Assistant Professor, Internal Medicine and Pediatrics, Sidney Kimmel Medical College of Thomas Jefferson University; Niraj Sharma, MD, MPH, Assistant Professor of Internal Medicine and Pediatrics, Harvard Medical School*

9:45am - 10:45am  
AMPPA Breakout Panel Discussion: CLER visits  
**Manhattan**

9:45am – 10:45am  
Breakout Sessions: Nuts & Bolts/How do they do that? (choose one of five)  
1. Integrating an inter-professional primary care-based substance use disorder curriculum into a (jam packed) Med - Peds residency program  
**Pacific Ballroom A**  
*Sharon Wretzel, MD, FAAP, Associate Program Director, Natalie Ronshaugen, MD, (Chief Resident), Baystate Medicine-Pediatrics Residency Program, University of Massachusetts Medical School - Baystate Medical Center*

2. Stress Reduction Techniques for Physician and Resident Wellness  
**Palos Verdes AB**  
*Ronald Williams, MD, Professor of Medicine and Pediatrics, Penn State Health Hershey Medical Center and Penn State Children’s Hospital*

3. Reducing unconscious bias in medical decision making  
**Santa Monica**  
*Alda Maria Gonzaga, MD, MS, FAAP, FACP, Associate Professor of Medicine and Pediatrics, Program Director, UPMC Combined Internal Medicine-Pediatrics Residency; Mumtaz “Taj” Mustapha, MD, Assistant Professor of Medicine and Pediatrics, Associate Program Director UMN Combined Internal Medicine-Pediatrics Residency, University of Minnesota, Departments of Internal Medicine and Pediatrics*
4. Making it Count Twice: Combined Milestones in Med-Peds

**Capistrano AB**
Emily Pearce Machogu, MD, Assistant Professor for Medicine and Pediatrics, Indiana University; Anna Voleman Beaser, MD, Assistant Professor for Medicine and Pediatrics, University of Chicago; Michael Aylward, MD, Assistant Professor for Medicine and Pediatrics, University of Minnesota; Benjamin Kinnear, MD, Assistant Professor for Medicine and Pediatrics, University of Cincinnati College of Medicine

5. Implementing health care transition in your practice setting

**Malibu**
Russ Kolarik, MD, Program Director Greenville Health System/University of South Carolina Greenville; Brett Robbins, MD, Med-Peds Program Director, University of Rochester; Kitty O’Hare, MD, Assistant Professor of Medicine and Pediatrics, Harvard Medical School

10:45am - 11:00am Break

11:00am - 12:15pm Keynote Address (Looking forward). MedPeds: A Catalyst for Addressing Disparities and Promoting Health Equity through Diversity

**Pacific Ballroom A**
Nicole E. Alexander-Scott, MD, MPH, FAAP, Rhode Island Department of Health, Director; Brown University, Assistant Professor of Pediatrics, Medicine and Health Services, Policy, and Practice

12:15pm - 12:30pm Break

12:30pm - 1:30pm Lunch and Business Meeting: Committee reports and membership representative updates.

**Pacific Ballroom A**

1:30pm - 1:45pm Break

1:45pm - 3:00pm Plenary Session IV: Regulatory Updates (Peds RRC; ABIM; ABP)

**Pacific Ballroom A**
Roger W. Bush, MD, MACP, Clinical Professor of Medicine, University of Washington, Attending Physician, Neighborcare Health, Seattle, Director, American Board of Internal Medicine, Member, ABIM Internal Medicine Specialty Board; Caroline Fischer, MBA, Executive Director, RC for Pediatrics, Physical Medicine and Rehabilitation, ACGME; Gail McGuinness, MD, Executive Vice President, ABP

3:00pm - 3:15pm Break

3:15pm – 4:15pm Membership Networking Session:

**Pacific Ballroom A**
Ivelisse Ann Verrico, MD, FACP, FAAP, MPPDA Member Representative, Assistant Professor of Internal Medicine - Pediatrics Program Director, Internal Medicine - Pediatrics Residency Program, Albany Medical College

3:15pm - 4:15pm AMPPA Small Group Breakout Session

**Manhattan**

4:15pm - 4:30pm Wrap up – Looking forward to 2017:

**Pacific Ballroom A**
Suzanne McLaughlin, MD, MPPDA President-Elect, Director, Med-Peds Program, Brown University / Rhode Island Hospital
Poster Session Details

FRIDAY, APRIL 7, 3:30 - 5:30 PM

Pacific Ballroom CD

PLEASE NOTE THAT POSTERS WILL BE ON DISPLAY THROUGHOUT THE DAY, BEGINNING AT 10:00AM

Posters will be separated in the following topic areas in the Poster Session:

- Clinical Skills/Simulation: Posters 1-16
- Teaching/Curriculum: Posters 17-46
- Safety/QI: Posters 47-53
- CCC/Program: Posters 54-64
- Communication/Documentation: Posters 65-78
- Feedback and Evaluation: Posters 79-86
- Wellness/Resilience: Posters 87-99
- Global Health: Posters 100-104
- Social Determinants of Health/Poverty/Advocacy: Posters 105-114
- Bias/Diversity: Posters 115-118
- Entrustment/EPA/Milestones: Posters 119-128

Congratulations to the following APPD 2017 Research Award winners:

- APPD QI Project Award: Allison Rose, MD, Emory University - Platform Presentation #6 (see page 32)
- APPD Research Award: Betty B. Staples, MD, Duke University - Poster Abstract #90 (see page 77)
- APPD Trainee Research Award: Francis J. Real, MD, Cincinnati Children’s Hospital Medical Center - Poster Abstract #67 (see page 67)

CLINICAL SKILLS/SIMULATION

1. INCLUDING PEDIATRIC RESIDENTS IN A STANDARDIZED PROCESS OF RAPID SEQUENCE INTUBATION IN A PEDIATRIC EMERGENCY DEPARTMENT: A PILOT PROGRAM (DESCRIPTIVE ABSTRACT)

Benjamin T. Kerrey, MD, MS, Brad Sobolewski, MD, Med, Tara Kopp, MD, Cincinnati Children’s Hospital Medical Center/University of Cincinnati College of Medicine, Javier Gonzalez-del-rey, MD, Med, Cincinnati Children's Hospital Medical Center/University of Cincinnati College of Medicine, Cincinnati, OH

Background: In our academic pediatric emergency department (PED), a checklist-based improvement project for rapid sequence intubation (RSI) standardized performance and reduced hypoxemic events. Pediatric residents were not initially included in the project and lack opportunities in general to learn critical procedures. Objective: To provide motivated senior pediatric residents with pediatric RSI training and experience. Methods: In the summer of 2015, we emailed all senior residents (non-PGY 1) to offer an RSI curriculum to those with interest in acute care fellowships. Our academic pediatric institution has a large and diverse pediatric residency program. The RSI curriculum consisted of: (1) a 2-hour training session and (2) a 1-hour testing session. For the training session, the principal investigator for the improvement project met with 1-2 residents in our simulation lab. Residents were provided with a detailed description of the RSI process, including the checklist. Residents simulated executing the checklist and practiced laryngoscopy and intubation skills with immediate feedback. The testing session was a low-fidelity simulation in the PED trauma bay and consisted of residents both executing the checklist and performing laryngoscopy and intubation. Residents completing the curriculum were identified both by emails to PED providers and a laryngoscope sticker on their hospital badge. Measures of curriculum success were residents executing the RSI checklist for actual patients and comparison of key RSI process/outcome measures between resident versus non-resident cases. Results: Five of 40 senior categorical pediatric residents completed the RSI curriculum. All 5 residents executed the checklist for at least one patient in the PED; key process and outcome measures were similar to non-resident patients and no major adverse events occurred. In post-training interviews, residents stated that the RSI curriculum was more valuable than airway skills training alone. Conclusions: In the context of a standardized process, pediatric residents can meaningfully contribute to a critical procedure without deterioration of performance or safety.

2. LEADERSHIP FOR URBAN PRIMARY CARE EDUCATION AND TRANSFORMATION (LUCENT) (DESCRIPTIVE ABSTRACT)

Rita Rossi-Foulkes, MD, MS, Anna Volerman, MD, Alisa McQueen, MD, Deborah Burnet, MD, MA, University of Chicago, Chicago, IL

This HRSA-funded program is multidisciplinary, including the Departments of Medicine, Pediatrics, and Family Medicine. Resident and faculty scholars participate in biweekly symposia to develop knowledge and skills needed for primary care transformation and leadership. Residents receive enhanced ambulatory training to strengthen clinical skills specific to
primary care. Finally, each scholar leads an innovation project to translate knowledge and skills into practice. During the first year (2015-2016) prior to scholar selection, 8 symposia were held attracting individuals from a variety of specialties (24% Internal Medicine; 19% Pediatrics, 6% Medicine-Pediatrics, 5% Family Medicine) and levels (35% attending physicians, 26% medical students, 17% residents, 2% fellows). Evaluations from the 115 attendees revealed that 93% felt the topics were useful for ambulatory practice transformation, 93% felt the information was useful for the development of urban primary care leadership skills, and 100% stated they were likely to attend a future symposium. A Steering Committee and Community Advisory Board were formed to support the program’s development and ongoing improvement. A curriculum was developed using Kern’s model with input from primary care physicians, care delivery leaders, and community partners. In July 2016, the first cohort of 12 scholars began the program, including 6 residents, 1 fellow, and 5 faculty. Their projects focus on: chronic pain, mental health, palliative care, pediatric obesity, and social determinants of health. Short-term outcomes include scholars’ knowledge and skills of primary care transformation and leadership, patient care access and delivery, disease outcomes, and attitudes about the program and are assessed with surveys, direct observation, electronic medical record reports, and project presentations. Long-term outcomes for scholars include entry into primary care, implementation of transformative initiatives, and attainment of primary care leadership roles. In addition to fostering career development, the program builds a stronger institutional network for primary care delivery and transformation.

3. SIMULATED ENCOUNTER IN PRIMARY CARE (DESCRIPTIVE ABSTRACT)

Candice C. Dye, MD, Nancy Tofil, MD, MEd, University of Alabama Medical Center, Birmingham, AL

Purpose: This project exposes pediatric and medicine-pediatric residents to a simulated suicidal patient who has presented to clinic for a routine well child visit. It is crucial residents gain knowledge and experience in caring for suicidal teenagers.

Methods: This research study is designed to evaluate a resident’s experience in handling a difficult diagnosis in the primary care setting. Each intern has a simulated encounter with a standardized patient. Sessions occur in the simulation center and are recorded. During history taking, the resident learns the patient is acutely suicidal. The resident then has to determine how to further investigate these symptoms and then the appropriate management course for the patient. The scenario is scripted and was piloted to ensure standardization in educational intervention. Following the scenario each resident participates in a nonjudgmental debriefing with the attending. An anonymous post-survey is completed assessing the simulation’s effectiveness on a 5 point Likert scale and open ended questions. Results: Simulation sessions started in July 2016. To date 6 interns have completed the simulation. Surveys show 6/6 (100%) learners strongly agreed the simulation was a helpful learning experience and were satisfied with content and quality of simulation. 5/6 (83%) strongly agreed they would be able to apply the concepts, knowledge and skills. 6/6 (100%) strongly agreed they wanted more primary care simulation. Learning themes included: Value of learning with a standardized patient and receiving feedback directly from them, practicing being in an uncomfortable situation, and talking through the protocol of safely getting the child emergent help. Improvement suggestions included: Adding a component of talking to the mother about the suicidal condition and more time to discuss ways to approach difficult conversations. Conclusion: A suicidal pediatric patient is a fragile encounter in the outpatient setting. Quickly developing a rapport with the patient so they share details is a skill that comes with practice. This simulation is designed to give residents this exposure and practice feeling more comfortable in future encounters. Feedback has been positive and learners feel more prepared after the simulation. It allows supervisors to observe a difficult patient care scenario assessing intern’s ability to communicate and think on their feet, important ACGME competencies.

4. LEADERSHIP DEVELOPMENT: AN INTEGRATED APPROACH TO CHANGING TRAINEE LEADERSHIP ATTITUDES, SKILLS, AND BELIEFS (DESCRIPTIVE ABSTRACT)

Susan B. Hathaway, PhD, John Rosen, MD, Angela L. Myers, MD, MPH, Rachel Laws, MBA, Children’s Mercy Hospital, Kansas City, MO

Background: Nearly every study on leadership in health care settings emphasizes the importance of leadership skills among physicians and refers to the call by ACGME and their competencies to build these skills. Physicians are asked to lead in an increasingly complex health care environment (Awad et al, 2004; Fairchild et al, 2004) with a more sophisticated set of leadership skills.

Objective: Our primary objective was to develop a well-received, cohesive, systematic, competency-based leadership course for all first-year fellows in the Children’s Mercy Kansas City System.

Methods: Prior lecturers, as well as identified experts from a mix of clinical and administrative contexts, were invited to join the faculty. Thirty sub-competencies were mapped, conceptual frameworks were developed, and goals and objectives were written across three domains: Inner, Other, and Outer. In 2015-2016, ten faculty members piloted the monthly classes required of all first-year fellows across all 35 programs. The course was evaluated three ways: 1. A pre- and post- test survey. 2. Reflective questions at the end of each course. 3. A course evaluation at the end of the year which is discussed below.

Results: The evaluation asked participants to indicate the extent to which the course met each of the course objectives, the relevance of the information, the quality of the instruction, and the time allocation of each subject. The objectives felt to be the best accomplished fell in the Inner domain with 85% agreeing or strongly agreeing that the objectives had been met. Eighty-two percent of participants strongly agreed or agreed that the material was applicable and relevant to their future profession. All participants agreed or strongly agreed that the content was organized, specific to the audience and included focused discussion. The majority of participants believed each topic was covered with the appropriate amount of time (59%-91% depending on the topic). Topics covered during the beginning of the course (Inner) were more likely to be rated as having too much time (average of 21%) and topics covered at the end of the course (Outer) were more likely to be rated as having too little time (24%). Some topics were simultaneously evaluated as the most helpful and least helpful in open-ended questions.

Conclusion: Overall, the course was well-received. Open ended responses to the evaluation indicated an appreciation for
5. RESPONSIBILITY FOR PATIENT CARE IN GRADUATE MEDICAL EDUCATION: DEFINING AND ASSESSING OWNERSHIP OF CLINICAL CARE (RESEARCH ABSTRACT)

Katie A. Greenzang, MD, EdM, Jennifer C. Kesselheim, MD, EdM, Children’s Hospital/Boston Medical Center, Boston, MA

Background: Learning to assume ownership of patient care is a critical objective of training. However, little is known about how ownership is best defined, fostered, and measured in residency programs. Objective: To define the construct of ownership, identify the elements of amenable to assessment, and elucidate characteristics of the current training environment that promote or inhibit ownership. Methods: Focus groups were held with pediatric residency program directors (N=18) and residents (N=11) in Spring 2016. Semi-structured phone interviews were conducted with 3 additional residents in order to achieve purposive sampling of residents from diverse programs and regions. Focus groups and interviews were audio recorded, transcribed verbatim, and qualitatively analyzed using thematic analysis. Results: Program directors and residents both define ownership as a feeling of being essential to a patient getting good care. Many comment on an affective, relational component, and use the terms care and my patient to describe the essence of ownership. Respondents find meaning in work when exerting ownership, and burnout when ownership is lacking. Structural barriers to ownership identified by both cohorts include duty hours, lack of continuity between attending-resident teams, scheduling constraints, patient volume, and a shift-work culture of just covering. However, only residents cited continuity clinic as one of the most challenging venues for ownership given scheduling and organizational issues. Promoters of ownership include faculty who provide an optimal balance of space and support, scheduling that permits continuity with patients and supervisors, and overnight call. Both groups agree that ownership can be taught, primarily through role modeling, and is best assessed by peers. Conclusions: Residents and faculty consistently define ownership as a cornerstone of patient care and value additional training and feedback on this skill. These findings will be used to develop a novel assessment instrument to measure ownership of clinical care in multiple settings.

6. INTERPRETER USE TRAINING THROUGH SIMULATION (DESCRIPTIVE ABSTRACT)

Kathryn Diamond-Falk, MD, Brian Youth, MD, Maine Medical Center, Portland, ME

Portland, Maine where Maine Medical Center trains Pediatric and Med-Peds residents is home to a large immigrant, refugee and asylee community. Portland Public Schools estimates that there are at least 59 languages represented and that 36% of the students’ primary language at home is not English. The resident clinics at Maine Medical Center care for many of the children and families that represent those numbers. Given the need to use interpreters regularly and variable training and use of interpreters prior to residency we developed training for our interns. Via the use of interpreters trained as standardized patients, all of our residents participate in a simulation session within the first 2 months of their training. Goals of this session are to learn about the importance of using interpreters during clinical visits, and practice their skills working with interpreters and “patients” through typical scenarios they will encounter. A liaison from Interpreter Services gives an introduction that includes some basics of cultural sensitivity as well as the requirements for offering and using interpreters with patients and families. Scenarios were developed that focus on recognizing when an interpreter is needed, the importance of room set-up, using short sentences, recognizing when interpreting needs are not being met and how to ask for a new interpreter, how to address sensitive topics through interpreters and with family/friends, and how to address cultural norms that may affect use of interpreters. We have aligned scenarios with milestones to focus on intrapersonal skills and communication, professionalism and systems based practice. Each resident participates in one scenario with standardized patients (interpreters serve the role given need for native speakers of a foreign language). The residents observe one another; then with faculty oversight all residents participate in feedback after each scenario. Residents complete a survey after the simulation session and feedback has been very positive. We feel that this type of training is something that many other programs who serve large refugee or any non-English speaking population would benefit from.

7. DE-ESCALATING ANGRY CAREGIVERS: A RANDOMIZED CONTROLLED TRIAL OF A NOVEL COMMUNICATION CURRICULUM FOR PEDIATRIC RESIDENTS (DESCRIPTIVE ABSTRACT)

Sarah Hilgenberg MD, Alyssa Bogetz MSW, Collin Leibold BS, David Gaba MD, Rebecca Blankenburg MD, MPH, Stanford University, Palo Alto, CA

Background: Physicians identify 1 in 6 outpatient encounters as difficult, including those involving angry patients and caregivers. As such, communication with angry caregivers has emerged nationally as an area of need for trainee and faculty development. In the pediatrics literature to date, only one article describes approaches physicians can take with “difficult parents;” no research describes how to approach angry caregivers or how to teach this skill to physician trainees. Objectives 1. Create a novel communication curriculum to teach pediatric residents de-escalation techniques to use with angry caregivers. 2. Conduct a randomized-controlled trial to evaluate the efficacy of the curriculum. Methods: We created an interactive 90-minute curriculum on de-escalation skills after a thorough literature review. The curriculum includes instruction on a 9-step de-escalation framework, specific language to use, and 3 role plays to apply skills. Content experts reviewed all materials prior to implementation. All pediatric residents (n=87) were randomized to participate in the curriculum (intervention) or to read and discuss an article on approaches to difficult patient/parent encounters (control). Descriptive statistics compare their pre/post self-efficacy and attitudinal data. Research in process will compare resident vs. standardized patient vs. faculty ratings of resident performance.
8. A NOVEL SIMULATION-BASED ULTRASOUND CURRICULUM (DESCRIPTIVE ABSTRACT)
Vinod Havalad, MD, Joanne Claveria, MD, William Tsai, MD, Advocate Lutheran General Hospital, Park Ridge, IL

Ultrasound (US) imaging technology has moved out of the realm of radiologists and technicians and into the hands of bedside clinicians. US is useful for guiding specific procedures such as central, arterial, and peripheral vascular access, thoracentesis, and paracentesis with dramatic improvements in patient safety. In addition, bedside US is consistently used in emergency departments to evaluate trauma patients in real-time and is increasingly being used across ICUs to evaluate unstable patients. US is non-invasive and can give useful, immediate information regarding cardiac function, lung function, and intra-abdominal processes, and the information gleaned often guides therapeutic and resuscitation decisions. Despite these benefits, US training is currently only a standard element in emergency medicine training and has not been required in other medical training specialties. In addition, it can sometimes be difficult to find enough willing patient participants for practice in a busy ICU and this methodology does not allow for consistent standardized practice. Our goal was to develop an ultrasound curriculum for Pediatric Critical Care Medicine fellows using simulation to augment live patient encounters. At the beginning of training, each fellow was assigned a SonoSim® handheld device and a registered ultrasound training account. The device allowed the fellow to practice how to hold the probe and obtain proper views for each study before approaching a patient. In addition, program leaders were able to track progress by overseeing their accounts on performance on knowledge assessments and practical training. The fellows then began performing supervised studies on live patients, with the goal of acquiring 25 cardiac, 25 lung, 25 FAST and 25 procedural exams, which were then all quality-controlled by a physician certified in bedside ultrasound. This was accomplished during their primary service months but also during three dedicated one-month long imaging rotations spread over the three years of fellowship. At any time during this process, fellows would return to the simulator technology to refresh skills or to potentially acquire new skills not required by the curriculum. By the end of this three-year curriculum, each fellow will have enough imaging experience, as demonstrated by their verified acquired images, that they will be able to be certified in critical care ultrasound. This has been made possible by the use of a hybrid training curriculum that leverages simulator technology.

9. PEDIATRIC CARDIOLOGY BOOT CAMP PROMOTES FELLOWSHIP READINESS AND ENABLES RETENTION OF KNOWLEDGE (RESEARCH ABSTRACT)
Scott R. Ceresnak, MD, David M. Axelrod, MD, Loren D. Sacks, MD, Kara S. Motonaga, MD, Emily R. Johnson, Catherine D. Krawczeski, MD, Stanford University, Palo Alto, CA

Background: We have previously demonstrated that a pediatric cardiology boot camp can improve knowledge acquisition and decrease anxiety for trainees. We sought to determine if participants in pediatric cardiology boot camp entered fellowship with a knowledge advantage over fellows who did not attend and if there was moderate-term retention of that knowledge.

Methods: A two-day intensive training program was provided for incoming pediatric cardiology fellows from 8 pediatric cardiology fellowship programs in April 2016. Hands-on, immersive experiences and simulations were provided in all major areas of pediatric cardiology. Knowledge-based examinations were completed by each participant prior to boot camp (PRE), immediately post-training (POST), and prior to the start of fellowship in June 2016 (F/U). A control group of fellows at the same level of training who did not attend boot camp also completed an examination prior to fellowship (CTRL). Comparisons of scores were made for individual participants and between participants and controls. Results: A total of 16 participants and 16 control subjects were included. Baseline exam scores were similar between participants and controls (PRE 47 ± 11% vs. CTRL 52 ± 10%; p = 0.22). Participants’ knowledge improved with boot-camp training (PRE 47 ± 11% vs. POST 70 ± 8%; p<0.001) and there was excellent moderate-term retention of the information taught at boot-camp (PRE 47 ± 11% vs. F/U 71 ± 8%; p<0.001). Testing done at the beginning of fellowship demonstrated significantly better scores in participants versus controls (F/U 71 ± 8% vs. CTRL 52 ± 10%; p<0.001), suggesting that boot camp participants began fellowship with a deeper fund of knowledge compared to those that did not attend. Conclusions: Boot camp participants demonstrated a significant improvement in basic cardiology knowledge after the training program and had excellent moderate-term retention of that knowledge. Participants began fellowship with a larger fund of knowledge than those fellows who did not attend and may be better prepared for the rigors of cardiology fellowship.

Results: 84 (97%) of residents participated. 43 (51%) participated in the intervention, 41 (49%) participated in the control. Of those in the intervention, 41 (95%) agreed or strongly agreed that the content was “helpful for my clinical practice,” compared with 38 (93%) of the controls, and that they would “apply the skills learned to my clinical practice,” compared with 33 (80%) of the controls. Forty (93%) reported that their ability to de-escalate angry caregivers would improve as a result of their participation, compared with 32 (78%) of the controls. Conclusions: We developed a curriculum on de-escalating angry caregivers that was feasible, well-received, and directly applicable to residents’ clinical practice.
11. A SIMULATION-BASED PROCEDURAL CURRICULUM FOR PEDIATRIC INTERNS IMPROVES SELF-PERCEIVED COMPETENCE (RESEARCH ABSTRACT)

Meera S. Meerkov, MD, MS, Thomas G. Saba, MD, University of Michigan, Ann Arbor, MI

Background: The American College of Graduate Medical Education (ACGME) requires pediatric residents to demonstrate competence in the performance of 13 procedures. However, studies have revealed poor perception of procedural competence among graduating residents. We aimed to determine if a curriculum employing both didactic and hands-on simulated training at the beginning of pediatric internship improves perceived procedural competence and increases the frequency of procedures performed on patients. Methods: Nine ACGME-required procedures were taught over 2 half-day sessions during intern orientation week. Teaching methods included checklists, videos, knowledge assessments and simulation. Self-perceived procedural competence was assessed using a blinded survey completed immediately before and after the curriculum. Interns from the previous year (2015) who had not participated in the curriculum also completed the survey at the end of intern year. Data were analyzed using unpaired student t-tests. The study was approved for IRB exemption. Results: Nearly all interns agreed or strongly agreed that this was a positive overall experience. Self-perceived competence improved significantly for all procedures except for peripheral IV insertion and venipuncture. Post-curriculum competence was greater than competence of the 2015 interns for all procedures except for bag mask ventilation, lumbar puncture, peripheral IV placement and venipuncture (Figure). Interns who completed the curriculum did not perform more procedures in the first 6 months of internship compared to the 2015 interns.

Conclusions: Implementation of a simulation-based procedural curriculum at the onset of internship improved self-perceived procedural competence for almost all procedures. We aim to assess competence at the end of the 2016 intern year and continue longitudinal surveillance of procedures performed to clarify the impact of this curriculum and determine skill and confidence retention.

<table>
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<th>Procedure</th>
<th>Intern Post-training Mean Score (N)</th>
<th>Second Year Resident Mean Score (N)</th>
<th>P Value</th>
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<tr>
<td>Procedural Knowledge</td>
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<tr>
<td>Confidence</td>
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12. A SIMULATION-BASED LONGITUDINAL PROCEDURAL CURRICULUM FOR PEDIATRIC RESIDENTS IMPROVES SELF-PERCEIVED COMPETENCE (RESEARCH ABSTRACT)

Jason B. Fischer, MD, MSEd, Thomas Saba, MD, University of Michigan, Ann Arbor, MI

Background: Studies have shown that both residents and program directors perceive procedural competence to be poor due to the general low volume of pediatric procedures. We developed a novel, longitudinal, simulation-based procedural curriculum to teach procedures required by the American College of Graduate Medical Education (ACGME) including lumbar puncture (LP), simple laceration repair, bag mask ventilation (BMV), intubation, fracture splinting, abscess incision and drainage (I&D), foreign body removal and dislocation reduction as well as other procedures routinely performed during residency including nasogastric (NG) tube placement, nasointestinal (NI) tube bridling, and tracheostomy-and gastrostomy-tube management. We aimed to assess the change in self-perceived procedural competence as a result of this curriculum.

Methods: Procedural workshops were held monthly during noon conference. Teaching methods included checklists, videos, knowledge assessments and hands-on simulation training. Self-perceived competence was assessed before and after each workshop using online surveys. Data were analyzed using unpaired student t-tests. The study was approved for IRB exemption.

Results: The vast majority of residents agreed or strongly agreed that each workshop was a positive overall experience (98%), the content and models were helpful (87%), the instructors were good teachers (95%) and the workshops improved their abilities (71%). Self-perceived competence improved for 8 out of 12 procedures: NG placement, NI bridling, tracheostomy- and gastrostomy-tube management, fracture splinting, intubation, I&D, and foreign body removal. Competence improved but not significantly for BMV ventilation, and reduction of a dislocation.

Conclusion: We present a feasible model of a longitudinal, simulation-based curriculum to improve resident self-perceived competence in procedures required by the ACGME and others performed routinely during residency. Our next aim will be to investigate whether this improved competence leads to a greater number and quality of procedures performed on actual patients.

13. SIMULATION CURRICULUM ASSOCIATED WITH IMPROVED RESIDENT SELF-CONFIDENCE IN CODE TEAM LEADERSHIP SKILLS (DESCRIPTIVE ABSTRACT)

Cailyn Rood, MD, Amanda Rogers, MD, Abigail Schuh, MD, Michael C. Weisgerber, MD, Robert Treat, PhD, Medical College of Wisconsin Affiliated Hospitals, Milwaukee, WI

Background: Learning to function as a leader on an inter-professional code team is an important component of residency training. Baseline data demonstrated our residents often did not assume this role because they lacked confidence in their code leadership skills. Objective: We implemented a longitudinal simulation curriculum to improve resident confidence in their code leadership skills. Methods: A needs assessment indicated that residents do not lead codes because they lack confidence in 4 domains: recognition of critical patients, management of critical patients, procedural skills, and leadership skills. These results guided the development of a mannequin-based simulation curriculum which included a mock code and a leadership workshop.

Pre- and post-tests assessed the impact of the curriculum on resident confidence in those 4 domains. Residents were assessed on 14 individual five-point Likert scale items (1=strongly disagree, 5=strongly agree) grouped into the 4 domains. Data was de-identified and unpaired between pre- and post-assessments. The individual item and domain scores were compared with Mann-Whitney U-tests and independent t-tests, respectively. Effect size was calculated with Cohen's d. Inter-item reliability was assessed with Cronbach alpha.

Results: Fifty residents completed assessments. Nine of the 14 individual items (64%) reported significant increases in median scores (all p< or =.050), with the largest increases in leadership skills (delta=1.5, p<.001) and logistical abilities (delta=2.0, p<.001). There were statistically significant pre-post increases in resident confidence in their management (d=0.7, p<.001), procedural, (d=0.9, p<.001), and leadership skills (d=1.0, p<.001). The inter-item reliability for the 14 individual items was alpha=0.92.

Conclusion: Resident participation in a simulation-based code leadership curriculum is associated with improved confidence in their management, procedural, and leadership skills. Future results of the study will include assessing the impact of this improved confidence on residents’ ability to lead patient code events.

14. IMPROVING CARE OF CHILDREN ADMITTED TO THE HOSPITAL WITH FAILURE TO THRIVE (FTT) (QI ABSTRACT)

Taylor Heald-Sargent, MD, PhD, Daphne Vander Roest, MD, Jennifer Chapman, MD, Joseph Hageman, MD, Jasmine Umana, MD, Asad Qadir, MD, Brittany Hodgsdon, MD, Marguerite Costitch, MD, Katherine Anderson, RD, Martin Duncan, MD, Jill Glick, MD, University of Chicago, Chicago, IL

Background: While FTT in children is ideally managed in the outpatient setting, continued failed weight gain may necessitate hospital admission. While this cohort was admitted to our institution for FTT, prior to our intervention only 75% of children had weights recorded at least daily. Aim Statement Our primary goal was to record daily weights for 100% of children throughout admission within one year of implementation. Our secondary aims included decreasing length of stay (LOS), improving malnutrition diagnosis, and establishing an outpatient provider prior to discharge. Interventions Following the IHI Model for Improvement, we established a multidisciplinary team of physicians, nutritionists, nurses, and members of our child advocacy team who unanimously agreed on our primary aim and established measurable secondary aims important to an FTT admission. We created resident, nursing, and family-based bundles for improvement. Thus far, we have implemented the resident bundle, including standardized orders, an admission questionnaire, and a discharge checklist. Measurement
15. RESIDENT LEADERSHIP AT NEONATAL RESUSCITATIONS (RESEARCH ABSTRACT)

Andrew Z. Heling, MD, Wayne A. Price, MD, Kenya McNeal-Trice, MD, Sofia R. Aliaga, MD, University of North Carolina Hospitals, Chapel Hill, NC

Background: A key goal of residency training is leading multidisciplinary teams in neonatal resuscitations. Resident competency in neonatal resuscitation program (NRP) and leadership skills may be compromised by insufficient exposure to neonatal resuscitation events. Objective: Describe patient and team characteristics of resident-attended neonatal delivery room resuscitation events at a level IV NICU. Design/Methods: We collected a longitudinal convenience sample of resident-attended neonatal resuscitations at UNC. Resuscitation videos were recorded; those for which intervention was not required were excluded. Patient characteristics were identified via chart review. Low risk and high risk deliveries were defined. An existing 3-phase curriculum during each NICU block encourages increasing resident autonomy at low risk deliveries. Residents receive 2 NRP-based programs each block, with each program signaling a transition between phases of resident autonomy. Results were analyzed via Chi-square test. Results: We analyzed 99 neonatal resuscitations (65 low risk and 34 high risk) involving residents. Patient and team characteristics are described for all deliveries (Table 1) and low risk deliveries (Table 2). Residents were identified as the initial team leader in 75% of low risk and 21% of high risk deliveries. Residents maintained leadership throughout 58% of low risk and 6% of high risk deliveries. Within NICU blocks, residents increasingly maintained leadership during low risk deliveries over time (phase 1: 19%, phase 2: 62%, phase 3: 79%). Within NICU blocks, experienced supervising providers (neonatal fellows and NPs) were present at fewer low risk deliveries over time (phase 1: 100%, phase 2: 81%, phase 3: 61%). Conclusions: Residents demonstrated increased autonomy at low risk deliveries over the course of a NICU block. Residents were offered no autonomy and limited leadership opportunities at high risk deliveries. To optimize resident competency in neonatal resuscitation, supplemental learning opportunities may be needed to augment existing neonatal resuscitation exposure, particularly high risk deliveries.

| Table 1: Patient characteristics for all resident-attended deliveries |
|------------------|------------------|------------------|
| Characteristics | Phase 1 (n=24) | Phase 2 (n=33) | Phase 3 (n=30) |
| GA, weeks | 38.3 (36.5-40.1) | 37.0 (36.3-39.1) | 39.1 (35.4-40.4) |
| BMI, grams | 2754 | 2757 | 2758 |
| Resuscitation length, min | 9.0 (1.4-16.4) | 6.2 (5.0-7.1) | 8.3 (7.0-12.4) |
| Resident leader at start* | 4.1 (0.0-8.0) | 4.0 (0.0-8.0) | 4.1 (0.0-8.0) |
| Resident leader at end | 5.0 (1.0-7.0) | 1.0 (0.0-2.0) | 1.0 (0.0-2.0) |

Data presented as median (IQR or n (%)). * Statistically significant difference between phases 1 and 3 (p<0.01, Chi-square test).

16. PHYS ED: PEDIATRIC INTERNS CURRICULUM FOR TECHNIQUES IN PHYSICAL EXAMINATION (DESCRIPTIVE ABSTRACT)

Fatima A. Dhaheri, MD, Aisha Barber, MD, Children’s National Medical Center, Washington, DC

Background: Inadequate physical examination (PE) skills in both faculty & residents have been reported. This is associated with a decline in bedside teaching rounds. Simply implementing residency education was not found to be adequate in improving PE skills. There is no standardized curriculum to teach PE skills & assess competency during residency despite it being a competency in ACGMEs milestone project. Design/Methods: A PE skills confidence survey was distributed to pediatric residents at Children’s National (CN). The PE skills are organ system based & adapted from University of British Columbia’s PE checklists that was modified by CN pediatric subspecialty content experts to determine skills most important for general pediatricians to be competent performing. The survey was distributed using red cap & responders remained anonymous. Results: 58% of all residents participated. There was an increase in confidence scores from interns compared with senior residents in some cases. For example, 44% of interns reported confidence with tympanic membrane exam compared with 86% of third year residents. For other skills, confidence scores were higher in interns compared with third year residents. For example 82% of interns reported confidence eliciting deep tendon reflexes compared with 45% of third year residents. There was also a decrease in confidence scores across all classes for some skills. For example, only 3% of overall cohort reported being confident locating the retina & optic disc. Conclusion(s): Our findings were consistent with prior studies & provided additional input regarding areas to focus on. Even though for many skills senior residents were more confident than interns, in some skills senior residents scored lower potentially due to awareness of their deficiencies. Other skills were associated with low scores across all classes suggesting overall deficiency in PE training. Using these needs assessment results, Phys Ed was developed. This longitudinal organ system based curriculum for interns is designed to provide a clear set of goal technical skills & opportunities for observed deliberate practice. PE sessions are facilitated at bedside by faculty at the start of every rotation followed by re-demonstration of skills by interns during rounds throughout the rotation. At the end of the academic year, Interns will undergo an observed skills clinical exam (OSCE) which will allow comparison to the senior residents who completed the OSCE without undergoing the curriculum. Results will be available in May 2017 for interpretation.
17. ACHIEVING CONSISTENT EXPECTATIONS AND EMPOWERING SENIOR RESIDENTS ON INPATIENT FAMILY-CENTERED ROUNDS (QI Abstract)
Erin E. King, MD, University of Minnesota, Minneapolis, MN, Heather Dahlquist, MD, Yale-New Haven Medical Center, New London, CT, Patricia Hickey, MD, University of Minnesota, Minneapolis, MN

**Background:** Inpatient rounding constitutes a major component of resident learning. At our tertiary care hospital, we encourage Family Centered Rounds (FCR) which increase patient and family satisfaction and provide opportunity for feedback and modeling leadership. Through observation and evaluation data, we note considerable variation in rounding expectations and the extent to which the senior resident is empowered to lead FCR. Our baseline data was collected using a tool created at MCW (SREA-21). Using this, we found the senior resident entered first 19%, felt empowered to lead 56%, the senior and attending discussed as colleagues 68%, and the attending directed eye contact to the senior 86% of the time. After sharing these findings, the group agreed upon the following three goals: setting clear expectations, senior resident empowerment, and in-room rounding. **Aim Statement:** There were two aims of our project. The first was to increase the % of rounding weeks where senior residents felt empowered as a leader from 56% to 75% within 6 months. The second was to encourage attending physicians to provide clear expectations to their team during 100% of their weeks on service. Balancing measures included evaluation of in versus out-of-room rounding and timing of FCR to aid future quality improvement. **Interventions:** Our intervention was a presentation to the hospitalist group on effective clinical teaching. This included information about ACGME recommendations, the history of FCR, current practice as observed, self-assessment tools, and introduction to rounding like a ninja (focusing on senior resident empowerment). During the data collection period, we provided an interim report on metrics, re-emphasized education, and goals of the intervention. **Measures:** We collected data over 6 months, using an adapted version of SREA-21. Chief residents, the associate director, and/or a trained observer collected data. Timing of each rounding encounter, rounding location (in- versus out-of-room), diversion of primary eye contact to the senior resident, senior speaking first, the senior adding teaching points, and whether the senior resident and attending discussed the case as colleagues were recorded. Senior residents were surveyed weekly regarding subjective feelings of empowerment and whether clear expectations were set by the attending. All responses were recorded in a shared, password-protected spreadsheet. **Results:** After the 6 months, the percent of rounding weeks senior residents felt empowered as a leader increased from 56% to 75%. Rounding expectations were provided to the learners 92-100% of the service weeks surveyed. We noted subjective and objective factors prolonging rounding encounters. Our group rounds longer than published average with FCR at an average of 14.47 minutes (range 2-43 min). Our group went ~30% faster when completing rounds inside the patient room. Results were shared with attending hospitalists in an online newsletter and a department meeting. **Conclusions and Next Steps:** Senior resident empowerment and establishing expectations for FCR are possible with minimal effort. Rounding consistency is achievable within a diverse group of inpatient hospitalists at a tertiary-care pediatric hospital, however we may have noted a Hawthorne Effect. The most significant factor leading to increased leadership was allowing the senior resident to respond first to the intern or student presentation. During our study, we also switched from phone to pager-based communication which improved senior resident participation. Next steps in this project include providing tips on rounding efficiency, implementing FCT best practice guidelines, and creating a “rounding coach” program.

18. A NOVEL APPROACH TO TRAINING PEDIATRICIAN-SCIENTISTS DURING INTERIM YEAR OF PEDIATRIC RESIDENCY TRAINING (DESCRIPTIVE ABSTRACT)
Audrea M. Burns, PhD, Jake A. Kushner, MD, Mark A. Ward, MD, Jordan S. Orange, MD, PhD, Baylor College of Medicine (Houston), Houston, TX

**Background:** It has been well established that the development of clinician scholars is most successful through continued mentorship, protected research time, and tailored didactic instruction throughout residency. To continue the support of research-oriented MD or MD/PhD students as they transition to intern year, the Baylor College of Medicine Pediatrician-Scientist Training and Development Program (PSTDP), a new track within the Department of Pediatrics, has created a tailored curriculum for residents interested in a career in academic pediatrics. **Objective:** To allow for uninterrupted development of research progress from medical school training, PSTDP residents complete a novel PSTDP mini rotation during the middle of intern year. The PSTDP rotation includes tailored didactic sessions for learning how to think of patients in a scientific manner through understanding the process of developing a clinical case report, professional writing seminars, understanding informed consent, tailored mentoring from established clinician-scholars around identifying unique patient cases and completing a capstone project of submitting a clinical case report manuscript for peer review. **Results:** As the track
matriculated its first residents in summer of 2015, early outcomes include four interns who have undergone intern year within the PSTDP track. Within one year of completion of the PSTDP rotation, 100% of PL-2 PSTDP residents (n=4) have a clinical case report manuscript in final draft anticipating submission within less than six months as verified through their assigned mentors and 25% (n= 4) have a published manuscript in a peer-reviewed academic journal. **Conclusion:** The PSTDP track at Baylor College of Medicine offers a novel mini rotation tailored for interns committed to the American Board of Pediatrics Integrated Research Pathway who have committed to a career as a pediatrician-scientist.

19. **TELEPHONE MANAGEMENT TRAINING BY PODCAST - LENGTH AND CONTENT CONSIDERATIONS** *(Descriptive Abstract)*  
**Michael J. Cosimini, MD, Juan Espinoza, MD, Children's Hospital of Los Angeles, Los Angeles, CA**  
**Background:** Podcasting is on the rise in graduate medical education. Some logistical guidance is available but evidence to support best practices in content creation and format is lacking.  
**Objective:** To evaluate whether an educational podcast could be well accepted by pediatric trainees and explore what length, format and delivery platform is most accepted.  
**Methods:** A 20-minute-long professional quality podcast on the topic of telephone management of cough was recorded and distributed to pediatric trainees. A survey was also created based on common issues discussed in the literature, and was distributed along with the podcast to assess format preferences. The podcast was distributed using Soundcloud and YouTube, both of which recorded the total number times the podcast was accessed, and the latter of which recorded what percentage of the podcast was played.  
**Results:** Twenty-one surveys were returned and the podcast was accessed a total of 60 times between the two platforms. Some (19%) reported 20 minutes was “a little too long” and most (81%) reported the length was “about right.” Objectively, most who listened past one minute listened to the entire podcast. There was a subtle difference at the 10-minute mark suggesting this may be the ideal length for some. One respondent specifically recommended 15 minutes as a maximum length. A dialog format was preferred over monolog (90%). Citation of current evidence (71%), use of personal anecdotes (57%), call samples (42%), examples of how to phrase questions or advice (43%) and use of humor (38%) were highlighted as desirable approaches. Multiple trainees requested summary points, either between sections or at the end. Itunes (75%) was the most used platform for those who already listened to podcasts, and one trainee requested a platform where 1.25 or 1.5x speed was available.  
**Conclusions:** Dialog format, use of personal anecdotes, citation of current evidence, and a length between 10-20 minutes may be good strategies in development of podcasts for graduate medical education.  

20. **OVERCOMING BARRIERS TO THE IMPLEMENTATION OF AN ACADEMIC HALF DAY** *(DESCRIPTIVE ABSTRACT)*  
**Amy C. Stier, MD, Emily S. Peterson, MD, Eyad Hanna, MD, Erin Howe, MD, Glenda Rabe, MD, University of Iowa Hospitals and Clinics, Iowa City, IA**  
**Background:** Residency programs must ensure that residents attend educational sessions while preserving patient care opportunities. Historically, most programs used morning report and noon conference formats. Many programs have transitioned to an academic half day model to improve attendance and enhance the perception of protected educational time, but data is lacking on the best approach to improve buy-in and ensure success.  
**Objective:** To identify barriers to implementing the academic half-day and overcome them in a yearlong transition, using continuous feedback from key stakeholders and a variety of educational methods.  
**Methods:** Our program underwent a comprehensive needs assessment using conference attendance data and surveys of residents and faculty. We reviewed the current literature and discussed conference structure with similar-sized programs in the region that have implemented the half-day effectively. We then scheduled 6 case-based sessions centered around ABP content, while specifics regarding session structure, patient care coverage, faculty involvement, and educational methods were adjusted after each session based on feedback. Implementation included frequent communication among key stakeholders to improve buy-in, using surveys from residents and faculty pre- and post-session, and debriefing after each session.  
**Results:** The needs assessment revealed a variety of stakeholder concerns, including clinical coverage barriers, format preferences, and content expectations. Surveys showed high buy-in, high value from residents, and less interruption in patient care than anticipated. Debriefing after each session allowed continued process improvement and adjustment of goals based on feedback. Each session generated further goals toward improving subsequent sessions.  
**Conclusion:** Our program used a needs assessment to identify potential barriers, both at other programs and locally, and planned a yearlong transition to mitigate barriers, improve stakeholder investment, and adapt to feedback, to make the transition successful. We intend to move forward with more academic half-day sessions in upcoming years.

21. **SURFBOARDS PROGRAM: AN INNOVATIVE MIXED METHODS COMPREHENSIVE PEDIATRIC RESIDENT BOARDS REVIEW CURRICULUM** *(DESCRIPTIVE ABSTRACT)*  
**Amanda J. Rogers, MD, Michael Weisgerber, MD, Medical College of Wisconsin Affiliated Hospitals, Milwaukee, WI, Jennifer Di Rocco, DO, University of Hawaii, Honolulu, HI, Sara Lauck, MD, Medical College of Wisconsin Affiliated Hospitals, Milwaukee, WI**  
**Background:** The Medical College of Wisconsin Pediatric Residency Program’s average General Pediatrics Certifying Examination (GPCE) first-time pass rate was below goal, at or below the national average. Our residency program created a comprehensive curriculum aimed at improving this rate.  
**Methods:** We began with a needs assessment survey to learn why some residents failed. We identified several factors: poor test taking skills, boards specific knowledge deficits, poor long term and end game preparation, and external factors. We then developed the SURFboards (Strategic Unified Regimen For passing the boards) program grounded in 3 guiding principles: 1) Focus on contributing factors, 2) Align with resources
22. INDIVIDUALIZED RESIDENT EDUCATION AND RESIDENCY TRACKS: EVALUATION AND OUTCOMES (RESEARCH ABSTRACT)

Jamie Librizzi, MD, Kelly Kelleher, MD, Phoenix Children’s Hospital, Phoenix, AZ, Ryan Bode, MD, Nationwide Children’s Hospital/Ohio State University, Columbus, OH

**Background:** The objectives of this study were to determine residents’ general feeling regarding the importance and availability of individualized resident education and report American Board of Pediatric (ABP) exam scores, scholarly production and ultimate career choice of residents participating in individualized tracks. **Methods:** Three graduating classes were studied 2012-2015 from a single, large pediatric residency program. Individualized track options during the study period included: ambulatory, hospitalist and specialty-based. Pediatric residents’ perceptions of an individualized education curriculum were collected via an anonymous survey. ABP exam scores, scholarly production and ultimate career choice were compared between residents who participated in a standard 3rd year curriculum and those who participated in an individualized track. Comparisons were performed using the Fisher exact and Kruskal-Wallis tests. **Results:** 80 pediatric residents responded to the survey (response rate 89%). The majority of residents felt there needed to be more flexibility and individualized education in residency and the availability of an individualized curriculum was important in their decision for choosing a residency program. 91.4% of residents felt an individualized educational curriculum would help them better prepare for their future career and 70% thought it would make them a more competitive applicant entering fellowship or practice. First time pass rate for the ABP exam was 78% for residents in the standard curriculum, 88% in the ambulatory track, 86% in the hospitalist track and 81% in the specialty track (p-value 0.82). Mean ABP scores were not statistically different between the individualized and standard tracks (p-value 0.75). Residents in the specialty track had the most scholarly production. **Conclusion:** Flexibility within a residency program and individualized curriculum is important to residents. Participating in an individualized track does not compromise a resident’s ability to pass the general ABP certifying exam. Scholarly production is increased for those participating in an individualized track.

**Table 1. Outcomes among residency tracks**

<table>
<thead>
<tr>
<th></th>
<th>Standard Curriculum (n=19)</th>
<th>Ambulatory-based Track (n=26)</th>
<th>Hospitalist-based Track (n=22)</th>
<th>Specialty-based Track (n=16)</th>
<th>P-value</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>ABP 1st time, N (%)</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pass</td>
<td>15 (78)</td>
<td>23 (88)</td>
<td>19 (86)</td>
<td>13 (81)</td>
<td>0.82</td>
</tr>
<tr>
<td>Fail</td>
<td>4 (21)</td>
<td>3 (12)</td>
<td>3 (14)</td>
<td>3 (19)</td>
<td></td>
</tr>
<tr>
<td><strong>ABP Exam score</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Mean (SD)</td>
<td>198 (19)</td>
<td>205 (23)</td>
<td>204 (17)</td>
<td>202 (21)</td>
<td>0.75</td>
</tr>
<tr>
<td>Median (IQR)</td>
<td>198 (180, 212)</td>
<td>199 (192, 219)</td>
<td>196 (177)</td>
<td>196 (182, 214)</td>
<td></td>
</tr>
<tr>
<td><strong>Scholarly Production</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No</td>
<td>17 (89)</td>
<td>24 (92)</td>
<td>18 (82)</td>
<td>9 (56)</td>
<td>0.03</td>
</tr>
<tr>
<td>Yes</td>
<td>2 (11)</td>
<td>2 (8)</td>
<td>4 (18)</td>
<td>7 (44)</td>
<td></td>
</tr>
<tr>
<td><strong>Career</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Outpatient Pediatrics</td>
<td>11 (58)</td>
<td>22 (85)</td>
<td>3 (14)</td>
<td>1 (6)</td>
<td>&lt;0.0001</td>
</tr>
<tr>
<td>Hospitalist</td>
<td>2 (11)</td>
<td>0 (0)</td>
<td>11 (50)</td>
<td>0 (0)</td>
<td></td>
</tr>
<tr>
<td>Subspecialty Fellowship</td>
<td>6 (32)</td>
<td>4 (15)</td>
<td>8 (36)</td>
<td>15 (94)</td>
<td></td>
</tr>
</tbody>
</table>

23. CREATING A CURRICULUM FOR A CERTIFICATE IN MEDICAL EDUCATION FOR PEDIATRIC RESIDENTS (DESCRIPTIVE ABSTRACT)

Karen A. Mangold, MD MEd, Sharon M. Unti, MD, Robyn Bockrath, MD, Zarina Dohadwala, MD, McGaw Medical Center of Northwestern University, Chicago, IL

**Background:** Residents interested in careers as clinician educators would benefit from additional training during residency to teach them to be educators and prepare them to navigate an academic career in medical education. The pediatric residency program at the McGaw Medical Center of Northwestern University developed a certificate program in medical education designed to allow residents to pursue career interests via electives and experiences over the 2nd and 3rd years of residency. **Objective:** Our aim was to design the curriculum and subsequent evaluation of a certificate program in Medical Education **Design/Methods:** We followed Kern’s 6-step approach to curricular development in medical education: 1. Problem identification and general needs assessment: Achieved via PubMed search using keywords medical education, residency, track, pathway and concentration and reviewing references in all relevant articles; 2. Targeted needs assessment: Achieved via focus groups and faculty interviews. 3. Goals and objectives; 4. Educational strategies; 5. Implementation; and 6. Evaluation and feedback. **Results:** General needs assessments: Fifteen articles were identified and reviewed for specific educational strategies: 1 with an internal medicine program with a track in medical education, 6 with tracks in rural health, research, global health and primary care, and 8 with Residents-As-Teacher curricula. Targeted needs assessment: Held 2 focus groups: 1) residency program leadership, and 2) with 8 interested residents. We also held individual interviews with 5 faculty members involved in medical education. Participants discussed the feasibility and desirability of various proposed strategies identified by the literature search. Focus groups developed goals and objectives and five main educational strategies: didactic sessions, elective months, teaching experiences with reflection and feedback, scholarly project and...
24. ENGAGING RESIDENTS IN DIAGNOSTIC REASONING BY CREATING A CHIEF RESIDENT CLINICAL PATHOLOGIC CONFERENCE (DESCRIPTIVE ABSTRACT)

Daniel J. Sklansky, MD, Brittnay J. Allen, MD, Sabrina M. Butteris, MD, University of Wisconsin, Madison, WI

**Background:** Increasing emphasis on guidelines and consultants to inform clinical decisions may discourage learner engagement in diagnostic reasoning. Clinical Pathologic Conference (CPC), a case-based teaching conference, was developed to demonstrate diagnostic reasoning. **Objective:** Create and evaluate a chief resident-run Grand Rounds CPC to model and encourage diagnostic reasoning. **Methods:** Following a visiting professorship by a faculty member from an institution with an existing CPC, we formed a CPC taskforce. We outlined key steps in CPC construction. (1) Case criteria: Presented at least 5 years ago; uncommon disease or unusual presentation; encourages differential diagnoses related to specific findings; test or imaging confirms the diagnosis. (2) Case acquisition: Solicit cases from faculty by providing criteria and select based on best fit. (3) Case writing: Condense case into 1-2 pages with history, exam, clinical course, and data to suggest one unifying diagnosis. (4) Vetting: Ask blinded faculty to work through draft and comment on presumed diagnosis, feasibility and learning value; edit or reject case. (5) Chief resident role: Give written case six weeks prior to CPC; faculty mentor assigned to assist chief in making a 45 minute presentation on his/her diagnostic reasoning process and conclusions. (6) Specialist role: Recruited to discuss the test or finding confirming the diagnosis. (7) Institutional engagement: Promote the event to faculty and learners; remind specific faculty; evaluate sessions for future improvement. **Results:** Attendance at Grand Rounds was 28% higher for CPCs. Evaluations revealed enthusiasm for the format, requests for more CPCs, and appreciation for exploring diagnostic reasoning. Participants agreed they could use the CPC as a platform to discuss diagnostic thinking in difficult cases (N=42, 29% met expectation, 71% exceeded expectation). **Conclusions:** Created a CPC program that engaged learners and faculty in the process of diagnostic reasoning. We will continue to evaluate and adjust our process to improve learner engagement.

25. SIMULATION-BASED TRAINING TO IMPROVE PEDIATRIC RESIDENTS’ COMMUNICATION WITH PATIENTS AND FAMILIES ABOUT DIAGNOSTIC AMBIGUITY (DESCRIPTIVE ABSTRACT)

Maren E. Olson, MD, MPH, University of Minnesota, Saint Paul, MN, Emily Borman-Shoap, MD, Andrew P. Olson, MD, University of Minnesota, Minneapolis, MN

**Background:** Clinical encounters that involve diagnostic ambiguity are prone to diagnostic error and communication challenges. We have built on our diagnostic error curriculum to include a focus on communication. Simulation-based training will be used to improve pediatric residents’ ability to communicate with families about medical decision making and diagnostic ambiguity, as well as to enlist families as partners in the diagnostic process. **Objective:** Residents will practice and receive feedback on their ability to communicate with families during times of diagnostic uncertainty in order to improve their skills in engaging families in the diagnostic process. **Methods:** After a small pilot for validation, second year pediatric residents will participate in a simulation-based training. We will evaluate residents’ performance using an initial simulation workshop. Residents will be rated using a modification of Kalamazoo Communication Checklist as well as 3 pediatric milestones (ICS 1, ICS 2, and PROF 6). Residents will receive immediate feedback after each simulation as well as a debriefing session for reflection and skill-building. A second workshop will occur 6 months later. **Results:** We piloted our simulation cases with six residents to test the feasibility and validate our modifications to the rating checklist. Overall, mean scores ranged from 2.89 to 3.51 on a 5 point behaviorally anchored scale (with 1=did not attempt and 5=could teach others.). Inter-rater reliability was good overall at 0.633 with individual questions ranging from 0.298-0.898, compared with previous analysis of the non-modified checklist of 0.83 with individual questions ranging from 0.527-0.8. **Conclusion:** Our pilot showed that there is substantial room for improvement in residents’ skills in communicating about the diagnostic process and ambiguity. Our modified tool has good inter-rater reliability. We hypothesize that simulation-based training will be an effective tool to improve pediatric residents’ ability to discuss diagnostic ambiguity with patients and families.

26. DESIGN AND IMPLEMENTATION OF AN INNOVATIVE RESIDENTS-AS-TEACHERS LONGITUDINAL CURRICULUM FOR PEDIATRIC RESIDENTS (DESCRIPTIVE ABSTRACT)

Robert J. Casey, MD, Tyler E. Reimschisel, MD, Tara Minor, MAT, Vanderbilt University, Nashville, TN

**Background:** There is a strong interest among residents for formal instruction in medical education. To address this need, we developed the Residents-as-Teachers Longitudinal curriculum (RATL) that provides a robust educational experience for self-selected residents who have a desire to make medical education a significant component of their careers. **Methods:** RATL’s goal is to develop residents’ skills as educators by exposing them to primary education literature, providing teaching opportunities with structured feedback, and establishing mentorship for curriculum development. This is accomplished through monthly
In this study we measured the efficacy of RATL by comparing anonymous pre- and post-participation survey results. **Results and Discussion:** Seven second-year and 1 third-year resident completed RATL during the 2015-2016 academic year. Fifty percent of the residents were women. Attendance at the monthly meetings included 4 to 8 residents, a chief resident, a program director, and an educationalist. At the end of RATL, residents felt significantly more comfortable teaching in large (73% increase in strongly agree and agree responses) and small groups (28.7%), in an ambulatory setting (46.4%), as well as teaching a skill (46.4%). They felt more comfortable teaching both medical students (78%) and residents (71.4%). One hundred percent of residents felt they had been exposed to the skills necessary to improve their teaching, as compared to 25% prior to participation. Based on our results, residents who participated in RATL felt that their ability to teach in multiple settings improved.

**27. USING COMPUTER-ASSISTED LEARNING IN PEDIATRICS PROGRAM (CLIPP) CASES FOR A LONGITUDINAL RESIDENTS-AS-TEACHERS PROGRAM (DESCRIPTIVE ABSTRACT)**

**Danielle Walker, MD, Brian Pomeroy, MD, Tammy Camp, MD, Lesley Mothereal, MD, Elisabeth Conser, MD, Lara Johnson, MD, MHS, Texas Tech University (Lubbock), Lubbock, TX**

**Background:** Residency programs require training for residents to develop teaching skills, but few design formal methods to emphasize practical application. Our novel longitudinal program aimed to enhance teaching via mentor-led deliberate practice. Residents used Computer-assisted Learning In Pediatrics Program (CLIPP) cases, determined the instructional strategy, and delivered the content to pediatric clerkship groups six times per year while observed by faculty mentors. At the end of each session, residents reviewed student ratings and comments with a mentor. Strategies to improve the presentation were discussed and implemented with the next clerkship group. **Objective:** Our objective was to determine whether resident teaching skills improved during a longitudinal mentored teaching program. **Methods:** For academic years 2013-2016, we utilized student assessments that graded presentation quality and overall impression on a six-point Likert scale. We pooled all PL1s, PL2s and PL3s to develop descriptive statistics for each resident level over the study period. Using the Wilcoxon Signed Rank test, we compared average assessments of the resident cohorts. **Results:** We analyzed data from three different resident classes. For one class, student assessments of overall presentation quality increased from 5.28 to 5.56 (p=0.007) from the PL2 to PL3 year. Another class had no significant difference across years with averages of 5.72 in the PL1 year and 5.66 in the PL2 year (p=0.21). For a class with all three years of data, the average improved from 5.4 in the PL1 year to 5.58 in the PL3 year (p<0.001). This group improved the most from the PL1 to PL2 year (5.4 to 5.87, p<0.001) with some decline from the PL2 to PL3 year (5.87 to 5.58, p=0.001).

**Conclusion:** We observed significant intra-group variation in student assessment of resident teaching performance. Most groups improved during mentored teaching. Future efforts should focus on analysis at the level of the individual resident.

**28. UNITED STATES PEDIATRIC RESIDENTS’ COMFORT AND KNOWLEDGE LEVEL WITH AUTISM SPECTRUM DISORDER: A SURVEY BASED STUDY (RESEARCH ABSTRACT)**

**Katherine Myers, DO MPH, Case Western Reserve University/University Hospital Case Medical Center/Rainbow Babies, Cleveland, OH, Charina Reyes, MD, University of Maryland, Baltimore, MD, Steven Lewis, MS, MBA, Case Western Reserve University (MetroHealth), Nancy Roizen, MD, Case Western Reserve University/University Hospital Case Medical Center/Rainbow Babies, Cleveland, OH**

**Purpose:** The purpose of the study is to determine current US pediatric residents’ exposure to, as well as knowledge and comfort level providing appropriate medical care to patients with autism spectrum disorder (ASD). **Methods:** This national survey consisted of US pediatric residents completing an investigator-designed questionnaire in spring 2016 on their comfort level and knowledge of autism based on the American Board of Pediatrics content specifications for general pediatrics. The survey included questions involving residents’ knowledge and comfort level managing children with autism. Comfort level was measured using a 4-item scale for ASD, which demonstrated good reliability (Cronbach’s alpha 0.82). **Results:** A total of 1700 US-based pediatric residents completed the survey. 38.2% of respondents were in their first year of training, 31.3% second year, 24.8% third year, and 5.8% were either chief residents or 4th year residents. 44.6% reported plans to go into primary care, while the remainder reported interest in pursuing subspecialties. Multiple linear regression revealed that more educational opportunities for ASD, increased residency training level, and higher numbers of patients with ASD seen were all associated with increased comfort level in managing ASD (all p<.001). No significant difference was noted in the comfort level or knowledge of those who were going into primary care versus specialty care, program size, or program type. Of respondents in their final year of residency, only 66% reported that their training program prepared them well for managing patients with ASD. **Conclusion:** A significant proportion of pediatric residents in their final year of training reported that their residency did not prepare them well for managing ASD. Increased educational opportunities and patient exposure in residency were associated with improved comfort level in managing children with ASD. These findings suggest increased educational and clinical experiences surrounding ASD during residency may increase the comfort level of pediatric residents managing patients with ASD.

**29. DECODING THE ALPHABET SOUP OF WASHINGTON: EMPOWERING PEDIATRIC RESIDENTS TO ENVISION THEMSELVES AS POLITICAL ACTORS (DESCRIPTIVE ABSTRACT)**

**Anna Weiss, MD Msc, Angela Castellanos, MD, Anne Sullivan, MD, Rebecca Green, MD, Maire Conrad, MD, Jane Nathanson, MD, Beth Rezet, MD, Children’s Hospital of Philadelphia, Philadelphia, PA**

The ACGME mandates that pediatrics residencies provide curricula introducing the core principals of advocacy and community pediatrics. Few programs include specific training for residents seeking to understand their place in the
governmental and the non-governmental agencies responsible for crafting healthcare policy. No data exists exploring pediatric residents’ understanding of civics as it pertains to the career of a pediatrician. This study aimed to assess pediatric residents’ attitudes toward and preparedness for civic engagement after residency training. We solicited and compared responses from all pediatric residents at our Children’s hospital during two general election cycles. Data was collected via electronic survey during the fall of 2012 and 2016. 92 residents responded to our survey in 2012; 96 responded in 2016. Few residents reported confidence in their own understanding of the healthcare policy-making roles of legislative committees (21.2%), federal agencies (20.6%), and NGOs (17.5%), despite the majority (78.5%) reporting that they felt it was important for pediatricians to possess this understanding. In 2012, 36.9% of residents felt it was important for pediatricians to be actively engaged in the work of healthcare policy-making bodies, while in the 2016 election cycle, 78.2% felt similarly (p < 0.001). In 2012, 29.3% of residents anticipated spending at least 20% of their future career engaged in healthcare policy, while in 2016, that number increased to 59.4% (p < 0.001). In an uncertain political climate, pediatric trainees increasingly envision themselves as actors on the healthcare policy stage. While they consider it important for pediatricians to understand the details of healthcare-policy formation, residents report a significant lack of confidence in their own knowledge of the organizations that shape healthcare in the United States. This data highlights an opportunity for training programs across the country to enhance their curricula to prepare trainees for leadership in advocacy at the local and national levels.

30. IMPACT OF A NOVEL DIRECT OBSERVATION OF TEACHING EVALUATION (DOTE) ON FEEDBACK FOR RESIDENTS-AS-TEACHERS (DESCRIPTIVE ABSTRACT)
Sarah C. Isbey, MD, Justin Lockwood, MD, Colin J. Sallee, MD, Leonard Seltz, MD, University of Colorado, Aurora, CO

Background: Educating fellow learners is an ACGME core competency for residency programs, yet residents seldom receive quality feedback about their teaching. The DOTE was created to provide personalized, directed feedback about teaching strengths and areas for improvement, replacing a numeric grading system with infrequent comments previously used only after formal conferences. Methods: The DOTE was implemented in Aug 2015. Resident and faculty learners can access it through the residency’s online learning management system and complete it for any resident teaching context. Completion requests are also assigned by chief residents after resident-led noon conferences. Rates of completion were followed for 15 months. A pre/post implementation survey questionnaire (4-point Likert scale) was sent to all residents (n=92) at the beginning and end of the 2015/16 academic year to assess perceptions of feedback about teaching skills. Chi-squared was used to compare proportions of agree/strongly agree between pre/post groups. Results: Residents received 2.7 DOTEs/year on average; 68% of residents received e1 DOTE. Most (87%) addressed PowerPoint teaching. Survey response rates were 67% pre-DOTE (42% PGY1, 24% PGY2, 27% PGY3) and 49% post-DOTE (24% PGY1, 44% PGY2, 31% PGY3). Of post-DOTE responders, 38% had received e1 DOTE. Comparing responders who had received e1 DOTE to those who had not, 47% v. 54% felt they received timely feedback (p=0.7) while 71% v. 46% received useful feedback (p=0.1). The proportion of all responders reporting timely feedback pre/post increased from 26% to 51% (p<0.01) and useful feedback increased from 23% to 56% (p<0.01). Resident awareness of individual teaching strengths remained similar (65% v 75%, p=0.25) among all responders, while PGY1 awareness of teaching strengths increased from 54% to 81% (p<0.01). Conclusions: There was a trend toward improved perception of usefulness of feedback about resident teaching skills following DOTE implementation. More work is needed to increase use in informal teaching scenarios and evaluate the impact on learners.

31. P-VALUE: A NOVEL, RESIDENT-DRIVEN, INTERACTIVE EVIDENCE-BASED MEDICINE CURRICULUM INCREASES EBM KNOWLEDGE AND CONFIDENCE (RESEARCH ABSTRACT)
Thao Vu, MD, Brandon Alexander, DO, David Skey, MD, J. Gene Chen, MD, MHS, University of Florida (Orlando), Orlando, FL

Background: The Institute of Medicine and the Association of American Medical Colleges have called for improved training in Evidence-Based Medicine (EBM), and the ACGME has defined Practice-based Learning and Improvement as a core competency in pediatric medical education. Educators have created various EBM curricula for trainees with mixed results. In pediatrics, there is a relative paucity of literature on curricula and their effectiveness. We created a novel EBM curriculum called P-VALUE (Pediatric Validated Approach to Learning and Understanding EBM) for our pediatric residency. Objective: To evaluate the efficacy of P-VALUE using validated assessments of EBM knowledge. Methods: We designed P-VALUE to be interactive, driven by residents, and moderated by faculty. Pre-assigned groups of 3 residents presented monthly conferences in which they formulated a clinical question, selected and appraised a single article, presented a short overview, and facilitated group discussions. Conferences were moderated by faculty who were EBM and content experts. This study was a pre-post intervention study. Before and after undergoing the curriculum for one academic year, residents completed the Berlin Questionnaire and Assessing Competency in EBM (ACE) tool, two validated objective tests of EBM knowledge based on pre-written clinical scenarios. Data were collected in July 2015 and July 2016 and were compared within-group. Results: 23 residents (14 PGY1s, 9 PGY2s) completed the study. On the Berlin Questionnaire, the mean pre-intervention score was 63%, and the mean post-intervention score was 76% (difference 13%, p < 0.001). On the ACE tool, the mean pre-intervention score was 64% and the mean post-intervention score was 67% (difference 3%, p = 0.27). On a 5-point Likert scale, residents rated their agreement with receiving adequate EBM education in medical school at a mean of 2.8 (neutral). They rated their ability to appraise articles for validity and clinical significance at a mean of 2.8 pre-intervention and 3.2 post-intervention (difference 0.4, p = 0.03). Conclusions: Among pediatric residents, our resident-driven EBM curriculum increases EBM knowledge and confidence in appraising articles.
33. BOARDREVIEW: A QI PROJECT TO IMPROVE RESIDENT SATISFACTION AND PARTICIPATION IN PEDIATRIC BOARD EXAMINATION REVIEW (QI ABSTRACT)
Natan Cramer, MD, Natalie Shwaish, MD, Sean Elliott, MD, Hillary Franke, MD, MS, Rachel Cramton, MD, Jasna Seserinac, MD, University of Arizona, Tucson, AZ

Background: If you look at residents walking through hospital hallways, it is clear that technology is pervasive. Surveys such as the 2010 Kaiser Family Foundation highlight this, showing youth are exposed to digital technology for a staggering 7.5 hours of the day. As remote network access improves, portable devices such as smartphones are becoming more integrative. This continual improvement and accessibility of technology, combined with the massive amount of time spent “plugged in”, offer great potential for educators to reach modern learners. Some studies have evaluated the use of social networking sites for educational purposes with positive results. We sought to apply this trend to our group of pediatric residents to increase satisfaction with and participation in pediatric board examination review, as our previous didactic presentation format was not meeting the needs of the millennial learners. Aim Statement: We planned to increase overall satisfaction with board review and to increase participation by experimenting with various dispensation modalities. Interventions: For our first PDSA cycle, board review was changed from a periodic presentation format during scheduled didactic sessions to a daily review question that was distributed digitally via text or email. To increase motivation to participate, residents responded as teams that were based on their clinical assignment. Each month, the team with the most responses won a prize. After 3 months, a survey was distributed to evaluate the change. For our second PDSA cycle, the modality of distribution of the review question was changed to daily postings on a closed Facebook group, which automatically incorporated the questions into each resident’s personal news feed. The competition component was eliminated. Initial feedback was again solicited via survey. Measures: We used serial PDSA cycles to test the change to a digital daily format for board review. We used multiple surveys through the website Survey Monkey to evaluate our changes. Also, Facebook reports the number of “views” for each posted question, allowing for quantitative results for the number of residents who accessed each question. Results: Average resident perception of value increased with each modality change (Figure 1). Additionally, for each modality change, at least half of the residents that responded reported an increase in board review participation (Figure 2). Overall, the proportion of residents recalling participation in 10-20 questions per month increased from 36% to 41% (Figure 3). The number of views of Facebook questions average 40.2, which is 63.8% of our residents. Conclusions and Next Steps: For our group of residents, daily board review that could be accessed digitally at any time or location was more valuable than a traditional presentation format. Furthermore, integrating board review into social media increased both perceived educational value and subjectively reported number of questions participated in per month. Next steps include evaluation of the barriers to participation, assessment of in-training exam scores after implementing daily digital board review, and solidifying sustainability of the change through training for future chief residents.

Figure 1. Average Perceived Value of Board Review Modalities

<table>
<thead>
<tr>
<th>Modality</th>
<th>Average Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Presentation</td>
<td>2.50 (n=14)</td>
</tr>
<tr>
<td>Email/Text</td>
<td>2.80 (n=17)</td>
</tr>
<tr>
<td>Facebook</td>
<td>3.30 (n=17)</td>
</tr>
</tbody>
</table>

Figure 2. Did your participation in board review increase when dispensation was changed?

- from a daily email/txt format to the current Facebook group format?
  - No: 59%
  - Yes: 50%

- from a batched format to a daily email/txt format?
  - No: 59%
  - Yes: 50%

33. DESIGNING AND ASSESSING RESIDENT EDUCATION AND SERVICE (DARES): SURVEYING ATTENDANCE AND EVALUATION OF DIDACTIC CONFERENCES (DESCRIPTIVE ABSTRACT)
Kelsey A. Miller, MD, Elyse A. Portillo, MD, Camila A. Mateo, MD, Paul A. Critser, MD, Katherine A. Brunsberg, MD, Children’s Hospital/Boston Medical Center, Boston, MA

Background: The ACGME stipulates that pediatric residencies must deliver quality didactic education balanced with clinical responsibilities and that resident participation must be monitored. Objective: To develop a system to simultaneously track resident attendance at didactic lectures and quality of content delivery within a large pediatric residency program. Methods: We developed and implemented a daily web-based survey accessible via QR scanner or hyperlink. The survey was designed to measure: 1) individual resident attendance at didactic noon conferences, 2) the ability to stay for the entire conference, and 3) the quality of each didactic session on a 5-point scale. Results: Initial survey responses were predominately from interns (78%), who are the primary target of the noon conference curriculum. Of the 50 interns, 48 responded at least once (96%); only 45 of the 101 PGY2+ residents responded (45%). Eighty-one percent of respondents were able to stay for the entirety of the conferences they attended. The average lecture was scored at 4.6 (range: 2.75-5). To increase participation by non-interns, we revised the survey to allow respondents to indicate the inability or decision not to attend a conference. On the revised survey, there was an increased proportion of responses from non-PGY1 residents (51%). The majority of responding PGY2+ residents either could not attend (47%) or chose not to attend (11%) the conferences. With increased non-intern responses, the average lecture score remained 4.6 (range 3.25-5). However, participation remained an issue, with only 81 of 151 residents responding (54%), and 13 of those responding only once. Conclusion: Despite delivery of high quality didactic education, many trainees...
in this large pediatric residency were unable or elected not to attend the offered noon conference curriculum. However, tracking didactic attendance and quality is limited by resident participation. To address this, we are piloting a further refined survey incorporating resident feedback on ease-of-use and evaluation priorities to augment participation.

34. CREATING A SCHOOL HEALTH CURRICULUM (DESCRIPTIVE ABSTRACT)
Lauren Anderson, MD, Jillian Cotter, MD, Cheryl Yang, MD, Daniel Nicklas, MD, Mandy Allison, MD, University of Colorado, Aurora, CO

Background: School health (SH) refers to the physical, cognitive and emotional needs of a child that impact classroom performance. A needs assessment showed that our residents frequently serve as liaisons between patients and schools but feel poorly prepared for this role and desire formal SH training. Objective: Create a curriculum for residents to: 1) understand school accommodations available under federal law; 2) explain how to obtain accommodations to families; 3) communicate effectively with schools about patients’ medical, learning or psychosocial needs. Methods: We developed a 3-hour curriculum with 3 parts: 1) defining an individualized education program (IEP), individualized health plan and 504 plan, 2) IEP process, 3) school staff and communication. It is delivered to interns in an interactive, small group format, facilitated by a pediatrician, family navigator, school nurses and parents. Pre- and post-curriculum surveys assess SH knowledge and behavior via multiple-choice, Likert scales and free response questions. School medical forms and reflection assignments are completed prior to a feedback session. Results: 14 of 36 interns completed the curriculum. 21% of interns pre-curriculum vs 71% post-curriculum scored >90% on school accommodation questions. 0% pre-curriculum vs 80% post-curriculum scored >90% on school personnel questions. During post-curriculum feedback residents reported: 1) increased awareness of how medical diagnoses affect school; 2) increased discussions with families of children struggling in school to facilitate obtaining accommodations; 3) increased communication with schools via written correspondence. The multidisciplinary and interactive nature of the curriculum was identified as a key strength. Interns desired longer Q&A sessions with nurses and families to glean their insight. Conclusion: Results indicate that a curriculum can be implemented to improve resident clinical practice on SH issues. We plan to continue our curriculum and incorporate changes based on feedback. Future work will analyze curriculum effectiveness based on retained knowledge and long-term behavior change using a 6-month post-curriculum survey.

35. E-LEARNING IN PEDIATRICS: VIRTUAL PATIENT SCENARIOS (DESCRIPTIVE ABSTRACT)
Oloruntosin Adeyanju, MD, Katie Pestak, DO, Cecile Foshee, PhD, Cleveland Clinic Foundation, Cleveland, OH

Background: E-learning involves the use of electronic technologies such as Web 2.0 in education. It allows for standardization of learning materials, facilitates self-direction and self-pacing, and offers unlimited access to content. There is clear evidence that e-learning is at least as good as more traditional methods, and may be a useful adjunct for enhancing knowledge acquisition, bridging the gap between theory and practice, and improving clinical competencies. At the inception of this project, there was little application of this modality at our pediatric residency program. Objective: To create interactive cases which simulate real patient interactions, geared towards early pediatric trainees. The cases aim to illustrate and reinforce principles of evaluation and management of common pediatric conditions. Methods: Case topics were chosen from commonly encountered conditions, and aligned to the American Board of Pediatrics Content Outline for General Pediatrics. These virtual patient encounters presented trainees with history and physical exam findings, prompting them to make diagnostic and management decisions. Knowledge questions were embedded into each case to test learners’ grasp of the topic, and trainees received immediate feedback for their answers. Cases conclude with sources from the literature for further study. After each case learners are prompted to give feedback on both form and content. Cases were designed using Microsoft PowerPoint and the Office Mix add-on. Results: 2 completed cases are currently available to residents and medical students online. Initial feedback suggests that trainees enjoyed the interactive nature of the cases, and felt that the design helped them focus on the application of knowledge in clinical scenarios. Conclusions: E-Learning is a useful complement to bedside teaching in medical education. The use of interactive technology is a natural next step in case-based learning, and a promising application of blended learning in medical education. References Al-Shorbaji et al, WHO 2015. BMC Med Educ. 2014;14:17. J Med. Internet Res. 2016;18(1):e2.

36. DESIGNING AND EVALUATING A NOVEL RESIDENT-AS-EDUCATOR CURRICULUM (DESCRIPTIVE ABSTRACT)
Holly Hodges, MD, Alexander Hirsch, MD, Carolyn Marcus, MD, Kelsey Miller, MD, Zeena Audi, MD, Catherine Michelson, MD, MMSc, Children’s Hospital/Boston Medical Center, Boston, MA

Background: Residents play a major role in medical education by teaching, supervising, and providing feedback to other learners. Residents often report a lack of comfort with these skills, and tools to develop them can be difficult to deliver. Objective: To design, implement and assess a novel resident-as-educator curriculum aiming to improve residents’ comfort and confidence in teaching, supervising, and feedback skills. Design/Methods: A 2-week rotation was designed and implemented in June 2016. At the start, participants watch original videos on learning theory, teaching, supervision, and feedback. During the rotation, they present formal and informal didactics, lead physical exam rounds, precept students, observe senior residents supervise, and give feedback to learners. Faculty mentors guide, observe and give feedback throughout. Teaching activities are repeated at 2 separate hospitals to promote deliberate practice and immediate feedback incorporation. Learners scan a QR code on their mobile devices to generate online feedback for the participant. Technology allows for recording of teaching and feedback for later review. A Supervisor Future Contract is generated for reflection on supervisory skills participants hope to incorporate into their practice. Participants complete pre- and post-rotation surveys to assess confidence and comfort with their skills, using 10-point Likert scales, and attitudes about the block. Descriptive statistics were used to analyze results to date. Further analysis is planned as the rotation continues. Results: 6 months after initiation, 13 residents have completed the pre-rotation survey, and 9 have completed...
37. BACK TO OSLER’S “SEA” - RETURNING RESIDENTS TO THE BEDSIDE (DESCRIPTIVE ABSTRACT)
Marissa J. Orenstein, MD, George Dalembert, MD, Children’s Hospital of Philadelphia, Philadelphia, PA, Nicole A. Hames, MD, Emory University, Atlanta, GA, Rebecca Tenny-Soeiro, MD, Children’s Hospital of Philadelphia, Dorene F. Balmer, PhD, Lisa B. Zaoutis, MD, Children’s Hospital of Philadelphia, Philadelphia, PA

**Background:** Osler said, “He who studies medicine without books sails an uncharted sea, but he who studies medicine without patients does not go to sea at all.” Bedside teaching has declined from 75% in the 1960s to <20% of clinical training. In a recent review and in discussion with residents at a large, urban academic medical center, notable barriers include time constraints, declining bedside skill of instructors, varied experiences with attendings and a perceived burden on patients. **Design/Methods:** Using Kern et al’s 6 step approach to curriculum development, we conducted a needs assessment and established learning objectives for each of four 1-hour subspecialty bedside teaching sessions (cardiology, neurology, pulmonology, dermatology) led by master clinicians for pediatric interns. The curriculum was designed to facilitate intern participation and to encourage attending feedback on exam techniques and report of findings. We evaluated the curriculum by administering unique surveys to residents and master clinicians at the conclusion of each session and the 4 week program. Feedback was incorporated in a rapid cycle improvement approach. **Results:** The curriculum was developed and implemented for the 2016-2017 academic year. In the evaluations, residents reported receiving effective feedback on exam skills, intended application of pearls learned in the sessions, and belief that bedside teaching sessions were important to their training. Both master clinicians and residents reported improved performance of exam skills. Based on evaluation data and direct feedback, barriers to curricular implementation were finding times amenable to patients and instructor schedules. Additionally, instructors were asked to compare more than one patient and to encourage critical thinking. **Conclusions:** Bedside teaching sessions were positively regarded by residents and master clinicians and may improve exam skills. Next steps include identifying opportunities to integrate similar teaching sessions throughout the resident curriculum, development of best practices that can be shared with all faculty members, and assessment of actual skill improvement.

38. THE INFLUENCE OF COMPREHENSIVE CARE COORDINATION ON PATIENTS WITH SPECIAL HEALTH CARE NEEDS IN A COMMUNITY PEDIATRIC RESIDENCY CONTINUITY CLINIC (DESCRIPTIVE ABSTRACT)
Erica Owchar, MD, Josh Baker, DO, University of Illinois College of Medicine at Peoria, Zohra Moeneuddin, MD, Not Affiliated with Program/Institution listed above, Caroline Kim-Kuper, MD, MPH, University of Illinois College of Medicine at Peoria, Amy Duffield, LCSW, Crystal Coan, MA, MBA, Kristin Crawford, MBA, Not Affiliated with Program/Institution listed above, Thomas Santoro, MD, University of Illinois College of Medicine at Peoria, Peoria, IL

**Background:** The prevalence of chronic diseases among children has increased. Pediatric residents/providers must be more prepared to care for an increasing number of children with special health care needs (CSHCN) via team based care coordination. Method: Prospective intervention in which CSHCN patients were identified from 2 resident PCP continuity panels. Patients were eligible with a score greater than 2 on the CSHCN Screener, with 27 patients enrolled. Interventions included extended appointment (appt) times (initial 1 hour, subsequent 40 mins) with team, personalized care coordination binder, direct phone access to social worker, and monthly team meetings to discuss patients. Team included resident PCP, Attending, RN, and social worker. Measurements were number of continuity clinic appts with PCP, number of missed appts, subspecialty appts, hospitalizations, ED/urgent care visits, and patient satisfaction. The patients served as their own historical controls and retrospective data was collected for a 6 and 12 month period prior to the study. **Results:** The number of office visits with resident PCP improved by 15% post intervention. The number of missed patient appts at the continuity clinic (pre 23%; post 24%) was unchanged, while the number of subspecialty appts decreased (pre 29%; post 23%). ED/urgent care visits decreased by 45% (28 pre-intervention visits vs 16 post-visits). Number of hospitalizations for patients was unchanged. **Conclusion:** The highest impact of the interventions of comprehensive coordination on CSHCN was on patient/PCP continuity. Given time constraints of a resident clinic, continuity may be difficult to achieve for children who need frequent appts. Team based care, with social work contact may have attributed to this increase. Patients were given expanded appt times to address their chronic medical and social concerns, possibly improving trust, ultimately increasing compliance. ED/urgent care use was reduced, supporting an argument that improving access to care may decrease healthcare costs for CSHCN.

39. A SPACED-PRACTICE MOBILE PLATFORM FOR PEDIATRIC RESIDENT BOARD REVIEW PRACTICE (DESCRIPTIVE ABSTRACT)
Cameron J. Escovedo, MD, Suzanne Cambou, MD; Jean Hwang, MD; Jasen Liu, MD; James Lee, MD; Armen Carapetian, MBA; Shannon Thyne, MD, Alan Chin, MD, UCLA Medical Center, Los Angeles, CA

**Background:** Multiple-choice question practice is crucial for resident preparation of both in-training and board examinations. Resident-identified barriers to accessing popular online question banks include multiple log-in steps and limited mobile accessibility. We found that our residents use these questions for “cramming”, which ultimately causes poor long-term retention. The spacing effect says that despite an equal amount of cumulative study time, distribution of testing sessions over weeks to months results in superior long-term retention and overall knowledge gains. This mobile platform both utilizes the spacing effect and sends questions directly via e-mail, thereby preventing any online access issues. **Objective:** We aim to evaluate the effect of the post-rotation survey. 100% recommend the rotation to peers. Mean scores in comfort and confidence increased in all areas (supervision, teaching, feedback) with largest gains in confidence teaching and comfort providing feedback. **Conclusions:** Early assessment of a novel resident-as-educator curriculum leveraging mentorship, technology, deliberate practice, feedback and reflection suggests improvement in resident comfort and confidence in teaching, supervising and feedback skills.
delivering multiple-choice practice questions via the spaced-practice mobile platform on the rate of question usage. Methods: In October 2016, the platform started sending 2 questions via e-mail to all UCLA pediatric residents every other day. The questions were from a well-known online question bank used by our residents prior to this study. For each PGY, we compared the rate per month of questions answered before and after platform implementation. We used a student’s t-test to compare pre and post-intervention mean rates of each cohort. Results: The mean rate of questions answered per month increased for PGY1 from 3.5 to 4.9 (p = 0.26), PGY2 from 6.8 to 7.2 (p = 0.79), and PGY3 from 6.5 to 7.8 (p = 0.52). Conclusions: While the increases are not statistically significant, the standard deviations decreased profoundly, suggesting that a greater proportion of residents are answering questions. In fact, 15 of 53 PGY2 and PGY3 (28.3%) only started answering questions after the implementation of the platform. Another 10 upperclassmen (18.9%) had rates that decreased by >50%, likely because they had already answered >90% of the question bank prior to the intervention. Lastly, limiting the platform to 2 questions every other day effectively caps the rate at ~30 questions per month, which would affect the mean rates negatively. Therefore, the platform technologically simplifies spaced-repetition, encourages usage, and allows advisors to evaluate the needs of their residents.

40. HIGH RELIABILITY TEAM TRAINING FOR CRITICAL PATIENT SAFETY EVENTS IN THE PEDIATRIC INTENSIVE CARE UNIT: AN ADVANCED FELLOW SIMULATION CURRICULUM (DESCRIPTIVE ABSTRACT)

Ben D. Albert, MD, Nilesh M. Mehta, MD, Meredith van der Velden, MD, Children’s Hospital/Boston Medical Center, Boston, MA

Background: Highly reliable healthcare organizations design systems to anticipate early failures in patient safety. Focused safety training using simulation might increase exposure to high-risk/low-frequency events to minimize cognitive bias and develop critical reasoning skills in frontline providers. Objective: We aimed to incorporate a simulation-based High Reliability Team (HRT) training curriculum for pediatric critical care trainees to improve knowledge, timely recognition, and critical thinking around high-risk events in the pediatric intensive care unit (PICU). Methods: A novel HRT training curriculum was designed for a large fellowship training program using high-fidelity medical simulation. Each scenario re-created a recent event that was associated with patient deterioration or a near-miss. The events were selected based on the need for high level critical thinking skills. Scenarios included emergent need for ventricular decompression in a neurosurgical patient, laryngospasm in a patient with myocardial failure, and local anesthetic toxicity. Debriefing after simulation was focused on pathophysiology and ICU systems thinking, as well as specific cognitive behavior and biases. Results: During the 2015-2016 academic year, 16 pediatric critical care fellows participated in 15 HRT simulation sessions that exposed the trainees to 10 unique clinical scenarios. Each simulation session had 3-4 fellows per simulation; which was facilitated by the Program Director. The scenarios were rotated for equal exposure among participating fellows. Preliminary data by post-simulation fellow evaluation survey shows a perceived increase in recognition of changes in patient condition requiring critical thinking skills. Conclusion: We describe an advanced HRT simulation curriculum that might increase critical care fellow exposure to real-life events they otherwise may not experience during their training. Future work includes assessing the impact of this intervention on knowledge retention, improvement in managing such events, and eventually, improving patient outcomes.

41. DEVELOPMENT OF A LONGITUDINAL CURRICULUM FOR A RESIDENCY MEDICAL EDUCATION TRACK (DESCRIPTIVE ABSTRACT)

Abdelazis Farhat, MD, Caren Gellin, MD, Rita Dadiz, DO, University of Rochester, Rochester, NY

Background: Many physicians are involved in educating trainees, peers, and other health professionals. There is little to no evidence in the literature of a structured approach for developing educators during residency training. We aimed to develop a dedicated Medical Education Track to improve the effectiveness of pediatric residents as teachers by improving their foundational knowledge, skills, and attitudes in education, as well as by increasing their opportunities to teach with structured feedback from a clinician educator. Methods: The curriculum for this track was developed over the course of 2016. Pediatric residents in the Medical Education Track have dedicated time of two 2-week blocks and approximately 30 afternoons per year during their second and third years. Residents learn educational theory and teaching skills through didactics and a menu of teaching opportunities. Didactics include utilization of fellowship training sessions and faculty development workshops that already exist at the medical center. Teaching opportunities include educational activities for medical students and residents that employ small group facilitation in flipped classrooms, problem-based learning, lectures, bedside teaching, medical student precepting, and simulation training sessions. In addition, residents develop a medical education-focused project to apply knowledge of educational theory and teaching skills to teaching, curriculum development, and evaluation. Engagement in curriculum design and evaluation is accomplished by either developing a novel educational experience for the residency program or improving on an existing curriculum. All experiences incorporate evaluation opportunities through self-assessment as well as feedback from learners and supervising clinician educators. The program directors support the overall track curriculum, and faculty members with expertise in education serve as mentors for medical education projects. Residents present their educational projects at local, regional, and/or national conferences. Residents also develop an educational portfolio. Outcomes: We surveyed resident attitudes towards the idea prior to development of the curriculum. We plan to evaluate the effectiveness of the Medical Education Track by monitoring longitudinal changes in resident teaching skills and attitudes through self, learner, and mentor evaluations. Progress will be tracked over the 2-year duration for each resident. Over time, evaluation of the track will include the number of participants, participant experience, curricular changes in the residency program, alumni leadership in the educational field, and recruitment patterns to our residency program. Conclusions: Through creation of a medical education experience focused on postgraduate medical learners, interested residents acquire basic knowledge, attitudes, and skills to nurture their early development as educators. Utilizing existing modalities for providing foundational knowledge and teaching opportunities is important in the feasibility and sustainability of the curriculum’s development and implementation.
42. THE HOUSESTAFF HUNT: A MODEL FOR INCORPORATING ADULT LEARNING THEORY (DESCRIPTIVE ABSTRACT)

Chase W. Shutak, MD MPH, Dana Irrer, MD, Garrett Jones, MD, Elizabeth Mann, MD, Emily Borman-Shoap, MD, University of Minnesota, Minneapolis, MN

Background: Our pediatric residency began a Hospitalist Curriculum morning report series in 2013. The curriculum reviewed guidelines for common causes of pediatric hospitalization. The original sessions were case presentations with didactic review. Though the content was meaningful, resident engagement was low. Via Kern’s approach to curriculum development and cognitiveist educational theory, we used prior feedback to reshape our approach. Objective: Restructure the Hospitalist Curriculum to engage housestaff with short, active, and relevant education. Our goal was to move learners higher in Miller’s Pyramid from simply knowing about guidelines to showing how they would use guidelines. Methods: To transform the Hospitalist Curriculum through adult learning theory, we designed a new structure—the Housestaff Hunt—that maintained the 30-minute format (short). We re-structured sessions to begin with a board-question that introduced the topic. Housestaff were split into teams to complete a worksheet that reviewed an evidence-based practice guideline. Teams used electronic resources to find pertinent guidelines and evidence. Answers were reported back to all housestaff with concurrent visual slides (active).

Sessions concluded by using the reviewed material to answer the board-question (relevant). Qualitative feedback was sought regarding the quality and interactivity of the structure. Results: We converted 6 of the 8 Hospitalist Curriculum lectures into the revised Housestaff Hunt. The new model’s structural changes led to increased engagement with positive feedback from residents regarding the sessions’ length, interactivity, and relevance. Conclusion: Restructuring our Hospitalist Curriculum into the novel Housestaff Hunt improved resident engagement while teaching the same material. The new design implemented adult learning theory’s emphasis on short, active, and relevant education. We have made the Housestaff Hunt available as open-source for other programs via this link (http://tinyurl.com/housestaffhuntumn), which includes prior and revised curricula and presentations, worksheets, and facilitator guides.

43. REACH OUT AND READ AS AN INPATIENT EDUCATIONAL INTERVENTION (RESEARCH ABSTRACT)

Colleen K. Gutman, MD, Mollie Grow, MD, MPH, Emily Gallagher, MD, MPH, Emily Myers, MD, University of Washington, Seattle, WA

Background: Reach Out and Read (ROR) is an evidence-based primary care intervention in which providers give books to families, emphasizing the importance of shared reading. Many pediatric residents report a need for practical training in developmental assessment. Incorporating ROR into inpatient academic settings may support trainee education and promote childhood literacy. Objectives: (1) To evaluate an inpatient ROR program as a tool to teach residents and medical students child development; (2) To evaluate trainee and parent response to ROR in an inpatient setting. Methods: Residents on the Developmental Pediatrics rotation received didactics about typical child development, including instruction about using books as a tool for developmental observation. Residents then taught medical students on the pediatrics clerkship about developmental assessment using the ROR model. Residents observed and coached medical students as they provided books to inpatient families. Surveys using 5-point Likert scales were collected from residents, medical students, and participating caregivers. Results: Over 3 months, 12 residents, 17 medical students, and 12 families completed surveys. After participating, medical student perceived knowledge of developmental milestones in early childhood increased (at age 5 to 6 years: mean 2.7 at baseline vs. 4.0 at completion, P = 0.001) and they reported increased confidence in discussing developmental milestones with families (mean 3.1 vs. 3.9, P = 0.04) and in using books to promote child development (mean 3.4 vs 4.4, P = 0.01). Residents reported higher confidence in teaching medical students about childhood development at post-intervention (mean 3 vs 4.3, P = 0.0001) and reported they were more likely to talk about reading in clinic (3.6 vs 4.3, P = 0.04) and in the hospital (1.8 vs. 3.4, P < 0.0001). There was high satisfaction with the program and qualitative responses from trainees emphasized their positive experience and the educational value of this approach. Conclusions: ROR methods are a promising tool to promote literacy and educate trainees about early childhood development within the inpatient setting.

44. ASPIRE: A SCHOLARLY PROJECT INCUBATOR FOR RESIDENTS (DESCRIPTIVE ABSTRACT)

Elizabeth A. Mann, MD, Emily Borman-Shoap, MD, Bryce A. Binstadt, MD, Jeff A. Louie, MD, Michael B. Pitt, MD, University of Minnesota, Minneapolis, MN

Background: Promoting resident scholarship engages trainees in medical discovery early in training, expanding medical knowledge while inspiring new academicians. At our institution, we noted an opportunity to improve resident scholarship participation. Objective: Develop and implement a program to transform clinical curiosity into scholarly work, foster peer mentorship, and facilitate partnerships that promote shared scholarship. Methods: We created a two-part workshop series called ASPIRE, A Scholarly Project Incubator for Residents. The first session, We Should Write That Up, focused on basic scholarship concepts and case reports with residents discussing possible cases and receiving feedback. The second session, Project Brainstorm, highlighted three fields of scholarship: medical education, community engaged research, and basic-clinical research with each resident choosing one field and possible mentors prior to the session. After a brief primer by expert faculty, each group divided into teams of 3-5 residents to develop a scholarly project proposal. Teams used Robert Kegan’s Step-Back Consulting method from the Harvard Business School to critically appraise each other’s projects. Larger groups reconvened to talk about lessons learned and next steps before all participants were surveyed. Results: Nearly all respondents (51 of n=54, 94%) found the workshop useful in supporting career scholarship. The most useful aspects cited were the discrete steps forward and idea generation from the brainstorming session (21 of 54, 38.9%) followed by peer and mentor connections (10 of 54, 18.5%). Most residents generated a scholarly project from the session that they will consider continuing after the session (Definitely: 7 of 54, 13%, Maybe: 30 of 54, 55.6%). Discussion: Residents found the think-tank model of
46. AN ACADEMIC HALF-DAY FOR HEALTHCARE DISPARITIES AND SOCIAL JUSTICE (DESCRIPTIVE ABSTRACT)
Jason A. Yau, MD, Bindiya Bagga, MD, Michelle Bowden, MD, University of Tennessee, Memphis, TN
Background: Academic half-days (AHD's) have increased in use among residency programs. These discrete time periods allow for in-depth education of topics not explored elsewhere in training. Following national and local events highlighting ongoing social disparities and the influence of structural racism, we designed an AHD on healthcare disparities. Objective: Pilot and evaluate an AHD that educates residents on healthcare disparities and engages them in reflective discussion of their practice. Methods: Three goals were identified: 1) Review of the literature, 2) Personal reflection, and 3) Resident empowerment. A traditional lecture and moderated discussion reviewed the evidence. “Safe Space”, “Stereotype Threat”, and “False Dichotomies” were defined prior to dividing into small groups, where hypothetical cases were provided as reflection stimuli. Finally, residents returned to the large group setting and discussed the role of pediatricians in effecting change and social justice via implicit bias recognition. Feedback was obtained with our standard evaluation tool that includes qualitative and quantitative components. Results were compared with all sessions from the academic year. Results: The session received an average score of 4.0 for learning and 4.4 for interaction (on a Likert scale of 1-5, with 1 being least effective and 5 being most effective). The academic year’s previous evaluations (n=9) received an average of 4.0 (3.8-4.3) for learning and 4.1 (3.8-4.6) for interaction. We best met our goal of personal reflection (4.3) followed by empowerment (4.0) and evidence review (3.7). Qualitative feedback noted a desire for more discussion, local initiative examples, and personal practice improvements. Conclusion: We successfully piloted an AHD focused on healthcare disparities that can be used as a model for future sessions. Feedback indicated the need for more discussion time and practice tools. We have made this session’s structure available as an open-source for other programs via this link (http://tinyurl.com/umnhd), which includes learning objectives, discussion cases, evaluations, and resources.

47. IMPROVING HUMAN PAPILLOMA VIRUS VACCINATION RATES THROUGH RESIDENT EDUCATION: QUALITY IMPROVEMENT (QI) ABSTRACT
Chase W. Shutak, Emily Borman-Shoap, University of Minnesota, Minneapolis, MN
Background: Developing a group scholarship idea and receiving immediate peer feedback useful in providing discrete steps in scholarship with many planning to pursue their idea with mentors. We have provided a link to the materials used for the ASPIRE sessions including slides and worksheets for other institutions to modify (tiny.cc/ASPIREumn).

SAFETY/QI

46. AUGMENTING RESIDENT PULMONARY EDUCATION RELATED TO MANAGEMENT OF CHRONIC RESPIRATORY FAILURE THROUGH IMPLEMENTATION OF A TEXT MESSAGING CURRICULUM (RESEARCH ABSTRACT)
Hovig Artinian, MD, Thomas Keens, MD, Todd Chang, MD, Children’s Hospital of Los Angeles, Los Angeles, CA
Background: Spaced learning has been shown to prevent knowledge decay. Mobile technologies are ubiquitous and allow for distribution of content in manageable pieces over time that is learner-centered. Objective: To determine whether the use of text-messaging improves resident learner’s knowledge and confidence about chronic respiratory failure management. Methods: A formalized survey querying perceived knowledge gaps was sent to pediatric Residents at a large academic program from which the topic of chronic resident respiratory failure was chosen. Multiple choice knowledge questions were written, their face validity confirmed and each test item piloted to determine their item discrimination and Kuder-Richardson 20 reliability score (0.48). A prospective, randomized-control study using text-based content interaction as an intervention was employed. Subjects in the intervention arm received one scripted text-message scenario per day and if they responded, they received a scripted teaching text. Subjects in both arms completed a pre-test at the beginning of their four-week inpatient rotation and a post-test at the end. Given fixed sample size, effect size was calculated as 0.65 (Cohen’s d). Paired and unpaired T-tests were conducted to compare the changes in pre- and post-test scores in each group and delta (change in score between the groups). Results: 98% (N=27) of eligible residents agreed to participate (12 in intervention arm and 15 in control arm). Preliminary results demonstrate a decrease in post-test scores in both groups (Control group pre-test mean 56%, SD 14%; post-test mean 49%, SD 11%, p=0.016; Intervention group pre-test mean 64%, SD=14%, post-test mean 60%, SD 15%, p=0.374). The delta demonstrates (control M=−1.5, SD 2.1; intervention M=−0.9, SD=3.4). 88% of resident rated text-based learning as effective. Conclusion: Pediatric residents have shown high interest in participating in text-based learning and perceive it as effective. More subject participation will be required to demonstrate effect on knowledge.
Our study aims to identify drivers and barriers to reporting among pediatric residents at a tertiary care, academic institution to improve patient safety. Reporting data show that a minority of reports are made by physicians, which has been targeted for improvement both nationally & locally. Residents are front line providers, yet little is known about their reporting attitudes. Our study aims to identify drivers and barriers to reporting among pediatric residents at a tertiary care, academic institution to improve patient safety. 

Results: Pre-intervention vaccine initiation rates for 109 patients was 42%. Post-intervention average vaccine initiation rates were 62%. Residents’ HPV virus knowledge was strong at baseline, but immunization and recommendation knowledge was weaker. Significant improvement in vaccine knowledge and importance of a strong recommendation (72(2)=17.3, p<0.05) was seen.

Conclusions and Next Steps: While HPV vaccination is important and effective, vaccination rates remain low. Simple and practical QI interventions in a resident clinic led to an increase in HPV vaccination rates, and demonstrated improvement in resident vaccine knowledge and increased confidence in recommending the vaccine. Similar strategies can be applied towards other vaccines.

48. A LONGITUDINAL QUALITY IMPROVEMENT CURRICULUM TO PREPARE RESIDENTS FOR THE GROWING FIELD OF HEALTHCARE QUALITY (DESCRIPTIVE ABSTRACT)
Paula J. Young, MD, Medical College of Wisconsin Affiliated Hospitals, Milwaukee, WI

Background: Developing a Quality Improvement (QI) curriculum is essential to comply with ACGME requirements. In the era of the expanding field of healthcare quality, curriculums need to provide skills that prepare residents for roles in quality that are now affecting all medical professionals. Despite time constraints on resident training, the importance of integrating a longitudinal QI curriculum and project to provide adult learning opportunities and hands on experiences are essential.

Objective: Our primary objective was to develop a longitudinal quality improvement curriculum that supports residents through the completion of inter-professional improvement projects while increasing knowledge and competence in QI skill sets. Methods: Available literature and learning resources in medical education and quality improvement were reviewed to assess the variety in which programs were meeting ACGME requirements. A longitudinal curriculum was developed with subsequent modifications including enhanced workshop opportunities, increased curriculum timeframe and faculty mentorship since 2012. Results: A 2+ year longitudinal QI curriculum was developed with learning concepts based on the model of improvement in a combination of 6-8 didactic, workshop, and project review sessions per academic year. Residents self-identify projects of interest and work within small groups to develop and complete inter-professional team QI projects over approximately 2 years; culminating in a presentation experience. On self-assessment, residents have an increased proportion of rating moderate to extreme comfort in QI skill sets on completion of the curriculum. Conclusion: An effective longitudinal QI curriculum can be implemented despite time constraints, and support residents with hands on experience in the development, implementation, and presentation of QI projects. Further evaluation of data from our QI knowledge assessment tools and formally assessing the quality of improvement projects completed during the curriculum, may further demonstrate the benefits of this model.

49. RAPID CYCLE IMPROVEMENTS: USING EVERY DAY NUISANCES TO FUEL CHANGE (DESCRIPTIVE ABSTRACT)
Kristen Samaddar, MD, Lilia Parra-Roide, MD, Phoenix Children’s Hospital, Phoenix, AZ

Background: Completing relevant quality improvement (QI) projects in residency is sometimes difficult. Some efforts falter due to inconsistent time, competing priorities, and an ever-changing work environment. Program leaders wanted to see if rapid cycle QI projects could be accomplished in a one-month rotation. Methods: Teams of PGY-2 residents were given weekly protected time to implement a QI project. Residents were required to write an aim, gather baseline and follow up data, implement at least one intervention, and reflect on next steps for success. Teams chose their own topics but were also encouraged to further other team’s efforts. QI mentors provided a template, scoring rubric, and guidance to help overcome obstacles. Residents presented their work at division meetings. Results: Over the course of a year, residents accomplished 8 unique projects: recognizing elevated blood pressure, improving end-of-visit instructions, obtaining records, decreasing time writing school excuses, implementing a new protocol for pulse oximetry, performing developmental screens, providing asthma action plans, and screening for food insecurity. 10 teams accomplished at least one full PDSA cycle while 2 were able to implement two full cycles of change. All teams demonstrated core QI knowledge and skills. Conclusions: While all processes cannot be fixed in one month, resident teams were able to achieve much in a short time. Two resident-inspired projects became annual division level quality goals: identifying elevated blood pressure and improving asthma management. The screening questions for food insecurity were included in new electronic note templates. New processes for obtaining patient records and writing school excuses were continued after only one month of concentrated effort. Key to the successful rapid cycle projects is setting realistic goals. By working on their biggest nuisances, residents stay motivated and see the benefits of their efforts. Providing sufficient time for QI emphasizes its importance and allows residents the freedom necessary for success.

50. PEDIATRIC RESIDENTS’ PERCEPTIONS OF EVENT REPORTING (RESEARCH ABSTRACT)
John Szymusiak, MD, Thomas J. Walk, MD, Maggie Benson, MD, MS, Megan Hamm, PhD, UPMC Medical Education, Pittsburgh, PA, Susan Zickmund, PhD, University of Utah, Salt Lake City, UT, Alda Maria Gonzaga, MD, MS, Greg M. Bump, MD, UPMC Medical Education, Pittsburgh, PA

Background: Event reporting is an important tool for recognizing the types of errors occurring in a hospital & identifying ways to improve patient safety. Reporting data show that a majority of reports are made by physicians, which has been targeted for improvement both nationally & locally. Residents are front line providers, yet little is known about their reporting attitudes. Our study aims to identify drivers and barriers to reporting among pediatric residents at a tertiary care, academic institution and to identify modifiable aspects of an institution’s culture of safety that could encourage resident reporting. In so doing, we...
hope to improve patient care and promote career-long reporting in trainees. **Methods:** Two focus groups were conducted with senior-level pediatric residents as part of a larger study. Participants were asked open-ended questions by a trained moderator based on a piloted focus group guide. All discussions were audio-recorded, de-identified, and transcribed verbatim. Using the Editing approach of qualitative analysis a codebook was developed, refined, and applied independently by 2 trained coders who came to complete agreement. **Results:** There were 17 residents in the 2 focus groups, of whom 11 (65%) were PGY-3. All participants reported a good or excellent understanding of how to report and 16 (94%) reported their likelihood of reporting an adverse event as >75%. The barriers and drivers identified by the residents clustered into three categories—issues with the event, with the institution or its culture, and with the reporting system or process. Table 1 summarizes these themes.

**Discussion:** Focus groups are useful to understand residents’ attitudes about reporting. Interventions to encourage reporting can target each of the 3 categories of drivers/barriers identified. These include showcasing potential system benefits of reporting others’ errors, building safety debriefs into rounding, including safety education in resident curricula, and resident training in error disclosure to families (with reporting as part of this process). Similar interventions could be effective at other academic institutions.

### Table 1: Residents’ Reported Barriers & Drivers

<table>
<thead>
<tr>
<th>Domain</th>
<th>Drivers</th>
<th>Barriers</th>
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<tbody>
<tr>
<td>Event Related Issues</td>
<td>Recurrent Events</td>
<td>Human Errors</td>
</tr>
<tr>
<td></td>
<td>Harm/Potential to Harm</td>
<td>Someone Else’s Mistake</td>
</tr>
<tr>
<td>Institutional &amp; Cultural Issues</td>
<td>Role Modeling Reporting</td>
<td>Differences in MD/RN Perspective</td>
</tr>
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<td></td>
<td>Patient Ownership</td>
<td>Culture of Low Expectations</td>
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<td></td>
<td>Potential for Improvement</td>
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<tr>
<td></td>
<td>Attending Involvement</td>
<td></td>
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<tr>
<td>Reporting System &amp; Process Issues</td>
<td>Follow-up on Event Reports</td>
<td>Busy</td>
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<tr>
<td></td>
<td>Non-punitive</td>
<td>Unclear Consequences</td>
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<tr>
<td></td>
<td>Disclosure to Families</td>
<td>Reported by Another Team Member</td>
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<td></td>
<td>Easy System</td>
<td>Blame-based System</td>
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### 51. IMPROVING PATIENT SAFETY THROUGH STANDARDIZED PAGING PRACTICES (QI ABSTRACT)

**Rachel M. Weigert, MD, Anna Schmitz, MD, Medical College of Wisconsin Affiliated Hospitals, Milwaukee, WI**

**Background:** Text paging is a primary mode of communication in hospitals, though it is asynchronous and often inconsistent among senders. Children’s Hospital of Wisconsin (CHW) does not have standardized paging format. Care team members (CTM) including residents, faculty, and nurses often note pages missing key information. **Aim Statement** Primary Aims were to improve communication via use of a standardized paging format including key elements identified by care team stakeholders, and improve satisfaction with paging communication with 80% of respondents rating paging satisfaction as excellent by June 2017. **Interventions** This quality improvement project was conducted starting 6/2016 and is ongoing. Pages received by 5 ward teams, an infectious disease consultant, and the pediatric surgery pager were analyzed for 6 key elements: sender’s first and last name, 7 digit call-back number, patient name, room number, and urgency indicator (FYI, Call, Come). A baseline rate of element inclusion and CTM satisfaction was established. Interventions have included education targeting housestaff and nurses, posting flyers, and an addition of a reminder to include critical elements to the alpha paging platform. **Measures** Outcome measures included monitoring provider satisfaction as rated on 5 point Likert scale. Process measures included percentage of pages containing individual elements and all 6 elements together. Balancing measures included response time to pages and number of pages sent per day. **Results:** 2800 pages were analyzed to date; 1900 were sent from nurses to residents. As of 1/2017 upward trends without special cause were noted in CTM satisfaction with the paging system, and in timeliness and appropriateness of response to pages. Special cause improvements were noted in inclusion of all senders’ last name, and both senders’ first name and patient room for nurse-generated pages. Upward trends without special cause were noted in the inclusion of 6/6 elements and 7 digit call back number. Inclusion of sender first name and patient name were consistently above 90%, while urgency indicator inclusion was stagnant at 50%. Special cause improvements were noted in inclusion of all senders’ last name, inclusion of 6/6 elements, and both senders’ first name and patient room for nurse-generated pages. Upward trends without special cause were noted in the inclusion of a 7 digit call back number. The 6/6 elements is currently in the sentence describing upward trends, but actually meets special cause criteria. **Conclusions and Next Steps:** Over the past year there were significant improvements in the use of a standardized paging format with regards to inclusion of the sender’s last name, and all 6 critical elements, though inclusion of other elements including urgency indicator remains below goal. Further interventions are needed to increase use of a standardized paging format and increase satisfaction with communication, including forced functionality of the alpha paging system.
52. SUPPORTING RESIDENT-LED QUALITY IMPROVEMENT THROUGH A NOVEL VISUAL BOARD (QI ABSTRACT)
Carmin Powell, MD, Stanford University, Palo Alto, MS, Whitney Chadwick, MD, Charlie W. Wickremasinghe, MD, Rebecca Blankenburg, MD, Stanford University, Palo Alto, CA, Alyssa Bogetz, MSW, Stanford University, Palo Alto, MS, Nivedita Srinivas, MD, Terry Platceh, MD, Lauren Destino, MD, Stanford University, Palo Alto, CA

Background: The ACGME CLER Pathways to Excellence promotes resident engagement in quality improvement (QI) activities. However, infrastructure to capture problems that residents encounter as frontline caregivers can be sub-optimal. Empowering residents to engage in problem resolution may be further challenged by a lack of a reliable process to solve these problems. Aim Statement Implement a resident-led quality improvement visual board at Lucile Packard Children’s Hospital Stanford by August 2016 and increase resident problem reporting and resolution by 25% by the end of the academic year. Interventions: In August 2016, a QI problem reporting visual board was placed in the residency common space for residents to report QI issues in four main categories (Figure 1). Residents received a 45-minute QI education session introducing the visual board. Problems were written on the board and also submitted electronically. Chief residents reviewed and responded to all submissions weekly, utilizing their knowledge of the local hospital system to guide residents towards problem resolution. Resident-identified QI issues were also discussed at weekly multidisciplinary leadership rounds and monthly residency council meetings. Measures: Primary outcomes were changes in pre vs. post-intervention number, characterization and outcome of problems reported. A run chart was used to track progress. Secondary outcomes were pre vs. post QI knowledge and confidence, assessed by surveys. Results: Pre-survey response rate was 86% (78/91). Residents reported low confidence in their ability to solve systems-related problems in all queried domains. After implementation of the visual board, problem reporting increased from 1/mth (pre) to 4.9/mth (post); problems resolved increased from 0/mth (pre) to 2.3/mth (post) (Figure 2). The majority of problems reported were EMR & Information Technology related. Conclusions and Next Steps: A standardized reporting process led to an increase in resident reporting and resolution of systems-level quality problems that impact resident work flow and patient care. A post-survey will be conducted in the spring.

53. PRIMARY CARE PROVIDER IDENTIFICATION AT TIME OF ADMISSION (QI ABSTRACT)
Matthew A. Magyar, MD, Priscilla Carvahlo, MD, David Gonzalez, MD, Tova Appleson, DO, Andrew Kreppel, MD, Geisel Collazo, MD, Sarah Bernstein, MD, Ariel Gliksberg, MD, Iman Al-Gadi, MD, University of Illinois College of Medicine at Chicago, Chicago, IL

Background: The Joint Commission requires a discharge summary to be completed within 30 days of discharge. For psychiatry they also mandate inpatient to outpatient transitions include a care plan in their discharge process. A similar concept could be beneficial in pediatrics. An important initial step is properly determining a patient’s primary care provider (PCP) which may be done during the admission process. This project aimed to improve residents’ awareness of the importance of PCP identification and increase compliance with listing a patient’s PCP on their Admission Note. Aim Statement Increase PCP identification on H&P documentation from baseline 59% to 90% by June 30, 2016. Interventions: H&P Template modified to include highlighted field for PCP identification Resident education of project incorporated into monthly rotation “on-boarding” process Measures: A retrospective data collection evaluated discharges from general pediatrics and intensive care during an eight months period (n = 528). Chart review included: admission/discharge dates, length of stay, admitting diagnosis, PCP on the H&P and presence of an address/phone number. Over this time course, two specific PDSA cycles were completed.
Data was tabulated into two control charts. **Results:** Overall PCP identification was inconsistent, with post-intervention month identification falling both above and below the established mean of 59.3%. When accounting for control limits, the results are not significant. When looking only to identification of the PCP name, overall results appear better, i.e. most months post-intervention are above the previous mean although the results are again not significant. **Conclusions and Next Steps:** After two PDSA cycles, there was no significant impact of PCP identification on admission, determined to be two standard deviations above the baseline of 59%. There was an upward trend of identifying PCP by name only versus including the address and phone number after the first intervention, however it was not sustained in time. Contributing to less than projected results were non-categorical pediatric residents who not only missed orientations sessions. There was also inadequate buy-in from all residents (categorical pediatrics and non-categorical) across time. The project is continuing for the 2016-2017 academic year with increased emphasis on education including off-service residents.

**CCC/PROGRAM**

54. QUANTIFYING FACULTY TIME COMMITMENT FOR CLINICAL COMPETENCY COMMITTEE MEMBERS ACROSS PROGRAMS (RESEARCH ABSTRACT)

Kathleen Bartlett, MD, Duke University Hospital, Durham, NC, Jennifer Di Pace, MD, New York Presbyterian Hospital (Cornell Campus), New York, NY, Mark Vining, MD, University of Massachusetts, Worcester, MA

**Background:** Effective assessment of resident performance by Clinical Competency Committees (CCCs) is a laborious, time-consuming process. The APPD Assessment Task Force identified understanding the time commitment for faculty CCC members as a priority research question. **Methods:** This cross-sectional, APPD-approved study employed a 15-question survey that was emailed to all pediatric program directors (PDs) in fall 2015. Questions asked about CCC composition and amount of time spent performing CCC-related work both during and outside of the meeting. Fisher’s exact test was used to discern significant differences in responses among programs. **Results:** 52 PDs responded (26% response rate). Mean program size was 40 residents (range 15-97). Mean number of non-PD/APD faculty CCC members was 8 (range 0-24). There was no correlation between program size and number of CCC members (Spearman correlation coefficient 0.18). 10% of programs provided protected time to faculty CCC members (range 0.025-0.10 FTE). 10% offered alternative compensation such as credit toward incentive plans. 88% of programs spent >4 hours annually in CCC meetings, and 39% spent >9 hours. The majority of programs spent 0-10 minutes in meetings discussing a typically-performing resident and >20 minutes discussing an underperforming resident (p<0.0001). 75% of programs assigned pre-work to CCC members. For both underperforming and typically-performing residents, completing pre-work was associated with an increased amount of time spent in CCC meetings (p=0.02, p=.04). There was no difference in time spent on CCC work between APDs and faculty CCC members. **Conclusions:** CCC composition varies across programs, and program size does not correlate with CCC size. Few programs offer compensation to faculty CCC members. Despite this, faculty members spend a similar amount of time on CCC work compared to their APD (compensated) colleagues. Underperforming residents require more CCC time than their typically-performing peers. Assigning pre-work does not decrease the amount of time spent in CCC meetings.
55. DEAR PROGRAM DIRECTOR...UNDERSTANDING LETTERS OF RECOMMENDATION (RESEARCH ABSTRACT)
Kris Saudek, MD, Peter J. Bartz, MD, Robert Treat, PhD, Rachel Weigert, MD, David Saudek, MD, Michael Weisgerber, MD, Medical College of Wisconsin Affiliated Hospitals, Milwaukee, WI

Background: The letter of recommendation (LoR) is a required part of applications for residency and fellowship programs. Literature describing program director (PD) perceptions of LoR features and the unwritten code behind the phrases letter writers use when describing an applicant is sparse. Objective: The purpose of this study was to analyze features of LoRs and discriminate between perceived levels of recommendation. Methods: A cross-sectional, descriptive study of pediatric residency and fellowship program directors was performed. We asked PDs to rate commonly used phrases and characteristics of LoRs via online survey to the APPD listerv. PDs were asked to rate phrases using a five-point Likert-scale (5=very positively) and specific features (5=very important). Items were grouped using principal components analysis (PCA). Median (M) score differences were analyzed with Wilcoxon signed-ranks tests. Results: We had a 43% response rate (486/1079). Overall, 82% of respondents rated the LoR as important in shaping their impression of a candidate. “I give my highest recommendation” was rated the most positive phrase (M=5, interquartile range (IQR)=1) while “showed improvement” was rated most negative (M=2, IQR=1). PCA yielded three tiers of phrases which reflected different levels of perceived strength of recommendation. Tier 1 conveyed an outstanding applicant (M=4.5, IQR=0.8), tier 2 conveyed a solid applicant (M=3.3, IQR=0.7), and tier 3 conveyed a weaker applicant (M=2.7, IQR=0.7) with three significant (all p<.001) pairwise differences in medians. Describing specific behavior traits of the applicant was rated the most important feature to include in a LoR (M=8, IQR=1), while a letter more than 4 paragraphs was rated least important (M=3, IQR=1). A well-crafted LoR convinced 86% to consider a weaker candidate more favorably. A poorly crafted LoR influenced 61% to consider a strong candidate less favorably. Conclusions: LoRs are an important part of applications for training positions and affect PDs’ impressions of candidates. Key elements of LoRs include distinct phrases depicting tiers of strength and other important features.

56. DO YOU KNOW WHAT YOU DON’T KNOW? HOW TO CONTROL THE VISITING RESIDENT INFLUX WHILE TRACKING YOUR OWN RESIDENTS (DESCRIPTIVE ABSTRACT)
Sarah K. Braet, MBA, Jill N. Edwards, MBA, Children’s Mercy Hospital, Kansas City, MO

Background: As the demand for well-rounded pediatric rotations increases, training programs are forced to find opportunities for their residents and fellows outside of their home institutions. Due to their size and variety of subspecialties, free-standing Children’s hospitals become a hot spot for these high demand pediatric rotations. Residents who visit an outside institution are subject to certain policies and procedures set forth by the ACGME (ACGME Common Program Requirements III.D., III.D.1.) as well as the host institution. In addition to following the host institutions requirements there must be agreements in place, specific licensure, orientations, immunization tracking, and scheduling. In order to control their own resident’s learning environment and protect the patients, it is critical for the host institution to track these visiting residents and fellows through the hospital system. Methods: Children’s Mercy Hospital annually accepts over 600 visiting residents and fellows into the hospital for purposes of pediatric clinical education due to the overwhelming need for pediatric education in multiple specialties. Strategies for tracking these visiting resident and fellows were developed utilizing fillable forms, finding a network, incorporating our resident tracking system, and integrating resident feedback. Results: There were several instruments implemented. The first was a checklist in our resident tracking system, New Innovations. Each step of the checklist incorporates a fillable form that populates the information into New Innovations or a fillable PDF that could then be exported and sent to outside departments for processing. In addition, our tracking spreadsheet was fine-tuned to include all necessary information needed for complete onboarding. The information is exported from New Innovations, several columns are added for manually tracked items such as immunizations, and then this spreadsheet is used to send other departments information regarding who will be coming and when. Lastly, we created a list of programs with the responsible program contact for purposes of reaching out for missing items. The data is difficult to compare because prior to July 2015, no immunization records were tracked for compliance. However, we know that we had more than a 20% noncompliance rate prior to implementation of this plan, and have decreased that number to 0%. Visiting residents and fellows that are found to be noncompliant with hospital and program requirements are not allowed to rotate through the system. Once the rotation is approved by the department and the institutional agreement is in place, it is rare that we have to cancel a rotation due to missing items. Conclusion: Tracking visiting residents and fellows through a hospital system is necessary, but can also be overwhelming. Through the development of our tracking system and the efficiency of fillable forms, we were able to accomplish a 100% compliance rate for visiting residents and fellows within our system.

57. IMPLEMENTING A FACULTY DEVELOPMENT PROGRAM THAT WORKS (DESCRIPTIVE ABSTRACT)
Miriam E. Bar-on, MD, Samrat U. Das, MD, University of Nevada School of Medicine (Las Vegas), Las Vegas, NV

Background: Faculty development is required by the ACGME in both the common and the specialty specific program requirements. Faculty are also asked annually about their satisfaction with the faculty development provided to supervise and educate residents on the ACGME Faculty Survey. However, faculty have many competing priorities and attending faculty development sessions is frequently a challenge. Objective: To implement a faculty development program for a pediatrics department to meet the faculty's needs. Methods: After an emergent leadership change in August 2014, the program director (PD) and the associate program director (APD) approached the department chair with a proposal to start a faculty development program. The proposed program was brief (maximum of 20 minutes), employed a method developed by the APD - Snippets and occurred at monthly faculty meetings where attendance is required. Topics included teaching strategies, setting expectations, giving feedback and writing meaningful comments among others. A hands on activity or facilitated discussion accompanied all sessions. Results: The program was implemented in September 2014 and continues today. All sessions are led by the PD or APD. Faculty indicated that the sessions provided needed faculty development - in academic years
58. EASING THE TRANSITION FROM RESIDENCY TO FELLOWSHIP; LATER START DATE FOR NEW FELLOWS PROVES EFFECTIVE (DESCRIPTIVE ABSTRACT)

Brittney M. Luckett, Jean Ashley, MSBC, C-TAGME, Kimberly A. Boland, MD, University of Louisville, Louisville, KY

**Background:** Graduating pediatric residents are under contract until June 30. Those entering fellowship training are often expected to begin their training on July 1. This year, the University of Louisville Department of Pediatrics elected to move the start date of fellowship training programs to July 11. **Objective:** To facilitate the transition from residency to fellowship.

**Methods:** With permission from the DIO, the core program and fellowship programs moved the fellowship start date to July 11 for the 2016–17 academic year and a day-long common fellow orientation was held. This allowed time for fellows network and attend required training, tour the hospital and learn about opportunities during their fellowship training. Three weeks after orientation, a SurveyMonkey was anonymously sent to 9 fellows who participated in both the new start date and the common fellow orientation and 1 fellow who participated in only the common fellow orientation. **Results:** Of the surveys sent, 60% were completed. All fellows who responded agreed that the new start date gave them ample time to relocate and adequately prepare for the start of their new fellowships. They also agreed the information provided at the common fellowship orientation was helpful. We also obtained verbal feedback after a fellow conference. Two fellows who had just completed their residency with the University said the issues they had were with their e-mails not working and having a smaller paycheck for the period. However, all fellows moving from out of state said they were appreciative of the extra time to move and settle in. **Conclusions:** With minor changes to the common fellow orientation schedule, we plan to continue with delayed start dates and orientation in the future. While we feel we had given ample communication about what the changes mean, we will continue to heavily communicate with the incoming fellows regarding potential issues with the late start date.

59. SCHOLARLY ACTIVITY TRAINING: A NATIONAL SURVEY OF RESIDENTS AND PROGRAM DIRECTORS THROUGH APPD LEARN (RESEARCH ABSTRACT)

Erika L. Abramson, MD, MS, New York Presbyterian Hospital (Cornell Campus), New York, NY, Michelle Stevenson, MD, MS, University of Louisville, Louisville, KY, Monique Naifeh, MD, MPH, University of Oklahoma Health Sciences Center, Oklahoma City, OK, Hoda Hammad, MS, MPH, Linda Gerber, PhD, New York Presbyterian Hospital (Cornell Campus), New York, NY, Su-Ting Li, MD MPH, University of California (Davis) Health System, Sacramento, CA

**Background:** Participation in scholarly activity (SA) is an ACGME requirement. Yet, our previous research with program directors (PDs) suggests that the current state of SA training is widely variable and suboptimal. To help programs meet ACGME requirements in a more consistent, effective way, it is critical to understand resident perspectives. **Objectives:** To understand resident attitudes toward conducting SA during residency and to identify factors associated with: satisfaction with quality of research training; scholarly productivity; and positive attitudes toward conducting SA in residency. **Methods:** We conducted cross-sectional surveys of pediatric residents and PDs at 22 diverse programs. Our surveys assessed resident demographics and career intentions, program characteristics, beliefs about SA training, perceived barriers, and satisfaction. Data were analyzed using descriptive statistics and multivariable logistic regression. **Results:** We received responses from 464 of 771 residents (60.2%) and 22/22 PDs (100%). A majority of residents believe all programs should have a research curriculum (80%), that residents should participate in SA (82%), and that residents should have protected time to conduct SA (91%). Lack of time to conduct SA was the most significant barrier. Only 36% of residents were extremely or very satisfied with their training quality. Perceiving lack of training to conduct SA (OR 0.44, 95% CI 0.20-0.98), lack of research curriculum (0.49, 0.29-0.84), and lack of mentorship (0.40, 0.28-0.61) as barriers negatively impacted quality perceptions. Productivity was associated with future goals to conduct research (2.07, 1.14-3.73) and funding to conduct SA (2.20, 1.01-4.77). Positive attitudes toward conducting SA in residency were associated with future research goals (3.86, 1.62-9.19) and having a SA requirement (2.60, 1.34-5.05). **Conclusions:** Residents believe in the importance of SA training. Having a dedicated program infrastructure appears key to improving poor perceptions regarding quality of training received. Protected time to conduct SA is strongly desired.

60. CONCORDANCE OF CLINICAL COMPETENCY COMMITTEE AND PROGRAM DIRECTOR RECOMMENDED SUPERVISION CATEGORIZATION (RESEARCH ABSTRACT)

Daniel J. Schumacher, MD, MEd, Cincinnati Children’s Hospital Medical Center/University of Cincinnati College of Medicine, Cincinnati, OH, Beth A. King, MPP, APPD LEARN, McLean, VA, Michelle M. Barnes, MD, Chicago, IL, Kathleen W. Bartlett, MD, Duke University Hospital, Durham, NC, Natalie J. Burman, DO, MA, Naval Medical Center (San Diego), San Diego, CA, Sharon Calaman, MD, St. Christopher’s Hospital for Children, Philadelphia, PA, Sean P. Elliott, MD, University of Arizona, Tucson, AZ, John G. Frohna, MD, MPH, University of Wisconsin, Madison, WI, Lynn C. Garfunkel, MD, Caren Gellin, MD, University of Rochester, Rochester, NY, Kathleen Gibbs, MD, Mount Sinai School of Medicine (Jersey City), New York, NY, Javier Gonzales del Rey, MD, MEd, Cincinnati Children’s Hospital Medical Center/University of
Background: The relationship between CCC member and program director (PD) recommendations for resident supervisory capacity is unknown. This relationship between those who perform more extensive performance reviews (CCC members) and those who ultimately make decisions (program directors) is important to understand. Aim: Determine concordance between CCC member and PD supervision categorization. Methods: Categorical pediatric residents in 14 pediatric residency programs had CCC member and PD supervision categorizations made in conjunction with both performance review and milestone assignment periods for the 2015-2016 academic year. Both groups were asked to categorize residents as follows: 1) may serve as a supervisory resident in all settings, 2) may serve in a supervisory role as a resident in all settings, but is just above borderline/marginal mark, 3) may serve in a supervisory role as a resident in some settings, 4) may serve in a supervisory role as a resident in some settings, but is just above borderline/marginal mark, or 5) may not serve in a supervisory role. PDs saw CCC member decisions. When they recommended a different categorization, they were asked for justification. Results: 801 supervision categorizations were made by both CCC members and PDs. Concordance between CCC members and PDs across all categorizations was strong (Krippendorff’s alpha = 0.81). In 118 non-concordant instances, PDs assigned a lower level (n=73) more often than a higher level (n=45) compared with CCC members. In 6 additional instances, PDs assigned a category when the CCC member felt unable. PDs offered multiple explanations for adjusting categorization, as shown in Table 1. Conclusion: Concordance between CCC member and PD supervision categorization is strong, supporting the validity of these decisions. Where decisions were not concordant, PDs often used demonstrated abilities to move residents up, consistent with a competency-based approach. They most often moved them down based on level of experience, not consistent with a competency-based approach.

| Table 1: PD Most Common Justification for Supervision Categorization Change |
|-----------------------------|-----------------------------|
| Moving to Higher Level | Moving to Lower Level |
| No concerns with resident (n=12) | Insuffcient experience (n=44) |
| Demonstrated supervision ability (n=6) | Acute care setting concern (not ready for this) (n=16) |
| Demonstrated clinical abilities (n=5) | Lower performance compared to peers (n=8) |
| Is an upper level resident (n=4) | Insufficient skills (n=7) |
| Improvements seen (n=3) | Needs further development (not specified) (n=4) |

61. KEY FACTORS FOR RECOMMENDING A RESIDENT MAY SERVE AS A SUPERVISOR: A NATIONAL STUDY OF CLINICAL COMPETENCY COMMITTEE MEMBERS (RESEARCH ABSTRACT)

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Background: Given the central role of CCC members in reviewing performance data, understanding how they consider resident readiness for serving as a supervisor and their subsequent ability to move residents up and down is important. Aim: Determine the key factors that drive CCC members recommending that a resident may serve as a supervisory resident. Methods: Categorical pediatric residents in 14 pediatric residency programs were categorized and asked to provide the key factors driving their decision. Results: 86 CCC members completed 806 resident forms. Each CCC member completed forms for an average of 9.1 resident. EachCCC member completed forms for an average of 9.1 CCC member and PD supervision categorization. Concordance between CCC member and PD supervision categorization was strong (Krippendorff’s alpha = 0.81). In 118 non-concordant instances, PDs assigned a lower level (n=73) more often than a higher level (n=45) compared with CCC members. In 6 additional instances, PDs assigned a category when the CCC member felt unable. PDs offered multiple explanations for adjusting categorization, as shown in Table 1. Conclusion: Concordance between CCC member and PD supervision categorization is strong, supporting the validity of these decisions. Where decisions were not concordant, PDs often used demonstrated abilities to move residents up, consistent with a competency-based approach. They most often moved them down based on level of experience, not consistent with a competency-based approach.
residents, with a range of 1-38. The majority of forms categorized residents as being able to supervise in all settings (n=531). CCC members provided several key factors for making this decision. The most common responses are shown in Table 1. **Conclusion:** CCC members cited key factors leading to their decision that a resident was ready to serve as a supervisor that were largely competency-based (i.e., based on the performance of the resident). This is reassuring as the education community strives to make a meaningful shift toward criterion-based assessment with milestones. However, CCC members cited level of experience as their second most common key factor. This is not consistent with a competency-based framework and provides an area of focus for future improvements in the work CCC members complete.

**62. QUIET DOCTORS: HOW DOES INTROVERSION AFFECT RESIDENCY TRAINING? (RESEARCH ABSTRACT)**

Danielle H. Shin, MD, PhD, Alyssa Bogetz, MSW, Rebecca Blankenburg, MD, MPH, Stanford University, Palo Alto, CA

**Background:** There is growing awareness that introversion may be a disadvantage in the workplace. Studies show that extraversion may be correlated with better performance in medical school, but less is known about residency where the effect may be even greater. **Objective:** To determine how introversion affects: 1) residents’ experience of training and 2) faculty assessment of resident competence based on ACGME milestones and evaluation comments. **Methods:** In this 2016 IRB-approved, cross-sectional mixed-methods study, residents were identified as having a preference for introversion or extraversion using the Myers-Briggs Type Indicator and then completed an open-ended survey. ACGME milestones (levels 1-5) were compared between the two groups within each PGY level using the Mann-Whitney test. Survey data and faculty evaluation comments were analyzed using conventional content analysis. **Results:** 78% (67/86) of residents participated; 45% identified as introverts and 55% as extraverts. 73% of introverts felt this preference affected their residency experience and 80% felt it affected feedback from faculty, compared with 57% and 40% of extraverts, respectively. 63% of introverts reported being described as quiet, needing to speak up, or think out loud; 57% reported being perceived as less confident, knowledgeable, engaged, or less of a leader. The most common theme identified by extraverts was their ability to work well in a team (51%). No significant differences were found between the two groups in the Clinical Competency Committee-assessed ACGME milestones. Qualitative analysis of faculty evaluation comments for interns revealed similar strengths and areas for improvement for both introverts and extraverts. **Conclusions:** Introversion and extraversion come with strengths and challenges, and raising awareness about personality types and how they affect processing, presentation styles, and patient and team interactions may help normalize these differences. Both introverted and extraverted residents achieve similar levels of competence throughout their training, which should be encouraging for introverted residents who may feel misperceived.

**63. EVOLUTION OF AN INPATIENT FLOW CHIEF RESIDENT (DESCRIPTIVE ABSTRACT)**

Judson A. Moore, MD, Jolie J. Brit, MD, Betsy A. Cowling, MD, Linessa M. Zuniga, MD, Michelle A. Lyn, MD, Baylor College of Medicine (Houston), Houston, TX

**Background:** Tertiary care pediatric facilities are encountering increasingly complex patients creating obstacles to high quality and efficient discharges. The role of chief resident of flow (Flow Chief) was developed in 2015 with 4 areas of focus - flow management, patient safety, resident education, and quality improvement. **Objective:** Describe the evolving role of the Flow Chief and its impact on discharge barriers. **Methods:** One of the main functions of the flow chief is facilitating communication between nursing/ancillary staff, residents, faculty, and administration to improve hospital throughput. Daily activities entail identifying and resolving inpatient discharge obstacles along with assistance and dissemination of information on patient throughput to residents. The accumulation of discharge barrier data has facilitated larger scale interventions and identification of trends over time. **Results:** A total of 463 barriers have been addressed. The 3 main obstacles have been delayed imaging orders, consultant recommendations, and provider discharge responsibilities (patient instructions, home prescriptions, discharge order, and primary team rounding). Analysis has allowed for prioritization of frequent barriers and focus on specialties with higher barrier burdens. Summative reports were created for individual specialties and presented to service leadership and hospital administration. The reports also included recommendations focused on increasing efficiency and effectiveness for their common barriers. Along with summaries, annual longitudinal projects have been developed to address high priority matters related to discharges. The initial year sought to facilitate the efficiency and quality of asthma discharges. The second year has aimed to address coordination of discharges for congenital heart patients. **Conclusion:** A chief resident with recent frontline provider experience can be an effective conduit for coordination of care to facilitate discharges throughout the hospital system. These open lines of communication foster a better inpatient experience, improved quality, favorable financial impact, and informative resident atmosphere.

**64. SUPPORTING RESIDENTS AS PARENTS THROUGH PEER SUPPORT (DESCRIPTIVE ABSTRACT)**

Lydia M. Rabon, MD, Leslie-Anne J. Dietrich, MD, Angela Ibragimov, MD, Vasudha L. Bhavaraju, MD, Phoenix Children’s Hospital, Phoenix, AZ

**Background:** Studies have demonstrated a greater number of residents are having children during residency and family friendly benefits are emerging as criteria for choosing a program. Data suggests that trainees have more complications in pregnancy, have shorter breastfeeding durations than their peers in practice, and are less likely to meet their breastfeeding goals. Program Directors perceive that female trainees with children have decreased well-being compared to peers. The purpose of this project was to create a program for resident moms to navigate through pregnancy, maternity leave, and return to work and achieve their parenting and breastfeeding goals without compromising their academic success or well-being. **Methods:** Multiple methods were used to provide peer support to resident moms: 1. A private “Residency Moms” Facebook page to share advice, 2. A formal mentoring plan where expectant moms are paired with experienced resident mothers and
meet each trimester, within a week of birth, and prior to returning to residency and, 3. Lactation support. Results: Seven moms have participated in the program since its start in Spring 2016, 4 have transitioned back to work while 3 are still on leave. There were 2 PGY1s, 2 PGY2s, 2 PGY3s, and 1 PGY4 - all are first time moms. One mother having her 2nd child opted out. All are exclusively breastfeeding up to 9 months post-partum. The Facebook group has 25 current and former residency moms. The top posts include childcare, pumping tips/locations, and navigating harder rotations with an infant. Participants report benefits of feeling supported in residency and motherhood, lactation support, and access to multiple resources. Conclusion: A formal peer mentorship program for expectant trainees is a way that programs can support their trainees in pregnancy and through parenthood while ensuring continued success in residency. We plan to expand our program by creating a forum to discuss family planning and by implementing a “Parental Leave” Elective for residents to increase their comfort with early childhood development through self-study and parenthood, while minimizing delay in graduation.

COMMUNICATION (AND DOCUMENTATION)

66. PROMOTION OF HIGH-QUALITY DOCUMENTATION AMONG RESIDENTS ON INPATIENT PEDIATRIC WARDS USING A STANDARDIZED TOOL TO ENHANCE FACULTY FEEDBACK (RESEARCH ABSTRACT)

Danita R. Hahn, MD, Julie M. Kolinski, MD, Heather L. Toth, MD, Michael C. Weisgerber, MD, MS, Caitlin Pilon, BA, Amalia Wegner, MD, Medical College of Wisconsin Affiliated Hospitals, Milwaukee, WI

Introduction: Inpatient progress notes are a key component of care for hospitalized patients. The Accreditation Council for Graduate Medical Education (ACGME) has emphasized high quality documentation for residents. Methods: Education regarding high-quality progress notes was provided to residents, and education on the use of the Physician Documentation Quality Instrument 9-item version (PDQI-9) tool was provided to Pediatric Hospital Medicine (PHM) faculty. The PDQI-9 evaluates the following attributes on a 1 (not at all) to 5 (all the time) Likert scale: up-to-date, accurate, thorough, useful, organized, comprehensible, succinct, synthesized, and internally consistent. Each PHM faculty member was asked to evaluate one progress note per resident per week using the PDQI-9. The faculty was encouraged to provide this feedback to the resident and indicate the mode of feedback. Descriptive statistics were analyzed for PDQI-9 scores and type of feedback given, and a correlation between resident PDQI-9 total score and documentation subcompetency score (Interpersonal Communication Skills-6 [ICS-6]) was performed. Results: Data were collected from October 2015 to October 2016 and is ongoing. There were a total of 258 faculty-resident pairings created for evaluation, and 58.1% of evaluations were completed. The highest-rated note attributes were “comprehensible” (mean 4.66) and “accurate” (mean 4.54). The lowest-rated attributes were “synthesized” (mean 4.24) and “succinct” (mean 4.23). 68.9% of completed evaluations noted feedback was given (58.6% verbal, 10.3% emailed). Resident PDQI-9 total scores statistically correlated with ISC-6 scores (Spearman’s rho correlation coefficient 0.38, p=0.003). Conclusions: A new initiative to provide residents with feedback on progress notes using a validated tool has resulted in the majority of residents on the PHM service receiving faculty feedback. The use of the PDQI-9 tool has the potential to identify areas for improvement in resident progress notes and can be used to inform resident feedback on their documentation.

66. REFRAISING PATIENT-PROVIDER COMMUNICATION: A CROSS-CULTURAL APPROACH (DESCRIPTIVE ABSTRACT)

Abena Knight, MD, Allison LaRoche, MD, MPH, Kashena Konecki, David Breland, MD, MPH, University of Washington, Seattle, WA

Introduction: The U.S. continues to increase in racial/ethnic, religious, and language diversity. However, research studies show that health disparities among underrepresented populations persist. Training programs should educate providers to detect their own biases in order to interact with others with cultural sensitivity. Methods: Pediatric interns at the University of Washington participate in a week-long retreat. In 2015 and 2016 residents participated in a Cultural Humility session that combined an icebreaker, didactic, and small group case discussion. Objectives of each session were: to identify personal experiences that may affect interactions with other healthcare providers and patients/families; to distinguish three different communication tools proven effective in cross-cultural interactions and demonstrate how they can be used in complex patient interactions; to identify patient/family traits that may contribute to positive/negative interactions. Feedback was elicited after both sessions, and pre- and post-participation surveys were administered in 2016 to determine to what degree (strongly disagree to strongly agree) interns were able to perform the objectives in practice. Results: Feedback following the 2015 session was favorable. Several residents reported that the didactic was long and cases unchallenging. The 2016 session utilized a shorter didactic with cases developed from provider encounters. Survey data revealed that perceived ability to perform the objectives improved after the session, with objective 2 showing the largest change (pre 20% strongly disagreed, 20% disagreed, and 10% neutral; post 10% neutral, 70% agreed, and 30% strongly agreed). Feedback following the 2nd session was more favorable of the case discussions with minimal negative feedback for the didactic portion. The icebreaker was rated highly both years. Discussion: Sessions aimed at training providers to interact with patients from diverse backgrounds are helpful in improving perceived ability to manage complex interactions. Work should be done to determine how best to help providers minimize their biases and interact with cultural awareness.
**Winner - APPD 2017 Trainee Research Award**

67. A VIRTUAL REALITY CURRICULUM FOR PEDIATRIC RESIDENTS DECREASES RATES OF INFLUENZA VACCINE REFUSAL (RESEARCH ABSTRACT)

Francis J. Real, MD, Cincinnati Children’s Hospital Medical Center/University of Cincinnati College of Medicine, Dominick DeBlasio, MD, MEd, Andrew F. Beck, MD, MPH, Nicholas J. Ollberding, PhD, David Davis, Bradley Cruse, Zeina Samaan, MD, Daniel McLinden, EdD, Cincinnati Children’s Hospital Medical Center/University of Cincinnati College of Medicine, Melissa D. Klein, MD, MEd, Cincinnati Children’s Hospital Medical Center/University of Cincinnati College of Medicine, Cincinnati, OH

**Objective:** Communication skills can be difficult to teach and assess in busy medical settings. These skills are particularly important for effective counseling such as in cases of influenza vaccine hesitancy, a common occurrence in primary care practice. Though physicians can affect caregivers’ attitudes toward vaccination, physicians report uneasiness discussing vaccine hesitancy. We hypothesized that physician-patient communication training using virtual reality (VR) can decrease rates of vaccination refusal.

**Methods:** An immersive VR curriculum was created to teach pediatric residents best-practice communication skills when discussing influenza vaccine hesitancy. This pilot curriculum consisted of three VR simulations during which residents counseled graphical character representatives (avatars) who expressed vaccine hesitancy. Instruction was delivered via the Oculus Rift headset. Participants were randomized to the intervention (n=24) or the control group (n=21). Only residents in the intervention group underwent the VR curriculum. Impact of the curriculum was assessed through (1) a pre/post self-assessment survey evaluating resident confidence in addressing influenza vaccine hesitancy and (2) difference in influenza vaccine refusal rates between the intervention and control groups in the three months following the VR curriculum.

**Results:** Participants included postgraduate level (PL) 2 and PL3 pediatric residents. All eligible residents (n=45) participated and the survey response rate was 100%. Residents in the intervention group reported increased confidence in addressing vaccine hesitancy compared to controls (p=0.02). In patients aged 6-59 months, residents in the intervention group had a decreased rate of influenza vaccination refusal in the post-curriculum period when compared to the control group (27.8% v. 37.1%; p=0.03). (Figure 1)

**Conclusion:** This pilot study suggests that VR might be an effective modality to teach communication skills to medical trainees.

68. DEVELOPING A BLOG TO ENHANCE PEDIATRIC RESIDENCY: A PILOT STUDY (DESCRIPTIVE ABSTRACT)

Brian E. Lee, MD, Adam Pallant, MD, Brown University, Providence, RI

Social media as an educational platform is increasing in residencies across the US, however pediatric programs have been slow to incorporate them as a feasible and sustainable tool. At the start of the 2016-2017 academic year, an online survey was sent to all pediatric residents at our program (n=80) to assess use of online medical resources and social media. We then created a residency blog using previously published criteria for high-quality medical blogs. Cases and their discussion are primarily developed by the author (BL) and reviewed by selected faculty serving as content experts prior to publication. Topic selection was based on personal interest. Using site-specific analytic tools (WordPress), we collected various data about blog use. The focused needs assessment survey was completed by 35 residents (44%). Of those responding, 97% agreed or strongly agreed that online sources were their primary source for independent learning, with 64% agreeing that medical blogs were useful for consuming medical information. During the first 5 months following inception of the blog, 18 posts have been created. Posts about both general pediatric and subspecialty topics have been published. During this period, the blog recorded 495 visitors, constituting 1,053 views of individual pages. 5% of viewers access the site from international locations. Building off a targeted needs assessment demonstrating an interest in medical blogs, we found that publishing 1-2 posts each week attracted a consistent audience, evidenced by site traffic. Anecdotal evidence has been positive, with residents regarding the blog as a positive addition to their education. Challenges have included: time needed to generate posts, alerting residents to new posts, and obtaining more granular data about the blog audience (e.g. level of training, number of visits per person, etc). Given the initial successes and acceptance of the blog, next steps include gathering more specific data related to how individuals use the blog, increasing the number of resident-generated posts, and determining whether the blog can deliver educational curricula.
Measures Quality of communication and comprehension of action plans were assessed by 9 questions, using a 5-point scale. Residents and nurses completed pre-intervention surveys assessing perceived quality of communication between residents and nurses. Whether its use resulted in perceived improvement in communication between nurses and resident physicians on a busy service was not known.

Assessment, Recommendation). Aim Statement We instituted SBAR for nurse updates by resident physicians and examined its impact. Method: A communication framework is SBAR (Situation, Background, Assessment, Recommendation). Aims Statement We instituted SBAR for nurse updates by resident physicians and examined its impact. Method: A new website, published June 2016, provided a responsive user experience that facilitated quick online and mobile access to rotation guides, educational resources, program policies, and resident updates. Additionally, program announcements were made via blog posts on the website over the following 6 months, totaling 113 individual posts. Links to new posts and updates were advertised in the chief resident weekly email. Analysis of utilization via page views (PV) was completed via Google Analytics. Results: For the first six months of the 16-17 academic year, a total of 20,787 PV was recorded, an average of 216 PV/resident. The 3 categories with the highest PV included rotation guides (38.9%), blog posts (22.8%), and clinical resources (16.5%). Of the top 10 most viewed blog posts consisted of monthly state-of-the-program updates from the program director. Analysis of the variance in PV of programmatic updates and clinical, logistical, and educational resources point to resident interest and engagement in program development, as well as the need for improvement in various curricular and resource areas. Conclusion: A residency program specific website can be created and used not just as a storehouse of program and clinical resources, but also as an effective means of communicating program news and updates to residents who are accustomed to consuming news and media via the internet. Analysis of website utilization and user behavior can also provide insight into resident interests and curricular needs providing real-time feedback loops that can be utilized for program improvement.
Surveys were completed anonymously to improve response. Unmatched pre- and post-intervention responses were compared for nurses and residents using chi-square analysis. **Results:** 75% of the 24 residents responded to both surveys. Approximately 25 nurses responded; the nursing response rate is difficult to calculate due to variation in staffing. Pre-intervention, 44% of nurses reported very good-excellent communication with residents, improving to 78% (p=0.03). Among residents, very good-excellent communication with nurses increased from 39% to 90% (p=0.001).

85% of nurses and 100% of residents agreed that SBAR improved communication.

**Conclusions and Next Steps:** Regular use of SBAR by residents after inpatient rounds improved communication between physicians and nurses. Future work will involve incorporating SBAR into the resident curriculum, encouraging its use with other specialties, examining whether it is associated with fewer errors in patient care and improvement in perception of teamwork by patient families.

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**72. UNDERSTANDING PATIENT AND FAMILY PREFERENCES TO ACCESSING THEIR PRIMARY CARE PROVIDER WITHIN A PEDIATRIC RESIDENT CONTINUITY CLINIC (DESCRIPTIVE ABSTRACT)**

Monica P. Luttrell, MD, Aimee Janesky, MD, William Gilmore, MD, Melissa Weddle, MD, Windy Stevenson, MD, Sarah Green, MD, Megan Aylor, MD, Oregon Health and Science University, Portland, OR

**Background:** Developing patient continuity within pediatric resident clinic is challenging. In our own clinic, we identified the need for improved continuity between patients and providers. Further information on family perceptions and preferences was required to enhance continuity and improve family experience with accessing care. **Objective:** To understand patient and family perspectives on access to primary care providers (PCPs) within resident clinic, as well as identify discrete barriers to care and inform areas for improvement. **Methods:** A family survey was developed to assess current access to care, perceived barriers, and areas for improvement. Previously developed assessments were used to guide question content, and questions were reviewed by a family focus group. Family surveys were distributed to patients with a pediatric resident PCP. **Results:** A total of 101 surveys were collected. 55% of respondents knew their PCPs name and 58% reported attending a previous visit with their PCP. 57-88% of respondents prefer to see their PCP for well child care and follow-up visits over flexibility in scheduling, while 22% of families report it is more important to see their PCP for urgent or same-day visits. 88% of people prefer non-urgent appointment availability within two weeks. Families indicated that the time until next available appointment and the day of PCP availability posed difficulty in accessing care. Comments helped identify areas for improvement. When unable to see their PCP, families report stress over providers’ lack of familiarity with their child’s medical care. Families requested more appointment availability, timely access, and greater flexibility in scheduling. **Conclusions:** Continuity of care and access is important to patients and families, particularly with respect to well child and follow up care. The largest perceived barriers are time until the next available appointment and the overall flexibility in the PCP’s schedule. Further improvement efforts will focus on access to resident PCPs for well child care and follow-up visits.

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**73. IMPROVING RESIDENT COMMUNICATION WITH VACCINE-HEISITANT FAMILIES THROUGH SIMULATION (DESCRIPTIVE ABSTRACT)**

Garrett M. Jones, MD, Dawn L. Martin, MD, MPH, Emma Schempf, MD, University of Minnesota, Minneapolis, MN

**Background:** Childhood immunizations are the cornerstone of pediatric preventive care, yet vaccine hesitancy remains a challenge. Provider communication is a significant factor in immunization delivery and acceptance. Conversations about vaccine hesitancy are challenging, and simulation provides a unique opportunity for resident education. We hypothesize that participating in conversations with vaccine-hesitant families will improve communication skills and provide a framework for these discussions. **Objective:** Enrich resident learning through a standardized simulation curriculum on vaccine hesitancy. **Methods:** We designed 4 scenarios, including influenza vaccine refusal, MMR denial in a Somali immigrant family, HPV concerns and an alternative vaccine schedule request. We conducted the simulation sessions at Hennepin County Medical Center with trained simulated caregivers. All first-year residents in the University of Minnesota Pediatric Residency Program participate as part of an outpatient rotation. Each session begins with a short presentation on effective communication strategies, including the C.A.S.E. method and prescriptive vs participatory approach to vaccine discussions. Pre- and post-simulation data were gathered about resident comfort with these difficult conversations (Likert scale 1-5, with 1 being least comfortable, 5 being most comfortable). **Results:** After simulation training, residents report higher levels of confidence regarding conversations with vaccine-hesitant families (pre: 3.0 vs post: 4.2). Residents also felt they had more strategies for talking to vaccine-hesitant families (2.8 vs 4.0) and were more comfortable utilizing reliable vaccine resources (2.8 vs 4.4). 91% of residents reported they planned to change their approach to vaccine-hesitant families following the training. **Conclusions:** Pediatric residents who participated in these simulations acquired strategies and gained confidence in effective communication with vaccine-hesitant families. By improving communication skills, we anticipate residents will engage in more effective discussions with vaccine-hesitant families.
74. THE ATTENDING-RESIDENT HAN DonF SKILLS AMONG RESIDENTS (DESCRIPTIVE ABSTRACT)

Elana B. Mitchel, MD, Morgan Brown, MD, Dylan Graetz, MD, Lisa Karamessinis, MD, Michelle Marie Pena, MD, Marissa Orenstein, MD, George Dalembert, MD, Children’s Hospital of Philadelphia, Philadelphia, PA

Background: The implementation of a standardized handoff process within a training institution can be challenging due to practice variability, cultural buy-in and differences in individual experience. A comprehensive curriculum with direct observation has been shown to be important for uptake and utilization of a handoff system. Peer-led teaching has also been suggested to be beneficial. Aim: To develop a peer-led curriculum and direct observation system to teach and reinforce the use of I-PASS at a pediatric residency program. Methods: A core group of senior residents were trained as I-PASS champions and helped to facilitate the implementation of I-PASS using resident experience. The I-PASS introductory module was adapted and presented by these residents. Direct observation of intern sign-out by senior residents was incorporated into a teaching-focused 3rd year rotation. I-PASS Week, an intensive week of handoff training led by residents, was held 6-months after the introduction of I-PASS. An evaluation tool and focus group were used after I-PASS week. Results: Ninety-one (98%) of eligible residents formally underwent peer-led I-PASS training. A total of 71 peer observations of handoffs were completed over a 6-month period, 38 (75%) interns were evaluated. After I-PASS week, 15 (54%) of participating interns indicated increased confidence in their verbal handoff skills and 21 (75%) in their written. The most effective format for teaching handoffs was simulation. Protected handoff time, updated and succinct handoffs and cultural buy-in were reported as essential for successful I-PASS implementation. Residents described the peer-led activities and observations as effective in teaching and reinforcing handoff practices, which was attributed to the creation of a more comfortable learning environment, as well as increased approachability and understanding of workflow and culture by resident-teachers. Conclusions: A structured curriculum is necessary to ensure continued development of resident handoff skills. A peer-led model that focuses on making handoff training relevant for residents may help to both introduce and reinforce practices.

75. A PILOT STUDY: IMPROVING HAN DonF SKILLS AMONG RESIDENTS (DESCRIPTIVE ABSTRACT)

Joanna M. Hales, MD, University of North Carolina Hospitals, Durham, NC, Ashmita Chatterjee, MD, Margaret Kihlstrom, MD, Christine Williams, MD, Kenya McNeal-Trice, MD, Eric Zwemer, MD, University of North Carolina Hospitals, Chapel Hill, NC

Purpose: In response to resident duty hour restrictions, handoffs occur more frequently and are often covered by non-resident providers. The I-PASS mnemonic has been shown to decrease medical errors without sacrificing efficiency for resident handoffs, but studies have not examined the efficacy and efficiency of the I-PASS method applied to handoffs between residents and attendings. We developed a multipronged intervention to improve resident handoffs using I-PASS components and examined resident attitudes toward sign-out on a general ward team covered by both residents and attendings. Methods: Our intervention consisted of a review of the I-PASS curriculum via a team-based educational session, direct observation and feedback on resident sign-out by a attending, and creation of a sign-out macro within our electronic medical record. Under a non-concurrent multiple baselines design, each resident team received the intervention at the start of a randomly chosen week of their 4-week block. Participants included all residents on a general ward team covered by residents during the day and by a hospitalist at night. Pre- and post-intervention analysis on the overall quality and efficiency of sign-out was provided by a nightly written assessment by an attending receiving sign-out from a resident. Results: Overall, quality of sign-out was significantly higher in the post-intervention group (p=0.007). There was no significant change in the time spent per patient post-intervention (p = 0.58). 86% of residents agreed that the overall intervention led to improved patient care. Use of I-PASS components significantly increased post-intervention. Attendings were significantly more likely to report adequate preparation from sign-out after the intervention (p=0.0058). Conclusion: The TARHEELS intervention was associated with significantly increased sign-out quality without loss of efficiency. Attendings felt more prepared for patient care after the I-PASS intervention was introduced. As more pediatric teams are covered by non-resident providers, the I-PASS mnemonic should be employed to ensure efficient, safe, and high-quality handoffs.

76. A PILOT STUDY: IMPROVING PEDIATRIC RESIDENTS COMMUNICATION SKILLS THROUGH TEACHING HEALTH LITERACY PRINCIPLES (RESEARCH ABSTRACT)

Caroline Okorie, MD, MPH, Stanford University, Los Altos, CA, Lee Sanders, MD, MPH, Stanford University, Palo Alto, CA, Ann Elizabeth Stuart, MD, MEd, Stanford University, Atherton, CA

Background: Low health literacy is associated with poorer health outcomes, including worse asthma control. Studies demonstrate physicians lack knowledge about advanced communication techniques. Additionally, physicians tend to significantly underestimate their use of complex jargon in clinical encounters. Physicians in training should learn, not only about health literacy concepts, but ways to communicate effectively with patients/caregivers of all health literacy levels.

Objectives: The objective of this pilot study is to determine the feasibility of implementation of a study to assess a newly created curriculum to teach residents about health literacy and effective communication methods. This study is also to determine the usability of the communication evaluation tool. Methods: In this quasi-experimental study, pediatric residents were randomly assigned into one of two groups. Each resident completed a questionnaire to assess baseline knowledge, attitudes, and perceived skill level in caregiver communication and health literacy. This was followed by a video-taped simulated clinical encounter in which they communicated a pre-determined diagnosis of asthma and treatment plan to a caregiver. Following this simulation, residents in the control group participated in an hour long didactic about asthma pathophysiology and management, and were given a handout about health literacy principles and communication. Residents in the intervention group had an hour long interactive session teaching health literacy and effective communication, and were given a handout of asthma management guidelines. The simulated clinical encounters were repeated, followed by...
a questionnaire to reassess knowledge, attitudes, and perceived skill. Participants provided written and real-time verbal feedback of the sessions to the primary investigator. The scenarios were later watched by 2 independent video evaluators using a tool adapted from established communication tools and proposed competencies from the literature. Resident performance will be considered in regards to use of 4 key health literacy principles. **Results/Conclusion:** A total of 5 residents completed all aspects of the pilot study. We are unable to make conclusions of the curriculum effectiveness based on pilot data; however, the studying the effectiveness of the curriculum proved feasible. The sessions were highly rated by the residents and evaluators using the evaluation tool demonstrated good inter-rated reliability. The next steps will involve data collection and comparison of resident performance. We hope our intervention will cause a change in resident performance in simulated encounters leading to favorable changes the effectiveness of physician/caregiver communication in practice.

**77. SMARTPHONE USE AMONGST PHYSICIANS AND THE POTENTIAL EFFECT ON PATIENT SAFETY AND PRIVACY.** (RESEARCH ABSTRACT)

Tyson J. Tidwell, DO, Trevor J. Laborda, MD, Lynn Thoreson, DO, Lynn Campbell, MD, University of Texas at Austin Dell Medical School Pediatric Program, Austin, TX

**Purpose/Objective:** Smartphone use has become widespread throughout society and has now become a means of fast and efficient communication. They are a prevalent means of communication amongst healthcare providers within the hospital setting, particularly through the use of text messaging. This study aimed to assess physician to physician and nursing to physician communication via smartphone use and the potential effect on patient safety and privacy. **Design/Methods:** 48 pediatric residents were surveyed regarding smartphone and pager use. 29 nurses working in 5 patient units were also asked to identify the most commonly used means of contacting residents, whether via the paging system or HIPAA compliant texting. Following the initial survey all residents were provided with a password protected smartphone and all communication was directed through a HIPAA compliant text messaging service. **Results:** Pre-intervention: Residents reported an average of 61 work related text messages daily with only 23% (14) of the messages sent via HIPAA compliant text messaging apps. 51% of residents reported >6 daily errors with texting, sitting inability to send/receive messages due to poor cellular service within the hospital. 54% reported difficulty using the HIPAA compliant messaging app due to app malfunction, device incompatibility and recipients not enlisted in the app service. Of the 29 nurses surveyed nearly half (48%) reported preference towards HIPAA texting over using the paging or telephone service. Post-intervention: A 4 month follow up survey demonstrated an increase in HIPAA compliant texting (47% vs 23%), a decrease in texting errors (3% vs 51%) and a decrease in app malfunction (6% vs 54%). **Conclusions/Discussion:** Smartphone text messaging amongst healthcare providers, although more commonplace, may introduce the potential for patient safety and privacy concerns. In our population, the elimination of personal cell phone use along with the introduction of a work sponsored smartphone with HIPAA compliant text messaging resulted in the reduction of HIPAA violations, missed messages and app malfunction.

**78. IMPROVING HANDOFF OF PATIENT CARE FROM THE PEDIATRIC ED AND THE PICU (RESEARCH ABSTRACT)**

Lauren M. L’Hommedieu, MD, Ann Mary Bacevice, MD, Ingrid Anderson, MD, Case Western Reserve University/University Hospital Case Medical Center/Rainbow Babies, Cleveland, OH

**Background:** Recent studies document that handoffs across various settings are among the most dangerous events in a patient’s care. The ACGME requires that trainees receive education related to handoffs, but no consensus exists as to what procedure is best. Specifically, no published literature supports a specific tool for transferring patients from the pediatric emergency department (PED) to the pediatric intensive care unit (PICU). **Objectives:** Phase 1 of our study involved a needs assessment, with the objectives of assessing the current state of the patient handoff between the PED and PICU and collecting data to inform development of a structured handoff tool. Phase 2 objectives, involving implementation of this novel process, include assessing for improved efficiency and communication in PED to PICU transitions of care. **Methods:** We distributed, after IRB approval, an electronic questionnaire to PED and PICU physicians in our institution (N=41). Based on the results of this needs assessment, we developed a tool to guide the process of PED to PICU handoffs. After training all involved physicians, we are evaluating, via direct observation of handoffs, the tool’s effectiveness in improving PED to PICU handoff efficiency and the communication of essential information. **Results:** Our needs assessment was completed by 12/19 PICU (63%) and 11/22 PED (50%) physicians. 86% indicated dissatisfaction with the current handoff practice. They estimated that patients’ medications, weights, allergies and vital signs were communicated at handoff less than half of the time. These results informed development of a standardized tool to guide the process of PED to PICU handoffs, which is currently being assessed. **Conclusions:** The results of our needs assessment document that our current handoff practice from the PED to the PICU is suboptimal and support the development of an improved process that is more complete, concise, and systematic. The handoff tool, which we believe will improve patient transitions from the PEDS to the PICU and will be easily spread to other institutions, is currently being evaluated in Phase 2 of our study.
79. HEARING OUR PATIENTS’ VOICES: A MULTI-INSTITUTIONAL QUALITATIVE STUDY OF RESIDENTS’ PERSPECTIVES ON FACULTY’S ROLE IN OPTIMIZING LEARNING FROM PATIENT FEEDBACK (RESEARCH ABSTRACT)

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Introduction: Learning from multi-source feedback is a complex process influenced by feedback timeliness, specificity, credibility and learners’ goals. Learners’ willingness to accept and implement feedback improves when it is actively discussed; however, the specific strategies used in these discussions are unknown. Objective: To explore pediatric residents’ perspectives of patient feedback delivery and identify strategies faculty use to promote meaningful feedback exchange and practice improvement Method: We conducted 7 focus groups with a purposeful sample of pediatric residents from 3 institutions until thematic saturation was achieved. This study followed an IRB approved randomized-controlled trial in which residents received written patient feedback and discussed the feedback with an advisor (intervention, I), or reviewed the feedback on their own (control, C). Residents who received feedback from at least 3 patients were recruited to participate in separate focus groups (I, C). Discussions were recorded, transcribed and thematically analyzed through a combined deductive and inductive approach informed by social cognitive theory. Two authors independently coded the transcripts and reconciled codes to develop themes (Interrater reliability, k=.92). All authors reviewed the codes and finalized themes through consensus. Results: 36 residents participated (n=17 I, 19 C). Residents identified five strategies faculty use to enhance their learning from patient feedback: 1) Translate general feedback into specific individualized goals; 2) Help resident identify and overcome emotional responses to negative feedback; 3) Frame feedback in the context of lifelong learning; 4) Encourage perspective-taking of patients, and 5) Hold the resident accountable to change. These themes were consistent across both groups (I, C). Discussion of feedback within a trusting relationship was believed to be needed to promote self-reflection and learning. Conclusion: This study identifies several strategies faculty can use to enhance resident learning from patient feedback.

80. GROUP EVALUATIONS OF INDIVIDUAL FACULTY HOSPITALISTS (QI ABSTRACT)

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Background: Faculty evaluations are an instrumental tool used to improve faculty-to-resident instruction and faculty development. Residents in our program would routinely complete rotation evaluations for the inpatient pediatric service but would only seldom evaluate individual faculty hospitalists out of concern for anonymity. Hospitalists requested more individualized feedback. Aim Statement: This project aimed to 1) Increase the percentage of completed evaluations of hospitalists above 80% 2) Improve the quality of hospitalist feedback as determined by resident and faculty satisfaction surveys in 4 months Interventions: The hospitalist evaluation form was revised to address areas of importance to hospitalists and residents. Chief residents moderated meetings where members of the resident inpatient team completed group-based evaluations of individual hospitalists. Measures: A 4-question survey was distributed to hospitalists and another 4-question survey distributed to residents, both based on a 5-point Likert scale. Surveys were completed before and 4 months after implementation of the changes. A run chart was made, and pre- and post-survey data of responses were compared using the Mann-Whitney and probability proportion tests. Results: The percent of completed evaluations increased from 0% to 80% in one month and to 100% in the next 5 months. Hospitalist satisfaction increased above 80%, with statistically significant increases for all survey questions. Resident satisfaction with the evaluation process increased significantly. Positive trends that were not statistically significant included resident perception that evaluations are anonymous and that hospitalists use evaluations to improve. Conclusions and Next Steps: Group-based resident evaluations of individual hospitalists led to an increased percentage of completed evaluations and increased satisfaction with evaluations among hospitalists. These changes, which will be sustained, led to increased resident satisfaction with the evaluation process. Limiting factors included incomplete resident participation in the new evaluation process due to scheduling. This evaluation system will be implemented on additional services.
81. EVALUATING EARLY PREDICTORS OF OVERALL RESIDENT PERFORMANCE (RESEARCH ABSTRACT)
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Background: Residency programs want to select medical students who will be successful residents. Few clear predictors have been identified in the literature. The pediatric residency program directors at our institution developed a Global Director Rating (GDR) to assess residents in our program at the end of each academic year. The GDR is a 1-9 Likert scale rating their ability to be a role model, build morale, demonstrate trustworthiness, and contribute to the overall health of the residency program. Objective: The primary objective was to identify factors associated with resident performance assessed by GDR. Methods: We conducted a longitudinal cohort study of pediatric residents during the 2014-2016 academic years. Predictor variables identified from their application and interviews in our program included: USMLE/COMLEX scores, academic points (points for clerkship grades and select items from medical school training), and interview scores. Predictor variables identified after starting residency included: learning style, simulated patient encounter ratings (SIPPS), in-training exam scores (ITE), and the Clinical Competency Committee’s semianual milestone level assessments. The Pearson Correlation Coefficient between GDR and each predictor variable was calculated. Results: Data was analyzed for 135 pediatric residents. Predictor variables identified prior to starting residency that were moderately correlated with GDR (r=0.3-0.6, p<0.05) were academic points and interview scores. USMLE/COMLEX scores were not correlated with GDR. Predictor variables identified after starting residency that were moderately correlated with GDR were milestone ratings for the competencies Patient Care, Practice-based Learning and Improvement, and Interpersonal and Communication Skills. Learning style, SIPPS, ITE, and milestone ratings for the competencies Medical Knowledge, Professionalism, and Systems-based Practice were not correlated with GDR. Conclusions: Clerkship grades, interview scores, and select resident milestone ratings may be more useful in gaining insights into overall resident performance assessed by GDR than USMLE/COMLEX and ITE scores.

82. SMALL PROGRAM PROBLEM SOLVED! THE AGGREGATE ANONYMOUS PROGRAM REVIEW: PROVIDING A FORUM FOR CONFIDENTIAL EVALUATION AND THE ABILITY TO RAISE CONCERNS WITHOUT FEAR (DESCRIPTIVE ABSTRACT)
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Background: The ACGME requires that all trainees have the opportunity to evaluate the program confidentially and use the results to improve the program. The annual ACGME survey queries whether residents can raise concerns without fear and have opportunity to confidentially evaluate their program. Leaders of small programs face challenges in ensuring that learner feedback is confidential and actionable. Objective: Our primary objective was to develop means to ensure that learners in small programs had an opportunity to provide confidential feedback about their training that addressed ACGME requirements, permitted expression of other areas for improvement, could inform programmatic improvement plans and promoted learner-driven advocacy for change. METHOD: A brief survey was shared using Poll Everywhere software. Items on work hours, evaluations, teaching, supervision and feedback were included. Some were multiple choice, others used open responses for qualitative information. Learners from small programs were invited to attend a live session; if unable to do so, they were sent the identical survey via email. Aggregate responses were tallied and results shared with all learners and all program directors. The survey responses were shared approximately 1-2 months prior to the ACGME survey. Results: The survey was sent annually for three years to a total of 146 learners in small programs. Program size was from 1 to 11 learners in each of 15 programs. Participation was voluntary. Response rate was 54%. Common themes for improving learner experience were shared with program leaders for their PEC and APE. In the live forum, learners discussed and strategized implementing change within their own programs. Subsequent ACGME survey results had improved scores in “Ability to Raise Concerns Without Fear” and “Satisfied that Evaluations are Confidential” in the majority of participating programs. Conclusion: The use of an aggregate anonymous program review survey for learners in small programs provided a forum for confidential evaluation and the ability to raise concerns without fear, enriched the work of the PEC and APE, and may have contributed to improved scores on the programs’ own ACGME survey results.

83. A RESIDENT DRIVEN QUALITY IMPROVEMENT PROJECT TO IMPROVE FEEDBACK ON THE FLY (QI ABSTRACT)
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Background: Formative feedback plays an important role in helping residents identify actionable steps towards improvement. Applying quality improvement (QI) methods to educational problems leads to program improvement and application of QI concepts. Our residents identified feedback on-the-fly (FOF) or informal formative feedback as an educational problem at our institution. Aim Statement: By the end of 3 months, 80% of residents will receive FOF at least three times every two weeks. Interventions: In December 2016, 30 pediatric residents participated in a 2 hour QI workshop which reviewed the Model for Improvement®. Residents practiced writing aim statements and using two QI tools (fishbone and driver diagrams). Through that process a QI project was designed for receiving increased FOF. Two change strategies (1) weekly email reminders to faculty and residents and (2) a one-month long FOF campaign were developed. In December 2016, a 20 question baseline survey was sent to all residents electronically which focused on perception of feedback and FOF overall. In January 2017, change strategy 1 was implemented and change strategy 2 will be implemented in mid February 2017. Measures: An anonymous electronic survey measuring the amount of FOF received over the past two weeks was sent bi-weekly to all residents and will end in March 2017. A survey identical to the baseline survey will be sent in
84. MONTHLY FEEDBACK USING A NOVEL RUBRIC IMPROVES INTERN DOCUMENTATION (RESEARCH ABSTRACT)

Jason B. Fischer, MD, MSeD, Elise Gross, MD, Courtney C. Palka, MD, Jocelyn Schiller, MD, Heather Burrows, MD, PhD, University of Michigan, Ann Arbor, MI

Background: Electronic medical records (EMRs) have numerous advantages, due to medico-legal concerns, medical students are often restricted from documenting in the EMR. Therefore, prior note-writing experiences for incoming interns are variable, and often inadequate. Studies have demonstrated improvements in student documentation through use of a structured rubrics to improve feedback. A curriculum was created to educate pediatric interns on best practices and improve their documentation. Methods: A novel rubric that identified important components of an inpatient progress note was created containing 13 items scored 0 (not present), 1 (needs improvement), or 2 (present) in six categories: Clinical Data, Assessment, Problem List, Medical Decision Making, Disposition, and Style. Possible scores ranged from 0-26. Interrater reliability between residents was excellent (ICC=0.78). Interns were introduced to the rubric in June 2016. During inpatient rotations, interns received monthly structured feedback from chief residents using the rubric. To evaluate whether the educational intervention improved documentation, all resident progress notes on July 10 and December 10 from 2015 and 2016 were assessed using the rubric by three senior residents who were blinded to authorship and date. One-tailed t-tests were performed on the mean scores amongst groups. Results: Mean overall note score was 22 with wide variation (range: 14-26). No baseline differences between groups note writing mean score in July existed (control 21.5, intervention 21.9, p=0.25). No change in the control group scores between July and December was detected (21.5, 21.5, p=0.47). The intervention group showed improvements in documentation that approached statistical significance (21.9, 22.8 p=0.06). Conclusions: This preliminary analysis of ongoing data collection suggests that overall interns at this institution wrote variable quality notes and there was a trend towards improved documentation with the curriculum and feedback.

88. ALIGNING FEEDBACK WITH PERSONAL LEARNING GOALS: A PILOT INTERVENTION (DESCRIPTIVE ABSTRACT)

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Background: Although often considered a fairly straightforward behavior, feedback unfolds in a complex learning context. Research indicates that the quality and receptivity of feedback is enhanced when the message from the feedback giver aligns with trainees’ personal learning goals. However, an intervention specifically designed to improve an trainee’s feedback experience by aligning feedback with learning goals has not been described at our institution. Objective: We sought to improve feedback via a pilot intervention that promotes goal-oriented feedback in pediatric residency. Methods: During the 24-week study period (July-Dec 2016), interns on 5 general pediatrics inpatient floors were asked to submit personal learning goals for the week. Goals were submitted to the chief resident who then distributed them via email to the attending physician and senior residents. Attendings and seniors were encouraged to provide feedback on those goals. Process and outcome evaluation of the intervention were undertaken via interviews with 5 interns, 3 seniors, and 6 attendings. Interviews were transcribed and reviewed for commonly occurring concepts. Results: Of 640 requests for goals made to interns during the study period, there were 240 responses (40.1%). Process evaluation information collected in the first half of the study period indicated that writing relevant learning goals required familiarity with the inpatient floor. Timing of goal collection and distribution was altered to improve intervention uptake. Data relevant to outcome evaluation suggested the intervention enabled seniors and attendings to be intentional in providing specific, targeted feedback that aligned with interns expressed learning goals, but did not increase the frequency of feedback. Despite theoretical utility, practical utility was hindered by time constraints and limited buy-in among interns, attendings, and seniors. Conclusion: Aligning feedback with personal learning goals may improve the quality and receptivity of feedback. However interventions to promote goal-oriented feedback need to consider over-riding barriers of time and buy-in.
**WELLNESS/RESILIENCE/MINDFULNESS/BURNOUT**

87. EDUCATIONAL INTERVENTION IMPROVES PEDIATRIC AND MED-PEDS RESIDENTS’ EMOTIONAL INTELLIGENCE SCORES & STRESS MANAGEMENT/RESILIENCE SCORES (RESEARCH ABSTRACT)

Ramzan Shahid, MD; William Adams, MA; Loyola University, Maywood, IL

**Purpose:** Several studies have shown emotional intelligence (EI) scores can be improved by providing teaching sessions to resident physicians. In one study of ENT residents, educators introduced an 8-hour EI training session and showed a significant improvement of EI scores one year after the training session. Another study evaluated the EI level of Internal Medicine residents and used a 3-hour session that included a didactic presentation, videos, and role-playing. The authors concluded they could enhance residents’ understanding of their own EI and its importance in leadership. The purpose of our study was to compare EI scores of Pediatric and Med-Peds Residents before and after an educational intervention. **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 and then again in May 2016. During the 2015–2016 academic years, residents attended two separate 2-hour long educational workshops (total of 4 hours) focusing on developing EI skills. **Results:** 31 pediatric and med-peds residents completed the survey at both time points. 28 residents (90%) attended one or both educational sessions. There was a significant increase in total EI scores before and after the educational intervention (110 vs 114, p=0.005). Other sub-scores that significantly increased included self-regard, self-expression, independence, and decision making. The stress management composite score significantly increased (105 vs 111, p <0.001), along with its subcomponents of flexibility, stress tolerance, and optimism. **Conclusion:** As a group, Pediatric and Med-Peds residents had a significant increase in total EI score and several other components of EI following an educational intervention. This educational intervention focusing on the development of EI skills increased the residents’ scores for stress tolerance, flexibility, and optimism. Increasing a resident’s overall EI level may improve their resilience and stress management skills and reduce the risk of burnout.
88. SOLUTION-ORIENTED APPROACH TO IMPLEMENTATION OF A RESIDENT WELLNESS SERIES (DESCRIPTIVE ABSTRACT)

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Background: ACGME guidelines on physician wellbeing mandate residency programs to focus on wellness. Common challenges include identification of engaging topics, optimal venues, and program sustainability. A collaborative, goal-directed approach to wellness curriculum development with resident engagement can promote program sustainability. Objective: Our primary objective was to develop a sustainable resident-supported wellness series that promotes personal growth for individual residents. Methods: The UA pediatric residency program prioritized resident wellness based on year-end resident feedback. Wellness activities currently in place include topic talks, yearly retreats and participation in the Pediatric Integrative Medicine in Residency (PIMR) national pilot program, comprised of evidence-based teaching on mind-body therapies, nutrition, sleep, exercise and self-care. The goal was to develop a more formalized Resident Wellness Series to build on to the current curriculum. A focus group of interested faculty and residents outlined the aims of the Resident Wellness Series. Evaluation is underway and ongoing. Results: The focus group determined that the wellness series be a protected time to relieve resident's stress and allow exploration of new approaches to wellness. A half-hour time period during teaching day was carved out monthly. All sessions are organized by residents or have resident support. Topic examples are enhanced coping skills, chair yoga, meditation, and gratitude journaling. Session leaders are content experts, either UA faculty or community practitioners. Evaluations show that residents look forward to the sessions and like a schedule of stress management activities with one activity requiring movement (yoga) alternating with one centering on contemplation (meditation). Conclusions: The residents have embraced the Resident Wellness Series. A focus on stated goals and active involvement of residents in curriculum development and planning of sessions has been integral to its success. A goal-driven, solution-oriented approach to a Resident Wellness Series can be successful and sustainable.
90. BURNOUT STATUS AND MILESTONE PERFORMANCE IN PEDIATRIC RESIDENTS (RESEARCH ABSTRACT)
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**Background:** Burnout in trainees has gained attention because of its potential relationship to depression and negative impact on patients. Milestones have been utilized to measure the competency of residents in training. **Objective:** To compare the mean Milestone scores between pediatric residents who met criteria for burnout and those who did not by level of training. **Methods:** This work was completed as part of the Pediatric Residency Burnout and Resilience Consortium (PRBRC), a consortium of 34 programs, with the support of APPD LEARN. PRBRC conducted a confidential online survey of its members’ residents in April to June, 2016, which included the Maslach Burnout Inventory (MBI). In addition, programs submitted their assessment of residents’ milestones. Burnout was defined as high range for either emotional exhaustion or depersonalization domains of the MBI. We examined the relationship between burnout and performance as assessed by milestones by domain of competence and stratified by post-graduate year. **Results:** 1494 residents at 31 programs completed the MBI and had milestone data submitted. While residents who met criteria for burnout scored lower on all 21 Milestones compared with those without burnout, when PGY2 and PGY3 residents were examined the association between burnout status and milestone performance was not statistically significant. However, in the PGY1 cohort, those who screened positive for burnout had lower milestones in the following domains: patient care (2.97 vs 2.76, p=0.001), systems based practice (2.68 vs 2.86, p=.004), problem based learning and improvement (2.93 vs 2.74, p=.002), professionalism (3.24 vs 3.07, p=0.007), and interpersonal and communication skills (3.12 vs 2.93, p=.001) but not in medical knowledge. **Conclusion:** Burnout status is most closely associated with decreased milestones for PGY1 in every domain of competence except medical knowledge. Future research needs to address whether strategies to mitigate burnout results in improved PGY1 performance.

91. PEDIATRIC RESIDENT STRESS AND ATTITUDES ABOUT MINDFULNESS (RESEARCH ABSTRACT)
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**Background:** Psychological stresses are prevalent during residency and impact well-being. Mindfulness can mitigate stress, increase self-awareness, and promote wellness. Prior studies of non-pediatric residents showed high stress levels and moderate mindfulness awareness; females had higher stress levels, but there was no difference by PGY level. Little is known about pediatric resident perceived stress and mindfulness awareness. **Objective:** To determine stress level and attitudes toward mindfulness in a pediatric residency and to determine characteristics of residents associated with higher stress and greater receptivity toward mindfulness. **Methods:** Pediatric residents in a single program voluntarily participated in a survey about stress and mindfulness prior to mindfulness intervention. The anonymous survey was IRB-approved and collected demographics and responses to the Perceived Stress Scale (PSS) and the Mindfulness Attention and Awareness Scale (MAAS), which measures attention to the present moment. Pearson Chi-Square, t-test and Pearson R2 were utilized to detect associations among demographic data, PSS, and MAAS responses. **Results:** The survey was completed by 65% of pediatric residents. Of respondents, 64% reported high stress (PSS>13), 93% thought residency was stressful, and 96% had positive attitudes towards mindfulness. Interns trended towards lower PSS score compared to upper class peers (p=0.09), yet had higher average MAAS score (p=0.01). Females trended toward strongly agreeing that residency was stressful (p=0.08), and males perceived lower utility of mindfulness training (p=0.04). Increased PSS was strongly associated with increased MAAS (p<0.0001, R2=0.33) among respondents. **Conclusion:** The majority of respondents endorse that residency is stressful, yet had positive attitudes toward mindfulness. Unlike prior studies, our study found no significant differences in PSS by gender. The effectiveness of a mindfulness curriculum is perceived differently by gender. These findings may offer potential explanations for differential effects of our subsequent mindfulness intervention in stress reduction and mindfulness behavior.

92. ASSESSING THE CHANGE IN BURNOUT AND RESILIENCE IN PEDIATRIC RESIDENTS FOLLOWING GRADUATION FROM GENERAL TRAINING (RESEARCH ABSTRACT)
Rebecca Y. Petersen, MD, Stuart Slavin, MD, St. Louis University School of Medicine, Saint Louis, MO, Anne Vo, PhD, Dixie L. Fisher, PhD, University of Southern California/LAC&USC Medical Center, Los Angeles, CA

**Background:** Professional transitions in medical education create periods that can lead to physical and emotional exhaustion. Studies have shown burnout levels as high as 25% in some residency groups. The effects of stress and burnout can correlate with anxiety, depression and suicidal ideation, which have far reaching sequelae beyond the residency period and into practice. **Objective:** Measure graduating resident level of concern about graduation, job satisfaction, and trend burnout and resilience through the transition period. **Methods:** Residents from the pediatric program at Saint Louis University were sent an anonymous survey in the month prior to graduation asking them to rate level of concern about aspects of graduating from residency and to fill out the Brief Resilience Scale (BRS) and Oldenburg Burnout Inventory (OLBI). Four months following graduation, the same
93. ASSOCIATION OF RESIDENT DEPRESSION WITH HARMFUL MEDICAL ERRORS (RESEARCH ABSTRACT)
Katherine A. Brunsberg, MD, Christopher Landrigan, MD MPH, Briana Garcia, BS, Carter Petty, MA, Theodore Sector, MD, Children's Hospital/Boston Medical Center, Arabella Simpkin, MD MMS, Massachusetts General Hospital, Boston, MA, Nancy Spector, MD, St. Christopher's Hospital for Children, Philadelphia, PA, Amy Starmer, MD MPH, Children's Hospital/Boston Medical Center, Boston, MA, Daniel West, MD, University of California (San Francisco), San Francisco, CA, Sharon Calaman, MD, St. Christopher's Hospital for Children, Philadelphia, PA

Background: Rates of resident depression and burnout are high and have been associated with increased rates of self-reported medical errors. Whether depressed residents actually make more errors or are just more likely to perceive or report them is unclear. Objective: Determine whether depressed or burned out residents are more likely to make medical errors. Methods: We conducted a prospective cohort study from 2011-2013 at 7 pediatric medical centers, concurrent with the I-PASS Handoff Study. We measured burnout using the Maslach Burnout Inventory and depression using the Harvard Department of Psychiatry/National Depression Screening Day Scale. Data collectors and adjudicators, blinded to resident burnout and depression, measured medical errors using a two-step active surveillance methodology. We used mixed effects regression models to evaluate the relationship between burnout, depression, medical errors, and preventable adverse events. Results: 388 of 537 (72%) residents completed surveys. Nineteen percent (n=76) and 46% (n=178) of residents met criteria for depression and burnout, respectively. Rates of preventable adverse events by depressed residents were higher than non-depressed residents (IRR 2.99, CI 1.40-6.36, P=0.005) (Table 1). There was no association between positive depression scores and total medical errors or positive scores for burnout and total errors and preventable adverse events. The mean number of preventable adverse events for depressed vs. non-depressed residents was 0.33 (CI 0.18-0.61) vs. 0.08 (CI 0.05-0.13) and burned out vs. not burned out residents was 0.20 (CI 0.12-0.33) vs. 0.08 (CI 0.04-0.13). The mean number of total errors for depressed vs. non-depressed residents was 1.54 (CI 1.04-2.29) vs. 0.99 (CI 0.79-1.25) and burned out vs. not burned out residents was 1.28 (CI 0.93-1.67) vs. 0.98 (CI 0.74-1.29).
Conclusions: Depressed residents were nearly three times more likely than non-depressed residents to make harmful errors. Our findings suggest that resident mental health is a critical component of patient safety. Interventions to identify and mitigate depression in residents may improve patient safety.

Table 1. Association of depression and burnout with preventable adverse events and total errors.

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<th>Preventable adverse events</th>
<th>Total errors</th>
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<tbody>
<tr>
<td>Depression</td>
<td>IRR 2.99</td>
<td>p-value 0.005</td>
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<td></td>
<td>95% CI 1.40-6.36</td>
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<tr>
<td>Burnout</td>
<td>1.24</td>
<td>0.57-2.67</td>
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94. THE POSITIVE INFLUENCE OF PROGRAMMATIC SUPPORT ON PROGRAM COORDINATORS’ STRESS LEVELS: A NATIONAL SURVEY OF PEDIATRIC COORDINATORS (RESEARCH ABSTRACT)
Charlene Larson Rotandi, AB, Megan Christofferson, BA, Meghan Stawicke, BA, Susan Freeman Ike, BS, Emily Johnson, MA, Stanford University, Department of Pediatrics, Diane Steinberg, PhD, Stanford Health Care, Department of Graduate Medical Education, Palo Alto, CA

Background: Program coordinators (PCs) are essential to their educational programs’ overall success. Stress is an issue for coordinators, as their positions seem to have high turnover rate that can be disruptive to training programs. A review of residency and subspecialty programs in the Department of Pediatrics at a single academic institution over a five-year period (July 2010-June 2015) revealed a PC attrition rate of 32%. Objective: Determine PCs’ perceptions of stress and job satisfaction, and investigate the relationship between self-perceived stress levels and programmatic support. Methods: Pediatric PCs on the Association of Pediatric Program Directors (APPD) Listserv were sent an email message with a request to anonymously participate in a national survey created using Qualtrics. This IRB-exempt survey was open from March 11 to May 2, 2016, and it included a modified Professional Quality of Life Scale (PROQOL 5) for measures of job burnout and job satisfaction. Survey items also came from a national obstetrics/gynecology survey of PCs designed by Curran et al. from the University of Michigan (2014), and the APPD Research and Scholarship Task Force influenced the final version of the survey.

Results: We obtained responses from 12 out of 18 residents prior to graduation and 13 out of 18 residents in the follow-up survey. Residents rated finances, changes in location, and level of responsibility to be the highest concerns regarding graduation. Prior to graduation the mode on the BRS was 4 points (scale of 1-5 with higher scores indicating higher resilience) with an average of 3.7 and standard deviation of 0.6. Following graduation the mode was 4, the average 3.6 and standard deviation was 0.7. Prior to graduation the OLBI revealed an average score of 2.7 points (scale of 1-4 with lower scores indicative of higher burnout), standard deviation of 0.3. The engagement subset score revealed an average of 2.8 points, standard deviation of 0.4. The average energy subset score was 2.6 points with a standard deviation of 0.3. Following graduation the average total score and standard deviation remained unchanged, however the range was lower at 2.25-3. The engagement and energy subset score averages trended to 2.8- and 2.5-points, respectively. Standard deviations were 0.3 for both subsets. Job satisfaction scores (scale of 4-points where high scores indicated higher satisfaction) showed an average of 3 points, standard deviation of 0.6. Residents also commented on difficulties with a steep learning curve, balancing fellowship and studying for licensure, and higher expectations. Conclusions: The transition out of general pediatric training is difficult and results in a possible trend towards lower resilience, lower engagement and higher exhaustion. Overall job satisfaction was high, however the range included those that were very unhappy with their current position. These results indicate that graduating residents may benefit from an intervention aimed at addressing the concerns surrounding transitions in medical education.
95. DREAM: DEVELOPING RESIDENT EMOTIONAL AND MENTAL HEALTH (DESCRIPTIVE ABSTRACT)

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Background: Physicians experience disproportionately high rates of burnout and depression, with increasing rates each year of residency training. This impacts care, as depressed residents make more medical errors. However, best practices for fostering resident wellness and screening for and managing burnout and depression are inadequately described. Methods: Developing Resident Emotional and Mental Health (DREAM) is a chief resident-led program to coordinate residency-wide efforts to promote wellness and reduce rates of burnout and depression. A resident wellness committee guides selection and implementation of interventions and oversees evaluation. DREAM focuses on: 1) fostering innovative, complementary curricula aimed at improving wellness; and 2) implementing a mental health screening program. Screening aims to: quantify and trend rates of burnout and depression; create opportunities for residents to self-identify burnout and depression; and quickly and confidentially link residents to support. Periodic screening will occur via an optional survey with questions from the Maslach Burnout Inventory and Patient Health Questionnaire-2. Results will be de-identified to the program but reviewed by the hospital’s independent Office of Clinician Support (OCS), who will contact residents screening positive. OCS will offer in-person appointments, support from chiefs and peer supporters, and additional resources. Results: In the first year, DREAM mapped existing efforts in the domains of supportive program components, assessment, wellness education, and mental health intervention. We identified gaps where innovation is needed and started to 1) enhance existing curricula; 2) establish wellness half-days, a peer support program, and a personal story sharing program; and 3) raise awareness about existing mental health services. Screening will begin in February 2017, after which rates of burnout and depression will be trended. Conclusions: By implementing DREAM, we increased resident self-awareness of mental health issues. Next steps include measuring the effectiveness of our interventions to achieve decreased rates of burnout and depression.

96. CREATING A PEDIATRIC RESIDENCY WELLNESS CURRICULUM (DESCRIPTIVE ABSTRACT)

Matthew Campbell, MD, Jodi Dingle, MD, Laura Sartori, MD, Savannah Walker, MD, Whitney Browning, MD, Rebecca Swan, MD, Vanderbilt University, Nashville, TN

Background: Resident health and wellness is an increasing topic of discussion in Graduate Medical Education. Although our residency has emphasized the importance of wellness, we did not have a formal plan to address the topic. Objective: To improve wellness and mindfulness in our Pediatric Residency. Methods: A resident committee was formed with subcommittees to address specific aspects of wellness. Monthly resident conference time was allotted for topics related to wellness and mindfulness. Residency leadership allocated an annual budget to be used for resident-led wellness activities. Residents were surveyed about understanding and perceived residency support of wellness and mindfulness. This survey was performed prior to and six months following the initiation of the curriculum. A second survey was conducted to assess the ability to utilize recommended health services. Results: In our initial survey, 71% of respondents felt comfortable defining the term “wellness”, but 47.3% did not feel that the residency adequately promoted wellness. 54.1% felt comfortable defining...
97. PILOT OF A NOVEL FACILITATOR-FRIENDLY SIX-MONTH MINDFULNESS CURRICULUM FOR INTERNS (RESEARCH ABSTRACT)

Yarden S. Fraiman, MD, Christine Cheston, MD, Catherine D. Michelson, MD, Med., Colin M. Sox, MD, MS, Boston Children's Hospital/Boston Medical Center, Boston, MA

**Background:** Burnout affects physician well-being, patient care, and safety. Mindfulness is the quality of being fully present in the moment during everyday activities, and mindfulness curricula have been shown to reduce physician burnout and improve wellness and empathy. **Objectives:** To design and pilot a six-month mindfulness curriculum during pediatric internship in order to assess feasibility and acceptability. **Methods:** Adopting a longitudinal study design, we implemented a 7-session mindfulness curriculum during the first six months of internship in a large pediatric residency program. Prior to implementation and following the final session, we invited all interns to complete surveys that included the Maslach Burnout Inventory, Jefferson Scale of Physician Empathy, 5-Facet Mindfulness Questionnaire, and items assessing resident knowledge, attitudes, and behaviors about mindfulness practice. Data were analyzed using chi-square and t-tests. **Results:** All 80 interns participated in the curriculum. The survey response rate at baseline was 100%, and six months later was 84%. Curriculum implementation was feasible, as all 7 sessions occurred as scheduled, and the vast majority of interns (80%) attended all three sessions. Participants reported improved knowledge, attitudes, and behaviors about mindfulness practice were impacted by the curriculum, as a majority reported: 1) Improved attitudes toward mindfulness (89%); 2) Increased knowledge on how mindfulness impacts well-being (87%); 3) Increased knowledge on how to apply mindfulness in real-life (82%); 4) Mindfulness training positively benefited their lives (82%). We successfully assessed participants levels of burnout, empathy, and mindfulness at baseline and six-month follow-up; these scores did not significantly change. **Conclusion:** Our novel six-month mindfulness curriculum targeting physician trainees was feasible to implement during a busy pediatric internship. Interns reported improved knowledge, attitudes, and behaviors toward mindfulness. Larger, controlled studies are needed to determine how this six-month curriculum impacts trainee burnout, empathy, and mindfulness.

98. A PROGRAM’S RESPONSE TO BURNOUT: CREATION OF A MULTIFACETED RESILIENCY CURRICULUM (DESCRIPTIVE ABSTRACT)

Linessa M. Zuniga, MD, Taylor R. McLain, MD, Jolie J. Britt, MD, Betsy A. Cowling, MD, Judson A. Moore, MD, Roger K. Nicome, MD, Teri L. Turner, MD, MPH, MEd, Baylor College of Medicine (Houston), Houston, TX

**Background:** Physicians often experience burnout secondary to physical and psychological stress during residency. Interventions thus far have been limited. **Objective:** Develop a comprehensive resident resiliency curriculum that is individualized, feasible, and easily replicated using self-determination theory (SDT) as a framework. **Method:** A curriculum was developed using the conceptual framework of SDT to build a culture of resiliency. The focus was on autonomy, competence, and relatedness. First, trainees developed an individualized resiliency action plan (autonomy/competence) involving identification of support individuals and combining self-assessment and development of personal coping skills along a wellness-burnout continuum. The program also includes periodic protected social time during the clinical work day (relatedness). Lastly, a resident resiliency team (RRT) was developed. The team is composed of peers who create avenues for social connections and serve as an on-call support system available to residents having difficulty with work and/or life experiences (relatedness). The primary outcome measure will be perceptions of burnout using the Maslach burnout scale, before and after institution of the curriculum. Secondary measures include resident satisfaction, utilization of curriculum offerings, implementation feasibility, and ease of replication. **Results:** Residents completed their resiliency action plans early in the academic year and are now utilizing terminology in the plan to discuss their own feelings of burnout. The RRT has held monthly events to discuss and prevent burnout. Each event was attended by 25-30 residents. A total of 6 social noon conferences have been scheduled, clustered in the middle of the year. Resident verbal feedback has been positive. **Conclusion:** This resiliency curriculum was well received and feasible to implement. Outcome data are pending. Our approach, which specifically targeted resident autonomy, competence, and relatedness by focusing on development of coping self-efficacy, protected break time, and supported peer interaction, has potential to be applied to other programs.

99. IMPACT OF RESIDENT BURNOUT ON MEDICAL STUDENTS (DESCRIPTIVE ABSTRACT)

Julie Doering, MD, Joanna Kramer, DO, Rebecca Scherzer, MD, John Mahan, MD, Rebecca Wallihan, MD, Nationwide Children’s Hospital/Ohio State University, Columbus, OH

**Background:** Burnout in medical trainees may impact factors including professionalism, medical knowledge, medical errors, career choice, and mental health. In teaching hospitals, residents are responsible for a significant portion of medical student education. The interaction between resident and student could affect student well-being, burnout, and career choices. **Objective:** Develop a comprehensive resident resiliency curriculum that is individualized, feasible, and easily replicated using self-determination theory (SDT) as a framework. **Method:** A curriculum was developed using the conceptual framework of SDT to build a culture of resiliency. The focus was on autonomy, competence, and relatedness. First, trainees developed an individualized resiliency action plan (autonomy/competence) involving identification of support individuals and combining self-assessment and development of personal coping skills along a wellness-burnout continuum. The program also includes periodic protected social time during the clinical work day (relatedness). Lastly, a resident resiliency team (RRT) was developed. The team is composed of peers who create avenues for social connections and serve as an on-call support system available to residents having difficulty with work and/or life experiences (relatedness). The primary outcome measure will be perceptions of burnout using the Maslach burnout scale, before and after institution of the curriculum. Secondary measures include resident satisfaction, utilization of curriculum offerings, implementation feasibility, and ease of replication. **Results:** Residents completed their resiliency action plans early in the academic year and are now utilizing terminology in the plan to discuss their own feelings of burnout. The RRT has held monthly events to discuss and prevent burnout. Each event was attended by 25-30 residents. A total of 6 social noon conferences have been scheduled, clustered in the middle of the year. Resident verbal feedback has been positive. **Conclusion:** This resiliency curriculum was well received and feasible to implement. Outcome data are pending. Our approach, which specifically targeted resident autonomy, competence, and relatedness by focusing on development of coping self-efficacy, protected break time, and supported peer interaction, has potential to be applied to other programs.

The term “mindfulness”, and 23.7% felt comfortable practicing mindfulness at work. In the six month follow-up survey, only 5.8% of respondents did not feel that the residency program adequately promoted wellness, though 20.4% remained undecided. 33.3% felt comfortable practicing mindfulness at work. In our health care utilization survey, 61.6% of 2nd and 3rd year respondents stated that they do not have a primary care physician. Four (36.4%) of 11 residents with a “chronic medical problem” stated that they had not followed up within the recommended time frame. When asked to cite barriers to seeking medical care, 92.3% cited lack of time and 84.6% cited lack of schedule predictability. **Conclusion:** We have implemented a curriculum that has improved understanding and promotion of wellness, but more specific focus must be placed on empowering residents to practice mindfulness at work. Based on the results of the second survey, the residency has implemented scheduled ‘Health and Wellness’ days for each resident to attend to health care and wellness needs.
GLOBAL HEALTH

100. THE IMPACT OF GLOBAL AWAY ROTATIONS ON HOST COUNTRY LEARNERS (RESEARCH Abstract)
Shane C. Quinonez, MD, University of Michigan, Ann Arbor, MI, Abate Yeshidinber, MD, Not Affiliated with Program/Institution listed above, Addis Ababa, Ethiopia, NA, Hilyar Haffel, MD, University of Michigan, Ann Arbor, MI

Background: The education benefit of global away electives for developed-country trainees has been studied extensively in the past. Little is known, however, on the positive and negative impact these away electives have on host country medical trainees. Objective: To determine the impact of global away electives on host country trainees' medical education and their perception of international trainees. Methods: An anonymous survey was conducted with Pediatric, Internal Medicine, Surgery residents from St. Paul’s Hospital Millennium Medical College (SPHMMC) in Addis Ababa, Ethiopia about their experiences hosting international trainees on global away electives. A 4-item Likert-type scale was used to determine Ethiopian residents' overall experience with international trainees, how their medical education was affected using the framework of the ACGME core competencies, their comfort level with supervising international trainees, and their preferences regarding future work with international trainees. Results: A total of 42 SPHMMC residents completed the survey. Thirty-three (79%) had previously worked with an international trainee. Of these 33 respondents, 17 (52%) were in Pediatrics residency, 7/33 (21%) were in Internal Medicine residency, and 9/33 (27%) were in Surgery residency. Sixteen (49%) of the 33 respondents rated their overall experience as Excellent, 14/33 (42%) rated it as Good, and 3/33 (9%) rated it at Poor. When asked about the impact of international trainees on their education in the 6 core competencies, the majority of residents expressed a positive impact and highly rated the abilities of international trainees in these areas. Only 4/33 (13%) of surveyed residents reported feeling Somewhat Uncomfortable supervising international trainees below their level of training while 11/33 (37%) and 15/33 felt Extremely Comfortable and Somewhat Comfortable, respectively. Twenty-four (73%) of the 33 respondents reported wanting a great deal in the future to work at a hospital that houses rotations for international trainees as. Conclusions: Residents at Ethiopia's SPHMMC find international trainees to be a welcomed aspect of their healthcare system and residents on away global electives appear to have predominantly positive impact on medical education in their pediatrics, internal medicine, and surgery training programs.

101. BENEFIT OR BURDEN? INTERNATIONAL PRECEPTORS’ PERCEPTIONS OF SHORT-TERM GLOBAL HEALTH ELECTIVE LEARNERS AT TWO SITES IN SUB-SAHARAN AFRICA (RESEARCH Abstract)
Elizabeth M. Keating, MD, Heather Lukolyo, MD, MHS, Chris R. Rees, MD, MPH, Padma Swamy, MD, Teri L. Turner, MD, MPH, MED, Stephanie Marton, MD, MPH, Baylor College of Medicine (Houston), Houston, TX, Jill Sanders, MD, Edith Q. Mohapi, MBBS, Peter N. Kazembe, MBChB, Baylor College of Medicine (Houston), N/A, NA, Gordon E. Schutze, MD, Baylor College of Medicine (Houston), Houston, TX

Background: Short-term global health electives (STGHEs) have become more popular with evidence showing the benefits that short-term learners (STLs) derive. Despite increased recognition that STGHEs should aim for mutuality of benefits between host sites and STLs, evidence showing benefits to the host preceptors is lacking. Objective: Gain an understanding of international host preceptors’ perceptions regarding benefits and burdens of supervising STLs. Methods: Focus group discussions with clinical preceptors were conducted by 3 authors at 2 pediatric STGHE sites in Malawi and Lesotho. Institutional review board approval was obtained from each site and Baylor College of Medicine. Sessions were recorded and transcribed. Two other authors performed qualitative content analysis using Dedoose software to identify themes using a deductive-inductive approach. Results: Ten preceptors who supervise on average 5-10 STLs per year participated in 2 focus group discussions. Common themes regarding benefits to host preceptors included increased knowledge and resources for learning from STLs, broadened differential diagnoses, and the satisfaction of teaching. Regarding burdens, preceptors perceived that supervising STLs decreases efficiency, especially when they also serve as interpreters. Preceptors identified the burden of having to intervene in instances that could lead to patient harm, including when STLs give incorrect medical advice. Some perceived that STLs under-valued preceptors’ clinical decision-making in resource-limited contexts. Preceptors suggested ways to improve benefits to the hosts, including pre-departure preparation, longer duration of STGHEs, improved host orientation, and opportunity to learn more about STLs’ cultures. Preceptors perceived that mutuality of benefits is more likely to occur when STLs are interested and engaged learners. Conclusions: Preceptors identified ways in which STLs benefit and burden...
their hosts. They suggested factors that may improve benefits to hosts to ultimately enhance the mutuality of benefits between STLs and hosts.

102. NECESSITY: THE MOTHER OF INNOVATION AND ADVOCACY IN RESOURCE-LIMITED SETTINGS (RESEARCH ABSTRACT)
Stephanie M. Lauden, MD, CTropMed, Sophia Gladding, PhD, Cynthia R. Howard, MD, MPH, Tina M. Slusher, MD, Michael B. Pitt, MD, University of Minnesota, Minneapolis, MN

Background: Participation in global health (GH) experiences during residency is increasing. Little is known about the ways the challenge of working in limited resource (LR) settings is manifested or interpreted. Objective: To identify sub-themes in trainee’s perception of impactful clinical scenarios encountered on GH electives, as they relate to the broader theme of working in LR settings. Methods: Pediatric (8) and IM-peds (5) residents participated in 4-8 week electives as part of a GH curriculum from March to December 2016. Residents maintained online disease log of the 10 most interesting or impactful clinical scenarios encountered. Authors analyzed and coded themes. The coded responses were then compared and discussed by the authors until consensus was reached. Emergent themes included a group relating to resource limitations, and these were analyzed further.

Results: Disease logs were received from all 13 residents who participated in electives and yielded 129 unique clinical scenarios from 8 countries. The first-order analysis generated 28 unique codes, of which 5 (18%) related specifically to the implications of LR settings (Table 1). The majority (59%) of described clinical scenarios included at least one LR theme, with 100% of residents including one or more of these themes in at least 30% of their descriptions of impactful scenarios.

Conclusions: Consistent with the sentiment that resource limitations represent predictable challenges for physicians serving abroad, almost all residents wrote that LR contributed to negative patient outcomes or a change in clinical approach. Yet, resource limitations were not all perceived as negative. Notably, over 1/3 of residents planned to apply at home the lessons learned from working in LR settings. LR led to opportunities for advocacy or innovation. Residents planned to bring lessons learned from these creative solutions home. This insight into both the challenges and lessons learned from working in resource limited settings may inform pre-departure training.

<table>
<thead>
<tr>
<th>Limited Resource (LR) Theme</th>
<th>Clinical Scenarios (n=28)</th>
<th>Residents Who Referred LR Theme (n=13)</th>
<th>Examples from Resident Disease Log</th>
</tr>
</thead>
<tbody>
<tr>
<td>Different Clinical Approach or Incomplete Workup</td>
<td>42%</td>
<td>100%</td>
<td>*Residents often described reliance on physical exam rather than tests (60% of responses from entire data set). *Family unable to afford diagnostic tests, or tests are not available, so empiric therapy is chosen. Empiric therapy is often based on cost.</td>
</tr>
<tr>
<td>Negative Patient Denial or Death</td>
<td>25%</td>
<td>92%</td>
<td>*Radiologic reduction in immunocompromised patient was not available. *A family could only afford a cup of salt for child dying of untreated malaria. *A child had a skin abscess, no providers able to do drainage wash-out.</td>
</tr>
</tbody>
</table>

Table 1: Thematic Analysis of Trainees’ Experiences in Limited Resource Settings

103. “TUTORING REFUGEES AND IMMIGRANTS: US BASED EDUCATIONAL OPPORTUNITIES FOR PEDIATRIC RESIDENTS INTERESTED IN GLOBAL HEALTH.” (DESCRIPTIVE ABSTRACT)
Anik Patel, MD, Courtney Winterer, DO, Jennifer Watts, MD, Children’s Mercy Hospital, Kansas City, MO

Purpose: Global health (GH) training is an increasingly important component of pediatric residency programs. In order to increase GH experiences without leaving the country, residents in the GH program at Children’s Mercy Hospital participate in tutoring experiences with refugees and immigrants in English as Second Language (ESL), citizenship, and General Educational Development (GED) sessions. This study seeks to understand the impact of tutoring experiences on pediatric residents training in GH. Methods: GH residents who participated in tutoring sessions from 2014-2016 were asked to complete a brief evaluation. Topics included resident satisfaction, perception of cultural awareness, application of skills to a clinical setting, and the overall value of the experiences. Responses were analyzed using quantitative and qualitative methodology. Results: Twenty-one residents (91%) completed the survey. Overall, residents valued and enjoyed their experiences. Tutoring sessions taught residents how to better interact with refugees and immigrant families in clinical and non-clinical settings. Tutoring sessions also helped residents gain a better understanding of different cultures. Examples of specific comments residents made describing their experiences included they would be sensitive to the struggles/hardships that [refugees] have faced and the tutoring sessions helped them to visualize the refugee community outside of just a clinic. Conclusions: Volunteering at ESL, GED, and citizenship classes with refugees and immigrants offers valuable educational opportunities for residents interested in global health. In addition to enhanced cultural awareness, residents improved their patient care and communication skills with refugees and immigrants. Volunteer experiences with refugees and immigrants, such as tutoring, are a beneficial stateside component of the global health education of pediatric residents.
**Background:** Residents are increasingly participating in global health (GH) electives in resource-limited settings. While anecdotally these experiences are deemed valuable by residents, little is known about the breadth and impact of the clinical scenarios encountered. **Objective:** Identify themes in residents’ perception of the most interesting/impactful clinical scenarios they encountered on GH electives as part of the University of Minnesota GH track. **Methods:** Pediatric (8) and medicine-pediatric (5) residents participated in 4-8 week electives as part of a global health curriculum from March to December of 2016. Each was asked to maintain an online disease log where they described the ten most interesting/impactful clinical scenarios encountered. One author read the de-identified comments multiple times identifying themes. A second author then independently coded all of the written comments using the updated themes. The two authors met and compared their coding for each question, agreed upon 28 unique codes, mapped to ACGME core competencies, and discussed areas of disagreement until consensus was reached. **Results:** We received disease logs from all 13 residents who participated in electives, yielding 129 unique clinical scenarios from eight countries. During the first-order analysis, 8 themes were found in more than 10% of comments and are summarized in Table 1 along with the ACGME Core Competencies which they address. **Conclusion:** Residents reported a wide variety of reasons for why the clinical scenarios they encountered on GH electives were impactful, with the most frequent themes mapping well to ACGME core competencies. GH electives may provide an opportunity for residents to develop meaningful competencies in areas which can be difficult to address in traditional residency training. These themes can inform best practice in pre-departure training, highlight potential risk factors for resident moral distress, and demonstrate personal development.

### Table 1: Mapping Themes to ACGME Core Competencies

<table>
<thead>
<tr>
<th>Theme</th>
<th>Clinical Scenarios Referencing Theme (n=129)</th>
<th>Residents Who Referenced This Theme in a Scenario (n=13)</th>
<th>ACGME Core Competencies Addressed*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dealing with diagnostic ambiguity</td>
<td>29%</td>
<td>85%</td>
<td>PC, MK, SBL, PBLI</td>
</tr>
<tr>
<td>Limited resources necessitating variation in approach to treatment or diagnosis</td>
<td>25%</td>
<td>100%</td>
<td>PC, MK, SBL, PBLI, PROF</td>
</tr>
<tr>
<td>Encountering severe presentations of common diseases</td>
<td>24%</td>
<td>85%</td>
<td>MK, SBL, PBLI</td>
</tr>
<tr>
<td>Seeing disease which are rare everywhere</td>
<td>21%</td>
<td>69%</td>
<td>MK, SBL, PBLI</td>
</tr>
<tr>
<td>Seeing diseases common in elective setting, but rare in US</td>
<td>19%</td>
<td>69%</td>
<td>MK, SBL, PBLI</td>
</tr>
<tr>
<td>Relying on physical exam to make diagnosis clinically</td>
<td>18%</td>
<td>85%</td>
<td>PC, MK</td>
</tr>
<tr>
<td>Dealing with death</td>
<td>15%</td>
<td>69%</td>
<td>SBL, PROF, ICS</td>
</tr>
<tr>
<td>Addressing differences in economic and political determinants</td>
<td>13%</td>
<td>62%</td>
<td>SBL, PROF, ICS</td>
</tr>
<tr>
<td>Relishing in a “clinical win” with a positive outcome</td>
<td>12%</td>
<td>54%</td>
<td>PC, SBL</td>
</tr>
</tbody>
</table>

*PC: Patient Care; MK: Medical Knowledge; SBL (Systems Based Learning); PBLI: Practice-Based Learning and Improvement; PROF: Professionalism; ICS: Interpersonal and Communication Skills

**Objective:** To develop and implement a hospital-wide advocacy initiative focused on enhancing poverty awareness for all pediatric providers. A secondary objective included engaging our pediatric residents in the design of an educational advocacy campaign. **Methods:** The advocacy initiative resulted in a 7-day educational event held at our institution. Residents from all training levels and other hospital leaders were engaged in the initiative. Daily, thematic educational forums were offered by residents to enhance access to inter-professional teams including an institutional grand rounds session. The effect of the initiative was assessed by evaluating pre/post-provider comfort level with identifying and providing resources for poverty using a Likert-based survey. Utility and interest in the initiative was also assessed via Twitter Analytics. **Results:** At least 226 hospital faculty and staff were directly engaged during the resident-led face-to-face outreach sessions. Furthermore, the initiative was viewed on over 5,000 Twitter feeds. Provider confidence in referring patients to community resources, identifying food insecurity, and helping patients seek health insurance increased significantly after the advocacy initiative. Over half of the trainees in the program were successfully engaged in various aspects of the initiative. **Discussion:** Advocacy is an important competency for pediatric trainees, however obtaining purposeful experience for trainees is difficult to achieve. We successfully implemented a hospital-wide, resident-led advocacy initiative that directly improved providers' confidence in addressing multiple poverty-related issues. Based on the success of this project, our residency program is implementing an annual advocacy curriculum that will provide residents with practical experience in developing and executing advocacy efforts.
106. QUALITATIVE EVALUATION OF A POVERTY AND SOCIAL JUSTICE ROTATION (DESCRIPTIVE ABSTRACT)
Kimberly A. Boland, MD, Tara McKinley, MA, University of Louisville, Louisville, KY
In 2014, 21% of US children lived below the poverty line. Childhood poverty puts children at increased risk for negative health outcomes. Pediatricians are positioned to advocate for children yet may have a limited understanding of the barriers facing patients with fewer resources. Providers give better care when they have insight into their patients’ limitations and obstacles. Pediatric programs have various curricula to address these issues. It is not well known if existing curricula are effective in educating residents about social determinants and barriers and if they lead to change in attitudes and actions. Our Poverty and Social Justice (PSJ) rotation is geared toward providing such experiences. The aim of this study was to identify what effect this rotation has on our trainees. Methods: Reflective essays of 11 residents who participated in the PSJ rotation over 3 years were reviewed by 4 individuals to identify recurring themes. A triangulation meeting with the 4 reviewers and 2 others, to ensure lack of bias, was held to develop themes and resolve discrepancies. Using these themes, a model was developed to explain and identify the effects of this rotation. Results: Analysis showed that previous life experiences colored trainees’ perceptions. These schema were challenged by the injustices they witnessed. This led to cognitive dissonance between their perception of life and the reality of what they saw. They had emotional responses such as shock and disbelief. They learned about the complexity and severity of barriers facing the underserved, and the influence of social well-being on health. As their awareness grew, they assimilated newly discovered community resources and tools to aid them in their future practice. This culminated into future goals including advocacy, education, changes in practice and the realization of individual limitations. Conclusions: Using the above themes, we created a model for the framework of learning that occurred. This model aligns with the Kolb cycle of experiential learning. By using this model, we and others can adjust learning experiences for future residents.

107. ILLINOIS COMMUNITY PEDIATRICS AND ADVOCACY TRAINING COLLABORATIVE: DEVELOPING A ROADMAP FOR THE FUTURE (RESEARCH ABSTRACT)
Michelle M. Barnes, MD, Jalene Shoener, MD, University of Illinois College of Medicine at Chicago, Chicago, IL
Background: Since 2013, the ACGME has required pediatric residency programs to provide “ambulatory experiences to include elements of community pediatrics and child advocacy.” Programs vary in how they incorporate community pediatrics and advocacy (CPA) into their programs. Prior work has demonstrated the benefits of utilizing a collaborative model to facilitate improved integration of CPA into pediatrics residency programs. Methods: In 2015, we developed the Illinois Community Pediatrics and Advocacy Training Collaborative to organize CPA educators in Illinois, and we conducted a needs assessment of the 11 residency programs in Illinois. We utilized a survey developed by CPA educators in California and New York as a framework for our 26-item survey. Results: 100% of CPA directors and 73% of chief residents completed the survey. 53% of respondents reported using block rotations to teach CPA, 42% used a block rotation with other experiences, and 5% used a longitudinal experience. 50% of block rotations were in the PGY1 year, 43% in PGY2, and 8% in PGY3. Programs addressed many topics recommended by CPTI in their CPA experiences, but they were less likely to incorporate training in: environmental pediatrics (32%) and the role of pediatricians in regional emergency medicine (5%). The greatest barriers for programs in developing and maintaining CPA experiences included time and funding for organization and maintaining community partnerships. 95% of respondents expressed interest in collaborating, especially in legislative advocacy (100%) and curricula and resource sharing (94%). Conclusions: Considerable variation exists among residency programs in Illinois for CPA training. There may be a need for educational support for programs in environmental pediatrics and the role of pediatricians in emergency medicine. The greatest barrier in directing CPA experiences was time, and the collaborative may help to address this by facilitating sharing of resources, providing opportunities for scholarship, and helping faculty to leverage their scholarship in negotiations regarding their time.

108. ADDRESSING SOCIAL KEY (ASK) QUESTIONS FOR HELPING Adversity in LIFE to HEAL (HEALTH) STUDY: PREVALENCE OF ADVERSE CHILDHOOD EVENTS (ACES) AND UNMET SOCIAL NEEDS AND REFERRAL RATES WITH IMPLEMENTATION OF NEW SCREENING TOOL (RESEARCH ABSTRACT)
Jan D. Chang, Angela S. Holliday, Lekui Xiao, University of Illinois at Chicago, Chicago, IL, Jean Aschkenasy, PhD, Rush Medical Center, Chicago, IL, Anthony Heard, MSW, LCSW, University of Illinois at Chicago, Chicago, IL, Melissa Pavelack, BS, Ann & Robert H. Lurie Children’s Hospital of Chicago, Chicago, IL, Melissa J. Ruiz, MD, Ventura County Medical Center, Ventura, CA, Monica Samelson, MD, University of Washington Medical Center, Seattle, WA, Alan Schwartz, PhD, University of Illinois at Chicago, Chicago, IL, Margaret A. Scotelaro, MD, Rush University Medical Center, Chicago, IL, Kavitha Selvaraj, MD, MEd, Ann & Robert H. Lurie Children’s Hospital of Chicago, Chicago, IL, Alisa Seo-Lee, MD, Stan Sonu, MD, John H. Stroger Jr. Hospital of Cook County, Chicago, IL, Audrey Stillerman, MD, University of Illinois at Chicago, Chicago, IL, Barbara W. Bayldon, MD, Ann & Robert H. Lurie Children’s Hospital of Chicago, Chicago, IL, Mark Minier, MD, Stacy Laurent, DO, Amanda D. Osta, MD, University of Illinois at Chicago, Chicago, IL
Background: Screening for social determinants of health and ACEs should be viewed as a fundamental component of the preventative pediatric visit. Despite the strong evidence supporting this need, such screening is not completed often or thoroughly enough. Objective: To determine the prevalence of both ACEs and USN at the University of Illinois Health (UI Health) Child and Youth Center (CYC) using a newly created screening tool (ASK survey) and to establish increased resource referral rates. Methods: The study design was a longitudinal observational cohort study that occurred over a two month period in a pediatric academic health center’s outpatient clinic. Patients less than 18 years of age and their parents or guardians seeking well child services at the UI Health CYC received the ASK survey. The patient’s physicians collected completed surveys, reviewed any positive responses, and determined the need for referral. The data was then collected and analyzed to determine the prevalence of ACEs and USN as well as the frequency of referrals. Results: ASK questionnaires were completed and collected from 1,369
patients. The largest USN was lack of employment. 19.4% of respondents reported needing help finding a job, while 17.8% needed childcare assistance, and 15.1% needed assistance with paying utility bills. The most frequent ACE was the loss of a caregiver, reported by 8% of respondents. 4.7% of families answered having someone in the home feeling sad/depressed on most days. Meanwhile, 3.9% reported that they had been bullied or had bullied others. **Conclusions:** A variety of ACEs and USN were prevalent in our population of pediatric patients at UI Health CYC with the top 3 needs being employment, childcare and assistance paying utility bills. The top 3 ACE identified in our population were losing a caregiver, depression in the home, or have been bullied or bullied others. Ten percent of all respondents were given resources on the day of their visit.

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109. APPLYING ASSET MAPPING TO THE SCHOOL SETTING: TEACHING RESIDENTS TO IDENTIFY PROMOTERS OF HEALTH AT SCHOOL (DESCRIPTIVE ABSTRACT)

Cambria L. Garell, MD, UCLA Medical Center, Los Angeles, CA

**Background:** Learning about the promoters of health in school is not a pediatric residency requirement. Schools provide opportunities for healthy eating and physical activity, and awareness of these resources can make pediatricians more effective in counseling their patients on healthy lifestyle. UCLA Pediatric Residents in the Public Health Ambulatory Basics and Beyond (PHABB) track are trained in Asset-Based Community Development (ABCD) and asset mapping, a model that identifies and mobilizes existing resources within a community rather than focusing on unmet needs. We applied this concept to the public school setting by pairing PHABB residents with Los Angeles Unified School District (LAUSD) schools. **Methods:** PHABB faculty and LAUSD providers jointly established objectives. Residents received a didactic lecture on the ABCD approach and asset mapping. School-based activities included observing breakfast in the classroom, eating a school meal, identifying the physical activity opportunities at the school, meeting with key stakeholders including the school principal, school nurse, cafeteria manager, parents, and athletic director. Residents created an asset map of the school and the immediate surrounding neighborhood identifying opportunities for students to engage in well-being activities. Surveys were administered to 9 residents in October 2016 to evaluate knowledge, attitudes, and practices before and after the experience. **Results:** Surveys indicate that a one-day experience in a school improves residents’ knowledge, attitudes, and practices related to school health resources and asset mapping. Only 11% of residents felt confident taking an inventory of the assets in schools prior to the rotation, while 100% of residents felt confident after the activity. Prior to the rotation, 11% of residents felt confident in their ability to help patients access health resources at a school and were aware of LAUSD’s Breakfast in the Classroom program, which improved to 100% after the experience. **Conclusion:** A one-day experience in a public school provides important insight for future pediatricians about school-level promoters of health in nutrition and physical activity.

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110. PEDIATRIC RESIDENT ATTITUDES AND PRACTICE REGARDING ADVOCACY PRE- AND POST-IMPLEMENTATION OF AN INNOVATIVE ADVOCACY CURRICULUM (RESEARCH ABSTRACT)

Yonit Lax, MD, Montefiore Medical Center/Albert Einstein College of Medicine, New York, NY, Milani Patel, MD, Sandra Braganza, MD, MPH, Montefiore Medical Center/Albert Einstein College of Medicine, Bronx, NY

**Background:** In 2016, The American Academy of Pediatrics released a policy statement on poverty and child health, urging pediatricians to screen for social determinants of health (SDH) during patient encounters. However, training pediatricians to advocate for their patients by recognizing and addressing SDH, and engaging in individual, community and legislative advocacy is currently lacking in medical education. In July 2015, we implemented an innovative advocacy curriculum at our residency program. **Objective:** We examined residents’ comfort, practice, and attitudes regarding advocacy pre/post curricula implementation at an urban Children’s hospital. **Design/Methods:** All pediatric residents (N=79) at the Children’s Hospital at Montefiore (CHAM) were invited to complete a 15 item anonymous survey in summer 2015 and fall 2016, prior to and after curricula implementation. The curriculum consisted of an intern orientation case based workshop, 6 subsequent workshops given over a 9 month period divided by social determinant of health (Income, Housing, Education, Legal, Psychosocial), and culminated in an experiential legislative advocacy day. The survey assessed: 1) perceived benefit of advocacy curriculum 2) experience in discussing SDH 3) training and comfort with advocacy 4) barriers to advocacy. **Results:** Response rate of pediatric residents was 88% pre- and 70% post-curricula implementation, with no difference by training year (PGY1-3). 69% of residents report attending at least one workshop and 75% of interns participating in 3 or more workshops. Overall, 46% endorsed taking a more in depth social history, 38% guided patients to more community resources, and 66% agreed the curriculum changed their clinical practice. Feeling well trained to discuss SDH in the ER [58% vs 78%, p<0.001] and in clinic [46% vs 65%, p=0.023] improved from pre- to post implementation. The biggest barrier to advocacy was not having enough time for: individual advocacy in ED [91%], individual advocacy in clinic [61%], and legislative advocacy [44%]. Further results found in chart. **Conclusions:** Post implementation, the majority of residents reported the curriculum changed their clinical practice. Residents’ knowledge and comfort with advocating for their patients on an individual level

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**Table:**

<table>
<thead>
<tr>
<th>Comfort, Practice and Attitude Towards Advocacy</th>
<th>Pre N=69/78</th>
<th>Post N=55/78</th>
<th>P value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Comfort Discussing SDH: In Emergency Room (ER)</td>
<td>54 (78%)</td>
<td>51 (93%)</td>
<td>0.001</td>
</tr>
<tr>
<td>In Clinic</td>
<td>32 (46%)</td>
<td>39 (71%)</td>
<td>0.001</td>
</tr>
<tr>
<td>Practice Discussing SDH: Income</td>
<td>27 (39%)</td>
<td>33 (60%)</td>
<td>0.025</td>
</tr>
<tr>
<td>Housing</td>
<td>40 (58%)</td>
<td>36 (65%)</td>
<td>NS</td>
</tr>
<tr>
<td>Education</td>
<td>49 (71%)</td>
<td>51 (93%)</td>
<td>0.008</td>
</tr>
<tr>
<td>Legal</td>
<td>9 (13%)</td>
<td>18 (26%)</td>
<td>0.01</td>
</tr>
<tr>
<td>Domestic Violence</td>
<td>29 (42%)</td>
<td>22 (40%)</td>
<td>NS</td>
</tr>
<tr>
<td>Positive Feeling about Pediatric Advocacy</td>
<td>59 (86%)</td>
<td>47 (85%)</td>
<td>NS</td>
</tr>
</tbody>
</table>
Though we reached >50% in insecure homes. Food insecurity screening can help identify families in need. which would lead to data underestimating the true number of patients in food addition, many patients may not be comfortable disclosing this information, families were possibly missed or screened without documentation. In documentation of food insecurity screening, a large number of food insecure provider comfort using the tool. Due to >40% of WCC visits including documentation of food insecurity screening, a large number of food insecure families were possibly missed or screened without documentation. In addition, many patients may not be comfortable disclosing this information, which would lead to data underestimating the true number of patients in food insecure homes. Food insecurity screening can help identify families in need. With an effective tool and intervention, there is a significant enough need to continue including this in our practice.

111. RESIDENTS AS VOTERS: ENSURING SUFFRAGE IN AN 80-HOUR WORK WEEK (DESCRIPTIVE ABSTRACT)

Annie Sullivan, MD, Rebecca Green, MD, Angela Castellanos, MD, Beth Rezet, MD, Anna Weiss, MD, Children's Hospital of Philadelphia, Philadelphia, PA

Background: Only 60% of the voting-eligible population voted in the 2016 election. Physicians vote at rates 9% lower than the general population. To our knowledge, there is no data describing voting practices among resident physicians. Objectives: To elucidate voting practices of pediatric residents and to describe one large pediatric residency program’s experience with encouraging voting among its residents, and ensuring coverage for residents to get to the polls. Design/Methods: We solicited and compared participation from all residents at our institution over two national election cycles. Data was collected via electronic survey between July and November 2012, and between July and November, 2016. During both election cycles, we conducted voting awareness campaigns and organized resident coverage for Election Day. Results: The majority (69.5%) of residents viewed their job as a barrier to voting, specifically citing length of workday (67.4%), unpredictable hours (79.8%) and fatigue (29.2%). 88% of residents said that if offered coverage during polling hours, they would utilize it to vote. Of the residents who responded to the survey, 99% voted in the 2016 election. Voting methods included in-person (71.6%), absentee ballot in-state (14.7%) and absentee ballot out-of-state (13.7%). Of those scheduled to be on-call on election day, 38% utilized coverage. The majority of residents encountered no obstacles to voting on Election Day (78%). Obstacles identified included long voting lines (12.5%) and difficulty finding time to vote (11.4%). Conclusions: Voter registration and turnout among residents was consistent across two general election cycles. While most residents viewed their job as a barrier to voting, respondents were eager to use coverage offered by the residency program in order to vote. Residents found deadline reminders to be the most useful component of a voting registration campaign. If offered, residents will utilize coverage to facilitate in-person voting. This data provides an opportunity for pediatric residency programs across the country to ensure that the suffrage of their trainees is protected.

112. IMPLEMENTATION OF FOOD INSECURITY SCREENING IN THE PRIMARY CARE CLINIC (QI ABSTRACT)

Christian B. Lawrence, MD, Jeffrey Okonye, MD, University of North Carolina Hospitals, Chapel Hill, NC

Background: Food insecurity is a significant issue at the local, national and international level. Food insecurity is defined as a household-level economic and social condition of limited or uncertain access to adequate food. It is estimated that 1 in 4 children in the USA live in food insecure homes. North Carolina is among the hungriest states in the US, having the 5th highest level of food insecurity. Aim Statement: Increase the percentage of provider visits that include food insecurity screening as a part of well child check (WCC) visits to >50% over a 9 week period Interventions: We introduced a two question screening tool as a part of well child check (WCC) visits to >50% over a 9 week period Interventions: We facilitated in-person voting. This data provides an opportunity for pediatric residency programs across the country to ensure that the suffrage of their trainees is protected.

Results: We found that 0% of WCC visits included documentation of food insecurity screening during our baseline week prior to implementation. This number increased to 58.75% after our interventions. Of those patients screened, 13.5% screened positive for food insecurity. Conclusions and Next Steps: Though we reached >80% of provider visits screening for food insecurity, this data is limited by several factors including lack of screening tool placement into every template and provider comfort using the tool. Due to >40% of WCC visits not including documentation of food insecurity screening, a large number of food insecure families were possibly missed or screened without documentation. In addition, many patients may not be comfortable disclosing this information, which would lead to data underestimating the true number of patients in food insecure homes. Food insecurity screening can help identify families in need. With an effective tool and intervention, there is a significant enough need to continue including this in our practice.
This lack of diversity has prompted many pediatric graduate medical education programs to engage in evidence-based recruitment of under-represented minority (URM) pediatric trainees in academia.

**Background**: Despite rapid growth of racial/ethnic minorities in the US, under-represented minority (URM) physicians (i.e. Latino, African American, Native American, Hawaiian/Pacific Islander) account for only 4% of US medical school faculty.

**Objective**: To address this disparity, we partnered with community-based organizations to develop a core set of experiences that all categorical pediatric residents will be equipped for recognition and addressing the needs of pediatric patients.

**Methods**: Beginning in the 2016-17 academic year, we removed the advocacy rotation from the program's intern year with the plan to incorporate 2-3 advocacy experiences per subspecialty rotation. We partnered with community-based organizations to develop a core set of experiences that all categorical pediatric residents complete during residency. We also surveyed the pediatric subspecialty faculty available to our residents to gather suggestions on community experiences pertinent to their subspecialties.

**Results**: We established 10 core community experiences required of each categorical pediatric resident. These include working with local palliative care services and attending multidisciplinary meetings with medical providers, law enforcement, and social work to discuss cases of suspected child abuse. We also received responses from 14 of 17 surveyed pediatric subspecialties, allowing us to also establish subspecialty-related advocacy experiences for different electives including asthma education in schools during a pulmonary rotation and involvement with the Turner Syndrome Society during an endocrinology rotation.

**Conclusions**: We were able to develop a longitudinal advocacy curriculum that encompasses both core and sub-specialty specific experiences. Ultimately, our goal is that, regardless of their ultimate setting of practices, residents will have a broad range of advocacy knowledge and skills, allowing them to be better equipped at recognizing and addressing the needs of pediatric patients.

**BIAS/DIVERSITY**

**115. BEYOND RECRUITMENT: A MODEL PROGRAM FOR STRENGTHENING RETENTION OF UNDER-REPRESENTED MINORITY PEDIATRIC TRAINEES IN ACADEMIA (DESCRIPTIVE ABSTRACT)**

**Background**: The ACGME requires that pediatric residency programs incorporate child advocacy in ambulatory educational units. The majority of pediatric residency programs have done this by including a discrete advocacy rotation. This model appears to limit the exposure to and isolate advocacy, rather than teach advocacy as a crucial component to the daily work of pediatricians.

**Objective**: Our primary goal was to create an advocacy curriculum that would embed exposure to childhood advocacy throughout a residency program. **Methods**: Beginning in the 2016-17 academic year, we removed the advocacy rotation from the program's intern year with the plan to incorporate 2-3 advocacy experiences per subspecialty rotation. We partnered with community-based organizations to develop a core set of experiences that all categorical pediatric residents complete during residency. We also surveyed the pediatric subspecialty faculty available to our residents to gather suggestions on community experiences pertinent to their subspecialties.

**Results**: We established 10 core community experiences required of each categorical pediatric resident. These include working with local palliative care services and attending multidisciplinary meetings with medical providers, law enforcement, and social work to discuss cases of suspected child abuse. We also received responses from 14 of 17 surveyed pediatric subspecialties, allowing us to also establish subspecialty-related advocacy experiences for different electives including asthma education in schools during a pulmonary rotation and involvement with the Turner Syndrome Society during an endocrinology rotation.

**Conclusions**: We were able to develop a longitudinal advocacy curriculum that encompasses both core and sub-specialty specific experiences. Ultimately, our goal is that, regardless of their ultimate setting of practices, residents will have a broad range of advocacy knowledge and skills, allowing them to be better equipped at recognizing and addressing the needs of pediatric patients.
to foster retention of URM trainees to increase departmental faculty diversity.

**Objective:** To describe the development and the components of the MENTOR (Mentor, Engage, Network, Train to Optimize Retention) for Diversity as a model program for replication among pediatric residency programs.

**Methods:** In June 2015, 11 interviews and one focus groups were conducted with URM trainees at our institution to investigate reasons for: (1) desire to leave home institution for fellowship/faculty positions and (2) lack of interest in academic careers. These results informed MENTOR for Diversity, which began in September 2015.

**Results:** Trainees reported social isolation, dearth of URM faculty, lack of support networks and little attachment to the target community as main reasons for leaving our institution. Residents cited unfamiliarity with the academic career trajectory, and lack of career mentors as reasons for interest in non-academic careers. MENTOR for Diversity has faculty and residents steering committees to coordinate monthly networking dinners as a platform for peer/faculty mentorship, career development and advice, and community engagement. Example program components are: trainee self-assessments and CV building with faculty review, identifying and succeeding at scholarly opportunities, overcoming impostor syndrome and interview/application preparation, and implementation of community projects.

**Conclusion:** MENTOR for Diversity, a robust, longitudinal program, addresses identified barriers to URM retention as academic faculty and is currently being evaluated for effectiveness.

### 116. Implicit Bias Training in Pediatric Residency: Attitudes Amongst Program Directors and Lessons Learned From Implementation (Research Abstract)

**Jessica W. Tsai, MD, PhD, Catherine D. Michelson, MD, MMSc, Children's Hospital/Boston Medical Center, Boston, MA**

**Background:** It is known that implicit bias influences pediatric providers and affects pediatric patients. However, less is known about attitudes toward implicit bias amongst pediatric program directors, whether residencies have begun to implement implicit bias training, what these curricula include, and how these curricula impact learners. Objectives: We sought to describe the degree to which pediatric program directors consider implicit bias to be a training issue, how many residencies have implemented implicit bias curricula, what these curricula look like, lessons learned, and barriers to implementation. Our ultimate goal is to develop a set of best practice recommendations for broad incorporation across programs.

**Methods:** We conducted a national, mixed-methods survey of pediatric program directors. Survey development was informed by implicit bias literature. Analysis of quantitative data used descriptive statistics. Analysis of qualitative data is ongoing, with thematic analysis being used to code data, identify categories, and coalesce categories into themes.

**Results:** 64 of 200 program directors responded. 86.6% believed that interactions between residents and patients were sometimes, often, or always affected by implicit bias. 87.5% believed that providers could learn strategies to reduce the impact of implicit bias on care. 62.5% of programs already provided implicit bias training, although of those, 75% were either uncertain of the impact or felt like the training had only minimally or mildly improved resident confidence in managing bias. Strategies for and barriers to implementation are in Table 1. Ultimately, 70% expressed interest in learning more about an implicit bias curriculum.

**Conclusions:** Implicit bias is an issue that is important to pediatric program directors, with the majority believing that trainees can learn strategies to mitigate the effects of implicit bias on care. While many programs have implemented implicit bias training, there is uncertainty as to the utility of current curricula and a desire to learn more about a formalized residency curriculum.

### 117. DERM: Diversity Education, Recruitment, and Maintenance (Descriptive Abstract)

**Camila M. Mateo, MD, Elyse M. Portillo, MD, MPH, Katherine Brunsberg, MD, Kelsey Miller, MD, Darryl Powell, MD, Paul Critser, MD, PhD, Catherine Michelson, MD, MMSc, Theodore Sectish, MD, Children's Hospital/Boston Medical Center, Boston, MA**

**Background:** The pediatric physician workforce remains disproportionately lacking in diversity with regards to race, ethnicity, sexual minority status, disability, and socioeconomic status. Efforts to improve diversity often focus on recruitment without similar attention paid to educational prioritization and community-building, both of which critically inform a climate of inclusion. **Objective:** To create a sustainable and effective residency-wide structure to promote diversity and inclusion within a large pediatric residency program. **Design/Methods:** In 2016, the DERM program was formed, supported by a resident diversity council and overseen by a steering committee composed of a Diversity Chief Resident, faculty leaders, and resident leaders. Our definition of diversity includes but is not limited to race, ethnicity, sexual orientation, gender identity, socioeconomic status, and disability. Representatives of these groups and their allies, make up the council. The diversity council is divided into three working groups: recruitment, education, and maintenance. **Results:** In our residency interview invitations, applicants are able to self-identify as diverse using the above definition with all who self-identify invited to attend a diversity dinner. As a result, the program has doubled the number of recruitment diversity dinners and improved applicant and program engagement with dinners. The education group has mapped our existing curricula in regards to implicit bias, cultural humility and racial justice training in order to identify gaps. The maintenance group has mapped pipeline programs, medical student diversity groups, and institutional diversity initiatives in order to form partnerships and mentoring relationships. A summary of the DERM program initiatives was presented to hospital and residency program leadership to align prioritization of diversity and inclusion. **Conclusions:** Through the DERM initiative we created a sustainable structure to promote diversity and inclusion in our residency. Next steps include measuring the effectiveness of these interventions through post match data analysis and residency-wide climate surveys.
118. RACIAL JUSTICE IS NOT EXTRACURRICULAR: AN INTERN-FOCUSED RACISM IN MEDICINE WORKSHOP
(DESCRIPTIVE ABSTRACT)
Camila M. Mateo, MD, Kate Antanovich, EdM, Christine Cheston, MD, Catherine Michelson, MD, MMSc, Children’s Hospital/Boston Medical Center, Boston, MA

Background: Teaching race and racism in medicine has historically involved a number of challenges: (1) until recently, race was most often taught as a biological concept rather than a socially-constructed one; (2) with a lack of social and historical context, learners are at risk of not fully understanding the implications and perpetuation of structural racism; and (3) discussions most often occur in extracurricular spaces - rather than the core curricula - and among self-selected individuals, which inadvertently excludes learners with the least amount of knowledge on the topic.

Objective: To create a racial justice workshop as a part of the core advocacy curriculum in the PGY-1 year of a large pediatric residency program.

Design/Methods: Using Kern’s model of curricular development, a local needs assessment was conducted. Goals and objectives were developed based on literature review and partnership with a community-based organization. A 3-hour workshop was created and led by a chief resident with intern groups of 10-12. Using the Burgess model of reducing racial biases in healthcare, the workshop includes didactics on the history of racism in medicine coupled with several small group exercises leveraging discussion and reflection. A survey was collected at the end of each workshop.

Results: 20 interns have participated in the workshop and survey so far, with data collection ongoing. Participants rate the workshop highly in terms of overall educational value and engagement (mean 4.85 on a Likert scale with 5 as the highest). 100% of interns felt this workshop was appropriate for the advocacy curriculum, that it should be repeated for future classes, and that it would impact their practice going forward. 16/20 respondents gave more information on practice change and of those, 15 stated they would be more open in engaging in conversations about race and racism with their patients.

Conclusions: We created a racial justice workshop for interns as a part of our core advocacy curriculum. The workshop was highly rated and all respondents felt their practice would change as a result of the workshop.

ENTRUSTMENT/EPA/MILESTONES

119. CORRELATION BETWEEN ATTENDING PHYSICIAN AND RESIDENT MEAN MILESTONES-BASED ASSESSMENT SCORES OF PEDIATRIC RESIDENTS (RESEARCH ABSTRACT)
Daniel J. Sklansky, MD, John G. Frohna, MD, MPH, Melissa A. Cercone, MD, Grant D. Syverson, MD, Kathleen A. Desantes, MD, University of Wisconsin, Madison, WI

Background: Milestones-based end-of-rotation assessments by faculty may be used to help Clinical Competency Committees (CCCs) assign summative resident sub-competency milestone levels. Resident assessment of residents provides CCCs a potentially valuable source of information, especially when the numbers of attending assessments are low, although the reliability of milestones-based assessments by residents is unknown. Aims: To determine correlation between attending assessments and 1) senior assessments of interns, and 2) intern assessments of seniors.

Methods: All residents at our institution receive end-of-rotation milestones-based assessments from faculty and residents outside of their class. Each intern and senior was assigned an aggregate mean milestone score based on weighted sub-competency assessments for the 2015-2016 academic year from residents and attendings, respectively. Second-year trainees were excluded due to having infrequent assessments by residents. Linear regression was used to analyze the relationships between attending-assessed mean milestone scores and peer-assessed mean milestone scores for the intern and senior classes.

Results: Over the 2015-16 academic year interns (n=15) had 1313 and 1693 sub-competency assessments by attendings and seniors, respectively. Seniors (n=15) had 1053 and 822 sub-competency assessments by attendings and interns, respectively. Attending and senior resident mean milestones scores of interns were strongly correlated (r²=0.70). Attending and intern assessments of senior residents were only weakly correlated (r²=0.23). Conclusion: Senior residents may provide reliable milestones-based assessments of interns. Stronger correlation to attending assessments from seniors suggests that residents may acquire assessment skills as part of their professional development during residency. Future studies will examine assessment correlation within specific core competencies.
120. DO MILESTONES REPORTED TO THE ACGME DESCRIBE RESIDENTS’ PERFORMANCE OR THEIR PROGRAMS’ ASSESSMENT PRACTICES? (RESEARCH ABSTRACT)
Kimberly A. Gifford, MD, Lebanon, NH, Su-Ting T. Li, MD, MPH, University of California (Davis) Health System, Sacramento, CA, Alan Schwartz, PhD, University of Illinois College of Medicine at Chicago, Chicago, IL, Ann E. Burke, MD, Wright State University, Dayton, OH, Daniel J. Tancredi, PhD, University of California (Davis) Health System, Sacramento, CA, Susan Guralnick, MD, Winthrop-University Hospital, Mineola, NY, Ann P. Guillot, MD, University of Vermont Medical Center, Burlington, VT, Franklin Trimm, MD, University of South Alabama, Mobile, AL, John D. Mahan, MD, Nationwide Children’s Hospital/Ohio State University, Columbus, OH

Background: The rapid implementation of milestones-based assessments in 2014 allowed little time for standardization of assessment practices across programs. Yet, graduating resident milestones are now reported to fellowships for residents from different programs. It is not possible to know how likely a given resident would be to receive the same milestone levels assigned by one program if s/he were in a different program. Aim: To use milestones levels for residents across programs to examine the program-to-program variance for CCC and self-assessment. Method: In the spring of 2014, residency programs reported resident self-assessment and CCC assessment for all 21 competencies reported to the ACGME. We fitted a mixed effects linear model to self-assessed and CCC-assessed milestone levels with fixed effects of assessment type (CCC or self), PGY, competency. We determined the intra-class correlation coefficient (ICC) of milestones levels within programs for both CCC and self-assessment. Results: Milestone levels were reported for 575 categorical residents across 18 programs of various sizes and regions. Milestone levels increased with PGY and varied between competencies. ICC for program was 0.318 for CCC assessment vs. 0.098 for self-assessment. As depicted in the figure for PGY3s, there was program-to-program variance in CCC mean milestones, yet minimal variance in self-assessed program mean milestones. Conclusions: In addition to effects of PGY and competency, we also noted variance in CCC assessment based on the programs to which residents belong, which may be due to differences in both residents’ performance and assessment practices between programs. We found less variance between programs in residents’ self-assessment, which may be less impacted by local assessment practices and thus may reflect actual similarities in residents’ performance across programs. Together, these results raise concerns about comparing CCC milestones assessments between programs. Faculty development should target standardization of assessment practices both within and across programs.

121. CREATING COMPETENCIES, MILESTONES AND A LEVEL OF SUPERVISION SCALE FOR THE SCHOLARSHIP EPA (DESCRIPTIVE ABSTRACT)
Richard B. Mink, MD, MACM, Los Angeles County-Harbor UCLA Medical Center, Torrance, CA, Angela L. Myers, MD, MPH, Children’s Mercy Hospital, Kansas City, MO, David A. Turner, MD, Duke University Hospital, Durham, NC, Carol L. Carraccio, MD, MA, American Board of Pediatrics, Chapel Hill, NC

Background: The Scholarship EPA is based upon Boyer’s definition of scholarship in which individuals engage in scholarly activities through discovery, application, and dissemination of new knowledge (broadly defined). This EPA is one of the Common Pediatrics Subspecialty EPAs but specific competencies and individual behaviors for progressive levels have not been defined. Objective: The objective was to create competencies, milestones and a level of supervision scale for the Scholarship EPA. Methods: A literature search was performed in which only one relevant paradigm was identified, the Vitae Researcher Development Framework. This had an insufficient number and inadequate description of milestones but served as a model for this effort. Using a modified Delphi approach, a small group developed specific competencies, each with milestones based on the progression from novice to expert. Content validity was obtained by circulating drafts to the pediatric subspecialty community, along with research and medical education experts, for feedback. Once finalized, a level of supervision scale was created. Results: To limit the number of new competencies, the first draft incorporated some competencies for which pediatric milestones were already written. However, feedback revealed that these were difficult to apply to scholarly activity. The second draft was well-received with over 40 comments obtained. The final version is comprised of 8 competencies (information seeking, formulation of question/intervention, methods & data management/analysis, collaboration, income & funding generation, knowledge dissemination, professional conduct, mentoring), each with 5 milestones. A 5-point supervision scale with progressively less supervision was also developed. Conclusions: Competencies, milestones and a supervision scale for the Scholarship EPA were created and content validity established. These may be useful in assessing the scholarship skills of fellows, as well as those of residents and faculty, especially physician-scientists. Another potential application is in guiding the development of non-physician researchers.
122. INTERN READINESS TO ENTER ORDERS (RESEARCH ABSTRACT)
Meredith L. Carter, MD, Fatuma Barqadle, MD, Darshita Bhatia, MD, Natalie G. McKnight, MD, Inova Fairfax Medical Campus/Inova Children’s Hospital, Falls Church, VA

Background: The Association of American Medical Colleges (AAMC) has identified 13 core entrustable professional activities (EPAs) for entering residency. However, no data has been published with objective measures of interns’ competence in these EPAs. Objective: Assess the competence of interns to enter orders and prescriptions without direct supervision (AAMC EPA 4) upon entry into residency. Methods: This was a prospective observational study of the 13 interns entering the Inova Pediatric Residency Program in 2016. Interns performed the following tasks: (a) write admission orders for 2 standardized history & physical exams, (b) write inpatient orders for 5 medications, and (c) write outpatient prescriptions for 5 medications. Each investigator made an entrustment decision for each intern in 3 sub-categories of EPA 4: (1) admission orders, (2) inpatient medication orders, and (3) outpatient prescriptions. The primary outcome was the percentage of interns to achieve entrustment threshold for EPA 4, defined as at least 3 of the 4 investigators concluding the intern was ready to perform all 3 tasks without direct supervision. The secondary outcome was the percentage of tasks in which interns were entrusted by at least 3 of the 4 investigators. Outcomes were analyzed using descriptive statistics. Inter-rater reliability for entrustment decisions was determined using Cohen’s kappa. Results: None of the interns achieved the entrustment threshold for EPA 4. Only 1 intern achieved entrustment by 3 of the 4 investigators in 1 task (2%). Of the 39 sub-categories, investigators were unanimous in 23 (59%) that interns were not ready to perform the task without direct supervision. However, Cohen’s kappa for all entrustment decisions was only 0.1. Conclusions: Interns were not prepared to enter orders and prescriptions without direct supervision at the start of residency. Because this was a single institution study, larger studies are needed to confirm these findings. Although not the focus of this study, the poor inter-rater reliability for entrustment decisions demonstrates that the process by which these decisions are made is an area for future research.

123. THE CHALLENGE OF MAKING HIGH-STAKES ENTRUSTMENT DECISIONS: VALIDITY EVIDENCE FOR TWO DIFFERENT STRUCTURAL CLINICAL OBSERVATION TOOLS TO INFORM ENTRUSTMENT DECISIONS ABOUT THE AMERICAN BOARD OF PEDIATRICS PATIENT HANDEOVER EPA (RESEARCH ABSTRACT)
Daniel C. West, MD, University of California (San Francisco), San Francisco, CA, Joseph Lopreato, MD, Walter Reed Army Medical Center, Bethesda, MD, Jorie Colbert-Getz, PhD, University of Utah, Salt Lake City, UT, Kathleen Wortmann, BS, Walter Reed Army Medical Center, Bethesda, MD, Carol Carraccio, MD, American Board of Pediatrics, Chapel Hill, NC, Robert Engleander, MD, University of Minnesota, Minneapolis, MN, I-PASS Study Group, Children’s Hospital/Boston Medical Center, Boston, MA

Background: Validity evidence to support using scores from assessment methods to inform high-stakes entrustment decisions is limited, yet critically important if the promise of competency-based medical education is ever to be achieved. The activity of handing over patients to another provider within and across care settings (EPA 16, American Board of Pediatrics) is an example of a high-stakes EPA because miscommunications during patient handovers can lead to medical errors and patient harm. The goal of this study was to test whether scores from two different structural clinical observation tools (SCO) to measure patient handover skills could be used to inform high-stakes entrustment decisions. Methods: Using a modified Delphi process, expert panels developed two different SCOs: (1) HandSCO tool (17-items derived from I-PASS curricular content, relevant ACGME Pediatric Milestone behavioral anchors, and scripts from a set of previously published handover standard-setting videos with each item rated on 3-point scale [maximum score, 51]); and (2) I-PASSco tool (10-items derived from I-PASS curriculum and used for feedback in the I-PASS study with each item rated on 5-point frequency scale [maximum score, 50]). In 2014-2015 trained faculty observers used these tools and a global EPA assessment item to rate 80 first-year pediatric residents during a patient handover OSCE station. We performed generalizability studies (one-facet [item]) to determine the internal consistency of item scores, decision studies to determine if the items could be reduced, and linear regression against the global EPA assessment score to determine threshold scores for entrustment. Results: Generalizability coefficients were 0.87 (HandSCO) and 0.77 (I-PASSco) (scale 0–1). Residents accounted for 82% (HandSCO) and 84% (I-PASSco) of score variance. Ten HandSCO and 12 I-PASSco items were required to maintain a reliability coefficient > 0.80 (target for high-stakes decisions). The regression equations (HandSCO [R2 = 0.50, Y = 30.33 + 5.60x]; I-PASSco [R2 = 0.47, Y = 25.94 + 5.8x]) indicated that a resident would need a minimum score of 47 (HandSCO) and 43 (I-PASSco) to reach entrustment. Conclusions: HandSCO and I-PASSco scores demonstrated strong content validity and reliability, but the HandSCO was marginally more reliable. The number of HandSCO items could be reduced. We identified threshold scores for entrustment for OSCE assessments and scores from both tools could be used to inform entrustment decisions about patient handovers. Additional evidence is needed to determine if these tools can be used in a similar way in workplace-based assessments.

124. CREATION OF A VALIDATED TOOL TO DETERMINE RESIDENT COMPETENCE IN NEONATAL RESUSCITATION (RESEARCH ABSTRACT)
Sara K. Kane, DO, Diane E. Lorant, MD, Indiana University School of Medicine, Indianapolis, IN

Background: The American Board of Pediatrics expects that pediatricians can initiate stabilization of newborns. We surveyed neonatology faculty and fellows in the Section on Perinatal Pediatrics regarding delivery room supervision. We found large variability in the autonomy fellows received and in the supervision neonatologists deemed necessary. Our national survey highlights the need for an objective assessment of resuscitation skills. Objective: Develop and validate a tool to measure trainee competence in neonatal resuscitation. Methods: A simplified tool was created following the Neonatal Resuscitation Program (NRP) algorithm. Emphasis was placed on communication, leadership, knowledge of equipment, and initial stabilization. We substantiated content validity, inter-observer reliability and context validity. Content validity was achieved...
125. DEVELOPMENT OF A MILESTONE-BASED EVALUATION TOOL FOR THE PEDIATRIC EMERGENCY DEPARTMENT (DESCRIPTIVE ABSTRACT)

Adam C. Patterson, MD, Sara M. Multerer, MD, Erin B. Owen, MD, Karen H. Miller, PhD, Michelle D. Stevenson, MD, MS, University of Louisville, Louisville, KY

Background: During a pediatric emergency medicine (PEM) rotation, a resident-preceptor relationship is often limited to multiple, brief interactions that can render the complex language of the current milestones less useful. A more pragmatic evaluation tool could improve the quality of feedback and evaluation of residents rotating in PEM. Objective: To describe a process of creating a milestone-based end of shift evaluation (MBESE) tool for use in the pediatric emergency department setting. Methods: We developed a set of succinct questions for seven reportable sub-competencies used in our traditional end of month evaluation. Questions were adjusted in several iterations to ensure quality. After faculty training, six residents were evaluated by 1-2 preceptors using a pilot form at the end of each shift. Questions about number of procedures, number of patients precepted, and direct observation frequency were included. Forms were modified based on feedback regarding individual questions and the overall evaluation process. Experts in medical education reviewed the tool prior to initiation and at completion, offering suggestions to improve content and face validity of the final instrument. Results: Milestone-based questions were created for seven reportable milestone sub-competencies with 4 to 11 questions each. Questions are concise, with most frequency responses ranging from almost never to almost always. Qualitative observations revealed that the dense language of the pediatric milestones could be confusing to the evaluator. Due to reported lack of sufficient interaction with residents to assess the frequency of a particular sub-competency anchor when only considering a single shift, evaluators were asked to consider interactions over shifts occurring in the past week. Finally, anchors expecting low frequency responses were confusing to evaluators and altered. Conclusions: Through an iterative process with input from diverse sources, we have created a MBESE tool, which can now be implemented, potentially improving the quality and meaningfulness of evaluations in PEM while keeping with the spirit of the milestones.

126. CAN MEDICAL SCHOOL PERFORMANCE SERVE AS A PREDICTOR OF FIRST TIME ABP EXAM PASS FOR NATIVE SPANISH SPEAKING PEDIATRIC RESIDENTS? (RESEARCH ABSTRACT)

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Background: Early recognition of residents who may struggle with medical knowledge (MK) competency provides ideal opportunities for developing early individualized learning interventions for the benefit and success of residents at risk. However, data on pre-residency elements associated with suboptimal performance on this competency is limited. Objective: This study aimed to identify elements of resident’s school of medicine (SOM) academic record that may indicate risk of failing the American Board of Pediatrics (ABP) certification exam for first time takers. Methodology: Retrospective review of residents completing pediatric residency from 2001-2015. SOM academic data included SOM attended, number of classes repeated in SOM, GPA Score during SOM preclinical years, GPA Score during SOM clinical years, SOM pediatrics rotation score and USMLE Steps 1, 2 CK, 2 CS and 3 pass or fail. Residency’s MK competency outcome variable was ABP certification exam pass or fail on a first attempt. Mean/standard deviation, frequencies/percentages, Chi-Square/Fisher exact, t-test and logistic regressions were employed. Results: 171 residents (100% native Spanish speaking residents) were included, mean age 26.4 years (SD 2.7) and 82% females upon admission to pediatrics residency. 70% passed the ABP on a first attempt. 81% attended LCME-accredited SOM in Puerto Rico. Preclinical GPA > 3 (OR 5.2, CI 1.7-16.3) and not repeating a class in medical school (OR 0.2, CI 0.3-0.9) were associated with passing the ABP on residents’ first attempt. Medical schools attended, gender, GPA during SOM clinical years, SOM Pediatrics Rotation Score, USMLE Steps 1, 2CK, 2CS and 3 were not associated with ABP pass on a first attempt. Conclusion: Preclinical GPA < 3 and repeating a class in medical school were associated with failing ABP certification exam on a first attempt in this sample of native Spanish speaking pediatric residents exclusively. Further studies are needed to assess whether these elements predict ABP certification exam pass on a first attempt in native English and Spanish speaking pediatrics residents from other ACGME-accredited Pediatric Residency Programs.
127. PILOTING AND ASSESSING AN ENTRUSTABLE PROFESSIONAL ACTIVITY (EPA) BASED EVALUATION AMONG SENIOR PEDIATRIC RESIDENTS IN A DENVER COMMUNITY HOSPITAL (DESCRIPTIVE ABSTRACT)
Joshua T. Williams, MD, University of Colorado, Denver, CO, Melisa Tanverdi, MD, University of Colorado, Aurora, CO, Carol Okada, MD, University of Colorado, Denver, CO

Background: EPAs are a novel tool to assess resident progression via observed activities. Approaches to EPA-based evaluations are lacking, as are resident perceptions of EPAs. OBJECTIVES To describe an approach to pediatric resident evaluation using multisource assessments of a specific EPA. To assess resident perceptions of the EPA-based evaluation.

Methods: We pilot an evaluation based on EPA #15 - “Lead an interprofessional health care team” - among senior residents rotating as ward supervisors at a community hospital in Denver, CO (6/1/16-12/31/16). Residents learned about the EPA at an orientation session and collected feedback from at least 8 different interprofessional care team members. After their rotations, residents received feedback forms, were placed on a 4-point entrustment scale (1 - trusted to lead with direct supervision and coaching; 4 - trusted to lead without supervision), and completed a brief survey. Results: Seven (7) residents completed rotations during the pilot phase. Residents received feedback forms from a mean of 10±2 team members (range 8-12). Evaluators were most often attending physicians (19%), bedside or charge nurses (10%), respiratory therapists (10%), social workers (10%), and pharmacists (10%). Most evaluators (65%) spent 3-4 weeks with the resident. The median entrustment level was 3 (range 2-4). The survey response rate was 100%. Residents agreed or strongly agreed that EPA-based evaluations identified areas of strength (7/7) and weakness (6/7). They agreed or strongly agreed that feedback came from team members who did not usually evaluate them (7/7), was higher in quantity than previous end-of-rotation feedback (7/7), and was higher quality (7/7). All residents agreed or strongly agreed (7/7) that the EPA-based evaluation was more helpful than previous end-of-rotation feedback. Conclusions: EPA-based evaluations are feasible in a community hospital setting and may provide high-volume, quality feedback that residents value more than traditional evaluations.

128. USING SIMULATION TO ASSESS THE COMPETENCY OF GRADUATING MEDICAL STUDENTS TO PERFORM THE ENTRUSTABLE PROFESSIONAL ACTIVITIES OF A PEDIATRIC INTERN (DESCRIPTIVE ABSTRACT)
Robert Guglielmo, MD, Sarah Gustafson, MD, Kelly Fong, MD, Robert Kelly, MD, Rebecca Dudovitz, MD, UCLA Medical Center, Los Angeles, CA

Background: Entrustable professional activities (EPAs) provide a framework for evaluating whether graduating medical students have achieved the competencies required of an incoming intern. Assessing EPAs in systematic, high-fidelity setting is challenging. To address this need we developed a simulation curriculum for graduating medical students entering pediatric residency and to develop a course assessing students’ competencies to perform these EPAs. Results: Published EPAs for medical students and pediatric residents were reviewed by five pediatric faculty members with expertise in undergraduate and graduate pediatric medical education. A core set of EPAs for medical students entering pediatric residencies were identified by consensus. Through the principle of backward design, a case-based high fidelity simulation (SIM) series was developed, including structured assessment tools, in collaboration of senior pediatric residents. Using progressive simulation cases, students demonstrate their ability to develop assessments and plans for core pediatric conditions, write appropriate orders and notes, perform core procedures, function in a team-based setting, and safely handoff a patient to a colleague. All graduating medical students entering the NRMP in pediatrics will complete this mandatory 1 week course in March 2017. Conclusions: High-fidelity progressive SIM scenarios with structured assessments provide a realistic environment for assessing pediatric specific EPAs for graduating medical students, ensuring they can fulfill duties of a pediatric intern. Universal implementation allows detection of areas of weakness with time for remediation and improvement prior to residency. This course will also provide insight into the strengths and weaknesses of the overall medical student curriculum with respect to pediatric training.
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The APPD Global Health PEG is delighted to welcome the first two recipients of the APPD Global Pediatric Educator Scholarship. Many pediatric educators from around the globe seek to improve child health by advancing pediatric education in their countries, but often lack access to the educational resources we enjoy through professional associations and conference attendance. Our goal is to recognize pediatric educators who demonstrate early leadership in improving pediatric education in low and middle income countries, and to provide them with additional career development and/or networking opportunities by inviting them to attend the APPD spring conference. We hope that by sharing educational resources and fostering collaboration with these colleagues that we will further the goal of ensuring the health and well being of all children everywhere.

Dr Mimi Lhamu Mynak has been working as a Pediatrician for the last seventeen years in Bhutan. She did her undergraduate study from IGMC, Simla and post graduate studies from Post Graduate Institute of Medical education and Research, Chandigarh, India. She is currently head of the Department of Pediatrics at the JDW National Referral Hospital in Thimphu and Khesar Gyalpo University of Medical Sciences, Bhutan. She started the country’s first pediatric residency training program there in 2014, building upon the support of the 7 pediatricians working in Bhutan.

In addition to her clinical and education work at the hospital she is also the Chairman of the National Committee on Immunization Practices where she provides the Ministry of health with technical advice on Immunization and training. She is a member of National Adverse Events Following Immunization (AEFI) Committee, providing technical advice for AEFI surveillance and overseeing AEFI investigations. She is also a member of the Technical Advisory Committee for National HIV/AIDS program, Child health advisory group (CHAG), Health expert for International Health Regulations Bhutan, Editor of Bhutan health journal, and United Nations examining physician.

Dr. Endale Tefera Dejene is from Ethiopia, and completed his medical training at Gondar College of Medical Sciences in 1994, joining faculty there in 1997. He completed residency in Pediatrics and Child Health at Addis Ababa University in 2003, followed by advanced training in Pediatric Cardiology at Sant’Anna School of Advanced Studies, Pisa, Italy from 2004-2005 and Fellowship in Pediatric Cardiology at Addis Ababa University from 2009-2011. He has been on faculty at Addis Ababa University since 2006, currently as an Associate Professor. He has won numerous teaching awards in Ethiopia, and has several publications in Pediatric Cardiology and Percutaneous intervention. Since 2015 he has been Co-Director for Congenital, Structural, and Valvular Heart Disease Intervention (CSI Africa).

In 2015 he spent 3 months with the Academic Consortium for Combating Ebola in Liberia (ACCEL) and taught in a new pediatric residency program developing there. Since February 2016 he has been on sabbatical leave to work for Liberia College of Physicians & Surgeons and continues to build their pediatric residency training program.
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