2015 Annual Meeting

APPD 2015
Annual Spring Meeting
March 25-28, 2015

Sharing Innovative Strategies for Optimizing Outcomes

MPPDA Annual Meeting
March 24-25, 2015

Walt Disney World
Swan and Dolphin Resort
Orlando, FL

*This activity has been approved for AMA PRA Category 1 Credit™
Welcome to the APPD 2015 Annual Spring Meeting in Orlando!

The seemingly endless winter is behind us and we are so happy for the sunshine, warmth, good company, and learning of our annual meeting. The meeting is a collaborative effort to which many of our members contribute and we are especially grateful for the leadership of the Program Chair, Debra Boyer, the Program Executive Committee (particularly Angie Myers), and the entire Program Planning Committee. We applaud the innovative and collaborative work of our members in Task Forces, Executive Committees, Pediatric Education Groups (PEGs), Regions, APPD LEAD, and APPD LEARN -- all of whom have contributed to the meeting content.

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

This year, our meeting reflects this diversity in the many activities of our membership. We are pleased to present some of our member’s outstanding research during the platform presentations, allow you to choose from a large variety of innovative and engaging workshops, as well as attend an outstanding poster session. Between the mentoring sessions, task force meetings and mini-poster symposia, we challenge you to expand your horizons and come innovate with us!! This year, we have a large number of trainee presentations, a reflection of an extended deadline for trainees that was piloted this year.

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

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

Debra Boyer, MD
APPD 2015 Annual Spring Meeting Program Chair
Boston Children’s Hospital

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

SSID: Pediatrics
Password: 2015meeting
# Schedule-At-A-Glance

**Detailed APPD Meeting Schedule** - Begins on Page 11  
**MPPDA Program Details** - see pages 33-35

## Tuesday, March 24, 2015

<table>
<thead>
<tr>
<th>Time</th>
<th>Event</th>
<th>Location</th>
</tr>
</thead>
<tbody>
<tr>
<td>7:30am-6:00pm</td>
<td>APPD LEAD Meeting</td>
<td>Northern A1/Dolphin</td>
</tr>
<tr>
<td></td>
<td>APPD Board of Directors Meeting</td>
<td>Oceanic 7/Dolphin</td>
</tr>
<tr>
<td>8:00am-2:30pm</td>
<td>MPPDA Pre-Course (additional fee required)</td>
<td>Mockingbird/Swan</td>
</tr>
<tr>
<td>12:00pm-4:00pm</td>
<td>AMPPA Coordinators’ Meeting</td>
<td>Northern A4/Dolphin</td>
</tr>
<tr>
<td>1:00pm-5:00pm</td>
<td>APPD TAGME Exam (prior appointment necessary)</td>
<td>Europe 10/Dolphin</td>
</tr>
<tr>
<td>3:30pm-5:00pm</td>
<td>MPPDA Committee Meetings</td>
<td>See page 35</td>
</tr>
<tr>
<td>5:30pm-7:00pm</td>
<td>MPPDA Reception and Poster Session</td>
<td>Osprey Ballroom/Swan</td>
</tr>
<tr>
<td>6:00pm-7:30pm</td>
<td>APPD Board, ED and TF Chairs Meeting</td>
<td>Northern A2/Dolphin</td>
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## Wednesday, March 25, 2015

<table>
<thead>
<tr>
<th>Time</th>
<th>Event</th>
<th>Location</th>
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<tbody>
<tr>
<td>7:30am-11:30am</td>
<td>APPD LEAD Meeting</td>
<td>Northern A1/Dolphin</td>
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<tr>
<td>8:00am-5:30pm</td>
<td>MPPDA General Session</td>
<td>Mockingbird/Swan</td>
</tr>
<tr>
<td>8:00am-5:30pm</td>
<td>APPD Forum for Chief Residents</td>
<td>Northern A3-A4/Dolphin</td>
</tr>
<tr>
<td>9:00am-4:00pm</td>
<td>APPD Coordinators’ Session (lunch on your own)</td>
<td>Swan 9-10/Swan</td>
</tr>
<tr>
<td>11:30am-3:30pm</td>
<td>APPD Pre-Conference Workshops (additional fee required; includes lunch)</td>
<td>See page 12-13</td>
</tr>
<tr>
<td>1:00pm-3:30pm</td>
<td>APPD Forum for Directors of Small Programs and Affiliate Chairs</td>
<td>Northern A2/Dolphin</td>
</tr>
<tr>
<td>3:45pm-5:45pm</td>
<td>APPD Grassroots Forum for PDs</td>
<td>Swan 7-8/Swan</td>
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<tr>
<td></td>
<td>APPD Grassroots Forum for APDs</td>
<td>Asia 5/Dolphin</td>
</tr>
<tr>
<td></td>
<td>APPD Grassroots Forum for FPDs</td>
<td>Europe 9/Dolphin</td>
</tr>
<tr>
<td>6:00pm-7:00pm</td>
<td>APPD Networking Reception (open only to APPD registrants)</td>
<td>Lake Terrace/Swan</td>
</tr>
<tr>
<td>7:00pm-9:00pm</td>
<td>MPPDA Dinner (additional fee required)</td>
<td>Animal Kingdom Buffet</td>
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## Thursday, March 26, 2015

<table>
<thead>
<tr>
<th>Time</th>
<th>Event</th>
<th>Location</th>
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<tbody>
<tr>
<td>7:00am-8:30am</td>
<td>Continental Breakfast</td>
<td>Southern Foyer I-III/Dolphin</td>
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<tr>
<td></td>
<td>APPD Pediatric Education Group (PEG) Meetings</td>
<td>See page 14</td>
</tr>
<tr>
<td>Time</td>
<td>Event</td>
<td>Location</td>
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</tr>
<tr>
<td>8:30am-9:35am</td>
<td>APPD Members Meeting: Awards and Annual Reports</td>
<td>Southern I-III/Dolphin</td>
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<tr>
<td>9:45am-11:45am</td>
<td>APPD Workshop Session 1</td>
<td>See page 15</td>
</tr>
<tr>
<td>12:00pm-1:45pm</td>
<td>APPD Research Platform Presentations with boxed lunch</td>
<td>Southern I-III/Dolphin</td>
</tr>
<tr>
<td>2:00pm-5:30pm</td>
<td>APPD Key Stakeholders Session</td>
<td>Southern I-III/Dolphin</td>
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<tr>
<td>5:30pm-6:30pm</td>
<td>Pediatric Hospital Medicine Fellowship Certification Discussion</td>
<td>Southern I-III/Dolphin</td>
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<tr>
<td>6:00pm-7:00pm</td>
<td>APPD LEAD Reception (APPD LEAD Graduates only)</td>
<td>Asia 5/Dolphin</td>
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<tr>
<td>6:30pm-7:15pm</td>
<td>PMAC Participant Meeting</td>
<td>Oceanic 6/Dolphin</td>
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<tr>
<td>7:30pm-8:30pm</td>
<td>APPD LEARN Advisory Council Meeting</td>
<td>Australia 1/Dolphin</td>
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**Friday, March 27, 2015**

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<tbody>
<tr>
<td>6:30am-7:30am</td>
<td>Group Run/Walk (informal gathering)</td>
<td>Outside Dolphin Entrance</td>
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<tr>
<td>7:00am-8:30am</td>
<td>Continental Breakfast</td>
<td>Southern Foyer I/Dolphin</td>
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**Session Closed**

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<th>Event</th>
<th>Location</th>
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<tbody>
<tr>
<td>8:30am-10:30am</td>
<td>APPD Workshop Session 2</td>
<td>See page 21-24</td>
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<tr>
<td>10:45am-12:45pm</td>
<td>APPD Task Force Meetings</td>
<td>See page 25</td>
</tr>
<tr>
<td>12:45pm-2:00pm</td>
<td>Lunch On Your Own</td>
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**APPD Council of Regional Chairs Lunch Meeting**

**APPD Council of Task Force Chairs Lunch Meeting**

<table>
<thead>
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<th>Time</th>
<th>Event</th>
<th>Location</th>
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<tbody>
<tr>
<td>2:00pm-4:00pm</td>
<td>APPD Workshop Session 3</td>
<td>See page 25-28</td>
</tr>
<tr>
<td>4:15pm-5:45pm</td>
<td>APPD Poster Session <em>(posters displayed 10:00am-5:45pm)</em></td>
<td>Atlantic Hall C/Dolphin</td>
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**Saturday, March 28, 2015**

<table>
<thead>
<tr>
<th>Time</th>
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<th>Location</th>
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<tbody>
<tr>
<td>7:00am-8:30am</td>
<td>APPD Regional Breakfast Meetings</td>
<td>See page 28</td>
</tr>
<tr>
<td>8:45am-10:15am</td>
<td>APPD Assessment Task Force Mini-Poster Symposia</td>
<td>Swan 5-6B/Swan</td>
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<tr>
<td></td>
<td>APPD Curriculum Task Force Mini-Poster Symposa</td>
<td>Swan 7-10/Swan</td>
</tr>
<tr>
<td>10:30am-12:00pm</td>
<td>APPD Workshop Session 4</td>
<td>See page 29-32</td>
</tr>
<tr>
<td>12:00pm-5:00pm</td>
<td>I-PASS Study Group</td>
<td>Oceanic 2/Dolphin</td>
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CME Information
Accreditation Statement
This activity has been planned and implemented in accordance with the accreditation requirements and policies of the Accreditation Council for Continuing Medical Education (ACCME) through the joint providership of Institute for the Advancement of Human Behavior (IAHB), Association of Pediatric Program Directors (APPD) and Medicine-Pediatrics Program Directors Association (MPPDA). IAHB is accredited by the ACCME to provide continuing medical education for physicians.

Credit Designation Statement
The IAHB designates this live activity for a maximum of 30.50 AMA PRA Category 1 Credits™ (MPPDA sessions only for a maximum of 12.0, and APPD sessions only for a maximum of 26.0). Physicians should claim only the credit commensurate with the extent of their participation in the activity.

<table>
<thead>
<tr>
<th>Session Time</th>
<th>Session Title</th>
<th>Credit Hours</th>
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<tbody>
<tr>
<td>Tuesday, March 24</td>
<td>MPPDA Pre-Course (additional fee required)</td>
<td>4.25</td>
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<tr>
<td>8:00am-2:30pm</td>
<td>MPPDA General Session and breakout sessions</td>
<td>7.5</td>
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<tr>
<td>Wednesday, March 25</td>
<td>APPD Pre-Conference Workshops (additional fee required)</td>
<td>3.0</td>
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<tr>
<td>11:30am-3:30pm</td>
<td>APPD Forum for Directors of Small Programs and Affiliate Chairs</td>
<td>2.5</td>
</tr>
<tr>
<td>1:00pm-3:30pm</td>
<td>APPD Grassroots Forum for PDs</td>
<td>2.0</td>
</tr>
<tr>
<td>3:45pm-5:45pm</td>
<td>APPD Grassroots Forum for APDs</td>
<td>2.0</td>
</tr>
<tr>
<td>Thursday, March 26</td>
<td>APPD Pediatric Education Group (PEG) Meetings</td>
<td>1.5</td>
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<tr>
<td>7:00am-8:30am</td>
<td>Workshop Session 1</td>
<td>2.0</td>
</tr>
<tr>
<td>9:45am-11:45am</td>
<td>APPD Research Platform Presentations with boxed lunch</td>
<td>1.5</td>
</tr>
<tr>
<td>12:00pm-1:45pm</td>
<td>APPD Key Stakeholders Session</td>
<td>3.0</td>
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<tr>
<td>2:00pm-5:30pm</td>
<td>APPD Task Force Meetings</td>
<td>2.0</td>
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<tr>
<td>Friday, March 27</td>
<td>APPD Mentoring Session</td>
<td>1.5</td>
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<tr>
<td>7:00am-8:30am</td>
<td>Workshop Session 2</td>
<td>2.0</td>
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<tr>
<td>8:30am-10:30am</td>
<td>APPD Task Force Meetings</td>
<td>2.0</td>
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<tr>
<td>10:45am-12:45pm</td>
<td>Workshop Session 3</td>
<td>2.0</td>
</tr>
<tr>
<td>Saturday, March 28</td>
<td>APPD Assessment TF and Curriculum TF Mini-Poster Symposia</td>
<td>1.5</td>
</tr>
<tr>
<td>8:45am-10:15am</td>
<td>Workshop Session 4</td>
<td>1.5</td>
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<tr>
<td>10:30am-12:00pm</td>
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APPD Fund Contributors
APPD thanks the following individuals who have generously donated to the APPD Fund in the past year:

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- R. Franklin Trimm, MD

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- Debra Boyer, MD
- Tammy Camp, MD
- J. Philip Saul, MD
- Teri Turner, MD, MPH, MEd

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- Laura Degnon, CAE
- Lynn Garfunkel, MD
- Gloria Kennedy, MD
- Jack Lazerson, MD
- Adam Pallant, MD, PhD
- Henry Schaeffer, MD
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Children’s Hospital/Boston Medical Center

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Lilia Parra-Roide, MD (2012 - 2015)
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JOIN AN APPD TASK FORCE!

The APPD Task Forces are seeking new members. Please attend one of the task force meetings and plan to become an active part of these important groups. Task force meetings will be held on Friday, March 27 from 10:45am-12:45pm. See page 25 for room locations. All are welcomed!

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

<table>
<thead>
<tr>
<th>Faculty and Professional Development Task Force:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Nancy Spector, MD, Chair</td>
<td>St. Christopher's Hospital for Children</td>
</tr>
<tr>
<td>Marsha Anderson, MD, Vice Chair</td>
<td>University of Colorado</td>
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<table>
<thead>
<tr>
<th>Learning Technology Task Force:</th>
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<tbody>
<tr>
<td>Mark Hormann, MD, Co-Chair</td>
<td>University of Texas at Houston</td>
</tr>
<tr>
<td>Emily Borman-Shoap, MD, Co-Chair</td>
<td>University of Minnesota</td>
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<table>
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<tr>
<th>Research and Scholarship Task Force:</th>
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<tbody>
<tr>
<td>Heather McPhillips, MD, MPH, Chair</td>
<td>University of Washington</td>
</tr>
<tr>
<td>Su-Ting T. Li, MD, MPH, Vice Chair</td>
<td>University of California (Davis) Health System</td>
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Javier Gonzalez del Rey, MD, MEd
Chair, Council of Task Force Chairs
Children's Hospital Medical Center/
University of Cincinnati College of Medicine

Assessment Task Force:
Kathleen Bartlett, MD, Chair
Duke University
Mark Vining, MD, Vice Chair
University of Massachusetts

Curriculum Task Force:
Rebecca Blankenburg, MD, MPH, Chair
Stanford University
Helen Barrett Fromme, MD, MHPE, Vice Chair
University of Chicago

2015 MEETING ● MARCH 25-28 ● ORLANDO, FL 7
Join an APPD Pediatric Education Group!

The APPD Pediatric Education Groups (PEGs) are seeking new members. Please attend one of the meetings and plan to become an active part of these important groups. Meetings will be held on Thursday, March 26 from 7:00am-8:30am. See page 14 for room locations. All are welcomed!

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

Sabrina Butteris, MD, Co-Leader
Chuck Schubert, MD, Co-Leader
Nicole St. Clair, MD, Co-Leader

LESBIAN-GAY-BISEXUAL-TRANSGENDER-QUEER/QUESTIONING-ALLY (LGBTQA) PEG
The LGBTQA (Lesbian-Gay-Bisexual-Transgender-Queer/Questioning-Ally) Pediatric Education Group is working on two aspects of LGBTQ well being. The first goal is addressing education of future pediatricians about LGBTQ health concerns. The second set of goals focuses on promoting a safe and inclusive work environment for LGBTQ residents and staff.

There is a workgroup focusing on each of these areas. The PEG is working in conjunction with groups with related goals in the American Academy of Pediatrics (AAP) and the Academic Pediatric Association (APA). 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.

Brian Lurie, MD, Co-Leader
Franklin Trimm, MD, Co-Leader

UNDER REPRESENTED MINORITIES IN PEDIATRIC GRADUATE MEDICAL EDUCATION PEG
Pediatric program directors are in a unique position to recruit and mentor underrepresented minority (URM) house staff. As well, it is critical for program directors to provide instruction regarding culturally effective healthcare and support a training environment that reflects the diversity of their patient population. Therefore the URM in Pediatric GME PEG aims to foster diversity in pediatric GME through addressing recruitment, mentorship, and support of URM pediatric housestaff, designing tools for program directors to support diversity, and cataloging pediatric-specific curricula which address healthcare disparities and cultural competency.

We welcome all interested members of the APPD to join us in addressing these goals through participation in the URM in Pediatric GME PEG.

Aisha B. Davis, MD, Co-Leader
Patricia Poitevien, MD, MSc, Co-Leader
**SIMULATION IN HEALTHCARE PEG**

The Simulation in Healthcare Pediatric Education Group has an overall goal of exploring, disseminating and sharing simulation methods used in healthcare to teach and assess these skills in pediatric residents and fellows:

- Procedural Skills
- Resuscitation Skills
- Communication Skills
- Exam Skills
- Data gathering and emotion handling skills
- Teamwork and interprofessional skills

We will accomplish this by working collaboratively to develop simulation cases and curricular materials that can be shared, particularly around milestones, teamwork, and procedures. We will work with the Society for Simulation in Healthcare in the efforts to standardize simulation terminology, as well as collaborating with simulation research networks on projects. Participation in the Simulation in Healthcare PEG is open to all members. We hope you will join us and participate in our efforts.

Sharon Calaman, MD, Co-Leader
Joe Lopreiato, MD, Co-Leader

**APPD LEARN**

(LONGITUDINAL EDUCATIONAL ASSESSMENT RESEARCH NETWORK)

APPD LEARN is APPD's research network, open to all member programs, with 130 currently participating. During the past year, APPD LEARN has facilitated studies on the validity of resident self-assessment using Pediatrics Milestones (Li and Gifford, PIs) and measuring the perceived balance between education and service (Boyer and Kesselheim, PIs), and two new studies will begin enrollment shortly: an examination of CCC member milestone judgments (Schumacher, PI) and a survey of scholarly activity during residency (Abramson, PI). 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 an assessment of the relationships between entrustable progression activities and milestones in the Pediatric subspecialties (with the Council of Pediatric Subspecialties and the American Board of Pediatrics). We expect to announce additional new studies and collaborations this year. 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
Robin Young, APPD LEARN Program Manager
Marina Seyon, APPD LEARN Program Assistant
APPD LEARN has its own web site at http://learn.appd.org
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 4 is underway. The deadline for applications for this group is April 24, 2015. Visit www.appd.org/ed_res/LEAD.cfm for details. For more information about LEAD, look for the APPD LEAD poster near the registration area, during the Poster Session on Friday, and on page 71 of this program.

LEAD Council Members / Faculty
Susan Bostwick, MD, MBA, Chair
New York Presbyterian Hospital/Cornell Campus
Su-Ting Li, MD, MPH
University of California (Davis) Health System

Grace Caputo, MD, MPH
Phoenix Children’s Hospital/Maricopa Medical Center
Richard Shugerman, MD
Seattle Children’s Hospital / University of Washington

John Frohna, MD, MPH
University of Wisconsin
Linda Waggoner-Fountain, MD, MEd
University of Virginia

Hilary Haftel, MD, MHPE
University of Michigan

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

Christine Barron, MD
Hasbro / Lawrence A. Aubin Sr. Child Protection Center
Natalie Lane, MD
Medical College of Georgia

Meredith Bone, MD
Ann & Robert H. Lurie Childrens’ Hospital of Chicago
Diane Lorant, MD
Indiana University SOM/ J.W. Riley Hospital for Children

Sharon Calaman, MD
St. Christopher’s Hospital for Children
Brian Lurie, MD, MPH, FAAP
Goryeb Children’s Hospital Atlantic Health

Pamela Dietz, MD
Maine Medical Center
Kate Perkins, MD, PhD
University of California-Los Angeles

Patrick Doherty, MD
University of Nebraska/Creighton University
Sydney Primis, MD
Carolinatas Medical Center - Levine Childrens’ Hospital

Albina Gogo, MD
University of California, Davis Medical Center
Jason Werner, MD
SLU SOM/ SSM Cardinal Glennon Childrens’ Medical Center

Casey Hester, MD
University of Oklahoma Health Sciences Center
Scott Williams, MD
Our Lady of the Lake, RMC

Lynne Huffman, MD
Stanford University
APPD 2015 Annual Meeting ~ March 25-28
MPPDA 2015 ~ Annual Meeting ~ March 24-25
Orlando, FL

Sharing Innovative Strategies for Optimizing Outcomes

APPD Meeting Schedule

**MPPDA Program Details** - See Pages 33-35

**Tuesday, March 24**

7:30am-6:00pm
- APPD LEAD Meeting (LEAD Cohort only)
  *Northern A1/Dolphin*

- APPD Board of Directors Meeting
  *Oceanic 7/Dolphin*

1:00pm - 5:00pm
- APPD TAGME Exam *(prior appointment necessary)*
  *Europe 10/Dolphin*

**Wednesday, March 25**

7:00am-8:00pm
- Registration
  *Convention Foyers 3-4/Dolphin*

7:30am-11:30am
- APPD LEAD Meeting (LEAD Cohort only)
  *Northern A1/Dolphin*

8:00am - 5:30pm
- APPD Forum for Chief Residents (Breakfast and Lunch will be included)
  *Northern A3-A4/Dolphin*

Coordinated by Erin L. Giudice, MD, Pediatric Residency Program Director, University of Maryland, Blair Dickinson, MD, Associate Residency Program Director, St. Christopher’s Hospital for Children, Cynthia Ferrell, MD, MSeD, Pediatric Residency Program Director and Megan Aylor, MD, Associate Program Director, Oregon Health Sciences University, Maria Ramundo, MD, Pediatric Residency Program Director, Akron Children’s Hospital, Kenneth B. Roberts, MD, University of North Carolina School of Medicine, Glenn Rosenbluth, MD, Associate Director, Pediatric Residency Training Programs, University of California, San Francisco, Edwin L. Zalneraitis, MD, Pediatric Residency Program Director, University of Connecticut, Amita DeSouza, MD and Caitlin Zaner, MD, Chief Residents at the University of Maryland, Ilona Kane, MD, Kheyandra Lewis, MD, and Valerie Martin, DO, Chief Residents at St. Christopher’s Hospital for Children, Bryan McKee, MD, Chief Resident at Akron Children’s Hospital, and Laura Holzum, MD, Chief Resident at Southern Illinois University. Sponsored by the APPD Faculty and Professional Development Task Force.

Rising Chief Residents and Graduating Chief Residents are invited to attend this forum! Chief Residents face a diverse set of challenges in academic medical centers related to the multiple roles that they assume as leaders, clinicians, educators, administrators, and mentors. To be effective across these multiple domains, Chief Residents must have a broad skill set and acquire new skills, especially to address the leadership and administrative aspects of the position. The APPD’s Forum for Chief Residents is a series of educational sessions designed to help residents learn key administrative, academic, and leadership skills in order to facilitate a successful year as a Chief Resident, and to be able to use the Chief Resident year for enhancing success in subsequent years. This one-day forum will include a variety of interactive workshops led by experienced program directors and educators.
directors and current Chief Residents to address these administrative, academic, and leadership topics relevant to Chief Residents. There will be opportunities to network with current and rising Chief Residents. The afternoon session will have two separate tracks: a track for rising Chief Residents will focus on planning the Chief Resident’s academic year and a track for graduating Chiefs will focus on professional development beyond the chief resident year.

9:00am-4:00pm  
**APPD Coordinators’ Session (lunch on your own)**

**Swan 9-10/Swan**

- **9:00-9:30am** Welcome and Introduction of the Coordinators’ Executive Committee
- **9:30-11:00am** Coordinator Workshop: Fostering Emotional Intelligence in Yourself and Those You Work With: Residents, Faculty and other Staff
  *Pamela Carpenter, C-TAGME, Amy Kearns, Jamie Bruse, C-TAGME; University of Utah; Pediatric Residency Program, Salt Lake City, Utah; Charlene Rotandi, Stanford University, School of Medicine, Palo Alto, CA; Teresa Flourney, MBA, C-TAGME, Children’s Mercy Hospital, Kansas City, MO*

  Emotional Intelligence (EI) is the ability to manage one’s emotions and the emotions of others. This is a vital key to guiding communication and professional relationships. As coordinators, our job can be seriously complicated by emotional relationships with our peers, leaders, and trainees. Studies have linked EI scores to strong or poor MD-RN and MD-patient relationships. Therefore, as coordinators, skills in assessing not only our response to interpersonal obstacles but coaching others to similarly react are invaluable. This workshop will consist of a didactic portion, explaining the tenets of EI and how it applies to our workplace. Coordinators will receive results of a previously emailed assessment of their EI scores and results will be explained. Next, an interactive portion will include small breakout groups where participants will receive direction to help coach themselves and their colleagues through a difficult scenario. Attendees will be able to effectively apply the skills learned to difficult situation and/or conversations.

  - **11:15-12:30pm** ERAS Demo and Update
  - **12:30-2:00pm** Lunch on your own
  - **2:00-4:00pm** Coordinator Table Talks

11:30am-3:45pm  
**APPD Pre-Conference Workshops**

*additional fee required ~ includes boxed lunch*

**Oceanic 7/Dolphin**

- **Pre-Conference Workshop 1**
  - **INCREASING THE VALUE OF THE INDIVIDUALIZED CURRICULUM BY CREATING OPPORTUNITIES FOR TRAINEES TO DEVELOP SELF-REGULATED LEARNING SKILLS**
  *Kimberly A. Gifford MD, Children’s Hospital at Dartmouth, Lebanon, NH, Patricia J. Hicks MD, MHPE, Children’s Hospital of Philadelphia; Perelman School of Medicine at the University of Pennsylvania, Philadelphia, PA, Franklin Trimm MD, University of South Alabama College of Medicine, Mobile, AL, Tai M. Lockspeiser MD, MHPE, University of Colorado, School of Medicine, Aurora, CO, Ann Burke MD, Wright State University, Dayton, OH*

  Rapid changes in health care delivery and expansion of medical science require graduate medical education programs to develop pediatricians who are self-motivated and have the ability to acquire new knowledge and skills throughout their career. In contrast to the standard curriculum offered to all residents, the individualized curriculum allows residents to focus their learning on individual career goals and develop the skills needed to be lifelong learners. Similarly, fellows have electives or other individualized experiences. The self-regulated learning (SRL) model provides a conceptual framework for physician lifelong learning.
learning (Artino 2003). In this model, learning occurs in three phases: self-reflection, forethought, and performance. Programs can provide opportunities for trainees to practice SRL with guidance through the process of planning individualized experiences and by engaging in certain curricular choices. During this workshop participants will explore opportunities for residents or fellows to practice SRL and create a plan to enhance the existing approach to the individualized experiences at their own institution to better foster the development of SRL skills. The workshop will begin with an example of a resident completing activities to plan and then engaging in her individualized curriculum. In small groups, participants will identify the SRL skills that the example resident is practicing with each activity. In pairs, participants will reflect on activities or strategies in place at their own institutions that enable trainees to practice SRL and share their own examples with other participants. They will then select one activity that they think would help trainees to develop SRL skills in their own program and create a plan to implement that activity with the guidance of workshop leaders and other participants who have similar ideas. The workshop will conclude with a discussion about potential outcomes to measure trainee development of SRL skills. Participants will leave with resources and ideas about potential opportunities for residents or fellows to practice SRL and a plan to implement one idea in their own program.

Pre-Conference Workshop 2
TEACHING PROFESSIONALISM: UNVEIL YOUR HIDDEN CURRICULUM
Oceanic 8/Dolphin
Brian Lurie MD, MPH, Atlantic Health/ Goryeb Children’s Hospital, Morristown, NJ, H. Barrett Fromme MD, MHPE, University of Chicago/ Pritzker School of Medicine, Chicago, IL, Kathleen Gibbs MD, Icahn School of Medicine at Mount Sinai, New York, New York, Auxford Burks MD, Albert Einstein College of Medicine, Jacobi Medical Center, Bronx, New York, Caren Gellin MD, University of Rochester, Rochester, New York, Jay Peacock MS, SUNY Upstate Medical University, Syracuse, NY

This Pre-Conference Workshop is presented by the APPD Curriculum Task Force. In this workshop, we will utilize Kern's widely accepted six-step model for the development of medical education curricula to develop ways to teach and assess professionalism. Beginning in a large group, the presenters and the participants will brainstorm the definition of professionalism and describe both exemplary behaviors and lapses of professionalism as witnessed in their individual programs. The presenters will then provide the participants with current definitions of professionalism from medical education literature. The group will identify several aspects of professionalism that could be addressed through curricula. This will be considered the Problem-Identification and early Needs Assessment steps of Kern’s Model. Participants will then be divided into small groups based on interest in these different group-developed topics. All groups will be introduced to Kern’s Six Steps, through an interactive process: large group introduction with small group work on each step. Through faculty-facilitated group work, participants will go through the remaining steps of Kern: writing goals and objectives, selecting instructional strategies, and planning for implementation and evaluation. Finally, groups will review the professionalism milestones. Each small group will then be charged with mapping their goals and objectives and teaching activity to the professionalism competencies. Each participant will utilize an interactive handout to record their ideas, which they can take home for future use. 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. Finally, the participants will return to the larger group to discuss favorite ideas and make a commitment to continue their small group work for contribution to a formalized Professionalism curriculum which can be instituted at their home institution.

1:00pm-3:30pm
APPD Forum for Directors of Small Programs and Affiliate Chairs
Northern A2/Dolphin
Janara Huff, MD, Marielisa Rincon-Subtirelu, MD, University of Tennessee College of Medicine / T.C. Thompson Children’s Hospital, Abhay Dandekar, MD, Kaiser Permanente Northern California

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

3:45pm-5:45pm
APPD Grassroots Forum for Program Directors
Swan 7-8/Swan

The Grassroots Forum for Program Directors will focus on timely topics of interest to Program Directors. This year’s facilitators will be Drs. Betty Staples (Duke University), Kate Perkins (UCLA) and Casey Hester (Oklahoma University Health Sciences Center).

APPD Grassroots Forum for Associate Program Directors
Asia 5/Dolphin

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: Drs. Lynn Gardner (Emory University), Sue Poynter (University of Cincinnati), and Michelle Barnes (University of Illinois-Chicago).
**APPD Grassroots Forum for Fellowship Directors**

**Europe 9/Dolphin**

This moderated open forum is designed specifically for subspecialty fellowship directors and coordinators to discuss a variety of current trends in fellowship education. There will be open discussion of fellowship training length and Hospital Medicine certification, next steps for EPAs, Milestone reporting, CCCs, and PD FTE needs. Representatives from the American Board of Pediatrics, CoPS, and the ACGME will be present to engage in dialogue related to these and other topics. Your active participation and sharing of possible solutions is important and will be facilitated by the APPD Fellowship Directors Executive Committee: Bruce Herman, MD, Michael Brook, MD, Geoffrey Fleming, MD, Kathleen McGann, MD, Angela Myers, MD, MPH, Pnina Weiss, MD

6:00 pm - 7:00 pm  
**APPD Networking Reception (open only to APPD registrants)**  
*Lake Terrace/Swan*

**THURSDAY, MARCH 26**

7:00 am-8:00 pm  
**Registration**  
*Convention Foyers 3-4/Dolphin*

7:00 am-8:30 am  
**APPD Continental Breakfast**  
*Southern Foyer I-III/Dolphin*

**APPD Pediatric Education Group (PEG) Meetings**

- Global Health  
  *Asia 4/Dolphin*
- LGBTQQA  
  *Asia 2/Dolphin*
- Simulation  
  *Asia 1/Dolphin*
- Under Represented Minorities in Pediatric GME  
  *Asia 3/Dolphin*

8:30 am-9:35 am  
**APPD Members’ Meeting: Awards and Annual Reports**  
*Southern I-III/Dolphin*

8:30-8:34 Welcome – *Dena Hofkosh, MD, MEd, APPD President*

8:34-8:35 APPD View Pages – *Robert Vinci, MD, Associate Editor, APPD*

8:35-8:38 Treasurer’s Report – *Javier Gonzalez del Rey, MD, MEd, APPD Secretary/Treasurer*

8:38-8:40 Special Projects Announced – *Javier Gonzalez Del Rey, MD, MEd*

8:40-8:44 Election Results – *Patricia Hicks, MD, MHPE, APPD Past President*

8:44-8:48 Farewell to exiting leaders – *Dena Hofkosh, MD, MEd*

8:48-8:50 Thank you to Program Chair – *Dena Hofkosh, MD, MEd*

8:50-9:00 Research/QI/Trainee Awards – *Debra Boyer, MD*

9:00-9:03 Holm Award and acceptance – *Patricia Hicks, MD, MHPE*

9:03-9:06 Tunnessen Award and acceptance – *Patricia Hicks, MD, MHPE*

9:06-9:10 Berkowitz Award and acceptance – *Patricia Hicks, MD, MHPE*

9:10-9:22 Executive Committee Chairs, Task Force Chairs and Regional/CORC update  
*Executive Committee Chairs (Aditee Narayan, MD, MPH, Kelley Pike, Bruce Herman, MD); Task Force Chairs (Assessment Task Force: Kathleen Bartlett MD, Chair, Mark Vining, MD, Vice Chair; Curriculum Task Force: Becky Blankenburg, MD, Chair, Helen Barrett Fromme, MD, MHPE, Vice Chair; Faculty and Professional Development Task Force: Nancy Spector, MD, Chair, Marsha Anderson, MD, Vice Chair; Learning Technology Task Force: Mark Hormann MD, Co-Chair, Emily Borman-Shoap MD, Co-Chair; Research and Scholarship Task Force: Heather McPhillips, MD, MPH, Chair, Su-Ting T Li MD, MPH, Vice Chair; J. Auxford Burks, MD, Chair of the Council of Regional Chairs*

9:22-9:27 APPD LEARN – *Alan Schwartz, PhD, APPD LEARN Director*

9:27-9:35 APPD LEAD Graduation – *Susan Bostwick, MD, APPD LEAD Council Chair*
WORKSHOP 1: HABITS OF HIGHLY SUCCESSFUL ACADEMICIANS: MAKING YOUR GRANDMOTHER (AND YOUR DEPARTMENT CHAIR) PROUD
Scott C. Borinestein MD, PhD, Vanderbilt University, Department of Pediatrics, Division of Pediatric Hematology/Oncology, Geoffrey M. Fleming MD, Vanderbilt University, Department of Pediatrics, Division of Pediatric Critical Care, Nashville, TN

Asia 4/Dolphin
Physician training in medical school and residency focuses on professionalism with patients, however little time is spent preparing trainees for career success in academic medicine. The goals of this workshop are to help workshop participants identify the key qualities of successful academic physician leaders and develop techniques to improve professional image. Using a combination of didactic, case-based, and small group learning techniques, important concepts of professionalism and communication will be addressed. The workshop will be broken into two thematic sections. The first will address common practices of effective academic physician self-management as a key to success using the acronym CREDO (Communicator, Reliable, Enthusiastic, Doer, Organized) as a tool for practice. The second focus of the workshop will be relationship management, including navigating political scenarios as well as networking. Using case-based small group discussion, participants will create generalizable rules for navigating charged political scenarios in academic medicine with report out to the whole group. The final segment will begin with a brief discussion of effective networking techniques. This will include a demonstration of a focused overview of current activities (the Elevator Speech). Participants will then divide into dyads to practice developing and delivering their Elevator Speech in a pair-share design. The workshop will conclude with take home points and a brief question/answer period. By the end of the workshop, participants will be able to use the CREDO acronym to identify and manage professional image and relationships, use tips for navigating academic politics and deliver an Elevator Speech to briefly summarize their current academic activities to others.

WORKSHOP 2: MINDFUL MEDICINE- AN APPROACH TO ACKNOWLEDGING AND AVOIDING COGNITIVE BIAS
Angela L. Myers MD, MPH, Children’s Mercy, Kansas City, Missouri, Bruce Herman MD, University of Utah, Salt Lake City, Utah, Kathleen McGann MD, Duke University, Durham, North Carolina, Chris Kennedy MD, Children’s Mercy, Kansas City, Missouri, Michael Brook MD, University of California San Francisco, San Francisco, CA

Asia 3/Dolphin
Missed diagnoses and subsequent treatment failures are common in medical practice. The goal of this workshop is to develop a better understanding of common cognitive pitfalls in the diagnostic process in the context of human clinical reasoning patterns. The workshop will begin with an introduction to typical clinical reasoning styles and different types of cognitive bias with specific examples from everyday practice in a facilitated large group discussion. We will then work on recognizing cognitive bias using specific case-based scenarios in small groups. Each small group will review a case scenario and identify where cognitive bias has occurred. Based on these thoughts and input from the facilitators, the next segment will discuss the concept of mindful practice along with strategies to mitigate cognitive bias in the example case scenarios. Finally, each individual will reflect on instances in which cognitive bias occurred with a trainee or in a patient they were directly involved in, factors that promoted cognitive bias in that setting, and possible ways to mitigate cognitive bias in future encounters, by using a checklist for medical decision making. We will then come back together in a large group to discuss ways in which these concepts might be included into trainee evaluations.

WORKSHOP 3: A ROADMAP TO TEACH SENIOR RESIDENTS TO FACILITATE DEBRIEFINGS AFTER CRITICAL INCIDENTS
Amanda D. Osta MD, University of Illinois, Chicago, IL, Janet R. Serwint MD, Johns Hopkins University, Baltimore, MD, Megan E. McCabe MD, The Children’s Hospital at Montefiore, Bronx, NY, Annamaria T. Church MD, U of TN COM-Chattanooga, Chattanooga, TN, Albina S. Gogo MD, U C Davis, Sacramento, CA, Ann Burke MD, Wright State University, Dayton, OH

Asia 2/Dolphin
The practice of pediatrics is both incredibly rewarding and incredibly demanding. Identifying and addressing critical incidents is necessary to promote resident well-being, self-reflection and successful integration of these experiences. Lack of attention to the impact of these experiences can lead to burnout, depersonalization and distancing from families. This workshop uses the train-the-trainer model to teach the use of debriefings for residents after critical incidents. Members of the AAP, APA and APPD collaboratively developed a curriculum focused on promoting resilience in the face of grief and loss, and the use of debriefing is one of the key components of this curriculum. Debriefings allow time for individuals to reflect on the critical incident, understand the emotional impact of the experience on themselves, and better understand the perspectives of other providers who were involved. In this highly interactive workshop, we will use individual work, pair-share, small group, and large group work to highlight the curriculum that has been developed to teach senior residents to facilitate a debriefing session. At the end of the workshop, participants will leave with the tools, including journaling worksheets, mock resident debriefing cases, and the facilitator’s guide to teach senior residents how to do debriefings.
relationship with the patient. Typically, Balint groups are held longitudinally over years. The challenge for pediatric programs is to
patient’s thoughts and emotions, and consider what is needed for the physician to build an empathic, fulfilling and effective relationship for the patient and family. Following a case presentation, the members explore different perceptions about the physician’s and patient’s roles.

Pediatric residents may feel frustrated or unsettled following interactions with some patients or their families. One way to address some of these feelings is through a Balint group experience. The Balint group model is a psychoanalytic group that focuses on self-reflection and understanding the emotional experiences of the physician.

Evelyn C. Reis MD, Children’s Hospital of Pittsburgh of UPMC, Phillip Phelps LCSW, BCD, UPMC Shadyside Family Medicine, Dena Hofkosh MD, Stephanie Dewar MD, Children’s Hospital of Pittsburgh of UPMC, Pittsburgh, PA

Oceanic 6/Dolphin

As the number of residents participating in global health (GH) rotations continues to rise, educators strive to prepare residents to embark on these rewarding but challenging situations. Preparation for GH rotations has generally involved self-study on the part of the resident (reading about the country, culture & diseases), discussion sessions with faculty and other residents, and didactic sessions about health and safety and disease specific lectures. While these elements are important, they fall short when it comes to emotionally preparing residents for the day-to-day emotional obstacles that they will encounter.

Given this preparatory gap, we have developed and evaluated a standardized, simulation-based curriculum (Simulation Use for Global Away Rotations, SUGAR) aimed at evoking the difficult emotions experienced by residents participating in GH rotations. SUGAR allows residents to experience challenging scenarios and emotions before they embark on their rotations. Structured debriefing allows them to process their emotions and problem solve as a group about how to approach similar scenarios during their rotation. We have piloted this curriculum at 7 sites and had overwhelmingly positive feedback about its content, structure and impact. We have since rolled out to nearly 40 institutions and begun publishing the results. SUGAR uses a novel, easy to follow case format that has been successfully used by both novice and expert simulation educators following a brief facilitator training session. In this workshop, we will train residency program educators to facilitate these standardized simulation sessions though a combination of debriefing training, case familiarization and interactive practice. Anyone who is involved in GH education is welcome to attend. No prior simulation experience is needed to attend the workshop and facilitate the sessions. As the cases can be run with a doll or inanimate object, participants do not need to have access to any simulation equipment at their home institutions. Programs of all sizes and stages of GH infrastructure are strongly encouraged to attend.

WORKSHOP 6: A TASTE OF BALINT: INTRODUCTORY EXPERIENCE WITH THE BALINT GROUP MODEL TO ENHANCE EMPATHY AND PROFESSIONAL DEVELOPMENT AMONG PEDIATRIC RESIDENTS

Evelyn C. Reis MD, Children’s Hospital of Pittsburgh of UPMC, Phillip Phelps LCSW, BCD, UPMC Shadyside Family Medicine, Dena Hofkosh MD, Stephanie Dewar MD, Children’s Hospital of Pittsburgh of UPMC, Pittsburgh, PA

Oceanic 2/Dolphin

Pediatric residents may feel frustrated or unsettled following interactions with some patients or their families. One way to better understand and learn from these challenging situations is to participate in a Balint group. A Balint group is a small group of physicians who meet regularly and participate in a supportive facilitated case discussion. In contrast to traditional case discussions which focus on problem solving, Balint groups focus on enhancing the physician’s ability to connect with and care for the patient and family. Following a case presentation, the members explore different perceptions about the physician’s and patient’s thoughts and feelings, and consider what is needed for the physician to build an empathic, fulfilling and effective relationship with the patient. Typically, Balint groups are held longitudinally over years. The challenge for pediatric programs is to find ways to facilitate these groups at their institutions.
finding time in the curriculum to add another longitudinal experience. To address this logistical challenge, we have implemented a weekly Balint experience for PL-2 residents during three of their 1 month-long block rotations. Residents have shared that they appreciate the Balint experience as it provides an opportunity to reflect on challenging cases and gain insights into their own and their patients’ perspectives. Results of an anonymous survey of all PL-2 residents revealed that participation in Balint group fosters skills in: self-reflection, ability to tolerate uncertainty, empathy, increased flexibility when responding to challenging patient relationships, and increased awareness of one’s own limitations. During this interactive workshop, we will provide participants with an introductory experience with the Balint method. We ask that participants have clinical contact with patients and be willing to present a case. In addition to participating in a Balint group, workshop attendees will learn the practical aspects of starting and maintaining Balint groups for trainees and opportunities for Balint leadership training.

WORKSHOP 7: WHY MAPS MATTER IN MEDICINE: CREATING A GEOGRAPHY-BASED RESIDENT CURRICULUM TO INTRODUCE THE IMPORTANCE OF GEOGRAPHICAL-CONTEXT IN HEALTH
Francis J. Real MD, Andrew Beck MD MPH, Cincinnati Children’s Hospital Medical Center, Cincinnati, OH, Catherine Distler MD, Boston University, Boston Medical Center, Boston, MA, Melissa Klein MD, MEd, Cincinnati Children’s Hospital Medical Center, Cincinnati, OH
Oceanic 7/Dolphin
More than 16.1 million children nationwide live in households with incomes below the federal poverty line. Poverty, which is often rooted in a family’s neighborhood context, adversely impacts health outcomes across the lifespan. Despite this, residents often know little about their patients’ neighborhoods, communities that are frequently characterized by health-related, and potentially-modifiable, social, economic, and environmental risk factors. This educational gap results in missed opportunities for screening, intervening, and advocating for families. Although, most residency programs have incorporated advocacy training, many lack community-based training to address this knowledge deficit. In this highly interactive workshop, participants will be provided a framework on the importance of geographical context and resource assessment in medical practice and consider how their respective institutions approach education on this topic. Video clips and individual reflection will be utilized to energize the audience around the theme of poverty. Participants will work in small groups to identify the critical topics and resources needed for the foundation of a geography-based resident curriculum. Based on these activities, participants will create their own geography-based education module and determine optimal delivery methods for their learners. Finally, participants will discuss which key stakeholders are necessary in order to bring their blueprint for a geography-based curriculum to life at their home institution.

WORKSHOP 8: GOING THE EXTRA MILE IN YOUR QUALITY IMPROVEMENT CURRICULUM: INTEGRATING QUALITY IMPROVEMENT ASSESSMENT TOOLS AND THE PEDIATRIC MILESTONES
Mackenzie S. Frost MD, Ashley Lucke MD, Jennifer Walsh MD, University of Texas Southwestern Medical Center, Dallas, Texas, Mario Cruz MD, St. Christopher’s Hospital for Children, Philadelphia, PA
Asia 5/Dolphin
Although the ACGME and Resident Review Committee require quality improvement (QI) training, systematic reviews of published QI curricula demonstrate a consistent lack of methodological rigor. Many programs have established QI projects and curricula, but lack assessment tools to evaluate trainee knowledge, demonstration, and application of quality improvement methodologies in practice. At the same time, the pediatric milestones are being implemented nationally to assess trainees. This workshop will focus on the development of robust assessment of trainees’ quality improvement skills by utilizing both published QI assessment tools and the pediatric milestones. Workshop facilitators will review the pediatric milestones directly related to quality improvement. Via large group discussion, workshop participants will share current practices in evaluating these milestones. Workshop facilitators will then introduce published QI assessment tools (Mayo Evaluation of Reflection on Improvement Tool (MERIT), Quality Improvement Proposal Assessment Tool (QIPAT-7), and Quality Improvement Knowledge Application Tool (QIKAT)). In facilitated small groups, participants will practice using each assessment tool with provided QI data and sample projects. The large group will discuss the pros and cons of each assessment tool. In a facilitated large group discussion, participants will then apply QI principles to construct a key driver diagram focusing on ways to successfully integrate the QI assessment tools with a focus on the appropriate pediatric milestones into the current QI curricula at their institution. Finally, small groups will identify and discuss potential areas for collaborative QI education research in curricular and assessment tool development.

COORDINATORS WORKSHOP 9: ENHANCING TEAMWORK IN YOUR GME OFFICE: A WORKSHOP FOR PROGRAM DIRECTORS AND COORDINATORS
Heather A. McPhillips, MD, MPH; Drake Kendermore; Maneesh Batra, MD, MPH; Scott Olson; Lauren Wilson, MD; Kashena Konecki; Mollie Grow, MD, MPH; Celeste Quitiquit, MD; Jennie Wild, MD; Carolyn Schook, MD; Sarah Dixon, MD; University of Washington, Seattle, WA
Asia 1/Dolphin
This workshop is an opportunity for residency and fellowship program leadership (PDs, APDs, Chief Residents and Coordinators) to understand more about their individual work styles and communication preferences, and how to adapt their preferences to work more effectively together as a team. Participants in this workshop will take the self-scored Myers Briggs Type Indicator. This instrument identifies individuals’ preferred different personality styles in 4 letter combinations: Extroversion (E) vs. Introversion (I), Intuition (N) vs. Sensing (S), Thinking (T) vs. Feeling (F), Judging (J) vs. Perceiving (P). After completion, the large group...
CORRELATION OF OSCE AND CLINICAL ROTATION MILESTONE RATINGS
Aisha B. Davis MD, Children’s National Medical Center, Washington, DC, Joseph O. Lopreiato MD, MPH, Uniformed Services University, Bethesda, MD, Dewesh Agrawal MD, Program Director, Children’s National Medical Center, Ashraf Harahsheh MD, FAAP, FACC, Children’s National Health System/George Washington University, Mary C. Ottolini MD MPH, Cara Lichtenstein MD MPH, Children’s National Medical Center, Washington, DC, Kathleen Wortmann, Uniformed Services University of the Health Sciences, Jerri Curtis MD, National Capital Consortium, Bethesda, MD

Background: The ACGME requires semiannual documentation of residents’ milestone attainment. OSCE data has correlated with other performance measures in some cases but it is unclear whether OSCE and clinical rotation evaluations correlate when assessing milestones. We compared milestone attainment measured by OSCE to those measured by rotation evaluations.

Methods: An OSCE was designed to assess select pediatric milestones. 5 standardized patient scenarios were created and tailored for observation of 8 of the subcompetencies required for semiannual reporting. Faculty observers were trained in the use of the milestones. Faculty used half-point increments to denote milestone levels. Milestone assessments from the OSCE were compared with the average milestone ratings from resident rotation evaluations for each intern in the preceding 6 months. Correlation was assessed with the Pearson correlation coefficient and significance was set at p<0.05. Results: 36 interns participated. The correlation of OSCE ratings and rotation evaluation ratings was not statistically significant, although the correlation for ICS-2 approached significance (R=0.28, p=0.057). Mean milestone scores and range of scores were notably higher for rotation evaluations than OSCE ratings. Conclusions: Milestone scores assigned in rotation evaluations did not correlate well with those assigned during direct observation of OSCE stations specifically designed to measure those subcompetencies. The range of scores assigned for each competency was higher for rotation evaluations. It is unclear whether rotation evaluation or OSCE scores best assess actual clinical performance. Clinical rotations offer the opportunity to observe the resident longitudinally; however, there are limitations to observing in a busy and unpredictable clinical setting. OSCEs offer the opportunity for faculty development regarding assigning milestones, focused faculty time for assessment, and controlled stations designed to assess specific competencies. Our results add data to the discussion regarding validity and reliability of using rotation evaluations to assess milestone achievement.

HOW WELL DO RESIDENT MILESTONE SELF-ASSESSMENTS CORRELATE WITH CLINICAL COMPETENCY COMMITTEE MILESTONE ASSESSMENTS?
Su-Ting Li MD, MPH, Daniel J. Tancred PhD, University of California Davis, Sacramento, CA, Franklin Trimm MD, University of South Alabama College of Medicine, Mobile, AL, Ann Guillot MD, University of Vermont College of Medicine, Burlington, VT, John D. Mahan MD, Nationwide Children’s Hospital/OSU, Columbus, OH, Ann Burke MD, Wright state University Boonshoft SOM, Dayton, OH, Kimberly A. Gifford MD, Children’s Hospital at Dartmouth, Lebanon, NH, Alan Schwartz PhD, APPD LEARN, McLean, VA, Susan Guralnick MD, Winthrop University Hospital, Mineola, NY, for APPD LEARN validity of resident self-assessment, APPD LEARN, McLean, VA

Purpose: Determine level of correlation between resident self-assessment and Clinical Competency Committee (CCC) measures of competency using milestones. Methods: We conducted a prospective multi-institutional study through APPD LEARN over the 2013-2014 academic year. Two time periods were studied: Fall 2013 (July 1, 2013 to December 31, 2013) and Spring 2014 (January 1, 2014 to June 30, 2014). Residents completed self-assessments and residency programs submitted CCC data using milestones on their residents for the same time period. Programs could choose to enroll in one or both time periods. Pearson correlation coefficients (PCC) were calculated to determine the correlation between self-assessment and CCC assessment scores. Results: A total of 47 pediatric residency programs, representing 1741 unique residents had 2290 observations of both self-assessment and CCC-assessment data. Overall correlation coefficients were fair (0.31-0.55). The highest overall PCCs were for patient care subcompetencies such as being able to organize and prioritize responsibilities (PC2: 0.55), gather information (PC1: 0.52), provide transfer of care (PC3: 0.50) and make informed diagnostic and therapeutic decisions (PC4: 0.50). The lowest PCCs were for professionalism subcompetencies such as humanism (Prof1: 0.30), self-awareness of one’s limitations that leads to help-seeking behavior (Prof4: 0.30), ethical behavior (Prof3: 0.31), and incorporating feedback into daily practice (PBLI4: 0.31). Correlation coefficients were uniformly higher during the second assessment period (Figure). Conclusions: Correlations varied between subcompetencies, with improvement in PCC during the second assessment period. Subcompetencies that may be easiest to directly observe, such as patient care, had higher correlation coefficients than those which may be more difficult to
Platform Presentation 4

ASSESSMENT OF RESIDENT PATIENT HANDOFF SKILLS: VALIDITY EVIDENCE FOR THE USE OF A STRUCTURED CLINICAL OBSERVATION TOOL TO MAKE COMPETENCY AND ENTRUSTMENT DECISIONS

Daniel C. West MD, University of California, San Francisco, San Francisco, CA, I-PASS Study Group, Boston Children’s Hospital, Boston, MA

Background: Patient handoffs have been identified as an important Entrustable Professional Activity (EPA) and GME programs are required to ensure trainees develop handoff skills. Training residents in the I-PASS handoff method has been shown to be associated with increased skills and reduced medical errors and patient harm. However, valid methods to assess individual resident handoff skills are lacking.

Objective: Generate validity evidence for a structured clinical observation tool of resident handoff skills.

Methods: From January 2011 to May 2013, we implemented the I-PASS Handoff Bundle to improve handoff skills in 9 pediatric residency programs. To support implementation, we developed the I-PASS structured clinical observation (I-PASSco) using an iterative, consensus-building process with an expert panel. The final tool consisted of 10-items aligned with the I-PASS curriculum and rated on a 5-point frequency scale (never, rarely, sometimes, usually, always). Following training to use the tool, faculty observers at each site used the I-PASSco to assess residents giving patient handoffs. To assess internal structure and reliability, we performed a 2-facet random effects analysis of variance with increased skills and reduced medical errors and patient harm. However, valid methods to assess individual resident handoff skills are lacking.

Conclusion: Incorporating patient safety discussions and event reporting into teaching team workflow can increase physician event reporting. Additional cycles are planned to test spread of the superintendent model to outpatient reporting, test methods of structured feedback on reported events, and implement topic-driven Patient Safety Rounds with faculty development around patient safety and event reporting delivered at the point of teaching (Faculty Development On the Go).
2:00pm-5:30pm  APPD Key Stakeholders Session  
**Southern I-III/Dolphin**

2:00pm-3:00pm  Milestones Session (PMAC, LEARN, ACGME)  
Milestones: What's now, what's new and what's missing (A Collaborative Exercise in Defining a Research Agenda)  
Participants: Stanley Hamstra, PhD and Laura Edgar, EdD, CAE, Executive Director, Milestones Development, ACGME; Patricia Hicks, MD, MHPE, PMAC; Su-Ting Li, MD, MPH and Kim Gifford, MD, APPD LEARN Self-Assessment of Milestones Study Group; Alan Schwartz, PhD (moderator)

3:00pm-3:15pm  Q&A

3:15pm-3:55pm  ACGME Update: Joseph Gilhooly, MD, Chair RC for Pediatrics, ACGME, Caroline Fischer, Executive Director, Accreditation Standards, ACGME Review Committee; Ingrid Philibert, PhD, Senior Vice President, Field Activities, ACGME

3:55pm-4:05pm  Q&A

4:05pm-4:35pm  ABP Update: Gail McGuinness, MD, Executive Vice President, American Board of Pediatrics

4:35pm-4:45pm  Q&A

5:15pm-5:30pm  Legislative Updates: Topics of interest to pediatric educators: Mark Del Monte, JD, Chief Public Affairs Officer of the American Academy of Pediatrics

6:30pm - 6:30pm  Pediatric Hospital Medicine Fellowship Certification Discussion  
**Southern I-III/Dolphin**

This optional session will include a panel discussion covering the questions from the American Board of Pediatrics to the APPD regarding pediatric hospital medicine fellowship certification.

6:00pm - 7:00pm  APPD LEAD Reception (APPD LEAD Graduates only)  
**Asia 5/Dolphin**

**Friday, March 27**

6:30am-7:30am  Informal Group Run/Walk  
*Main Entrance (Outside)/Dolphin*

Join your fellow attendees for this early morning exercise. Meet outside the main entrance of the Dolphin Hotel at 6:30am. In case of rain, this activity will be cancelled.  
*If you engage in this exercise or exercise program, you agree that you do so at your own risk, are voluntarily participating in these activities, assume all risk of injury to yourself.*

7:00am-8:00pm  Registration  
*Convention Foyers 3-4/Dolphin*

7:00am-8:30am  APPD Continental Breakfast  
**Southern Foyer I/Dolphin**

Coordinators Mentoring/Networking Session  
*Southern I / Dolphin*

In a continuation of our movement to improve peer mentoring groups, this breakfast meeting will be an opportunity for groups to reconnect and for new members (or unassigned coordinators) to make contact with a mentoring group. Grab your breakfast...
and join us in the Southern 1 room. This is a great way to get to know one another and to discuss the group's plans for the year and will be an excellent opportunity for networking!

APPD Mentoring Session
America's Seminar/Dolphin

(Limited to those previously registered. Registered mentees have been contacted by the Mentorship Committee)

Sponsored by the APPD Faculty and Professional Development Task Force

APPD Mentorship Committee of the Faculty and Professional Development Taskforce: Aditee Narayan, MD, MPH, Duke University Medical Center, Durham, NC; Nancy Spector, MD, St. Christopher's Hospital for Children, Philadelphia, PA; Marsha Anderson, MD, University of Colorado, Aurora, CO; Janet Serwint, MD, Johns Hopkins University, Baltimore, MD; Theodore Sectish, MD Children’s Hosp Boston, Boston Combined Residency, Boston, MA; Teri Turner, MD, MPH, MEd, Baylor College of Medicine, Houston, TX; Cliff Yu, MD, National Capital Consortium, Bethesda, MD; Joe Lopreiato, MD, MPH, National Capital Consortium, Bethesda, MD; Megan Aylor, MD, Oregon Health Sciences University, Portland OR; Mario Cruz, MD, St. Christopher's Hospital for Children, Philadelphia PA; Kimberly Gifford, MD, Dartmouth-Hitchcock Medical Center; Courtney Judd, MD, San Antonio Military Medical Center

We are excited to offer APPD’s first speed mentoring session. Prior to the meeting, mentors and mentees will have prepared and shared each others’ CVs for review. 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. The speed mentoring session will conclude with a small group debrief with breakfast. The speed mentoring session is complementary to the large group “Meet the Professor” session held in the Fall Meeting.

8:30am-10:30am Workshop Session 2

WORKSHOP 10: I DON'T WANT SOMEONE LIKE YOU TAKING CARE OF MY CHILD: IDENTIFYING STRATEGIES TO ADDRESS DISCRIMINATION TOWARD PHYSICIANS BY PATIENTS AND FAMILIES

Emily Whitgob MD, MEd, Alyssa Bogetz MSW, Ian Chua MD, Sarah Hilgenberg MD, Rebecca Blankenburg MD, MPH, Stanford University, Palo Alto, CA

Oceanic 3/Dolphin

There is a gap in the literature describing how physicians respond when confronted with discrimination enacted by their patients or patients' families. Medical trainees can feel alienated; clinical educators may feel powerless. Based on personal experiences, the presenters developed scenarios illustrating different types of discrimination and held structured interviews with faculty educators, who identified a range of approaches toward these difficult but inevitable situations. This research has confirmed that faculty development is needed, and review of the literature and faculty responses has led to new curricular materials for faculty development. In this interactive workshop using individual reflection, facilitated small group activities, and large group discussions, participants will first learn how this specific type of mistreatment fits into the broader conversation. Attendees reflection upon personal experiences of patient or family discrimination will lead into facilitated small group breakouts to create training scenarios. Sharing of these scenarios with the rest of the workshop will stimulate discussion of potential trainee and faculty strategies for managing these situations. The workshop’s focus will then transition to generating faculty development resources that prepare supervisors and trainees to effectively and confidently respond in these situations. In facilitated small group discussions, participants will brainstorm faculty development activities and then come together to discuss best practices for implementation. Participants will leave the workshop with tools to facilitate these essential conversations in their own learning environments and institutions. This workshop is applicable to all learners and educators who are interested in addressing a common but complex and rarely discussed topic.

WORKSHOP 11: CSI PEDIATRICS: COMMUNICATION SKILLS INSTRUCTION USING ROLE PLAY WITH SIMULATED PATIENTS TO OPTIMIZE RESIDENT MEDICAL ERROR DISCLOSURE

Evelyn C. Reis MD, Sylvia Choi MD, Dena Hofkosh MD, Stephanie Dewar MD, Children’s Hospital of Pittsburgh of UPMC, Pittsburgh, PA; Laurie Wilkie MD, MS, Riley Hospital for Children, Indianapolis, IN

Oceanic 1/Dolphin

Medical errors are the 8th leading cause of death in the US. Improving disclosure of medical errors and near misses is vital to increasing patient safety, but training physicians in disclosure skills is challenging. We have developed a course for pediatric residents consisting of 2 hour sessions focused on communication skills needed in provocative situations, using realistic clinical scenarios and simulated parents. The process of learning is experiential and uses guided self reflection, discussion among peers, and feedback from the simulator and faculty. Trained faculty members facilitate learning using positive commentary from fellow learners to highlight skills and gentle guidance about identifying and responding to emotion. We created scenarios which present different challenges based on the skills relevant for each trainee’s level. Interns experience delivering difficult news, 2nd year residents practice leading Family Centered Rounds, and 3rd year residents practice disclosing medical errors. The simulated parents are actors who are trained in portraying both content and emotion, and...
provide valuable feedback about specific aspects of the interaction. Residents are encouraged to reflect on their current skills and to develop a deeper awareness of internal obstacles to enhanced communication. In annual course evaluations, residents consistently self-report increased preparedness to recognize their own and parents’ emotions during challenging encounters. During this interactive workshop we will describe how to create similar courses at other institutions. The Primary Teaching Method of guided facilitation and self-reflection will be explained and demonstrated. 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 different levels of trainees. Participants will have the opportunity to practice facilitation of the medical error disclosure scenarios using role plays so they can receive real-time feedback from the course directors.

WORKSHOP 12: GLOBAL HEALTH GOES THE MILE(STONE)
Gitanjli Arora MD, DTMH, UCLA, Los Angeles, CA, Tania Condurache MD, MS, University of Louisville School of Medicine, Louisville, KY, Sabrina Butteris MD, University of Wisconsin School of Medicine & Public Health, Madison, WI, Charles Schubert MD, Cincinnati Children’s Hospital and Medical Center, Cincinnati, OH, Nicole St Clair MD, Medical College of Wisconsin, Milwaukee, WI, Maneesh Batra MD, MPH, University of Washington/Seattle Children’s Hospital, Seattle, WA, Lynn Garfunkel MD, University of Rochester, Rochester, NY, Kate Perkins MD, PhD, UCLA, Los Angeles, CA
Asia 3/Dolphin
While resident participation in global health grows, there continue to be no standard metrics for assessment of residents engaged in global health rotations. Current evaluation tools may not enable assessment of objectives unique to global health rotations and the milestone framework may be cumbersome for evaluators supervising residents abroad. This workshop will begin with an overview of global health rotations as opportunities to assess competencies essential to pediatrics. Resource-limited settings require that residents develop new knowledge and skills, and express empathy, humanism, and cultural humility. Additionally, residents on global health rotations must have an awareness of their own and their supervisors’ expertise, practice within their level of training, understand limitations in resources, display effective interactions with colleagues, and engage in appropriate help-seeking behaviors. In small groups, participants will use case scenarios and their own experiences to identify challenges of current assessment tools, and define key competencies to be assessed in global health settings. Findings will be presented to the large group for consensus on milestones specific to global health rotations. Participants will then be provided with examples of novel evaluation strategies, including use of technology for real-time assessment by faculty at US based institutions and tools to enable the supervising faculty abroad to assess milestones specific to global health objectives. Participants will divide into small groups to develop strategies for assessment of residents or to adapt current evaluation tools, from the perspective of the US institution and the partner institution abroad. Participants will be encouraged to consider using assessment tools as an opportunity for continuous and sustained communication between the global health partner institutions, to reaffirm expectations and responsibilities of each partner, and to encourage feedback. Proposed strategies and tools will be summarized for the large group. Participants can expect to receive updated assessment strategies and tools based on the workshop outcomes by email after the meeting.

WORKSHOP 13: CHAMP-THE COMMUNITY HEALTH AND ADVOCACY MILESTONES PROFILE: HOW AN INNOVATIVE APPROACH AND YOUR PROGRAMS COMMUNITY HEALTH AND ADVOCACY TRAINING CAN HELP YOU ASSESS YOUR RESIDENTS PROGRESS TOWARDS MILESTONES.
Benjamin Hoffman MD, OHSU, Portland, OR, Cara Lichtenstein MD, MPH, Children’s National Medical Center, Washington, DC, Caren E. Gellin MD, University of Rochester, Rochester, NY, Susan Guralnick MD, Winthrop University Hospital, Mineola, NY, Michelle Barnes MD, University of Illinois at Chicago, Chicago, IL, Cindy Ferrell, OHSU, Portland, OR
Asia 2/Dolphin
One of the most challenging aspects of the ACGME’s Next Accreditation System is translating a residency program’s training objectives and curricula into the language of competencies and milestones. This process is even more challenging for community health and advocacy training experiences as there are few well-established competency-based curricula. This interactive workshop will utilize an innovative curriculum mapping tool (Community Health and Advocacy Milestones Profile (CHAMP)) that was developed to match the AAP Community Pediatrics Training Initiative’s (CPTI) objectives for residency education in community health and advocacy to the milestone-based competencies. After briefly reviewing the CPTI objectives, the language of the milestones, and how the CHAMP was created, participants will discuss how such a tool could benefit both advocacy training programs and residency directors. In small groups of 2-3 participants will utilize the CHAMP tool to connect their current community health and advocacy training curriculum and activities to both the CPTI objectives and the ACGME competencies. As part of large group reporting of participants’ maps, we will also share several examples of completed CHAMP tools from workshop leaders. Based on the work done at each table, participants will discuss where their advocacy curricula are either meeting or failing to meet objectives and competencies. Groups will then brainstorm plans and share ideas for filling identified gaps with curricular activities and assessment tools. Workshop presenters will facilitate a large-group discussion on ways that this methodology can be used for other training objectives and curricula. Participants will leave with several examples of completed CHAMP tools aligning curricula with competencies, as well as tools to complete CHAMP mapping tools for their programs. Post-workshop, participants will be invited to upload their completed CHAMP tool to a Wiki site to foster connections and disseminate best practices.
WORKSHOP 14: CULTIVATING RESILIENCE AS PEDIATRIC HEALTH CARE PROVIDERS: TEACHING OURSELVES AND OUR LEARNERS
Janet R. Servint MD, Johns Hopkins University, Baltimore, MD, Annamaria T. Church MD, Univ of Tennessee COM-Chattanooga, Chattanooga, TN, Megan McCabe MD, The Children’s Hospital at Montefiore, Bronx, NY, Ann Burke MD, Wright state University Boonshoft SOM, Dayton, Ohio, Dena Hofkosh MD, MEd, Children’s Hospital of Pittsburgh, Pittsburgh, PA, Albina S. Gogo MD, U C Davis, Sacramento, CA, Amanda Osta MD, University of Illinois-Chicago, Chicago, IL

Asia 1/Dolphin
The September 2014 AAP clinical report on Physician Health and Wellness and the Pediatric Milestone project emphasize the importance of creating a health care provider culture of wellness and developing strategies to prevent burnout due to the inevitable stressors in clinical care. Developing resilience is crucial in preventing burnout, depersonalization, major depression, medical errors and dissatisfaction with career choice. However, historically, this concept has not been included in most training programs. To address this deficiency, members of the AAP, APA, APPD and COMSEP collaboratively developed a novel curriculum focused on promoting pediatric resident resilience in the face of grief and loss. In this highly interactive workshop we will use a train the trainer model to introduce components of this curriculum. Using individual work, pair-share, small, and large group discussion we will practice techniques for reflection, journaling, and identifying in the moment and long term strategies for resilience. Participants will develop their own Wellness Learning Plan. At the end of the workshop participants will receive the link to the curriculum including ready-to-use presentations, handouts, and facilitator instructions. Participants will leave the workshop with strategies of how to implement the curriculum at their own institution.

WORKSHOP 15: CREATING AND IMPLEMENTING A HIGH-VALUE COST-CONSCIOUS CARE CURRICULUM FOR PEDIATRIC RESIDENCY PROGRAMS
Suzanne K. Woods MD, Carolyn S. Avery MD, Duke University Medical Center, Durham, NC

Australia 3/Dolphin
Background: Healthcare expenditures will reach 20% of U.S. G.D.P. by 2020. Each year we spend $700 billion in healthcare waste and physicians are responsible for 87% of this unnecessary spending. Improving quality of care while decreasing the cost of healthcare has become a national priority. Nationwide initiatives have been launched to achieve this aim, including the American College of Physician’s (ACP) High-Value Cost-Conscious Care and the American Board of Internal Medicine’s (ABIM) Choosing Wisely and Teaching Value campaigns. None of the current educational initiatives target pediatric-specific diseases or measures. Design: A working group of 8 academic pediatricians reviewed the 2012 ACP HVCC curriculum. The curriculum was edited to include topics and cases pertinent to pediatrics and was incorporated into residents’ conferences for the 2012-2013 academic years. Survey of the residents’ attitudes and knowledge of cost-conscious medicine was performed before and after curriculum implementation. Audience response questions also assessed pre- and post-lecture understanding. Target areas of institution-specific inappropriate use were selected to utilize as metrics to monitor anticipated reduction over time. Results: Seven modules were created to introduce key topics of over-ordering of tests, biostatistics, health insurance, screening, and overcoming barriers to cost-conscious care. Pre and post survey data will be shared and we will discuss how this curriculum can be easily adapted by other training programs. QI and patient safety projects can result from implementation of this curriculum. Conclusions: Physicians are responsible for a large proportion of wasteful and inappropriate healthcare spending that has little benefit and potential harm to our patients. This pediatric-specific curriculum is the first to provide residents education on appropriate use of healthcare diagnostics, therapeutics, and resources.

WORKSHOP 16: ASSESSING RESIDENT TEACHING SKILLS: INCORPORATING OBJECTIVE, MEASURABLE, AND SKILL-BASED TOOLS IN RESIDENT EDUCATION
Matthew W. Zackoff MD, Jennifer K. O’Toole MD, MEd, Melissa D. Klein MD, MEd, Cincinnati Children’s Hospital Medical Center, Cincinnati, OH

Asia 4/Dolphin
Training medical providers to effectively and efficiently educate peers, learners, and patients is a critical component of medical education. The Accreditation Council of Graduate Medical Education and the American Board of Pediatrics Pediatric Milestones Project created a framework to assess and guide learning development. Since only one milestone focuses on teaching, medical educators have the opportunity to critically appraise current tools and design innovative new methods for assessing teaching skills of residents. In this highly interactive workshop, participants will discuss their program’s current metrics for assessing resident teaching competence and identify the advantages and challenges with these forms of assessment. Additionally, through review of examples, they will demonstrate the advantages of using objective, measurable, and actionable skill based tools to assess teaching skills. Participants will be guided through the use of an observed structured teaching evaluation (OSTE), an objective skill based assessment tool focused on attainment of teaching competence and mastery to objectively assess resident teaching. Participants will then utilize the OSTE in real time assessment using video vignettes and experience the power of this type of assessment in providing learners with objective feedback and clear goals towards improvement. Finally, participants will be guided through a model for integrating an objective assessment tool for teaching into resident clinical training.
Effective time management is of paramount importance for successful career development of physicians, particularly those in academic careers. The majority of our trainees and even most faculty have not had formal training in this essential life skill. Poor time management skills can lead to inefficiencies in patient care, self-learning habits and, most importantly, lack of organization and prioritization of global responsibilities affecting work/life balance. Technology, if used incorrectly, can actually make users more inefficient and unfocused. During this workshop, participants will develop an appreciation of different barriers to efficiency and common mistakes incorporated into daily routines that affect productivity. Attendees, through role playing, case discussion, and personal logs, will be able to walk through a typical day, identify distractions, personal barriers to efficiency, and potential solutions. An action plan will be developed utilizing their proposed solutions to begin practicing their chosen strategies at home. Embracing this blueprint for effective time management early in their careers can positively influence their growth into productive faculty and/or trainees. Participants will design a grid for getting everything necessary in on time. As program coordinators, our job requires just that: coordination, or prompting others (our residents or fellows, attendings, or even other coordinators) to do something or provide us with information quickly and completely. The question is: how can a coordinator efficiently elicit the help of others in such a task? Common quality improvement (QI) techniques can be implemented to help a coordinator analyze current work processes and plan improvements that have a lasting impact on his or her work. This workshop would introduce participants to two such techniques:

**WORKSHOP 17: TIME MANAGEMENT: USE IT OR LOSE IT**
Javier A. Gonzalez del Rey MD, MEd, Ndidi Unaka, MD, Sue Poynter Wong MD, MEd, Cincinnati Children’s Hospital
Medical Center, Cincinnati, OH

**Asia 5/Dolphin**

COORDINATORS WORKSHOP 18:
**Southern 1/Dolphin**

**COORDINATOR WORKSHOP 18A: WE ARE ESSENTIAL!**
Holly Hering, Duke University Medical Center, Durham, NC; Sarah E. Sonefeld, MEd, East Carolina University, Greenville, NC

With the requirement of reporting our resident’s milestone rankings being relatively new, many programs are not sure what the best way is to effectively complete this task. This workshop will help coordinators understand the purpose of the Clinical Competency Committee (CCC) and the role of the coordinator with the CCC. The workshop will begin with a group discussion reviewing the CCC requirements and membership. The leaders of the workshop will then lead the participants in a large group discussion about the roles coordinators already play in the CCC. Individuals will then fill out a worksheet, identifying how the CCC currently works at their institution and what challenges they face. They will discuss these challenges in small groups, coming up with possible solutions to their problems. Participants will be asked before the conference to bring tools they have developed in order to help the CCC function smoothly. They will be asked to share these tools with the large group. Finally, we will close with a small group activity in which participants will identify three new tools they have gained while participating in the workshop that they can bring back to their institution with them and share with the CCC.

**COORDINATOR WORKSHOP 18B: USING QUALITY IMPROVEMENT (QI) TOOLS TO IMPROVE WORKFLOW**
Megan Christofferson, BA, Lucile Packard Children’s Hospital, Stanford, Palo Alto, CA

A deadline is approaching, prompting a flurry of emails, phone calls, text messages, and in person reminders to get everything necessary in on time. As program coordinators, our job requires just that: coordination, or prompting others (our residents or fellows, attendings, or even other coordinators) to do something or provide us with information quickly and completely. The question is: how can a coordinator efficiently elicit the help of others in such a task? Common quality improvement (QI) techniques can be implemented to help a coordinator analyze current work processes and plan improvements that have a lasting impact on his or her work. This workshop would introduce participants to two such techniques: Plan Do Study Act (PDSA) cycles and swimlane diagrams. PDSA cycles provide a formal framework for implementing changes to a current process. The investigator follows a systematic approach as follows: 1. Plan - Identify the process that needs improving, what change you wish to implement, how to implement the change, and what a successful change would look like. 2. Do - Implement the change, monitoring the results of the change as the process progresses. 3. Study - Analyze the results from the change in process and compare to the expected results from the planning stage. 4. Act - Incorporate successful changes into standard workflow or begin new PDSA if tested changes did not produce desired results. During the planning stage of a PDSA, swimlane diagrams formalize your new workflow. Like a regular workflow diagram, swimlanes breakdown a process into individual steps in a chronological fashion. Swimlanes take this one step further by assigning the steps to the person responsible for their execution by putting them into the lane for each role. In addition, each step is color-coded to identify the timing of the step (daily, weekly, monthly). Through a single glance, one can determine not only which step is next, but also when it should be done and by whom. This workshop would introduce these QI tools and then ask that participants work in small groups to plan a PDSA and create a swimlane to implement at their home institutions.
10:45am-12:45pm  APPD Task Force Meetings - Everyone Welcome

Assessment Task Force
Curriculum Task Force
Faculty and Professional Development Task Force
Learning Technology Task Force
Research and Scholarship Task Force

12:45pm - 2:00pm  Lunch on your own

Council of Regional Chairs Lunch Meeting  
Oceanic 5/Dolphin

Council of Task Force Chairs Lunch Meeting  
Oceanic 7/Dolphin

2:00pm - 4:00pm  Workshop Session 3

WORKSHOP 19: OVERCOMING APPLICANT INTERVIEW & SELECTION CHALLENGES: MULTIPLE MINI INTERVIEW TO THE RESCUE!
Mona Hanna-Attisha MD, MPH, Crystal Cederna-Meko PsyD, Hurley Children’s Hospital/Michigan State University, Flint, MI, Franklin Trimm MD, Sophia Goslings MD, Rita Harper, University of South Alabama College of Medicine, Mobile, AL
Asia 4/Dolphin

Multiple mini interview (MMI) deviates from traditional interviews by using a series of short stations consisting of standardized behaviorally-based questions, activities, or scenarios to rate candidates on pre-specified characteristics. Applicants complete the MMI process in relatively less time than standard interview formats, allowing for more applicants per interview day and fewer interview days. The MMI process also provides more effective measurement of critical and valued applicant characteristics, especially as they relate to empathy, teamwork, professionalism, and communication skills. When combined with information from traditional sources (e.g., USMLE scores, letters of recommendation, transcripts, curriculum vitae, unstructured interactions on interview day), information obtained from MMI better informs rank-order decisions relative to the standard interview. The presenters will briefly review MMI literature, and share their experiences regarding implementation of MMI at two separate pediatric residency programs. The highly interactive workshop will enable participants to identify critical resident/fellow characteristics for MMI measurement and engage participants in creation of an MMI station activity. Faculty development for MMI will be reviewed and the session will wrap-up with review of the pearls and pitfalls of MMI implementation for resident and fellow interviewing and selection.

WORKSHOP 20: ENCOURAGING RESIDENT INITIATIVE ACROSS CLINICAL SETTINGS BY EMPOWERING LEARNERS AND SUPERVISORS.
Daniel J. Sklansky MD, Grant Syverson MD, John Frohna MD, MPH, University of Wisconsin, Madison, WI
Asia 5/Dolphin

Residents and faculty across medical specialties have lamented a perceived decrease in resident autonomy, with concern that residents will not be prepared for unsupervised practice. In some circles, autonomy is thought to be a vehicle to prepare residents for independent practice. Completely independent practice should not be the goal of residency training, due to the team-oriented structure in which physicians work. Likewise, autonomy should not be perceived as a key driver in creating competent physicians. A better term to describe resident involvement in decision-making is resident initiative. Residents should take initiative in caring for patients and in their own education. Initiative can peacefully coexist with graded supervision and with shared decision making. With the recent emphasis on 24-hour attending coverage, performance measures, and the extra caution inherent in the field of pediatrics, resident initiative may decrease without a deliberate effort to nurture it. To practice effectively, physicians need to take the initiative to commit to assessments and plans, consult appropriate parties for assistance, and improve their knowledge by asking questions and seeking answers in the literature. By encouraging initiative in residents, we can provide them with the skills they need to thrive as patient advocates and valued team members. Residency programs can foster a culture of initiative by establishing the expectation that residents should take initiative in clinical and educational settings. We can further encourage this culture by training faculty to expect resident-initiated discussions, and by providing faculty with tools to prompt initiative from residents. This interactive workshop will equip participants with the tools to foster resident initiative across all clinical settings in their institutions. Resource materials will be provided to participants, and suggestions from participant involvement will be condensed and emailed after the conference.
• WORKSHOP 21: UPPING YOUR GAME: IMPLEMENTING A SCHOLARLY PROJECT CURRICULUM IN YOUR PROGRAM
  Matthew J. Kapklein MD, MPH, Maria Fareri Children’s Hospital, Valhalla, NY, Erika Abramson MD, MS, Weill Cornell Medical College, New York-Presbyterian Hospital, Cornell Campus, New York, NY, Fernanda Kuperman-Meik MD, Nassau University Medical Center, East Meadow, NY, Monique M. Naifeh MD, MPH, University of Oklahoma, Oklahoma City, OK, Sandra E. Moore MD, MS, Morehouse School of Medicine, Atlanta, GA, Jawad Javed MD, Children’s Hospital of Illinois, Peoria, IL

Asia 3/Dolphin
This workshop will enable participants to conceptualize, plan and begin implementation of a scholarly project curriculum at their home programs, which the facilitators have done at their own respective institutions. Designed for program leaders who are looking to “step up” the quality, quantity and visibility of their trainees’ scholarly work, our workshop will give participants the tools they need to succeed. Participants will see examples of successful scholarly project curricula in programs of different sizes and types, and begin development or build upon their own curricula in a highly interactive, structured format. Small groups will be assigned based on program type and size to maximize the efficacy and applicability of discussion. We will approach implementation in stages: beginning with overall goals, working through resources and barriers, and strategies to overcome the latter, and finally committing to first steps upon returning home. Participants will leave with a plan “in hand” for implementation and follow-up, as well as a toolkit of numerous resources to bring their residents’ scholarly work to the next level. This workshop is a project of the APPD Research & Scholarship Task Force.

• WORKSHOP 22: UNDERSTANDING HOW WE ARE WIRED AND EXPLAINING WHY WE SHORT CIRCUIT: A WORKSHOP IN MEDICAL DECISION MAKING AND ERROR
  Andrew P. Olson MD, University of Minnesota, Minneapolis, Minnesota, Emily Ruedinger MD, University of Washington - Seattle Children’s, Emily Borman-Shoap MD, University of Minnesota - Pediatric Program Director, Minneapolis, MN, Maren E. Olson MD, MPH, University of Minnesota and Children's Hospitals-St Paul, Associate Program Director, St. Paul, MN

Asia 1/Dolphin
Diagnostic Error is an increasing area of focus in the United States. An IOM report on diagnostic error is due in 2015, drawing even more attention to the topic. Diagnostic error is likely to be incorporated into CLER visits in the future. Approaches to understanding, measuring, and mitigating the effects of error (and improving diagnosis) are fundamental. Diagnostic error includes misdiagnosis, missed diagnosis, and delayed diagnosis. Diagnostic errors are divided into system factors and cognitive factors. Much attention and curricular innovation have been devoted to the system factors that lead to error. However, less attention has been given to the cognitive processes that lead to error. In thought-based specialties such as pediatrics, cognitive factors contribute to more errors than systems factors. We will focus on the basics of medical decision making and diagnostic error, with a special focus on cognitive factors that lead to error. Approaches to proactive avoidance of the Second Victim phenomenon, where physicians (especially learners) involved in error also suffer trauma will be addressed. Attendees will be given curricular tools to begin formally addressing medical decision making and error. The session will begin with a brief interactive presentation covering how to teach about decision making, cognitive biases, and diagnostic errors. Attendees will then work to analyze different real-world cases to determine what errors occurred and what factors (especially cognitive factors) may have led to these errors. Specific approaches to discussing diagnostic error with trainees will be given, including strategies to integrate these concepts into daily clinical work and existing teaching conferences. These strategies will educators to create a culture of openness about improving diagnosis and avoiding blame. This workshop will build upon the successes of a longitudinal, integrated curriculum already implemented at the University of Minnesota, through one of five AAMC Innovation Awards.

• WORKSHOP 23: DIVERSITY AND INCLUSION: STRIVING FOR EXCELLENCE IN YOUR PROGRAM
  Aisha B. Davis MD, Children’s National Health System, Washington, DC, Brian Lurie MD, MPH, Atlantic Health/Goryeb Children’s Hospital, Morristown, NJ, Amanda D. Osta MD, University of Illinois-Chicago, Chicago, IL, Megan Aylor MD, Oregon Health & Science University, Portland, OR, Patricia Poitevien MD, MSc, NYU School of Medicine, New York, NY

Oceanic 3/Dolphin
The US physician workforce in academic medicine reflects neither the diversity of US society nor the diversity of the medical student population. A diverse academic pediatric workforce is important to instill knowledge, provide mentorship, and model skills necessary to facilitate the elimination of health disparities for an increasingly diverse population of US children. However, recruitment and support of a diverse workforce continues to be a challenge in pediatrics despite existing efforts. This workshop will focus on augmenting three specific aspects of diversity in pediatric residency programs: Underrepresented Minorities (IRM), International Medical Graduates (IMG), and Lesbian Gay Bisexual Transgendered and Questioning (LGBTQ) trainees. This workshop will address this issue via a combination of interactive large group discussions and small group work. First, presenters will review background information to help define current issues programs face in relation to diversity. Using a SWOT analysis, participants will then reflect on diversity within their institutions and identify existing gaps to address in the remainder of the workshop. Working in small groups, participants will then explore different methods to assess program diversity and create action plans to enhance diversity within their own residency programs. These proposals should address specific obstacles identified during the prior SWOT analysis. The workshop will conclude with participants making a commitment to implement changes within their program. All material will be compiled by facilitators and shared with participants to apply to their programs.
WORKSHOP 24: “NEEDS TO READ MORE” - WRITING MEANINGFUL COMMENTS ON RESIDENT/FELLOW EVALUATIONS
Joseph O. Lopreiato MD, MPH, Uniformed Services University, Bethesda, Maryland, Miriam E. Bar-on MD, Samrat U. Das MD, University of Nevada School of Medicine, Las Vegas, NV; Gregory H. Gorman MD MHS, NCC Pediatrics Residency, Walter Reed Bethesda, Christopher M. Watson MD, MPH, National Capital Consortium Pediatric Residency Program, Clifton E. Yu MD, FAAP, Walter Reed National Military Medical Center Bethesda, Bethesda, MD

Southern 1/Dolphin
Have you been disappointed in the quantity and quality of faculty written narratives on your trainees? In the era of the NAS, program directors and clinical competency committees (CCC) are heavily reliant on meaningful narratives from faculty to elucidate the scaled assessments based on milestones. These comments complement the scaled portion of evaluations and should provide both the learner and members of the clinical competency committee meaningful information regarding performance. However, content analysis of comments has demonstrated that there are many aspects of written narratives that can be improved for them to be meaningful. How can you get your faculty to provide better and more detailed written comments on the clinical performance of your residents and fellows? This workshop will provide program leadership with experience identifying deficits of written comments, a method for faculty development to improve faculty comment writing and suggestions to engage faculty to write comments describing resident/fellow performance. We will introduce participants to a scheme for standardizing your clinical observations using the mnemonic P.R.I.M.E. (Professionalism, Reporter, Interpreter, Manager, and Educator). P.R.I.M.E. is a valid and reliable method for organizing observations of learner performance along the lines of the ACGME competencies. We will provide practical examples of how to apply P.R.I.M.E. to the competencies and their milestone assignment as well as their usefulness to CCC members. The session will begin with introductions, audience assessment and expectations. A short didactic session based on information from the literature about written comments on resident/fellow performance will be presented. Participants in pairs or small groups will then review and assess for deficiencies a series of comments collected from resident/fellow evaluations. This will be followed by a writing exercise in which participants will practice writing resident evaluations in the P.R.I.M.E. format and learn to develop evaluation tools utilizing the P.R.I.M.E. system in the clinical context of their home institution. Participants will then debrief their narratives and discuss strategies to both engage and train their faculty to write effective comments as part of their resident/fellow evaluations. Participants will receive a faculty development snippet for implementation at their home institution. Come learn new skills with us. You will not be disappointed.

WORKSHOP 25: MEANINGFUL INTEGRATION OF DIRECT OBSERVATION INTO RESIDENT EVALUATION
Lynelle Boamah MD, MEd, Natalie Burman DO, MEd, Shellie Kendall MD, Naval Medical Center San Diego, San Diego, CA, Melissa Klein MD, MEd, Matthew Zackoff MD, Children’s Cincinnati, Cincinnati, OH, Christine Johnson MD, Naval Medical Center San Diego, San Diego, CA

Asia 2/Dolphin
Meaningful Integration of Direct Observation into Resident Evaluation In the era of the ACGME Next Accreditation System, multiple evaluation tools are necessary to effectively assess trainee progression. These tools, when used for formative evaluation, must be readily available, utilized frequently and be linked with timely feedback in a variety of clinical and educational experiences. To better inform the trainee’s progression in the biannual milestone assessment, real-time structured assessment to demonstrate trainee competence in patient care is required by the ACGME. These observations are vital to the overall development of a trainee and move along the educational continuum. Direct Observations, mapped to specific pediatric sub-competencies, can inform the Clinical Competency Committee and Program Director. While observations must become an integral portion of trainees’ comprehensive assessment, this can be difficult for busy faculty due to inconsistent implementation of assessment tools and competence providing timely and effective feedback. This interactive workshop, led by faculty and residents from different programs, will highlight the importance of implementing routine direct observation. After a brief review of different formats for direct observations, participants will engage in an interactive discussion of benefits and challenges. Then, using video vignettes, participants will practice using different direct observation tools suitable to a variety of clinical and educational settings. Participants will discuss the benefits and limitations of each tool while learning to map observation data to specific sub-competencies. Participants will then develop specific strategies to create a culture to endorse implementation of a program of routine direct observations in their own training program. By the conclusion of the workshop, participants will have identified a suitable direct observation tool for use in their respective program with a blueprint outlining specific steps necessary to incorporate it into their resident assessments.

WORKSHOP 26: BE PREPARED! GLOBAL HEALTH ROTATION PREPARATION BEST PRACTICES AND COMMON CONCERNS
Sabrina M. Butteris MD, University of Wisconsin School of Medicine & Public Health, Madison, WI, Nicole St. Clair MD, Medical College of Wisconsin, Milwaukee, WI, Mike B. Pitt MD, University of Minnesota Masonic Children’s Hospital, Minneapolis, MN, Maneesh Batra MD, MPH, University of Washington/Seattle Children’s Hospital, Seattle, WA, Gitanjli Arora MD, DTMH, UCLA, Los Angeles, CA, Parmi Suchdev MD MPH, Emory University, Decatur, GA, Charles Schubert MD, Cincinnati Children’s Hospital Medical Center, Cincinnati, OH, Christiana M. Russ MD, DTMH, Boston Children’s Hospital, Boston, MA

Oceanic 1/Dolphin
As more and more residents travel abroad during their residency training there has been an increased need for programs to develop strategies to prepare their residents for these experiences and simultaneously address common safety, legal, and professional standards for global health (GH) rotations. This workshop will provide participants with straightforward methods to prepare residents for GH rotations and a forum to discuss common issues encountered by residents and residency programs.

We will emphasize the importance of ensuring safety and supervision during GH rotations and will review ways to optimize the resident's experience while minimizing the burden placed on the overseas site. Workshop participants will work in small groups with a dedicated facilitator in each group. In a Choose your Own Adventure style, groups will pick which topics they would like to focus on during the workshop. Each topic will begin with a case vignette to be discussed by the participants and be accompanied by concrete solutions and resources that address the selected topic. Regardless of which topics are discussed in the individual groups, all participants will be provided with the full list of case vignettes and resources that cover key elements of preparation and various challenges. Workshop participants will leave with a toolkit of resources including a comprehensive preparation outline, links to the online modules, templated documents that can be adapted at their home institution, and a complete list of the case vignettes and associated resources. The workshop will be pertinent for programs with all levels of GH infrastructure. For those contemplating incorporating GH rotations into their training program, the workshop will provide a complete picture of the details involved in implementing GH rotations based on 28 best practices with regards to preparation, safety, ethics, and educational value. For participants from programs with established GH rotations the workshop will provide a forum to exchange dialogue regarding next steps in GH training and further strengthen current practices.

COORDINATORS WORKSHOP 27: PROGRAM EXCELLENCE: USING AN EVALUATIVE FRAMEWORK TO MOVE YOUR FELLOWSHIP CLINICAL COMPETENCY COMMITTEE FROM 1.0 TO 2.0
Tammy Bleaker, BS and Nicole Paradise Black, MD, MEd, University of Florida Health, Shands Children's Hospital, Gainesville, FL

Australia 3/Dolphin
This highly interactive workshop will introduce and engage participants in the program evaluation process in order to analyze and improve upon their current Clinical Competency Committee (CCC) structure and process. The facilitators will introduce participants to Patton's widely accepted twelve-step model for program evaluation, with a focus on the first eight steps. In a large group setting, the workshop will begin with introductions and a brief overview of Patton's Utilization-Focused model of program evaluation by using the University of Florida's CCC structure and process as an example. Participants will then be divided into small groups to first share their current CCC structure and process and then to work on their individual program evaluation, with the presenters facilitating the groups. During the workshop participants will critically examine their current CCC structure and process while collaboratively discussing successful and unsuccessful practices occurring at their institutions. Participants will adopt, adapt, and include practices introduced and discussed during the workshop into their evaluative model. The workshop will alternate between introduction of specific approaches to each step and small group brainstorming and applying those steps to their own CCC program evaluation. Participants will utilize an interactive handout to record their ideas, which will be taken home for future use. The facilitators will wrap-up the workshop with a Gallery Walk where participants from all groups will view the “in progress” program evaluation plans and ideas from other participants and provide feedback, while, at the same time, allow for sharing of ideas. Finally, the participants will return to the larger group to discuss best practices and plan next steps at their home institution.

4:15pm - 5:45pm  Poster Session  (see pages 36-68 for Poster/Abstract details)
Atlantic Hall C/Dolphin
(posters displayed 10:00am-5:45pm)

Saturday, March 28

7:00am-8:00pm  Registration
Convention Foyers 3-4/Dolphin

7:30am - 9:00am  APPD Regional Breakfast Meetings
Mid-America: West PA, OH, WV, KY, IN, MI  
Mid-Atlantic: Southern NJ, East PA, DE, MD, Washington DC
Midwest: IL, WI, MN, IA, MO, KS, NE, OK, SD
New England: ME, NH, MA, CT, VT, RI
New York: NY, Northern NJ
Southeast: VA, NC, SC, GA, FL, AL, MS, LA, AR, TN
Southwest: TX
Western: CA, NV, OR, WA, AK, CO, NM, UT, AZ, HI

2015 MEETING ● MARCH 25-28 ● ORLANDO, FL
Workshop with resources, strategies, and collaborative partners with whom they can implement future curricula. 

In this interactive workshop participants will collaborate on curricular development, and they will leave the facilitated discussion about implementation and evaluation of the curricula, and participants will identify potential challenges to employ at their institutions. Participants will describe the needs of their learners, construct goals and objectives, and design educational strategies with facilitator guidance. Participants will present their curricula to the large group. Presenters will discuss published challenges IMGs face as they transition to postgraduate training and into practice. In small groups participants will discuss their various steps in planning the games with time to think on their own, pair with someone else at their table and then share with the group. Each participant will leave the session with a QI Olympics portfolio that they can use in running their own activity.

International medical graduates (IMGs) make up a significant portion of the workforce in graduate medical education in the US. In the 2014 match, IMGs constituted 10% of matched applicants into pediatrics and 17% of matched applicants into pediatric fellowships, many of whom enter fellowship without completing a US residency. Further, 28% of practicing pediatricians in the US are IMGs, making the needs of IMGs a pertinent issue for program directors and employers. IMGs face unique acculturation challenges, especially in physician-patient communication and patient-centered medicine. However, there is little data outlining acculturation challenges, including abstracts that describe unique educational units (block or longitudinal). Shared abstracts are posted on the APPD website. https://www.appd.org/2015AssessmentView.cfm

The Clinical Learning Environment Review (CLER) and the Pediatric Milestones as key components of the ACGME Next Accreditation System have reinforced the importance of providing training in quality improvement (QI) and patient safety during residency. Patient safety and QI are two of the six CLER focus areas. In addition, QI processes are closely related to several of the milestone tracked by the ACGME for pediatric residents. Potential barriers to providing this training include lack of time, lack of enthusiasm from the learners, and lack of sufficient numbers of faculty experienced in QI. We designed the QI Olympics to introduce QI concepts using team-based educational games that are simple, engaging, and easy to run. In this workshop participants will experience a sample game from the QI Olympics firsthand and then will assemble the tools they need to create their own version of the activity at their home institution. In the first half of the workshop, teams of participants will compete in an abbreviated version of the QI Olympics. The goal is to provide an interactive QI refresher for faculty who are tasked with teaching QI at their institutions, as well as to model how the QI Olympics activity is run with residents and other learners. The activity begins with an overview of QI and the Model for Improvement consisting of a short didactic coupled with an opportunity to immediately apply and discuss the key concepts using a mock personal QI worksheet. These introductory activities are followed by a team-building game, which has been modified to allow the teams to apply the QI principles they just learned as they carry out various attempts at the game. The activity debrief completes the first portion of this workshop. In the second half of the workshop the participants will have a chance to plan their own QI Olympics activity. The participants will work through the various steps in planning the games with time to think on their own, pair with someone else at their table and then share with the group. Each participant will leave the session with a QI Olympics portfolio that they can use in running their own activity.
WORKSHOP 30: OPTIMIZING THE OUTCOME OF PATIENT HANDBOFFS: A PRACTICAL APPROACH TO IMPLEMENTING CURRICULUM WITH OBSERVATION & FEEDBACK TO TRAINEES
Stephanie B. Dewar MD, Stephen Hart MD, Children’s Hospital of Pittsburgh, Pittsburgh, PA, Linda A. Waggoner-Fountain MD, MEd, University of Virginia, Charlottesville, VA

Mockingbird/Swan

Patient handoffs between physicians are crucial elements in the effective and safe care of patients. The ACGME recommendations for resident duty hours have resulted in frequent transitions of care between residents who generally do not receive adequate training and experience in this vital process in medical school. We will present a review of the current literature around physician handoffs and discuss the current ACGME & pediatric specific RRC requirements for resident instruction in order to optimize safe patient handoffs. Several approaches to the successful implementation of a standardized curriculum (including IPASS, IDEAL, SBAR as some examples) will be shared along with data as to the success after implementation of a curriculum. Attendees will observe videotapes of sign-out & participate in simulated sign-out training sessions in both the inpatient to inpatient and ED to inpatient unit settings. Tools for observation and feedback of resident sign-out will be reviewed and utilized by the participants. Emphasis will be placed on the location, timing, content and quality of the communication involved of the verbal sign-out process. Participants will leave this interactive workshop with an increased knowledge of different types of curriculum for resident handoff of patients, as well as how to observe and give feedback on this process.

WORKSHOP 31: MANAGING MY PLATE: NEGOTIATING ROLES AND TIME FOR PEDIATRIC EDUCATORS
Maneesh Batra MD, MPH, University of Washington/Seattle Children’s Hospital, Seattle, WA, Hillary A. Franke MD, MS, University of Arizona, Tucson, AZ, Megan Aylor MD, Oregon Health & Science University, Portland, OR, Aditee P. Narayan MD, MPH, Duke University Medical Center, Durham, NC, Daniel J. Schumacher MD, MEd, Boston Combined Residency Program, Boston, MA, Glenn Rosenbluth MD, University of California San Francisco, San Francisco, CA

Asia 1/Dolphin

The number of Associate Program Directors (APDs) within APPD has increased from 196 (2006) to over 350 (2013). While the responsibilities of program directors may be consistent across institutions, the APD role varies widely. The majority of new APDs are junior faculty and must balance personal interests, clinical responsibilities, and scholarly pursuits in addition to new administrative leadership activities. In a recent national survey of pediatric APDs, the majority reported the lack of formal job descriptions and performance reviews related to their educational role. The leaders of this workshop comprise the APPD APD Executive Committee. Over the last 2 years, this committee has solicited formal feedback and has received informal requests regarding the most pressing needs for professional development activities. Managing and negotiating roles and priorities have been consistent themes, and as such the executive committee has developed this workshop aimed at addressing these needs. This workshop will begin with introductions followed by a large group exercise highlighting the diversity of roles, demographics, and reported priorities for professional development. Next, participants will complete a negotiation style inventory followed by a small group discussion of assets and challenges with various styles. Leaders will then present negotiation skills ‘pearls’ and best practices from other disciplines. The large group will engage in an interactive role-playing demonstration of negotiation scenarios and discuss elements for success. Participants will complete a negotiation worksheet based on the best practices and lessons learned from the large group role play. Leaders will facilitate small group discussions based on the completed worksheets to identify the next steps participants will use in their own institutions. The workshop will conclude with a brief large-group discussion, with time for questions and answers. Participants will receive resources for negotiation skills for future individualized work in this area.

WORKSHOP 32: UPPING YOUR GAME  EXPANDING YOUR MEDICAL EDUCATION TOOL KIT BY DESIGNING EFFECTIVE GAME BASED LEARNING SESSIONS
Michael B. Pitt MD, Adam Foss MD, Laura Hagemeyer MD, Abby Montague MD, Judy Wiltse MD, Emily C. Borman-Shoap MD, University of Minnesota, Minneapolis, MN

Asia 4/Dolphin

Innovative educational games have been shown to be effective alternatives (and reinforcers) to traditional didactics with participants reporting better attitudes about learning. Well-designed game-based learning sessions use non-threatening competition to capitalize on heightened learner engagement, allowing for dynamic group discussion that is fun, memorable, and effective. This workshop, which will build on the success of the one given at the 2014 Spring APPD meeting, will give participants the tools to create their own games and to maximize their impact as an educational tool for both large and small group settings. As a part of the session, participants will be introduced to a framework of Twelve Tips for Effective Game-Based Learning which they will immediately be able to apply in small groups to create and present a novel educational game. In addition, participants will share examples of games they have seen used before, and obtain group feedback incorporating the 12 Tips on how that game might be improved for future use. Participants will also be provided with access to a google site with a variety of effective pediatric education games that are easily adaptable for multiple settings and learners. These games, which will be reviewed in the workshop, have a wide range of technology requirements, with most requiring no computer at all. Several are intended to be played in short bursts, and are ideal for use on rounds in between patients. Many of the games developed in last year’s workshop, will be included on the google site.
WORKSHOP 33: LEARNER SELF-ASSESSMENT IN THE MILESTONES ERA: A WIN-WIN APPROACH TO LEARNER PROFESSIONAL DEVELOPMENT AND PROGRAM IMPROVEMENT

Kimberly A. Gifford MD, Children’s Hospital at Dartmouth Residency, Lebanon, NH, Ann Burke MD, Wright State University Boonshoft SOM, Dayton, OH, Franklin Trimm MD, University of South Alabama, Mobile, AL, Bridget M. Oliveri MD, Children’s Hospital at Dartmouth, Lebanon, NH, Susan Guralnick MD, Winthrop University Hospital, Mineola, NY

Australia 3/Dolphin

As we enter the Next Accreditation System, program directors are challenged with the implementation of Clinical Competency milestones and committees reporting. Learners too are challenged by this new approach to assessment, both in interpreting the milestones and understanding how milestones will be used to gage their progress. By integrating milestone-based learner self-assessment into the process of clinical competence determination, programs can acquire richer assessments of learners. During this workshop, participants will practice using self-assessment data to enhance the promotion of learner professional development and inform the program improvement processes. The session will begin with a brief review of the literature on self-assessment and milestones in education. Participants will then perform a self-assessment using the Pediatric Milestones and discuss this experience in groups based on learner focus (resident vs fellow). After a brief overview of the processes for clinical competence determination, participants will discuss in small groups how learner self-assessment and clinical competence assessments can be used to promote learner development and drive program improvement. Small groups will then share suggested approaches with the larger group. Presenters are conducting a multi-institutional study examining self-assessment vs external assessments, and will share additional strategies used by institutions in their study. These strategies will also be provided as a handout. Finally, participants will complete a commitment to action plan, identifying how they might utilize milestones-based assessments for learner development and/or program improvement at their own institution.

WORKSHOP 34: IT TAKES TWO TO TANGO: HOW INTROVERTS AND EXTROVERTS MAY THRIVE IN ACADEMIC MEDICINE

Anda K. Kuo MD, UC SF, San Francisco, CA, Mario Cruz MD, St. Christopher’s Hospital for Children, Philadelphia, PA, Jennifer K. O’Toole MD, MEd, University of Cincinnati College of Medicine, Cincinnati, OH, Tyler E. Reimschisel MD, Vanderbilt University Medical Center, Nashville, TN, Sharon Calaman MD, Blair Dickinson MD, St. Christopher’s Hospital for Children, Philadelphia, PA

Asia 5/Dolphin

As many as a third to a half of the United States population are introverts, and the world of academic medicine reflects this mix of introverts and extroverts. Both introvert and extrovert personality styles have positive features that enhance the function of teams. Leaders may miss the opportunity to capitalize on the strengths of diverse teams if they do not know how to effectively engage and harness the power of the introverts and extroverts on their team. For individuals, failure to learn how to adapt one’s introverted or extroverted tendencies may lead to missed opportunities, sub-optimal communication, and misguided mentorship. For example, those with a preference for introversion may be better served when they extend themselves in networking situations. Those with a preference for extroversion may communicate more effectively when they process thoughts internally before speaking. Program directors need to be able to effectively mentor and guide faculty and trainees with different traits, and coach them to success. In this workshop, faculty and participants will discuss the definitions and individual preferences for introversion and extroversion as well as how one can recognize these characteristics in themselves and others. We will explore the biases, myths, and assumptions around introversion and extroversion. Interactive activities, including reflective exercises and trigger videos, will be used to look at ways that different types may approach situations that are common in medicine, such as rounds, committee meetings, conferences, interviews, and project work. Next, we will explore strategies that can be used to facilitate the academic success of different types, including various ways to mentor individuals of different types. In addition, we will explore how the relationship between introverts and extroverts may play out in the academic world including possible conflicts and misunderstandings that may be a barrier to effective teamwork. Participants will leave with tools, resources and references to take back to their home institution.

WORKSHOP 35: TEAM-BASED LEARNING: AN ACTIVE LEARNING STRATEGY TO OPTIMIZE YOUR RESIDENCY CURRICULUM

Jerry G. Larrabee MD, University of Vermont Children’s Hospital, Burlington, Vermont, Priya S. Garg MD, Jamie Fey MD, Kelly Willis MD, Tufts Medical Center, Boston, Massachusetts, Alison Foertsch MD, Karen Leonard MD, University of Vermont Children’s Hospital, Burlington, VT

Asia 3/Dolphin

In the shift away from traditional pedagogy, there have arisen many learner-centered teaching strategies that have demonstrated promise in active learning. Team-Based Learning (TBL) is a learner-centered, instructor led, active learning strategy that has been used in undergraduate medical education, as well as a variety of other disciplines. TBL provides frequent opportunities for students to enhance learning (as evidenced by better test performance and positive behavior change), as they talk and listen to peers to arrive at consensus decisions. The success of TBL is anchored in its emphasis on active learning and collaboration, and promotes problem-solving skills, content application, and knowledge retention. It specifically can address the competency domains of interpersonal and communication skills and as well as enhance skills such as teamwork. In this workshop, we will explore the theory, structure and process of TBL and demonstrate the ease with which it can be incorporated into residency.
training. We will open with a brief interactive overview of the rationale behind TBL and discuss the essential components of TBL. Participants will be organized into small groups and participate in a simulated TBL session. Throughout the workshop, we will encourage questions about the process, and the simulation will hopefully help raise clarifying points. We will then facilitate a large group discussion about how the participants envision TBL being incorporated into their own curriculum. We will share how TBL has been successful in augmenting the workshop leaders’ curricular initiatives in domains such as Evidence-based Medicine, Quality Improvement, and Board Review. We will end the workshop by sharing TBL resources and will facilitate participants in developing an implementation plan to bring back to their home institution.

WORKSHOP 36: TEACHING PEDIATRIC RESIDENTS TO PROVIDE HIGH-VALUE, COST-CONSCIOUS MEDICINE
Alice Hensley MD, Michael J. Tchou MD, Elizabeth Burgener MD, Rebecca Blankenburg MD, Lucile Packard Children’s Hospital Stanford University, Palo Alto, CA, Adam Schickedanz MD, University of California Los Angeles Department of Pediatrics and Internal Medicine, Los Angeles, CA
Asia 2/Dolphin
US healthcare spending accounts for 18% of the GDP, totaling $3 trillion, and is increasing at an unsustainable pace. This investment in healthcare dwarfs spending in other developed countries, where outcomes are the same or better. Government and professional societies have called for action to incorporate resource stewardship into practice. Initiatives such as the Choosing Wisely Campaign and the ACP’s Internal Medicine High Value Curriculum have addressed the overuse of resources and the importance of education regarding costs. However, there is little emphasis on cost and value in most pediatric residency curricula. Several authors have proposed adding a seventh ACGME Core Competency on Cost conscious care and stewardship of resources, (Rosenbaum, NEJM 2012; Weinberger, Ann Int Med 2011), supporting the notion that a curriculum on value is needed for trainees. This workshop, led by chief residents and faculty members, will begin with an analysis of the current state of healthcare spending and a review of the definition of value. In facilitated small groups, participants will discuss practices and curricula at their own programs. Stanford pediatric chief residents will then share results from a 2014 survey of pediatric residency training programs revealing current state of cost-conscious care curriculum in residency programs around the country as well as expressed need for curriculum around the country. The majority of the session will be spent introducing and practicing a novel framework for teaching value to residents through case-based discussion. Audience members will be split into groups of 10-15 people and will participate in a simulated case conference in order to illustrate a value-based approach to clinical-decision making. This activity will be followed by a group debrief to address strengths and limitations of this approach.
MPPDA MEETING SCHEDULE

TUESDAY, MARCH 24, 2015

7:00am-8:00am  Registration and Continental Breakfast
Mockingbird Corner/Swan

8:00am-3:00pm  Pre-Course Meeting
Mockingbird/Swan

8:00am-8:45am  Welcome and Introductions
JR Hartig, MPPDA President-Elect, University of Alabama – Birmingham

8:45am-10:15am  Workshop 1: Setting Expectations – Adult Learning and Engagement
JR Hartig, MPPDA President-Elect, University of Alabama – Birmingham

10:15am-10:30am  Break

10:30am-12:00pm  Workshop 2: Program Director Skill Development (pick one of two)

1.0 – Developing Skills to be Most Effective as a Med-Peds Program Director  (Designed for PDs in the job 5 years or less)
Alda Gonzaga, MPPDA Secretary-Treasurer, University of Pittsburgh
Lauren Beal, Louisiana State University
Mockingbird/Swan

2.0 – Succession Planning – Getting your Med-Peds House in Order  (Designed for PDs in the job >10 years)
Jimmy Stewart, University of Mississippi
Macaw/Swan

12:00pm-1:30pm  Lunch/Networking/Break

1:30pm-3:00pm  Workshop 3: Creating a Med-Peds Program Director Textbook!
Introduction, Background, and Purpose
Sandi Moutsios, MPPDA President

Breakout/Brainstorming Groups
Facilitated by MPPDA Executive Committee Members

3:00pm-3:30pm  AMPPA Coordinator’s Meeting
Northern A4/Dolphin

3:00pm-3:30pm  Break
• 3:30pm-5:00pm  Committee Meetings
  Accreditation  Chair- Ben Doolittle, Yale University
  Lark/Swan
  Curriculum  Chair- Mike Aylward, University of Minnesota
  Pelican 1/Swan
  Recruitment  Chair – Allen Friedland, Christiana Care
  Pelican 2/Swan
  Research  Co Chairs – Mike Aronica, University of Buffalo
  Anoop Agrawal, Baylor University
  Peacock/Swan
  Transition  Chair – Alice Kuo, University California, Los Angeles
  Toucan/Swan

• 5:30pm-7:00pm  MPPDA Wine and Cheese Reception with MPPDA Poster Session
 Osprey Ballroom and Terrace/Swan

• 8:00pm  Dinner – on your own
  For those interested, we will go as a group to the Boardwalk which is within walking distance.

WEDNESDAY, MARCH 25, 2015

• 7:00am-8:00am  Registration and Breakfast
  Mockingbird Corner/Swan

• 8:00am-5:00pm  General Session
  Mockingbird/Swan
  8:00am-8:45am  Welcome and Introductions
  JR Hartig, MPPDA President-Elect, University of Alabama - Birmingham
  8:45am-9:15am  Presidential Address
  Sandi Moutsios, Vanderbilt University, MPPDA President
  9:15am-10:15am  Presentation 1: Discussing National Data on Med-Peds
  Facilitator for group discussion – Russ Kolarik
  • Collective SWOT analysis data from Med-Peds program
    Russ Kolarik, MPPDA Immediate Past President, University of South Carolina – Greenville
  • What Med-Peds Docs Do
    Michael Donnelly, Georgetown University
  • Med-Peds Workforce Data (PD survey)
    Jen O’Toole, University of Cincinnati
  • Annual MPPDA Survey
    Research Committee
  10:15am-10:30am  Break
  10:30am-11:30am  Presentation 2: Continuity Clinic Structure: 4x4 or 4x1 or Other Pieces of Wood
  Mike Aylward, University of Minnesota
11:30am-12:30pm  Keynote Address: Why Med-Peds? - Creating Your Med-Peds Elevator Speech
Brad Benson, Director, Division Internal Medicine, Co-Author, Pediatrics Milestones Project, Former President MPPDA, University of Minnesota

12:30pm - 2:15pm  Buffet Lunch and MPPDA Business Meeting

Organization Updates: MPPDA Secretary-Treasurer Report
Alda Gonzaga, MPPDA Secretary-Treasurer, University of Pittsburgh

NMPRA Update
Tristan McPherson, NMPRA President, Vanderbilt University

AAP Section Update
Allen Friedland, Chair, AAP Section on Med-Peds, Christiana Care

AMPPA Update
Kelly Barnes, Chair, AMPPA, Maine Medical Center

Awards Presentations:
Sandra A. Moutsios, Presenter, MPPDA President
Walter Tunnessen, Jr. Award
Med-Peds Leadership Award

MPPDA Election Results
Michael Lukela, MPPDA Past President

Committee Reports:
Accreditation  Chair: Ben Doolittle, Yale University
Curriculum  Chair: Mike Aylward, University of Minnesota
Recruitment  Chair: Allen Friedland, Christiana Care
Research  Co-Chairs: Mike Aronica, University of Buffalo and Anoop Agrawal, Baylor University
Transition  Chair: Alice Kuo, University California, Los Angeles

2:15pm - 2:30pm  Break

2:30pm - 4:00pm  Panel Discussion – Both Boards, Both RRCs
Presentations followed by Q&A
JR Hartig – Facilitator for Q&A Session

Gail McGuiness, Executive Vice-President, ABP
Furman McDonald, Vice President for Graduate Medical Education, ABIM
Caroline Fischer, Executive Director, Pediatric RRC
Jerry Vasilias, Executive Director, Internal Medicine RRC

4:00pm - 5:00pm  Structured Annual Networking
Facilitated by Jen O’Toole
Small group lead by the MPPDA Executive Committee (Small groups discussions – framed from the groups from the pre-course)

5:00pm - 5:15pm  Wrap-up / President-Elect Address
JR Hartig, MPPDA President Elect, University Alabama Birmingham

7:00pm-9:00pm  MPPDA Annual Dinner (separate ticket must be purchased to attend)
Animal Kingdom Buffet, Buses in Lobby
3. IMPACT OF SMALL-GROUP WORKSHOP ON RESIDENT PREPAREDNESS TO PROVIDE CULTURALLY COMPETENT CARE

Kathleen W. Bartlett MD, Duke University Pediatric Residency Program, Durham, NC, Philippa Streititz PhD, P.S. Consulting, Austin, TX, Jeffrey Hawley, Duke Office of Clinical Research, Richard Sloane M.P.H., Duke University Center for the Study of Aging, Betty B. Staples MD, Duke University Pediatric Residency Program, Durham, NC

Background: In 2010 the Duke Pediatric Residency Program implemented a new approach to cultural competency training. Utilizing a small-group workshop format with multiple didactic and experiential learning components, we introduced residents participating in global health electives (GHE) the opportunity experience and debrief common challenges encountered in resource-limited settings. OBJECTIVE: Determine residents' perceptions of the usefulness of participation in SUGAR after completing their GHE. METHODS: Residents from seven institutions who participated in SUGAR were sent an anonymous survey on returning from their GHE asking about the utility of SUGAR, and to identify aspects which were particularly helpful while abroad. We used descriptive statistics to analyze perceptions of usefulness and conducted a thematic analysis of written comments of the most helpful parts of the simulation sessions. RESULTS: We obtained surveys from 34 residents who had participated in SUGAR prior to their GHE. Respondents reported the simulations were useful with a mean score of 4/5 [SD 0.8] (1 = not at all useful to 5 = very useful). No residents felt they had done too many simulation cases, regardless of how many they had completed with 40% (6/11) of those who had participated in more than five cases indicating they should have done more. The most common themes for the aspect of SUGAR which was most helpful were: practicing working with limited resources (36%), learning to problem-solve (29%), and expanding medical knowledge (28%). These mirrored the most common themes identified in residents’ comments immediately after the simulation sessions. However, a greater percentage of comments (26%) on return from GHE contained the theme of cultural preparation as the most helpful aspect of SUGAR as compared to 2% of comments from immediately after the simulation sessions. CONCLUSIONS: Active pre-departure preparation for GHEs using standardized, simulated cases appears to be an effective way to prepare residents for the challenges they will face in resource-limited settings. Its usefulness appears to be durable with the utility of cultural preparation, in particular, increasing after participation in a GHE.

2. UNDERSTANDING GLOBAL CHILD HEALTH: RESIDENTS’ PERSPECTIVE ON RE-ENTRY

Stephanie A. Marton MD, MPH, Dorene F Balmer PhD, RD, Anne C. Gill DrPH, MS, Susan L. Gillespie MD, PhD, Gordon E. Schutze MD, Baylor College of Medicine, Houston, TX

Background: Pediatric residents at Baylor College of Medicine (BCM) may participate in international, resource-limited rotations. Categorical residents can spend 1 month abroad; global child health (GH) residents complete 12 months abroad, plus 3 years of residency. Global health programs emphasize preparation for international experiences, however little has been published about residents’ re-entry to clinical training. Objective: To describe and analyze residents’ re-entry experience post international rotations. Methods: We conducted qualitative interviews with 13 pediatric residents (7 categorical, 6 GH) from April-August 2014; all residents worked in either Swaziland, Lesotho, Malawi or Botswana. Residents answered open-ended questions about lessons learned from their international rotation; they also completed a card-sort task, making judgments and thinking aloud about emotions associated with reverse culture shock (Oberg). We transcribed interviews and analyzed data using principles of constructivist grounded theory to derive themes. Results: When comparing international and BCM training, residents identified lessons learned about differences in cultures, health systems and resource availability. All experienced similar emotions, but the depth of emotions such as confusion and disconnection was greater for GH residents whereas categorical residents felt more invigorated upon return. GH residents talked about changes in autonomy and role-confusion while categorical residents did not. For GH residents, in-patient work abroad was an important trigger of emotions upon re-entry. Discussion: With the exception of feelings related to role-confusion/autonomy and disconnection, categorical and GH pediatric residents experience similar emotions when they re-enter the BCM system, however the degree of emotions are greater for GH residents. Working in an in-patient facility abroad intensified GH residents’ emotions upon return. Our findings suggest a need for residency programs to increase faculty members’ awareness of the emotional response to re-entry and provide a support system, particularly for GH residents.

1. SIMULATION USE FOR GLOBAL AWAY ROTATIONS (SUGAR): USEFUL IN PREPARATION, BUT WHAT ABOUT WHEN ABROAD?

Michael B. Pitt MD, Sophia P. Gladding PhD, University of Minnesota, Minneapolis, MN, Sabrina M. Butteris MD, University of Wisconsin School of Medicine and Public Health, Madison, WI, On Behalf of the SUGAR Investigators, (Cincinnati, Case Western, Medical College of Wisconsin, Mayo Clinic, University of Minnesota, University of Wisconsin)

BACKGROUND: Simulation Use for Global Away Rotations (SUGAR) is a pre-departure simulation curriculum designed to provide residents participating in global health electives (GHE) the opportunity experience and debrief common challenges encountered in resource-limited settings. OBJECTIVE: Determine residents’ perceptions of the usefulness of participation in SUGAR after completing their GHE. METHODS: Residents from seven institutions who participated in SUGAR were sent an anonymous survey on returning from their GHE asking about the utility of SUGAR, and to identify aspects which were particularly helpful while abroad. We used descriptive statistics to analyze perceptions of usefulness and conducted a thematic analysis of written comments of the most helpful parts of the simulation sessions. RESULTS: We obtained surveys from 34 residents who had participated in SUGAR prior to their GHE. Respondents reported the simulations were useful with a mean score of 4/5 [SD 0.8] (1 = not at all useful to 5 = very useful). No residents felt they had done too many simulation cases, regardless of how many they had completed with 40% (6/11) of those who had participated in more than five cases indicating they should have done more. The most common themes for the aspect of SUGAR which was most helpful were: practicing working with limited resources (36%), learning to problem-solve (29%), and expanding medical knowledge (28%). These mirrored the most common themes identified in residents’ comments immediately after the simulation sessions. However, a greater percentage of comments (26%) on return from GHE contained the theme of cultural preparation as the most helpful aspect of SUGAR as compared to 2% of comments from immediately after the simulation sessions. CONCLUSIONS: Active pre-departure preparation for GHEs using standardized, simulated cases appears to be an effective way to prepare residents for the challenges they will face in resource-limited settings. Its usefulness appears to be durable with the utility of cultural preparation, in particular, increasing after participation in a GHE.
to concepts of implicit bias, health disparities, and patient-centered care. Objective: To determine if the cultural competency workshop improved residents' perceived preparedness to provide culturally competent care. Methods: Using a modified version of a published survey tool, residents self-assessed preparedness and skillfulness for cross-cultural care delivery prior to and immediately following the workshop. We analyzed survey responses in aggregate to look for change following the workshop. In addition, we matched individual resident surveys using anonymity codes to look for changes between pre- and post-workshop responses. Results: Seventy-five residents completed the pre-workshop survey; 52 completed the post-workshop survey. Of those, 92% found the workshop useful. At baseline, 92% of residents felt prepared to care for patients from different cultures, and this did not change significantly after the workshop. In aggregate, residents perceived increased skillfulness after the workshop in the following areas: assessing the patient’s understanding of illness (83% to 92%, p = 0.04); identifying cultural customs that might affect clinical care (69% to 90%, p = 0.01); and negotiating a realistic treatment plan (77% to 90%, p = 0.07). For the 52 paired surveys, only the skill of identifying cultural customs had a significant positive change (p = 0.02) from pre to post. Conclusion: A cultural competency workshop did not change residents' perceived preparedness in caring for patients from different cultures, but it did improve perceived skillfulness in specific areas important to providing culturally competent care. These results suggest that residents may underestimate their ability to practice culturally competent care or may not fully appreciate the skills needed to provide this care. Small-group workshops on cultural competency offer an opportunity to build these skills.

4. HOW DO CLINICAL COMPETENCY COMMITTEES FUNCTION IN PEDIATRIC RESIDENCIES?
Kimberly A. Gifford MD, Children’s Hospital at Dartmouth Residency, Lebanon, NH, Su-Ting T. Li MD, MPH, University of California Davis, Sacramento, CA, Franklin Trimm MD, University of South Alabama College of Medicine, Mobile, AL, Alan Schwartz PhD, APPD LEARN, McLean, VA, Susan Guralnick MD, Winthrop University Hospital, Mineola, NY, Ann Burke MD, Wright state University Boonshoft SOM, Dayton, OH, For APPD LEARN validity of resident self-assessment, APPD LEARN, McLean, VA

Background: Many different approaches to Clinical Competency Committee (CCC) determination of resident milestones have been reported, but common approaches used across programs have not been studied. Purpose: To describe how pediatric residency CCCs determine resident milestone levels. Method: As part of our study through APPD LEARN examining pediatric residents' milestone assessments, participating programs completed an electronic survey regarding the structure and process for their CCCs. Programs choose to enroll in the Fall/2013 and/or Spring/2014 reporting periods. Data from the most recent reporting period from each program was used for this analysis. Results: Data was reported for 47 programs in the study. The most common data sources for CCCs were evaluations from the following: faculty (100%), peer (91%), other health professionals (89%), in-training-exam scores (81%), patient/family (70%), self (64%), and students (49%). Programs were more likely to use verbatim milestones (43%) or modified milestones (55%) for their faculty evaluations than for their non-faculty evaluations (21% verbatim, 40% modified). Narrative comments were reviewed similarly from faculty (57%) and non-faculty (82%) evaluations. There is wide variation between programs regarding the process by which data was synthesized by the CCCs, but most programs (94%) include discussions among CCC members to determine resident milestone progression. Of the 30 programs who had conducted a prior CCC assessment report, 53% shared the prior report with their residents and 50% had a faculty member review the report with the residents, while only 10% asked residents to formally reflect on the report. Conclusion: CCC practices vary widely between programs, but most CCCs use evaluations from multiple sources and use discussion among CCC members to determine resident milestone progression. Few programs ask residents to reflect on their milestone progress. Despite challenges with varied environments between programs, future studies should examine the association between CCC processes and outcomes to determine best practices for CCCs.

5. VALIDATION OF AN EDUCATIONAL VIDEO: MEDICAL KNOWLEDGE (MK) MILESTONE
Sandra E. Moore MD, Meisha K. Graham MD, Chevon M. Brooks MD, Yolanda Wimberly MD, Morehouse School of Medicine, Atlanta, GA

Background: To educate faculty about Milestones, we created a five (5) minute video using the medical knowledge (MK) milestone as an example. The intent of the video was to portray a medical team with four different learners. Characters A, B, C, and D were written to represent a MK level of 1.5, 2.5, 4.0 and 5, or novice (student), beginner (intern), advanced (senior resident) and expert (Attending) learner, respectively. Methods: This was a cross-sectional survey of PDs that were enrolled in the 2013-2014 APPD LEARN program. After viewing the video, each PD rated each character's (A, B, C, D) MK level, using the published ACGME Pediatric MK Milestone (1-5). Descriptive variables were calculated. The mean MK milestone level and standard deviation was calculated for each character (A, B, C, D). One sample t-test was used to compare the mean measured (by PDs) MK level with the intended level for each character. Results: The PDs MK levels agreed with the intended levels. The average MK level for characters A, B, C and D was measured at 1.5, 2.4, 3.7 and 4.5, respectively. (See table) Conclusions: In general, there was high agreement among the PDs on each character's MK level and agreement with the intended level. PDs can use the video as a faculty development tool for milestone education and know that the characters indeed portray a specified level. Faculty (or residents) can compare how they rate the characters MK levels to the true levels. As new educational tools are developed for faculty, the validity of such tools is essential. Limitations: 1 Small sample size. 2 Bias: inadequate sampling of the content domain (construct underrepresentation) 3 Limited literature on how to validate such types of educational tools.

6. ALIGNING TRAINING WITH FUTURE PRACTICE: ROOM FOR IMPROVEMENT ACROSS ALL PROGRAM SIZES?
Daniel J. Schumacher MD, MEd, Boston Combined Residency Program, Boston, MA, Mary Pat Frintner MSPH, William Cull PhD, American Academy of Pediatrics, Elk Grove Village, IL

INTRODUCTION: Ensuring training outcomes prepare learners to meet the needs of their future patients is central to competency-based education. Program size is often cited as a variable in preparing residents for different career types. OBJECTIVE: Determine
resident career intent and preparation for potential future practice based on program size. Methods: AAP Annual Survey of Graduating Residents was sent to national, random samples of 1,000 graduating pediatric residents each year from 2010-2014; 60% (3008) responded across years. Chi-square analyses were conducted to examine for differences in career intent and report of preparation for potential future practice (primary care, fellowship, hospitalist) across 8 training program class size categorizations. RESULTS: Residents from smaller programs are more likely to report primary care as a career goal (Table). However, approximately one-third of residents from large programs also report this career intent, and the majority of residents from all program sizes do not report this career intent. Residents from smaller programs were more likely to report preparation for primary care with those in larger programs more likely to report preparation for fellowship. The majority of residents in all program sizes, especially those in larger programs, report being well prepared for hospitalist practice. DISCUSSION: Larger programs yield fewer residents interested in primary care and provide better reported training for fellowship, and smaller programs yield more residents desiring primary care and provide better reported training for this career. However, many residents across program sizes do not report career intentions and training experiences that align, including the majority not intending to enter primary care in smaller programs and approximately one-third who desire primary care in larger programs. Moreover, residents in most program sizes report being more prepared for hospitalist practice than the more common paths of either primary care or fellowship. Programs should re-examine whether training experiences optimally prepare all residents for their future careers.

### Table: Residency Training Experiences and Career Goal by Program Class Size

<table>
<thead>
<tr>
<th>Activity</th>
<th>Program Class Size</th>
<th>Number of Residents (n)</th>
</tr>
</thead>
<tbody>
<tr>
<td>% reporting primary care career goal at end of residency*</td>
<td>4-8 (47)</td>
<td>45.7</td>
</tr>
<tr>
<td>% reporting excellent or very good preparation for primary care practice*</td>
<td>6-10 (60)</td>
<td>43.7</td>
</tr>
<tr>
<td>% reporting excellent or very good preparation for fellowship training*</td>
<td>11-14 (899)</td>
<td>41.4</td>
</tr>
<tr>
<td>% reporting excellent or very good preparation for fellowship training*</td>
<td>15-19 (47)</td>
<td>43.0</td>
</tr>
<tr>
<td>% reporting excellent or very good preparation for fellowship training*</td>
<td>20-24 (442)</td>
<td>39.5</td>
</tr>
<tr>
<td>% reporting excellent or very good preparation for fellowship training*</td>
<td>25-29 (291)</td>
<td>37.6</td>
</tr>
<tr>
<td>% reporting excellent or very good preparation for fellowship training*</td>
<td>30-36 (749)</td>
<td>39.6</td>
</tr>
<tr>
<td>% reporting excellent or very good preparation for fellowship training*</td>
<td>36-40 (749)</td>
<td>50.3</td>
</tr>
</tbody>
</table>

*p < 0.001

### 7. MULTI-INSTITUTIONAL DETERMINATION OF INTER-ITEM RELIABILITY OF MILESTONE LEVEL BY ROTATION-SPECIFIC EPA ASSESSMENT AND CORRESPONDING PRIMARY SUBCOMPETENCY ASSESSMENT

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

BACKGROUND: Entrustable Professional Activities (EPAs) have been suggested to be a link between the theoretical framework of competencies and real world clinical practice. One approach to the assessment of EPAs is based on a scale of entrustment that reflects the level of supervision required for the trainee to perform that activity. There has been no study to look at the reliability of mapping the levels of entrustment directly to the milestone levels of the subcompetencies. OBJECTIVE: Our primary objective was to determine the inter-item reliability of milestone level by parallel and concurrent EPA assessments and primary subcompetency assessments. METHODS: Shared rotation-specific EPAs were derived from core rotation objectives using Delphi method across our 3 different and diverse programs. Rotation evaluation data for PICU, NICU, General Inpatient, and Continuity Clinic rotations from the 2014-15 academic year from the 3 institutions were entered into a REDCap database. Multivariate linear regression models were utilized to predict each subcompetency milestone assessment from the predetermined rotation-specific EPAs. RESULTS: For several subcompetencies, a consistently high proportion of the variance in milestone level assessment was explained by the set of mapped EPAs across the rotations: PC1 (R2=0.83-0.86), PC4 (R2=0.81-0.86), PC5 (R2=0.80-0.87), and PROF5 (R2=0.73-0.94). The PICU-specific EPAs appeared to best map to subcompetencies, with R2 values across 17 subcompetencies (of the 21 reportable ACGME subcompetencies) ranging from 0.63-0.94. CONCLUSION: We found a strong degree of inter-item reliability of milestone level as determined by rotation-specific EPA assessment using entrustment scales, and corresponding milestone level as determined by primary subcompetency assessment. Our data support the approach of creating evaluation tools where multiple subcompetencies can be mapped and validly assessed by a single rotation-specific EPA.

### 8. CREATING A LOW-FIDELITY HANDS-ON RESPIRATORY RESUSCITATION AND CODE CART MANAGEMENT NIGHTTIME CURRICULUM FOR RESIDENTS IN TRAINING


Objective: To determine the efficacy of a low-fidelity hands-on respiratory skills and code cart module as part of a pediatric residency program nighttime curriculum. Methods: Twenty residents were randomized to control or intervention groups prior to their two-week night float block. Structured Clinical Observations (SCOs) were used to assess respiratory management and code cart knowledge and skills, one week apart. The intervention group received feedback and teaching immediately after the first week’s simulation. SCOs measured time and abilities to complete tasks such as achieving a seal and chest rise during bag-
mask ventilation (BMV) and finding specific code cart items. An oral evaluation tool was used to test knowledge of different bag types, advantages, disadvantages and troubleshooting techniques. Mean times for tasks and total points for knowledge and skills for control and cases were compared using a one-tailed paired t-test while baseline scores for PGY1, PGY2, and PGY3 residents were compared using a one-way ANOVA, and awareness of code cart and EZ IO locations with a X-square test. Results: A total of 7 PGY1, 6 PGY2, and 7 PGY3 pediatric residents participated during the study period. Baseline times were significantly different between levels of learners in the areas of adequate bag-mask ventilation (PGY1 98s, PGY2 133s, PGY3 36s, p<0.05), respiratory skills and knowledge (PGY1 11 pts, PGY2 13 pts, PGY3 16 pts, p<0.05), and awareness of code cart location (PGY1 29%, PGY2 50%, PGY3 86%, p<0.01). Though there was no significant improvement in time to place patient on monitors and total time finding specific code cart items, there was significant improvement in locating the EZ IO drill (p<0.01, 1 ctrl vs 11 cases), time to achieving adequate BMV (+12s ctrl vs +66s cases, p<0.05) and respiratory skills and knowledge (p<0.01, +2 pts ctrl vs +8 pts cases).

Conclusions: A simple 15-minute hands-on nighttime curriculum with deliberate teaching and feedback can improve knowledge of core concepts in respiratory resuscitation and time achieving effective BMV.

9. A QUALITATIVE STUDY TO IDENTIFY ACCULTURATION NEEDS FOR INTERNATIONAL MEDICAL GRADUATES (IMGs) IN A UNITED STATES PEDIATRICS RESIDENCY

Amanda D. Osta MD, Regina Pessango MA, Morouge Al Ramadhan MBBS, Michelle M. Barnes MD, University of Illinois-Chicago, Chicago, IL

Background: IMGs make up a substantial portion of the workforce in graduate medical education in the US, and they face unique acculturation challenges. In Pediatrics, the only prior published needs assessment was conducted in a rural center, and a systematic review of the literature identified no published acculturation curricula for IMGs entering pediatrics residency. Methods: IMG pediatric residents in an urban academic center who attended medical school outside of the US or Canada and were non-native citizens of either country were divided into four focus groups based on cultural similarities. The authors conducted semi-structured focus groups to assess acculturation challenges that the residents faced entering residency. One author facilitated the groups and another took field notes. The authors used a backup recording for transcription clarification. The authors analyzed the field notes using grounded theory methodology. All authors independently coded the first focus group and developed a coding schema, and a small number of discrepancies were resolved through discussion. Pairs of authors then independently applied the schema to all of the focus groups, and primary and secondary themes emerged. Results: During the academic year 2011-2012, 27 residents (9M, 18F) from 12 countries participated in the focus groups.. The authors identified several major themes regarding acculturation needs of IMGs transitioning to pediatrics residency: English language (including understanding of urban slang), US culture (including the education system), the culture of medicine (including rounding in an urban academic center), the physician-patient relationship, the roles of gender and religion in health care, and the culture of Pediatrics (including preventive medicine). Conclusion: In this qualitative study, the authors identified significant needs for IMGs as they transition to residency, many of these unique to Pediatrics. Pediatric IMG residents would benefit from an acculturation curriculum to facilitate their transition to residency in the US.

Primary and Secondary Themes

<table>
<thead>
<tr>
<th>Primary Themes</th>
<th>Secondary Themes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Language and communication</td>
<td>Understanding slang</td>
</tr>
<tr>
<td>United States culture</td>
<td>Assimilation and acculturation in English (along)</td>
</tr>
<tr>
<td>Culture of medicine</td>
<td>Residency in an academic medicine center</td>
</tr>
<tr>
<td>Culture of pediatrics</td>
<td>Physician-patient relationship</td>
</tr>
<tr>
<td>Influence of gender roles in health care</td>
<td>Physician role in prevention</td>
</tr>
<tr>
<td>Role of religion in health care</td>
<td>Physician role in child advocacy</td>
</tr>
</tbody>
</table>

10. INTERVENING DURING INTERN YEAR TO AVOID LOSS OF EMPATHY

Betty B. Staples MD, Michelle L. Bailey MD, Duke University Pediatric Residency Program, Durham, NC, Shari A. Whicker EdD, MEd, Virginia Tech Carilion School of Medicine, Roanoke, VA, Elizabeth Strachan MD, Duke University Pediatric Residency Program, Audrey Brown PSM, Jeffrey Hawley, Duke Office of Clinical Research, Kathleen A. McGann MD, Duke University Pediatric Residency Program, Durham, NC

Background: Several sources have documented that physician empathy impacts important quality measures and patient outcomes. The ACGME includes development of empathy for patients as one of the core 21 sub-competencies to be reported semi-annually. At the same time, residency training, and in particular intern year, is a vulnerable period for loss of empathy. Objective: To determine if monthly workshops focusing on empathy, mindfulness and out of hospital patient/family interactions assisted pediatric interns with maintenance of empathy. Methods: We initiated a program in July 2013 to address empathy in the intern year. The curriculum included monthly intern workshops focused on discussing empathy and specifically building individual mindfulness skills, which have been shown to be tied to maintenance of empathy. Additionally, we organized regular interactions at the local Ronald McDonald House to increase resident exposure to patients and families outside of the clinical setting. All Pediatric Interns participated in the program. We administered the Jefferson Scale of Physician Empathy (JSPE) which is a commonly used tool to assess physician and trainee empathy to 13 of our 16 incoming interns in July of the intern year and again in June of intern year. We analyzed survey responses in aggregate to look for change over the course of the year. Results: Thirteen intern completed the JSPE in both July 2013 and June 2014. The mean JSPE score improved from 43.57 to 49.31 with a mean increase of 5.74 points.
(p=0.03, 95% confidence interval 0.67-10.81) at the end of the year. Conclusion: A multi-faceted approach including discussion sessions, mindfulness workshops and group community service was associated with a positive impact on the mean empathy score for our intern class. This exceeded our goal of maintaining empathy during this challenging year.

11. AGREEMENT OF MILESTONE ASSESSMENTS BY A CLINICAL COMPETENCY COMMITTEE AND AN OBSERVED STRUCTURED CLINICAL EXAMINATION

Gregory H. Gorman MD MHS, Matthew Eberly MD, Christopher M. Watson MD, MPH, Theresa A. Kiefer, Jennifer Hepps MD, NCC Pediatrics @ Walter Reed Bethesda, Bethesda, MD

Background: Clinical Competency Committees (CCC) assess trainees using ACGME milestones. We aimed to determine the agreement of competencies assessed by an Observed Structured Clinical Examination (OSCE) with CCC assessment after 1 year of improved CCC and OSCE faculty assessment standardization. Methods: The CCC of a single medium-sized pediatric program assessed PGY1 competencies at the end of an academic year using the educational portfolio and 360 degree evaluations. An 8 station OSCE was also conducted within 1 month of the CCC Meeting. OSCE competency ratings were made using 1-5 unique assessments by 1-3 pediatric faculty. OSCE assessments were averaged and rounded. The agreement between CCC and OSCE assessments for the ICS1, ICS2, PC1, PC4, PC5, and Professionalism 1 competencies was determined with kappa statistics using standard weighting. Results: The CCC reported milestones to the ACGME for each competency for 13 PGY1 residents. Ten (77%) PGY1 residents participated in the OSCE where up to 3 pediatric educators made assessments covering 6 competencies. OSCE assessments consistently underrated CCC assessments by 0.5-1.0 milestones, with the exception of the Professionalism 1 competency with an OSCE assessment 1.4 milestones lower than the CCC assessment. All kappa statistics were negative (less than chance agreement) except for ICS-2 (+0.24 ± 0.51) [Table 1]. Conclusions: Competencies assessed by a single-day OSCE at the end of internship continue to agree poorly with CCC assessments using 360 degree evaluations over the previous 6 months. The OSCE is a valuable tool for assessment but only as part of a comprehensive evaluation of a resident's progress.

<table>
<thead>
<tr>
<th>Competency</th>
<th>Kappa Statistic ± SD</th>
</tr>
</thead>
<tbody>
<tr>
<td>ICS1</td>
<td>-0.09 ± 0.19</td>
</tr>
<tr>
<td>ICS2</td>
<td>+0.24 ± 0.51</td>
</tr>
<tr>
<td>PC1</td>
<td>-0.07 ± 0.44</td>
</tr>
<tr>
<td>PC2</td>
<td>-0.22 ± 0.41</td>
</tr>
<tr>
<td>PC5</td>
<td>-0.03 ± 0.25</td>
</tr>
<tr>
<td>PROF1</td>
<td>-0.07 ± 0.09</td>
</tr>
</tbody>
</table>

12. COLLIDING CULTURES: RESIDENTS' PERCEPTIONS OF A NOVEL, INDIVIDUALIZED, CAREER-FOCUSED EDUCATIONAL EXPERIENCE

Tai M. Lockspeiser MD, MHPE, Janice L. Hanson PhD, EdS, Patricia A. Schmitter MEd, Sheilah Jimenez, Kathy Urban, Adam A. Rosenberg MD, Marsha Anderson MD, J. Lindsey Lane BM BCH, University of Colorado, School of Medicine, Aurora, CO

Background: While the ACGME introduced a requirement for 6 months of career-focused, individualized curriculum in pediatric residency training in 2013, the University of Colorado Pediatric Residency program has been offering a 4-month career focused experience (CFE) since 2010. Purpose: To describe residents' perceptions of CFE with particular emphases on: 1. Unique strengths of this experience, 2. Differences between CFE and more traditional residency rotations, 3. Barriers to this type of innovation and challenges to overcome. Methods: Focus groups were conducted with all residents who participated in the CFE at the end of each year from 2011 to 2013. Semi-structured focus groups were led by a trained facilitator, audio-recorded, and transcribed. All transcripts were coded by two separate investigators using the constant comparative method. All eight investigators discussed all coding and participated in reconciling differences. Results: 37 residents participated in 8 different focus groups. Four main themes were identified: 1. Benefits of an individualized experience (learning goals, career preparation, customized experiences), 2. Impact of the educational culture (attitudes and beliefs about learning and feedback), 3. Impact of clinical setting (time constraints, resident role, supervision, service vs. education), 4. Planning and implementation of the experience (mentoring, facilitation and support, scheduling, effort required). Discussion: Residents embraced the opportunity to individualize their education and use learning goals to guide their experience and career development. The underlying tenets of this experience collided with the prevailing culture of block rotations which the residents described as being based on service needs and what faculty members think residents should do and learn. This collision, as well as the logistical challenges, were the primary barriers to the success of this experience. Nevertheless, the overall consensus of the residents was that the CFE was a very positive experience particularly as it relates to preparation and readiness for the next phase of their career.

13. IMPACT OF GLOBAL HEALTH ELECTIVES

Christiana M. Russ MD, DTMH, Ton Tran, Judith Palfrey MD, Boston Combined Residency Program/Boston Children's Hospital, Boston, MA

Background: Despite strong interest in global health (GH) rotations, robust assessment of their impact remains elusive. This is a mixed methods retrospective study to identify improved skills, projects, or presentations (outputs), self-reported effect on knowledge, and
attitudes (outcomes), and impact on careers of GH electives done in the Boston Combined Residency Program (BCRP). Methods We developed a mixed methods survey based on a logic model describing outputs, outcomes and impact of GH electives. All BCRP alumni who received funding for a GH elective from 2002-2011 were eligible to participate. The survey was emailed via Redcap in March 2014. Associations between mitigating factors and means of the Likert responses for outcomes were assessed using Chi-squared testing for categorical and T testing for numerical responses. Qualitative data was analyzed using principles of thematic analysis. Results Of 104 eligible participants, we received completed responses from 69(66%) describing 94 rotations. 70% reported GH fieldwork prior to residency, with 20% having spent more than a year. GH electives significantly impacted clinical knowledge and skill, social determinants awareness, and systems awareness (Table 1). Longer elective duration was associated with higher impact on clinical knowledge (p=0.011), and awareness of social determinants (p=0.041). Work from the electives resulted in 11 presentations at conferences, and 7 academic publications. Continued work in global health or underserved was reported by 44 (64%) of respondents, and was associated with both previous experience (p<0.001) and cumulative time on GH rotations (p=0.005). Quantitative and qualitative data supported significance of career impact; trainees also described improving as domestic clinicians in areas of cultural competency, health equity, and resource utilization. Conclusion In an era of individualized learning, pediatric training programs and governance should support trainees desiring to work in global child health by enabling adequate time for global health rotations, and providing mentorship and training based on trainee experience, career goals and learning needs.

### Table 1 Impact of GH Electives

<table>
<thead>
<tr>
<th>Impact</th>
<th>None</th>
<th>Mild</th>
<th>Moderate</th>
<th>Large</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical knowledge &amp; skill</td>
<td>0 (0%)</td>
<td>38 (60%)</td>
<td>18 (30%)</td>
<td>2 (3%)</td>
</tr>
<tr>
<td>Social determinants awareness</td>
<td>1 (1%)</td>
<td>15 (16%)</td>
<td>47 (51%)</td>
<td>29 (32%)</td>
</tr>
<tr>
<td>Health systems awareness</td>
<td>1 (1%)</td>
<td>7 (8%)</td>
<td>46 (53%)</td>
<td>29 (32%)</td>
</tr>
</tbody>
</table>

### 14. AN EHR-BASED TOOL FOR CHARACTERIZING CLINICAL EXPERIENCES OF PEDIATRIC RESIDENTS

**Lara Johnstun BS, Arizona State University Biomedical Informatics/Maricopa Integrated Health System, Audrey Dickan MD, Sarada S. Panchanathan MD, Phoenix Childrens/Maricopa Pediatric Residency Program, Phoenix, AZ**

**Background:** The ACGME broadly defines the clinical experiences pediatric residents should have, but does not specify the quantity of experiences necessary to achieve competence; in fact, there is little data on this topic in all specialties. We have created a tool which characterizes clinical experience via exposure to diagnoses. Methods: We designed an EHR report of diagnoses and meta-data associated with encounter notes for a group of residents. An encounter was defined as any contact between resident and patient that produces a note. Patient age and rotation location were extracted for each encounter in order to capture complexity and acuity, which can vary even if patients’ diagnoses are the same. Encounter note diagnosis codes were matched to diagnosis codes mapped to concepts from American Board of Pediatrics content specification outline. Results: Report sensitivity and F-measure, validated through chart review and schedule matching, were 0.984 and 0.997, respectively. Because of differences in coding conventions between the inpatient and outpatient contexts, agreement (F-measure) between the diagnoses recorded by the resident in the note and the report diagnoses for the same encounter was as high as 0.90 in the clinic and as low as 0.58 for NICU rotation. Discussion: We validated a tool that can be easily scaled for application in residency programs. Because the report maps experiences to Pediatric Board Exam concepts, we anticipate being able to quantify strengths and gaps in the progress of an individual resident as he or she advances through a pediatric residency program, and link this to an individualized learning plan. Report data can also be partitioned to characterize the diagnoses seen in each department or rotation. If scaled to include all residents over a 3 - 4 year period, one could identify residency program strengths as well as concepts which residents are not experiencing through their patient care, thus requiring presentation through different avenues. Application of this tool may begin to objectively measure the amount of clinical exposure associated with development of competence.

### 15. A RETROSPECTIVE REVIEW OF PATIENT SAFETY EVENTS IDENTIFIED BY PEDIATRIC INTERNS THROUGH THE SYSTEMS IMPROVEMENT CONFERENCE

**Priya S. Garg MD, Megan Cardoso MD, Judi Cullinane MSN, RN, CCRN, Elisabeth Schainker MD,MSc, Tufts Medical Center, Boston, MA**

**Background:** The IOM’s report To Err Is Human identified that in the United States medical errors are a significant cause of deaths annually. The ACGME’s CLER program states that residents should participate in patient safety education and experiential learning. From 2011-14, our institution, required interns to present a self identified patient safety event at a monthly conference entitled the Systems Improvement Conference (SIC). This retrospective study aimed to classify the types and severity of events interns most often self identified as part of a required systems based practice experience. Methods: In May 2014, we performed a retrospective analysis of resident cases presented from 2011-2014 by interns during the SIC. We reviewed each presentation for the following: 1) Type of safety event presented, 2) Classification and severity of safety events brought forward by residents, 3) Proximate causes developed, 4) Action items developed and implemented. This was an IRB approved study. Results: Our retrospective data revealed that 27 different patient safety events were brought forward by pediatric residents. The majority of
these events were delay in patient care (12/27), followed by adverse drug events (7/27), failed communication, and readmission. 10 of the events were classified as potential safety events, 8 were classified as serious safety events, 4 were classified as near miss events, and 5 were unclassified. Of the 12 documented action items, 3 have been implemented including central line protocol and diabetes care pathway and order set. Other action items were difficult to implement or unsustainable. Resident feedback included frustration with implementation, lack of interprofessional buy-in, and repeated errors presented. Conclusions: Pediatric residents are able to identify and investigate patient safety events. Our residents recognized the value of investigating near miss and serious safety events. However, completion of action items and implementation that affect patient outcomes was difficult due to lack of interprofessional teams.

16. COMPARING PEER AND STAFF EVALUATIONS OF PEDIATRIC RESIDENTS USING THE ACGME MILESTONES
Stephanie A. Berdy MD, Gregory Gorman MD, Jennifer Hepps MD, National Capital Consortium Pediatric Residency Program, Bethesda, MD

Background: The optimal method of evaluating the clinical competence of pediatric residents using the ACGME Pediatric Milestones is unclear. Although staff evaluations from Clinical Competency Committees (CCC) are often used as the gold standard, this form of evaluation can be limited by infrequent observation of the trainee. Peer evaluations provide unique information in resident assessment. Methods: Thirty-three residents across three post-graduate years (PGY) were asked to complete evaluations on each of their fellow trainees. The evaluation was comprised of 28 anchor phrases that correspond to 11 of the 21 reportable ACGME sub-competencies. Residents were asked to rate their peer on a 5-point Likert scale for each anchor. The CCC evaluated each resident in 21 sub-competencies on a 9-point 1-5 Likert scale. Peer evaluations were de-identified and tagged to their corresponding staff evaluation. Means from the peer evaluations for each sub-competency were rounded to the nearest 0.5 increment for a 9 point scale. Pearson’s correlation coefficients were calculated to assess for agreement. Paired t-tests were calculated to determine mean differences between peer and staff evaluations. Results: Twenty-two pediatric residents across three years of training completed evaluations on 12 PGY-1s and 10 PGY-2s. Correlation coefficients for each sub-competency ranged from poor (Professionalism 1 = 0.09) to very good (Interpersonal & Communication Skills = 0.85) [Table 1]. Overall mean correlation for all sub-competencies was fair at 0.57. Peer evaluations had higher scores than staff evaluations (overall mean difference 2.14 ± 1.09, p=0.05) with a smaller mean difference among PGY-2s than PGY-1s (1.64 ± 0.97 vs 2.55 ± 1.02, p=0.05). Conclusions: Peer evaluation of residents provides useful assessment of milestones. Peer assessment of sub-competencies in interpersonal communication and professional behavior correlate best with CCC. Sub-competencies that assess patient care and physical exam skills correlated poorly. Residents assess the competence of their peers higher than CCC assessment.

17. A LOW-FIDELITY HANDS-ON DEFIBRILLATOR SIMULATION MODULE IMPROVES RESIDENT KNOWLEDGE AND SKILL
Alice Hensley MD, Ian Chua MD, Stanford University, Palo Alto, CA, Lynda Knight MSN, Stanford University, Menlo Park, CA, Rebecca Blankenburg MD, MPH, Deborah Franzon MD, Stanford University, Palo Alto, CA

Background: With increasing patient safety standards and limitations to work hours, interns have few opportunities to practice manual skills needed to develop procedural competency with manual defibrillation. Objective: To assess the effectiveness of a low-fidelity, hands-on defibrillator training module incorporated during night shift on improving interns manual skills and knowledge. Methods: A hands-on simulation module was developed using a live defibrillator and a low-fidelity mannequin coupled with a dedicated laminated facilitator guide. Pediatric interns (n=28) were eligible to participate during a two-week night shift block. Participants completed pre and post skills and knowledge assessments with primary outcomes including improvement in time to manual set up and discharge of shock for synchronized cardioversion. Confidence was assessed with a retrospective pre-post Likert Scale. Fischer exact test and paired t-tests were used when appropriate to compare confidence scores, outcomes of observed skills tests, and written knowledge tests of common medications and arrhythmia management. Results: 27/28 interns completed the observed pre-post tests. 5 (18.5%) passed pre-test simulated observation (mean time to synchronized cardioversion 2:10). On post-test 18 (67%, p<0.001) passed (mean time to synchronized cardioversion of 1:22). All residents who passed during the pre-intervention observation also passed on the post-test observation. 25/28 interns completed the written knowledge assessment, in which knowledge of appropriate joules and defibrillator settings for common arrhythmias improved from mean 5.44/11 to 8.04/11 correct responses (p<0.001). Interns reported improvement in confidence in manual usage of a defibrillator for
synchronized cardioversion (mean 1.84/4 to 2.8/4, p<0.001), as well as usage for defibrillation (mean 1.8/4 to 2.76/4, p<0.001).
Conclusions: A low-fidelity, hands-on simulation defibrillator curriculum improves both interns' knowledge of management of common pediatric arrhythmias and manual defibrillator skills in a timed observed simulated resuscitation.

18. I DON'T WANT SOMEONE LIKE YOU TAKING CARE OF MY CHILD: IDENTIFYING STRATEGIES TO ADDRESS DISCRIMINATION TOWARD PHYSICIANS BY PATIENTS AND FAMILIES
Emily E. Whitgob MD, MEd, Alyssa Bogetz MSW, Elizabeth Stuart MD, MSED, Rebecca Blankenburg MD, MPH, Stanford University, Palo Alto, CA
Background: Physician mistreatment is a serious issue that has received increased attention from medical educators. Mistreatment by members of the medical team has been well-described; mistreatment by patients’ families remains less understood.
Objective: To identify approaches for physicians and trainees to respond effectively to incidents of discrimination by patients' families.
Methods: Our non-clinical team member conducted semi-structured interviews with randomly selected core faculty educators. Participants were asked to respond to three clinical scenarios (addressing race, gender, and religion) as direct care providers and as supervisors. They were also asked to share strategies for faculty education in this area. Data were analyzed through an iterative inductive approach using modified grounded theory. This project was IRB-approved.
Results: Thirteen 75-minute interviews took place from April to June 2014. Three themes were: cultivating a therapeutic alliance, de-personalizing the event and maintaining a safe learning environment. Factors such as acuity of illness and care context (inpatient, outpatient, emergency) influenced whether participants felt accommodating families requests was appropriate. Participants wanted trainees to feel empowered to remove themselves from care when necessary, but acknowledged this was not always possible or easy to do. 92% said faculty development was needed. Suggested educational strategies included team debriefing, critical reflection and multi-disciplinary skill-building sessions.
Conclusions: Discrimination towards physicians by patients’ families is an important but difficult to address issue. It is unrealistic to think it can be prevented, thus effective preparation is essential. Education is needed to mobilize and empower physicians to respond in ways that protect and empower trainees and preserve patient care.

19. WHAT DO RESIDENTS WANT? FACULTY AND RESIDENT PERSPECTIVES ON POINT-OF-CARE CLINICAL TOOLS
Alexis Toney MD, Rachel Goldstein MD, Sarah Hilgenberg MD, Rebecca Blankenburg MD, MPH, Stanford University, Palo Alto, CA
Background: Prior studies have identified what resources residents use to make point-of-care (POC) clinical decisions. Residents prefer easily accessible resources that provide quick and concise answers, highlighting the role of mobile technology. Though anecdotal evidence suggests that there is a disconnect between what residents want from their medical education and what faculty often provide, no studies have explored this divide.
Methods: An IRB-approved, anonymous, web-based, mixed methods survey was sent to pediatric residents (N=83) and core educational faculty (N=70) at an academic institution. Responses were analyzed using descriptive and qualitative methods. Two independent coders analyzed faculty and residents' characteristics of an ideal resident POC resource using inductive coding and enumeration. Results: Forty-nine percent (41/83) of residents and 70% (49/70) of faculty responded to the survey. UpToDate, physician consultation, and practice guidelines were among the top resources used by faculty and residents for POC decisions, with UpToDate most commonly used by both groups. Residents most frequently listed the following qualities of an ideal POC resource (in order): conciseness, accessibility, organization, searchability, prescriptiveness, and portability. Faculty most valued resources that were evidence-based, accurate, accessible, concise and up-to-date. Eighty percent of residents use workarounds (using smartphones to take pictures of useful documents, storing items in a cloud-based service, etc).
Conclusions: There is a disconnect between what residents desire in POC resources and what faculty think residents should use. Residents want a resource to provide clear guidance while working on a busy ward with limited time for reading, whereas faculty are more focused on the need for EBM, primary literature and the nuance of management recommendations. Residents are creating workarounds to fill this void. Appreciating the difference between POC and non-POC decision-making in residency training could help faculty create resources that are better aligned with their intended uses.

20. IMPACT OF SELF-REFLECTION AND FOCUSED VERBAL FEEDBACK ON RESIDENT SENSE OF COMPETENCE, AUTONOMY, AND RELATEDNESS
Christa Matrone MD, Boston Combined Residency Program, Boston, Massachusetts, Daniel Schumacher MD, MEd, Boston Combined Residency Program, Jia Zhu BS, Harvard Medical School, Boston, MA
Background: Constructive feedback can challenge self-concept and undermine motivators that drive learning such as those described by self determination theory (SDT): sense of competence, autonomy, and relatedness. Feedback that attends to these variables may result in a preserved self-concept and increased drive to learn. Objective: Determine impact of self-reflection and focused verbal feedback on resident sense of competence, autonomy, and relatedness.
Methods: Randomized controlled study of intern cohort (N=23) receiving milestones-based feedback in Fall 2013 and Spring 2014. The intervention group completed a guided self-reflection targeting discrepancies between self and external milestones assessments prior to feedback sessions. Intervention group advisors were trained to provide verbal feedback attending to sense of competence, autonomy, and relatedness. A validated SDT survey evaluating these 3 areas (score range -12 to 12) was administered before and after feedback. Change in scores for the 3 areas were compared across survey administrations using two-sided t-tests.
Results: The control group had a significant increase in competence scores compared to the intervention group (Fig 1). There was a drop in relatedness scores that was more pronounced for the intervention group but no significant difference in the change in autonomy or relatedness scores between the groups.
Conclusions: While our intervention was designed to promote learners’ sense of competence, autonomy, and relatedness, we found improved competence ratings in the control group and diminished relatedness scores in the intervention group. These findings suggest that increased focus on current development,
including potential deficiencies that may not have been self-identified, may challenge these variables even with explicit intent to attend to them. This highlights the challenging task of learner-centered feedback and need for more effective methods to provide feedback that preserves learner sense of competence, autonomy, and relatedness.

**Fig. 1: Average Change in Needs Satisfaction Scores Before and After Milestones-Based Feedback**

<table>
<thead>
<tr>
<th>Feedback Type</th>
<th>Intervention Group (n = 10)</th>
<th>Control Group (n = 11)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Competence</td>
<td>p = 0.002*</td>
<td></td>
</tr>
<tr>
<td>Autonomy</td>
<td>p = 0.39</td>
<td></td>
</tr>
<tr>
<td>Relatedness</td>
<td>p = 0.16</td>
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21. IMPROVING INTERPROFESSIONAL COMMUNICATION AND COLLABORATION: FINDINGS FROM A NOVEL RECIPROCAL JOB SHADOW EXPERIENCE FOR PEDIATRIC RESIDENTS AND NURSES

*Jennifer M. Wild MD, University of Washington/Seattle Children’s, Naisha Erickson RN, Seattle Children’s, Heather McPhillips MD, University of Washington/Seattle Children’s, Kathryn Whitlock, Seattle Children’s Research Institute, Seattle, WA*

**Background:** Residents and nurses are the frontline in patient care in any academic hospital setting. High quality inpatient care relies on effective collaboration and communication; however, interprofessional education between residents and nurses remain uncommon. Objective: Examine the effect of a reciprocal job shadow experience between pediatric interns and pediatric nurses on communication and collaboration. Methods: This was a mixed methods evaluation of a curriculum. A convenience sample of first year pediatric residents (n=17) and randomly selected pediatric nurses (n=24) at Seattle Children’s Hospital participated in a 4-hour job shadow between June and November of 2014. Participants each anonymously completed the Jefferson Scale of Attitudes Toward Physician-Nurse Collaboration (JSATPNC) prior to participation, and again 2 months after their shadowing experience. The JSATPNC is a 15-item survey with a 4-point Likert scale; a higher score reflects more positive attitude toward nurse-physician collaboration. Criterion-related validity and internal consistency/reliability (alpha 0.77-0.86) has been established for this tool. Additionally we included several open-ended questions to assess perceived value of the experience. Free text responses were analyzed to extract key themes. The distribution of responses was summarized using frequency and percentage, by role (nurse, resident) and by time point (baseline, post-shadowing). Change from baseline was assessed in repeated measures MANCOVA models with role and time as independent variables. Results: Residents scored more highly than nurses on the Jefferson Scale (p<0.01). Shadowing was not associated with a statistically significant change in the Jefferson Scale (p=0.30). Shadowing was associated with significant increases in RN endorsement of nurses having special expertise in patient education and counseling (p=0.02); resident opinion of open communication at the institution (p=0.02), and the importance of residents playing a role in the education of nurses (p<0.01) among both groups. Shadowing was also associated with a decrease in RN endorsement of doctors as the dominant authority (p=0.02). Qualitative analyses revealed five common themes pertaining to improving interdisciplinary understanding: work-flow, communication, collaboration, empathy, and skills specific to each group (i.e IV pumps, pre-rounding, handoffs, etc.). After the shadowing experience, residents and nurses strongly agreed that, “All residents should shadow a nurse,” (93% and 88% respectively) and that, “All nurses should shadow a resident” (93% and 85% respectively). Conclusions: A reciprocal job shadow experience between pediatric residents and pediatric nurses resulted in improvements in communication and in understanding the role of both residents and nurses in patient care. This experience was highly valued by both interns and nurses at our institution.

22. PEDIATRIC RESIDENT PROCEDURAL EXPOSURE VS. COMPETENCY

*David W. Ashby DO, Ana Velazquez, Ben Thompson MD, Vasudha Bhavaraju MD, Jon McGreevy MD, MSPH, Phoenix Children’s Hospital, Phoenix, AZ*

**Background:** ACGME mandates Pediatric Residency Programs provide sufficient training for providers to develop competency in 14 procedures. Though there is no doubt that pediatric residents are performing these procedures, the overall exposure to pediatric procedural skills is low even in large pediatric residency programs. This becomes problematic when attempting to define procedural competency. Furthermore, there is a paucity of research conducted determining proficiency in performing pediatric procedures nor a definition set forth by the ACGME. This study looks to describe the average exposure to ACGME required procedures in our program. Objective: Evaluate the average categorical pediatric resident procedural experience at large pediatric training program throughout their residency training. Methods: A retrospective review was performed on self-reported procedure logs from 2005-2010 performed by categorical pediatric trainees in the Phoenix Children’s Hospital Maricopa Medical Center pediatric residency program. Required procedures outlined by the ACGME were mapped according to current recommendations. The New Innovations database was used for data gathering. Required procedures were identified, separated by year and by the post-graduate year resident. Results: The review demonstrated an alarmingly low exposure to critical life-saving skills such as Bag Mask Ventilation and CPR with the average pediatric resident not logging either procedure over the course of a 3-year residency. Furthermore, more basic skills such as peripheral IV
23. IMPACT OF COACHING ON RESIDENT SELF-ASSESSMENT OF COMMUNICATION SKILLS

Tyrone P. Chan MD, Rebecca Blankenburg MD, MPH, Caroline Rassbach MD, Stanford/Lucile Packard Children's Hospital, Palo Alto, CA

Background: The Communication Assessment Tool (CAT) is a validated measure of physicians' communication with patients. Faculty coaches serve as a source of valuable guidance and feedback for residents in training. Objective: To measure the effectiveness of using faculty coaches vs. email in helping residents learn from patient feedback. Methods: Cross-sectional IRB-exempt study at Lucile Packard Children's Hospital, from June 2014 to January 2015. Pre/post-intervention, the modified 14-item CAT was distributed to all pediatric residents to self-assess their confidence in performing key communication tasks. In July-September 2014, 2 non-MD teams administered CATs to admitted patients/guardians on designated units to evaluate residents who cared for them. In October-November, residents who received patient/guardian CATs were randomized to review their scores with either their coach or via email only. Pre-intervention and post-intervention mean scores were compared with paired t-tests. Qualitative data was also gathered regarding how residents valued the feedback and process by which it was reviewed. Results: 75/82 (91%) pediatric residents completed the pre-intervention self-assessment, and all 82 (100%) completed the post. 27 residents both received CAT evaluations from patients/guardians and completed the pre/post self-assessments. For the residents who reviewed their reports with their faculty coach (n=14), the self-assessment score increased from 3.64 on the pre-intervention self-assessment to 3.81 on the post-intervention self-assessment (p<0.0001). For the residents who received their reports through an email only (n=13), scores stayed the same at 3.74 vs. 3.72 (p=0.92). Comments reflected the positive value that residents placed on being able to discuss the feedback with their coach. Conclusion: Review of patient feedback with a faculty coach increases resident confidence in communication skills, compared to when feedback is reported via email only. The addition of a faculty coach may be helpful in improving residents' communication skills.

24. HOW WELL DO RESIDENTS COMMUNICATE WITH PATIENTS?

Tyrone Chan MD, Rebecca Blankenburg MD, Caroline Rassbach MD, Stanford/Lucile Packard Children's Hospital, Palo Alto, CA

Background: The ACGME requires programs to assess residents' communication skills. The Communication Assessment Tool (CAT) is a validated measure of physicians' communication with patients, but it has not yet been published in pediatrics. Objective: To implement the Communication Assessment Tool to compare residents' self-assessments with patient/guardian assessment of residents' communication skills. Methods: Cross-sectional IRB-exempt study at Lucile Packard Children's Hospital. In June 2014, a modified CAT with 14 5-point Likert-scale items was distributed to all pediatric residents to self-assess their communication skills. In July-September 2014, 2 non-MD teams administered CATs by iPad or paper to admitted patients/guardians on designated units. A mean summary score for the patient/guardian CATs and the resident self-assessments was calculated for each resident and class. Patient/guardian summary scores and resident self-assessment summary scores were compared with an unpaired t-test. Summary scores of each resident class were compared with one-way ANOVA. Difference between highest and lowest scoring self-assessment items was evaluated with a paired t-test. Results: 75/82 (91%) pediatric residents completed the self-assessment. Patients/guardians completed 98 CATs on 28 residents. 27 of these residents completed self-assessments. Self-assessment scores were lower than patient/guardian scores (mean difference=0.88, p<0.0001). Summary scores for self-assessments and patient/guardian assessments increased with year of training, but this was not statistically significant. For the self-assessment, the highest-scoring item (“Treating … with respect”) and lowest-scoring item (“Spending the right amount of time …”) were significantly different (mean difference=1.14, p<0.0001). Patient/guardian CATs had no significant variation between mean item scores. Conclusion: Pediatric residents underestimate their communication skills when compared to responses of patients/guardians. Furthermore, residents feel they excel at treating patients/guardians with respect and need improvement with spending the right amount of time with them.

25. TEACHING RESIDENTS TO PROVIDE HIGH-VALUE CARE: EVALUATION OF COST-CONSCIOUS CARE CURRICULUMS IN PEDIATRIC RESIDENCIES

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Background: Expenditure on healthcare in the US is increasing at an unsustainable pace, and there has been a call to action to incorporate education on resource stewardship into medical training; however, there is little emphasis on cost and value in most resident education programs. As this is self-reported, it is not clear whether the residents are not exposed to the procedure or if it is not logged. Regardless, it is likely that they are not meeting a level of competency. Further research needs to be performed to help define “competency” in performing procedures for pediatric residency programs.
residency curricula. Objective: To describe the current national landscape of curricula on high-value, cost-conscious medicine (HVCCM) in pediatric residencies, identify the potential factors that may interfere with a pediatric resident’s ability to perform HVCCM, and determine which educational modalities would be preferred as a means to teach pediatric residents to perform HVCCM. Methods: IRB-exempt, anonymous, web based survey of pediatric chief residents and pediatric program directors at all pediatric residency programs, with one response per role per program (n=199 programs). Results: We received responses from pediatric chief residents (CR) at 72/199 (36%) programs in 32 different states and pediatric program directors (PD) at 83/199 (42%) programs in 35 states. 12% of CR and 10% of PD reported to have a formal curriculum on HVCCM. Program directors perceived that a lack of cost transparency as the biggest barrier to residents’ performance of HVCCM, whereas chief residents identified attendings having a final say in treatment decisions. A majority of respondents (83%) agree that their program needs such a curriculum and 88% PD and 92% of CR stated that they would use a curriculum if it were available. Both CR and PD preferred a curriculum with case-based discussion in a morning report or noon conference setting (82% and 79%, respectively). Conclusion: The majority of pediatric residency programs responding to this survey do not have a formal curriculum on HVCCM. There is a strong need and desire nationally for HVCCM curriculum in pediatrics, particularly in a case-based discussion format.

26. PEDIATRIC RESIDENT EXPERIENCE WITH FAMILY CENTERED ROUNDS IN A MULTI-SITE TRAINING PROGRAM
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Background: Family centered rounds (FCR) have been described as a positive addition to patient care. Some concerns about implementing FCR include decreased teaching time, decreased resident autonomy, and increased presenter interruptions. Multiple studies have shown that both direct teaching and observational learning increase during FCR as well as increased feedback for learners. We will demonstrate the resident experience with medical decision making and teaching on FCR in our multi-site program.

Methods: We conducted a prospective, observational study of FCR at four local hospitals. Rounds were observed at each institution using a standardized form to assess time on rounds, participants, time spent teaching, resident decisions, presentation components, and number of presenter interruptions. We analyzed our results using Microsoft Excel software.

Results: A total of 86 patient encounters were observed. Average time spent rounding was 13.5 +/- 5.6 minutes per patient. An average of 2.2 minutes of teaching was done, with 0.4 minutes done by residents. An average of 2.7 key decisions were made in each encounter with resident involvement in 73%. Rounds occurred inside the room in 64% of encounters. A nurse was present for 79% of patient encounters. An assessment was missed in 22% of the presentations. Immediate feedback was given 16% of the time. The length of rounds were not significantly different inside the room (12.6 minutes +/- 4.7) versus outside the room (15 minutes +/- 6.8). Length of rounds does not correlate with number of interruptions.

Discussion: On observation, residents are key decision makers on family centered rounds. There are few interruptions to the resident presentation, however, overall assessment of patient should be encouraged. Proposed next steps include instructing residents on effective bedside teaching and coaching attendings to provide constructive feedback in a group setting.

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27. IMPROVING RESIDENT PERFORMANCE IN AN AFTER-HOURS PEDIATRIC TELEPHONE TRIAGE SERVICE
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Purpose: Answering after-hours phone calls for a clinic, combined with a curriculum that includes next-day monitoring and feedback from a preceptor, has been shown to be a valuable training experience for residents. Documentation rates of after-hour telephone calls in pediatric residency programs are known to be low, though there is little investigation as to why. At the general pediatric clinic at Maricopa Medical Center, barriers to documentation of after-hours calls placed to pediatric residents were identified and addressed, with a goal of achieving >80% documentation rate within two months.

Methods: Logs of after-hours calls were obtained from the clinic answering service. Patient charts were reviewed monthly for presence of documentation. Calls were excluded if the chart was unable to be located or if the pediatric resident was erroneously paged (e.g. for an adult patient). Residents were periodically interviewed to identify challenges to documenting calls. Changes were implemented between cycles.

Results: The initial cycle showed a baseline 70% documentation rate. Commonly identified barriers to documentation included unfamiliarity with the documentation process, unreliable access to electronic medical records from off-campus, and lack of regular feedback from a preceptor. Variability in resident diligence due to a changing call pool was also a factor. Residents were educated on the triage and documentation process via a conference lecture and monthly orientation e-mails. Unreliable EMR access was resolved by Month 2. Documentation rates markedly improved by following up with some non-documenting residents. Target rate was achieved by Month 4. PL-2s, who trained only under the new system, had higher documentation rates compared to PL-3s, MP-3s and MP-4s.

Conclusion: The greatest barriers to documentation included lack of a monthly orientation system, EMR access, and variability in resident diligence. Periodic chart auditing and preceptorship seem to be especially important. Documentation rates since remained above goal, showing that the changes are effective.
28. WECARE: ENGAGING PEDIATRIC TRAINEES IN PATIENT SAFETY AND ERROR REPORTING
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Background: Knowledge regarding the frequency and nature of medical errors is necessary to improve patient safety within a hospital. ‘iCare’ is an anonymous event reporting system at the University of Minnesota Masonic Children’s Hospital (UMMCH). Graduate medical trainees are on the front lines of the care provided at our institution but rarely utilize the iCare system to report breaches in patient safety. Objectives: Our objectives were to: 1) increase the monthly incidence of event reporting by pediatric trainees at UMMCH by 100% from baseline within 7 months of initiating the WeCare intervention; 2) score above national benchmark for Safety Climate on UMMCH Safety Attitudes Questionnaire (SAQ) in 7 months; and 3) promote a culture of safety among pediatric trainees in our multi-site program measured by increasing our baseline Culture of Safety program rating to above the national average for the fellow and resident ACGME surveys from 2014 to 2015. Methods: The Safety Attitudes Questionnaire was administered to assess baseline safety climate prior to intervention. In September 2014, we introduced a voluntary, anonymous tracking system for trainee submitted iCares. In October 2014, we began the WeCare educational intervention. This includes a monthly electronic distribution of information on core patient safety concepts, followed a week later by a discussion applying these concepts to event reports that occurred in our hospital. At the conclusion of this six-part series, the SAQ will be re-administered and annual ACGME survey completed. Results: Baseline data included three event reports by trainees in a six-month period and SAQ score below benchmark goals. In the first three months of our intervention period, nineteen events have been reported by our trainees. Discussion: We have observed a 12-fold increase in trainee event reporting within three months of WeCare implementation. Though we hope to see an improvement in two markers for safety culture within our hospital and the wider pediatric GME program, we may see a decline as trainees increase engagement in error reporting processes. WeCare curriculum will be revised for a second PDSA cycle to be done in the 2015-2016 academic year.

29. IMPROVED CYCLE TIMES IN A RESIDENT CONTINUITY CLINIC: A RESIDENT LED PROCESS IMPROVEMENT PROJECT
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Background: At Gardner Packard Children’s Health Center, a resident continuity clinic, patients were experiencing very long clinic visits for acute and well child care leading to patient and provider dissatisfaction. Average clinic time was 1 hour and 33 minutes across all encounters and 1 hour and 42 minutes for well child visits in November of 2013. Aim: To decrease cycle times and overall appointment times in well child visits by 30 minutes using a standardized patient flow model to limit variability. Methods: A multidisciplinary team led by a pediatric resident using an A3 Quality Improvement tool of Lean Methodology identified specific barriers to improved clinic flow. Variability in patient flow through clinic based on provider preference was targeted for improvement. Using an innovative tool of patient passports, staff members recorded start and end times at each stage of a clinic visit. This process allowed each stage of the clinic visit to be timed as well as wait times between stages. Initial data was collected in November of 2013. After analyzing different clinic flows at multiple sites within the Lucile Packard Children’s Hospital Stanford system a standardized process was chosen. Posters displaying the new flow and team huddles before the start of clinic were implemented to train staff and providers. Timers were also placed in patient rooms to prompt residents of time. Full implementation was delayed until February 23, 2015 due to changes in clinic leadership with repeat data collection starting on March 2nd. Results: Data from preliminary implementation of hearing and vision screening prior to provider exams and signing of orders before presenting to attendings showed a reduction of total clinic visit time by 20–30 minutes. Full results are still pending at time of submission but will be complete in 2-3 weeks. Conclusion: A standardized flow-through clinic may be helpful to minimize variability of care and to decrease wait and cycle times. Standardization becomes even more important in a resident continuity clinic with multiple different providers throughout the week.
30. CREATION OF RESIDENT PANELS TO IMPROVE CONTINUITY IN RESIDENT PRIMARY CARE CLINIC
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Background: Provider continuity of care in pediatrics has been associated with fewer patient ED visits and hospitalizations, as well as higher quality of care by parental report. Aim Statement: Our aim was to improve the percentage of resident clinic visits that were “continuity visits” by 50% over 1 year. Methods: “Continuity visits” were defined as visits with patients the resident had seen previously. This was divided by the resident’s total number of visits over the specified period to give the continuity visit percentage (CVP). Intervention: The main intervention was to improve schedulers’ and providers’ ability to identify the resident as a patient’s provider by creating a distinct patient panel for each resident that was reflected in the electronic medical record. Analysis: Prior to the intervention, baseline CVP for each resident of the class of 2015 was calculated for a 3 month period. This was repeated later in the year to account for potential seasonal variability. The class of 2015 and class of 2016 then created panels and CVP was reassessed 1 year later. Results: There was minimal increase in CVP for the class of 2015 (baseline 35%, 22%, average = 28%, after intervention = 34%). When comparing class of 2016 to class of 2015 at the same point in residency (fall of second year), there was some increase in CVP (22% - class of 2015 vs 34% - class of 2016). There was a modest positive correlation between resident panel size and CVP. Conclusion/Discussion: The creation of resident panels for primary care clinic had minimal effect on resident continuity. This may be because the effects of panel creation may not peak until the panel system has been in place for several years and allowed for transfer of panels from graduating residents to incoming interns. There may also be other obstacles in establishing resident continuity, such as limited resident time in clinic. Despite a minimal gain in continuity, this project developed the parameter of “continuity visit percentage” as well as a measurement of the current baseline, both of which can be used for further improvement projects in resident continuity.

31. USING QI METHODOLOGIES TO IMPROVE COMPLIANCE WITH ACGME REQUIREMENTS: INCREASING COMPLETED PARENT EVALUATIONS IN A NEONATAL FELLOWSHIP PROGRAM
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Background: Parent evaluation of medical trainees is an important feedback mechanism and an ACGME requirement. Obtaining parental evaluations can be difficult; identifying appropriate recipients, timing of evaluation, and optimal evaluation processes are important for success. Objective: To increase the number of completed parent evaluations to 2 evaluations per service block and to 2 evaluations per fellow by the end of the 2014-2015 academic year. Methods: Project implemented in a 90-bed Neonatal Intensive Care Unit. The NICU has two neonatal fellows on service for each 4 week block. The current process of obtaining parent evaluations was mapped out using a flow chart. Fellow feedback was obtained about how to improve the process and the importance of evaluations was reviewed. A group comprised of the associate program director, chief fellow, program administrator, and NICU family support specialist created a key driver diagram, and then designed and mapped the new process of obtaining evaluations. The new process included monthly emails asking service fellows to identify parents to receive evaluations. The list of parents was then distributed to the NICU family support specialist who would explain and deliver the evaluation to selected parents. After the first Plan-Do-Study-Act cycle, the evaluation form was revised based on parent feedback to include new fellow photos. Outcome and process measures were identified. Pre and post intervention data were graphed and analyzed using a Statistical Process Control chart. Results: The number of completed parental evaluations increased after the implementation of the new process (0 to 2.11 completed evaluations per block). Special cause variation was demonstrated by presence of a point above the upper control limit. ([figure 1]) Process measures show that 87.5% of fellows are identifying parents, 66.7% of parents identified are receiving evaluations, and 47.5% of evaluations were returned. Conclusion: Quality improvement methodologies are successful in improving training program ACGME goals such as obtaining parent-fellow evaluations.
32. RESIDENTS EXPERIENCING SECONDARY TRAUMA (REST): PROGRAM INTERVENTION AT A TERTIARY ACADEMIC PEDIATRIC HOSPITAL
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Background: Secondary trauma (ST) is the negative emotional response experienced by medical providers when unanticipated patient events occur. Critical Incident Stress Management recommends providing support within 24 to 72 hours. Children’s Mercy Kansas City (CMKC) Residency Program did not have a formal system for resident support after events at high risk for ST. Objective: To contact at least 75% of residents within 72 hours of involvement in a high risk ST event by March 2015. Setting: CMKC is a 301 bed hospital with 101 pediatric and medicine-pediatric residents. Intervention: High risk events were identified via multiple avenues of communication including daily safety briefings, email listservs, and open lines of communication with residents. A multidisciplinary team including palliative care, chaplaincy, social work, physician well-being, and chief residents was created to respond to these events. Classification of high risk events was adapted from prior studies. Primary Measurement: Time from high risk event to resident contact (hours). PDSA Cycles: PDSA Cycle 1 created a structured process and focused on data collection. Cycle 2 was a temporary project halt during review by the Legal Department (an unexpected but necessary step for project advancement). Cycle 3 had a more refined process and data collection tool based upon Cycles 1 & 2. Cycle 4 added a new notification system. Analysis: Cycle 2 was not included in data analysis due to temporary project suspension. Data was plotted on a run chart. Average time from event to contact for Cycles 1, 3, & 4 was 44.3, 65.0, and 42.2 hours. Combined average time from event to contact was 47.2 hours. Combined, residents were contacted in less than 72 hours 82.9% of the time. Limitations: Gaps may exist in the system resulting in under-notification of events. Conclusion: We were able to create a structured process providing timely contact to residents involved in events at high risk for secondary trauma. Next Steps: Streamline event notification and contact processes and assess its impact on resident well-being.

33. SHORTENING THE DISCHARGE PROCESS ON THE GENERAL PEDIATRIC FLOORS: A QUALITY IMPROVEMENT INITIATIVE
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Background: According to Journal of Hospital Medicine, 22.8% of all patients experienced at least one delay in their care, accounting for 82 delay-related hospital days and $170,000 in cost. 42.3% of those delays were resulted from physician behavior, and approximately 25% of patients could have discharged sooner than they were. The general pediatric floor at Jersey Shore University Medical Center is a 28 bed unit, managed by one general pediatric attending, two senior pediatric residents, and two pediatric interns during the day, and one pediatric senior resident and one intern at night. The discharge tasks fell on the daytime interns, who also had several other clinical responsibilities. As a result, prior to implementation of our quality improvement project in 2013, the average time for a patient to be discharged after rounds was 218 minutes. This time was inclusive of determination of the discharge plan, preparation of home prescriptions, coordinating home health and other home nursing issues, and contacting subspecialists for follow-up appointments. Aim Statement: The goal of this quality improvement project was to reduce the time to discharge of pediatric patients on the general pediatric floor to less than 1 hour, thereby increasing patient satisfaction, improving turnaround time, and increasing time for resident education on rounds. Methods: We ran our PDCA cycle from March 2013-June 2013, and determined that the longest time frame during the discharge process was the time between the decision being made on rounds to discharge the patient, and when the discharge order was placed. We then implemented a change in June 2013. The day team would inform the night residents of which patients were likely discharges the next day, based on clinical improvements made throughout the day. The discharge tasks of prescription writing, making follow-up appointments, and preparing discharge instructions were completed by the senior resident taking care of the patient on the evening before anticipated discharge. We then timed the discharge process to determine our effect. Results: After the implementation of our change, the average time from decision to discharge to the placement of the discharge order was 13 minutes, resulting in a 94% reduction (three hours and five minutes) in time. 100% of the patients (83 patients) were discharged within an hour of the decision to discharge. When polled, senior residents at night estimated that it took approximately 5 minutes of work per patient to have discharge materials ready for the day. They felt that it did not significantly hinder their clinical responsibilities overnight. Conclusions: By redistributing service-
related tasks to the night time on-call resident, we were able to decrease the time spent on discharging a patient, leading to better turnover between the general pediatric floor and pediatric emergency room, and improved patient satisfaction. We realized that an unintended consequence of this change was the ability to use the time saved on increasing education time on patient centered rounds. We feel that this method is sustainable, independent of inpatient census size. Further evaluation needs to be conducted to determine whether using this saved time on education based family centered rounds correlates to higher in-training scores or pediatric boards pass rate.

**DESCRIPTIVE POSTERS**

**34. CLINICAL COMPETENCY SUBCOMMITTEES**

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**BACKGROUND:** The ACGME requires programs to form Clinical Competency Committees (CCC), responsible for determining milestone levels for residents. Early reports from the Pediatric community suggest the task will require significant faculty time. **OBJECTIVE:** To evaluate whether use of subcommittees of the CCC can complete milestone ranks while optimizing use of faculty time and satisfaction. **METHODS:** We formed a CCC comprised of advisors, continuity clinic and other core faculty, and program leaders. Faculty development was provided. To determine milestone levels, advisors were asked to review resident portfolios and assign preliminary ranks. Subcommittees of the CCC, required to have at least 3 members and include the resident's advisor and a continuity clinic faculty, were convened asynchronously to review, modify, and finalize rankings. The process was piloted in Fall 2013, and repeated in Spring 2014 for submission of results to the ACGME. With IRB approval, CCC members were surveyed about the process. **RESULTS:** In Fall 2013, 7 subcommittee meetings were held to complete milestone rankings; 44 of 47 eligible residents were ranked. While the process took 8 hours overall, individual meetings lasted only 30 to 120 minutes. In spring 2014, the process required only 4 subcommittee meetings to rank all 46 eligible residents; each meeting lasted 60 to 90 minutes, and the process took 4 hours overall. Survey response rate was 76%; all advisors responded. Members agreed that advanced ranking by advisors made meetings more valuable and more efficient. Only 1 advisor believed it was “too much work.” Members reported that use of asynchronous subcommittee meetings made it more likely they could maintain their clinical schedules while participating in at least 1 meeting. Scheduling the asynchronous meetings was judged “easy” by 88% of CCC members. Most respondents (81%) and all advisors agreed we should continue asynchronous subcommittee meetings the following year. **CONCLUSION:** Use of subcommittees, with pre-review by advisors, allowed for successful and efficient determination of milestone levels for all program residents. Faculty report satisfaction with the process.

**35. STRANGERS IN A STRANGE LAND: AN ACCULTURATION CURRICULUM FOR INTERNATIONAL MEDICAL GRADUATES**

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**BACKGROUND:** In 2014, International Medical Graduates (IMGs) comprised 10% and 17% of matched pediatric residents and fellows, respectively. IMGs face unique acculturation challenges, particularly in patient communication and patient-centered care. Published work focuses on understanding IMGs’ specific needs and challenges, or proposes strategies to support IMGs or improve communication and language skills. **OBJECTIVE:** Goals of this study were to (a) better understand IMG residents’ knowledge, skills, and attitudes toward patient care and (b) evaluate a curriculum designed to improve knowledge of U.S. medical culture, increase confidence in communication, and ease transition to residency. **METHODS:** Focus groups identified IMGs’ perceived challenges. These challenges were addressed in a new PGY-1 curriculum, using three 2-hour workshops over six months and topics of patient-centered care, importance of social history, cultural/ethnic diversity, health literacy, non-traditional families, and communication with difficult patients. Teaching methods included group discussion, didactics, videos, and role play. Pre- and post- workshop evaluations with quantitative and qualitative measures were used to revise each subsequent workshop. Patient Practitioner Oriented Scales (PPOS) were completed to assess beliefs about patient-centeredness. After one year, 3 quantitative measures assessed whether curriculum goals were met and 6 qualitative measures evaluated impact on patient-care. **RESULTS:** Due to a small sample size a Wilcoxon signed-rank test, rather than a paired t-test, was used to analyze quantitative data. At baseline, there was a statistically significant difference in PPOS score indicating more patient-centeredness when considered from the perspective of a patient versus provider (W = 3, p <0.05). PPOS scores also revealed a statistically significant post-curriculum increase in importance of patient-centered care (W = 10, p <0.05). Mean enjoyment ratings for each of the 3 workshops were 8.4, 7.5, and 8.5 out of 10, revealing satisfaction with the workshop, including time allotted and opportunity to talk. Ratings for each workshop component were between “extremely helpful” and “helpful” for future patient interactions. At 1-year follow-up, residents reported drawing on workshop content specifically for communicating with difficult patients, coping with different cultures, and aiming for patient-centered care. Residents assessed the curriculum as “moderately” to “extremely” influential for meeting each curriculum goal. **CONCLUSION:** Participant evaluation and feedback suggest that goals were met with this acculturation curriculum. One year follow-up showed a lasting impact on resident behavior. Further study with OSCEs and direct observations will be helpful to investigate curricular impact on patient care.

**36. CREATING AN INDIVIDUALIZED SENIOR RESIDENT TEACHING EXPERIENCE**

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An innovative, individualized teaching rotation was developed in the University of Hawai’i Pediatric Residency Program as a means for improving senior resident leadership, teaching ability/confidence, team ownership, and professional development.
The rotation was developed partially to help lessen the burden of each resident creating 6 individualized rotations in addition to ensuring a more standardized experience in these areas. Entitled Resident Resource/Resident Educator (R3E), this PGY-3 rotation incorporates facilitation, bedside and didactic teaching, mentorship, curriculum development, evaluation and reflection. Specific Rotation Elements/R3E Resident Activities Include: 1. Senior resident continuity on the wards while team leader peers are in continuity clinic, with many opportunities to practice the clinician-educator role 2. Direct, ongoing observations of 3rd and 4th year students during family centered rounds with opportunities to diagnose the learner and to provide individual direct feedback 3. Direct observations and feedback to interns and juniors performing patient handoffs 4. Facilitation of morning report 5. Creation and delivery of formal teaching sessions with topics, methods and targeted audiences of personal choice, depending on individual career path 6. Creating and utilizing an evaluation for assessing teaching activities and 7. Professional development guidance from faculty. Evaluation of R3E Resident Performance Includes: 1. Presentation and scoring of a Teaching Portfolio including curricula the resident has developed and personal reflections on teaching and mentoring experiences 2. Direct observation of the R3E resident’s teaching skills using an established tool and 3. Direct observation of the R3E resident giving feedback to junior learners. Early feedback outcomes from senior residents who have completed the rotation include improved confidence in teaching skills, a better understanding of how to tailor individual and difficult feedback, and perceived positive reactions from medical students due to increased attention to their learning by a dedicated senior teaching resident.

37. REFLECTING ON REFLECTION: A COMPARISON OF TWO APPROACHES TO REFLECTIVE WRITING ANALYSIS IN THE EVALUATION OF A COMMUNITY-BASED ADVOCACY EXPERIENCE

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Background: Reflective exercises are growing in popularity in medical curricula and offer a window to evaluate learning that takes place outside of the traditional clinical structure. There are two main approaches to evaluating this data: qualitative analysis and analytical instructional rubrics designed to assess learner depth or quality of reflection. Methods: Residents at UTHSCSA participated in a community advocacy experience in the juvenile probation department and completed a written reflection on the experience. Twenty reflections were de-identified and reviewed by two independent reviewers using two different methodologies: thematic coding and an analytical instructional rubric (the REFLECT Rubric). Rolling inter-reviewer discussions were used to establish consensus and standardize the use of the REFLECT rubric. For coding, reviewers used a three-pass approach to identify themes, solidify the code, and apply it to the larger sample. The data from these two methods were compared. This study was certified as exempt by the UTHSCSA IRB. Results: Each review technique took approximately 10 minutes per reflection. Analysis using thematic coding revealed several recurrent themes including: the role of the physician, the importance of family and social context, and the recognition of biases and misconceptions. Analysis using REFLECT rubric revealed a range of reflective levels from habitual action to critical reflection with transformative learning. Distinguishing between introspection and reflection was the most difficult for the two reviewers, with recognition of the role that their own past experiences played in how they interpreted the reflections. Conclusions: Analysis of written reflections using thematic coding and the REFLECT rubric provided valuable but different information on the impact of an advocacy experience. Further discussion is needed around the best use of these reflective pieces and the possible applications of this type of data in feedback, debriefing and milestone-based evaluations.

38. THE PEDIATRIC CHAIR'S FRIDAY FORUM: AN INTERACTIVE CONFERENCE INVOLVING MULTIPLE LEVELS OF LEARNERS

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BACKGROUND: Department-wide conferences, involving multiple levels of learners (medical students, residents, fellows, attending physicians), are becoming less common as resident work hour restrictions and faculty productivity demands place greater strain on academic centers. Traditional “Grand Rounds” remains the main conference that consistently brings this diverse group of learners together. However, Grand Rounds is typically didactic in nature and does not encourage active learning or interaction among attendees. OBJECTIVE: Department educators sought to create an interactive conference that would have broad appeal to faculty and learners of all levels. In so doing, the department hoped to improve clinical reasoning skills and increase collegiality among and between these groups. DESIGN/METHODS: The Pediatric Chair’s Friday Forum (PCFF) was conceived by a group of educators, proposed and approved for administrative support. Under the tutelage of a Steering Committee, five distinct rotating forums according to the respective week of the month were organized to enhance various clinical and academic skills: Clinical Reasoning, Evidence-based Medicine, Morbidity and Mortality, Research in Progress, and Ethics. Teams of early and mid-career faculty aligned with interested residents and fellows to organize and coordinate each forum, with the conferences held from October to June of the academic year. RESULTS: At the end of the first year, faculty, fellows and residents were surveyed regarding their experience with the PCFF. Sixty-eight surveys were completed, including 38 faculty members, 7 fellows, and 23 residents. Of those surveyed, 58/68 (85%) attended at least 5 of the 34 sessions offered. Overall, Clinical Reasoning sessions were seen as having the highest educational value (4.69, on a Likert scale, 1=poor value, 5=high value), followed by Morbidity and Mortality (4.49), Ethics (4.33), Research in Progress (4.33), and Evidence-Based Medicine (4.22). The qualitative comments on positive aspects of the conference revealed two overarching themes: Community-building, and modeling of clinical reasoning by faculty. Attendance at the PCFF was at or near the level of Grand Rounds throughout the year. SUMMARY: The PCFF was a successful and well-received conference that actively fostered faculty and learner interaction, including robust discussion and community building. It could serve as a template for similar department-wide, interactive conferences at other institutions.
39. DEVELOPMENT OF A PROGRAM-SPECIFIC LONGITUDINAL HANDOFF CURRICULUM CAN IMPROVE SATISFACTION AND PATIENT CARE OUTCOMES

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Effective patient handoffs are key to patient care, particularly when limited resident duty hours have mandated increased numbers of patient handoffs. At our institution, infrequent handoff training sessions and handoff supervision have led to variability of these handoffs. Our objective is to study the impact of a program-specific resident handoff curriculum with the aims of establishing consistent use of a standardized handoff method and reducing negative patient outcomes related to resident handoffs. Through a pre-intervention survey of nurses, residents, and attendings, we identified key elements for improvement of resident handoffs. Based on survey results in conjunction with evidence-based models, we designed a handoffs framework specific to our patient population and hospital design. We then implemented an educational curriculum involving once yearly workshops, weekly handoffs evaluation by observing faculty members, and monthly resident refresher courses. Multiple parameters from handoff observations were trended via program-specific tool. Evaluative data collected on 256 resident handoff sessions after implementation revealed improvement in adherence to the correct handoffs structure and inclusion of specific problem-based directives. Post-intervention surveys of the aforementioned groups were distributed 6 months after implementation to assess perceived educational effectiveness and impact on patient care, with comparisons between pre- and post-surveys using Fisher’s Exact Test. No significant change was seen in any group regarding perceived negative outcomes directly related to resident handoffs; however, there was a significant increase in attendings who believe that residents are well prepared to provide excellent care of their patients as a result of handoffs (p=0.013). A program-specific, formalized handoff structure through educational curricular incorporation with consistent evaluation and feedback can improve effectiveness of patient handoffs. Next steps include revision of the handoffs evaluation tool to provide milestones-based, individualized patient care data.

40. CULTURALLY EFFECTIVE HEALTH CARE FOR PEDIATRIC RESIDENTS AND THE INTER-PROFESSIONAL TEAM: A CURRICULAR MODEL

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The American Academy of Pediatrics defines culturally effective health care (CEHC) as the delivery of care within the context of appropriate knowledge, understanding, and appreciation of cultural distinctions, including beliefs, values, actions, customs, and unique health care needs of distinct populations. A wide variety of CEHC training methods have been described but all focus on its implications for patient care in an environment of rapidly changing demographics. While it is crucial to resident education, CEHC training must also be extended to the broader inter-professional team in order to truly impact patient care. Our objectives were to enhance our residency CEHC curriculum to incorporate its application within inter-professional teams, and ultimately to create a CEHC assessment tool. We administered a needs assessment survey to pediatric residents at our institution, modified with permission from Weissman et al. (2005) and added items related to inter-professional relationships. The response rate was 48.7% (n=19). Results indicated that all residents consider it moderately or very important to consider the patient’s family’s culture when caring for them. However, most felt unprepared to provide CEHC to patients with limited English proficiency (89.5%), and those whose religious beliefs affect treatment (73.7%). Notably, most residents reported a lack of skills-based training and CEHC training as it impacts the inter-professional team dynamic. Based on these results, we assembled an inter-professional task force that met monthly to assist in revising our CEHC curriculum. We developed skills-based training for residents and a CEHC Pediatric Grand Rounds to engage hospital associates. Next steps include distribution of a modified needs assessment survey to all inter-professional teams, summative evaluations of the revised curriculum, and development of a CEHC assessment tool. Based on our experience, we propose that CEHC educational curricula be developed with an inter-professional task force to effectively engage the broader inter-professional team and impact culture change.

41. PEDIATRIC RESIDENT SATISFACTION WITH ACADEMIC HALF-DAY

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The Accreditation Council for Graduate Medical Education (ACGME) program requirements state programs must provide regularly scheduled didactic sessions for residents. Until the 2013-14 academic year, residents in our program were required to attend six separate conference sessions per week. Irrespective of rotation, residents were regularly late to or absent from these sessions, with only half of available residents attending any given session. The literature describes non-pediatric programs that have successfully implemented an academic half-day (AHD) to deliver education to residents and improve attendance, but information regarding pediatric resident satisfaction with half-day academic programming is limited. Starting with the 2013-14 academic year, our program began offering didactic sessions in the form of an AHD. Residents attend didactic sessions on Tuesday mornings, and are excused from clinical obligations. In order to ensure adequate patient care coverage, the inpatient team seniors are excused from conferences. In addition, the outpatient clinic switched attending only clinics to Tuesday mornings, eliminating need for resident coverage. The AHD consists of four, one hour conferences. Content is divided into one-month blocks by subject area. Journal club and teaching skills sessions also occur during the AHD. In April 2014, the residents were surveyed about the new structure. Attendance records were also reviewed. 59% of the residents responded to the survey. All approve/strongly approve of the AHD and overall new conference structure. 92% agree that the length of the conferences is appropriate. All responders feel the content is somewhat or mostly in alignment with learning goals. Nearly 2/3 of residents are satisfied with how interactive the conferences are. Attendance has greatly improved, with more than 95% of residents attending conference weekly. One intriguing benefit of the AHD has been the formation of a breakfast club by the residents, where a different cadre of residents brings breakfast for the group each week. We have been successful at providing residents with educational content in a desirable format by using an AHD, and successful at increasing resident attendance.
42. QUALITY IMPROVEMENT CURRICULUM IMPROVES CARE IN A PEDIATRIC RESIDENCY CLINIC
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Quality Improvement education has been incorporated into our training program since 2003. The format has been refined with a greater focus on individual resident projects related to their continuity clinic patients. Teaching quality improvement skills and mentoring residents through cycles of change has led to improved quality of patient care. Process: All intern learners are required to complete the following IHI modules: QI 101: Fundamentals of Improvement QI 102: The Model for Improvement: Your Engine for Change QI 103: Measuring for Improvement All residents are provided with access to an on-line quality improvement toolkit. 1. Approaching population health with a team based approach 2. Developing an effective aim statement 3. Hospital and community resources for quality improvement 4. PDSA worksheet and data table Residents are scheduled for 2 quality improvement 1 hour sessions during each of six ambulatory clinic rotations, as well as a half-day session each rotation to work on their project. Session goals include: 1. Reviewing sections of our quality improvement toolkit. 2. Querying patient population data with a question regarding care 3. Reviewing patient registries to determine gaps in care 4. Development of an aim statement addressing the quality gap 5. Implementation of a PDSSA cycle. 6. Measuring outcome by re-querying panel studied. Outcomes: Residents have identified a variety of care gaps and demonstrated improved care after interventions. Selected examples include the following, and process examples will be shared in the poster: 1. Improved rates of well child visits in patients delinquent from 83%-83% 2. Improved rates of newborns leaving the hospital with first dose of vitamin D given from 0% to 85%. Summary: Teaching residents the importance of quality improvement and giving them the skills and time to complete projects results in improved patient outcomes in a resident clinic. These skills will serve residents well as they participate in maintenance of certification activities required to maintain licensure post-graduation.

43. PREPARING LOCALLY TO LEARN GLOBALLY: THE DEVELOPMENT OF A JOINT UME AND GME PREPARATORY CURRICULUM FOR GLOBAL HEALTH ELECTIVES
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PURPOSE: Fewer than 30% of medical schools prepare their students for global health electives. To align with the Association of American Medical Colleges Guidelines for Premedical and Medical Students Providing Patient Care During Clinical Experiences Abroad, the Medical College of Wisconsin (MCW) developed a combined undergraduate and graduate medical education (UME and GME) pre-departure curriculum. To our knowledge, there are no other academic programs that jointly train UME and GME trainees. METHODS: An interdisciplinary group of MCW faculty determined the essentials of pre-departure preparation for UME/GME trainees based on a literature review, discussion with national colleagues and local expert consensus. 2.5 hours of training materials were developed: 1) Two 20 minute on-line preparation modules on health and safety) a Guide for Global Engagement; and 3) an in-person 1.5 hour seminar on the ethics of short-term global health electives. The curriculum was piloted, modifications were made, and exempt approval was obtained for the formal evaluation. Data was gathered through annual surveys (2013-2015) to assess whether the mandatory curriculum enhances trainee preparation for global health electives. RESULTS: A 100% response rate was obtained from the 48 trainees who participated in the ethics seminar over a two year period. Using a 5 point likert scale with a high score of 5, the seminar s ability to capture potential ethical situations was scored an average of 4.6 (high 4.9, low 4.2). The usefulness of the preparation curriculum was rated a 4.4 (high 4.6, low 4.2). The learners reported understanding the material with a rating of 4.63 (high 4.8, low 4.4) and felt the facilitators were effective in stimulating discussion with a score of 4.8 (high score 5, low score 4.5). The small group setting was felt to provide an opportunity for discussion scoring 4.7 (high 4.8, low 4.4). CONCLUSIONS: An interdisciplinary curriculum, with a combination of online tools and an in-person ethics seminar, can be an effective method to prepare both undergraduate and graduate medical trainees simultaneously for global health electives. This is a potentially scalable model for other academic programs seeking to prepare large groups of trainees for global health electives.

44. THE RESIDENT SCHOLARSHIP PROGRAM: USING SELF DETERMINATION THEORY AS A GUIDE
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Background: Residency programs are required by the ACGME to provide a scholarship-rich learning environment. However, residency programs receive little guidance regarding how to create that environment or what constitutes scholarship. Self Determination Theory (SDT) identifies three conditions that foster internal motivation and enhance learning: autonomy, competence, relatedness. We created an innovative Resident Scholarship Program (RSP) using SDT to guide program development. Methods: Consistent with SDT’s emphasis on the process of learning, RSP emphasizes process not product. Components of RSP (lecture series, mentored project, scholarship rotation) are designed to foster autonomy (e.g. residents select their projects based on career interests), competence (e.g. residents gain skills via lectures and hands-on experience) and relatedness (e.g. residents collaborate with faculty and other trainees). Our emergent program evaluation (via surveys of residents, interviews with mentors, review of residents’ project reports) is designed to capture intended and unintended program effects; findings from the pilot year are reported here. Results: All 31 PGY2 engaged in core lecture series, a mentored scholarly project, and a time-protected scholarship rotation. Based on project reports, residents engaged in a broad range of scholarship, reflective of diverse career interests, and approached their work in a scholarly fashion. Compared to before RSP, residents reported significantly more competence in certain scholarly skills (e.g. directing their own learning, and selecting a project that fosters career development); change in relatedness was less remarkable. Mentors expressed positive regard for RSP and, unexpectedly, created “mentoring teams” thus further supporting collaboration. Discussion: A resident scholarship program that emphasizes the process of
scholarship rather than products, and uses SDT as a theoretical framework, can meet ACGME requirements and create scholar-rich learning environment. While features of RSP may not generalize to other programs, using SDT to guide program development has broad applicability.

45. FROM CLINIC TO COURTROOM: THE OBJECTIVE STRUCTURED CLINICAL-LEGAL ENCOUNTER (OSCLE) FOR IMPROVED MANAGEMENT OF CHILD SEXUAL ABUSE
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Background: Child abuse and neglect are leading public health concerns. Residency programs struggle with teaching appropriate management of such cases. Studies show that practicing pediatricians lack knowledge and confidence on management of this issue. Objective: We sought to develop and evaluate a curriculum for teaching resident competencies for the recognition and management of child sexual abuse. Curriculum: The curriculum focuses on the following competencies: screening, eliciting and documenting a history, doing and documenting focused genital exam, knowledge of mandatory reporting statutes, communication of the medical evaluation to other agencies, and presenting medical findings in the courtroom. Incorporated are structured debriefings to discuss relevant curricular content and impact on the learner. It consists of three components: the patient encounter, documentation component and the court encounter. Methods: Pediatric Residents from a large training program in NYC completed a pre-OSCLE survey on with 19 Likert-scaled items on their experience, knowledge and confidence in handling child sexual abuse. One week after the OSCLE training, they completed the post survey. Results: To date 63 residents have completed the training. Since a new child abuse service and training was also implemented, we decided to focus on only the PGY 1 early in their training. Analyses are underway. Implications: This curriculum might prove a useful adjunct to didactics traditionally employed to teach and reinforce the competencies for management of child sexual abuse.

46. PEDIATRIC HOSPITALIST CLINICAL EDUCATOR TRAINING PROGRAM: A MULTI-INSTITUTION COLLABORATION
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Rationale: Pediatric hospitalists serve as teaching attendings for many learners, yet a 2012 Pediatric Hospital Medicine (PHM) Education Task Force needs assessment survey indicated that though most desire formal education in clinical teaching skills, options for obtaining training are limited. The Advancing Pediatric Educator eXcellence (APEX) Teaching Program was designed to bridge this gap. Methods: The 12-month American Academy of Pediatrics-sponsored curriculum consists of program-specific and elective workshops at national meetings, quarterly assignments, and direct observation. Program-specific workshops held during a half-day pre-course at consecutive PHM national conferences focus on learning environment, clinical teaching strategies, feedback, and learners in difficulty. Quarterly Web-based assignments build on workshop topics and include readings and asynchronous interactive reflections and discussions. At least twice, a local/regional mentor with educational expertise observes participants’ clinical teaching skills and provides structured feedback. During the second pre-course, participants present a successful/innovative clinical teaching technique and co-facilitate the workshops for the next cohort. There are 7 APEX faculty members, and in the 2014-2015 inaugural year, 16 pediatric hospitalists from 15 sites began the program. Evaluation: 1) Satisfaction: workshop and program evaluation; 2) Learning: pre-/post- self-assessment of content area knowledge and confidence; 3) Application: teaching evaluations, annual tracking of CVs for evidence of scholarship, formal recognition of teaching, and attainment of educational leadership roles. Impact: The APEX Teaching Program uses an innovative model to enhance clinical teaching skills of a national cohort of pediatric hospitalists. Aggregate learning assessment results show cohort members perceive statistically significant growth in content area knowledge and confidence after the inaugural pre-course. With continued success, this program can be modified to offer teaching skills training at a national level for clinicians from other specialties.

47. THERE S AN APP FOR THAT: RESIDENT USE OF A PROGRAM-SPECIFIC MOBILE APP - EARLY RESULTS
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Background: Mobile device use among medical providers has increased in recent years, as has the use of medical apps for clinical practice. Most commonly this includes reference to drug guides, medical calculators, and reference resources. However, objective data on the use of apps or mobile technology are lacking, as published studies have typically relied on self-reported data in the form of surveys or focus groups. In July 2013, the Nationwide Children’s Hospital Pediatric Residency Program launched a mobile app, MyResidency. After 15 months, we sought to determine how it is voluntarily used by pediatric residents. Methods: Total and resident-specific usage data from July 2013-Oct 2014 was obtained from the app developers. App use was divided into five main categories: Content [medical reference & clinical practice guidelines (CPG)], External Links, Calculators, Messaging, and Contacts. Descriptive statistics were used to report percentages, median and interquartile range. Results: The MyResidency app has been downloaded by 130 of 143 (91%) 2014-15 residents. Usage increased from 358 app opens July-Sept 2013 to 2861 opens July-Sept 2014 (615% increase). As of Oct 17, 2014, there were a total of 6919 app opens with a median of 25 opens/resident [IQR 11-47]. Use of the five categories described above accounted for 6433 opens (93%). The most frequently accessed areas were...
48. REFLECTIVE PRACTICE DURING RESIDENCY: EMERGENCY DEPARTMENT (ED) BOUNCE-BACKS AS AN EDUCATIONAL OPPORTUNITY
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Introduction: Feedback and reflection about patient care outcomes can improve residents clinical reasoning, communication, approach to patient care and facilitate self-directed learning. Development of competence in the domain of Practice Based Learning and Improvement requires reflection on ‘personal clinical effectiveness data.’ Residents in our program report few structured opportunities to review such data and to learn through reflection on personal practice. The Pediatric Emergency Medicine (PEN) rotation can be utilized to prompt and teach the use of reflection to improve individual practice. Hypothesis: The PEN Rotation Opportunity Patients evaluated and discharged to outpatient follow up by residents may return to the ED soon after discharge. These bounce-back clinical encounters present an opportunity for residents to improve quality of care through reflection and practice-based learning in domains such as clinical reasoning, patient management, communication, patient discharge education and anticipatory guidance. Methods: Pediatric residents at a large urban children’s hospital were included in the study. A data report of patients who were discharged from the ED and subsequently returned for re-evaluation within 48 hours (‘bounce-back visits’) was generated. Pediatric residents providing the care for these patients on the initial visit were identified and sent an email that informed them of the patients return to the ED and included an exercise in reflection consisting of several directed questions to facilitate reflection on their practice. Residents were invited to consider reasons for the return visit, potential for changes in practice that might have improved outcome, and specific learning points acquired through their reflection. Results: During the initial 15 month pilot period, there were a total of 284 ED ‘bounce-back’ patient visits for which at least one pediatric resident was the provider during the initial visit. A total of 289 reflective exercise emails were sent to 103 of 131 different pediatric residents who rotated in the ED during the pilot period with a response rate of 67% (195/289). Feasibility and qualitative data on ‘depth’ of resident reflection will be presented. Conclusion/Significance: ED ‘bounce-back’ visits provide pediatric residents an opportunity for using reflective practice and can incorporate elements of self-directed learning and develop competency in the domain of Practice Based Learning and Improvement.

49. ESTABLISHING STANDARDIZED EXPECTATIONS FOR MILESTONE LEVELS BASED ON TRAINING YEAR
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BACKGROUND Within our institution, the faculty use of ACGME milestones for evaluation of pediatric residents has demonstrated poor consistency. Our faculty tended to use the milestones as a Likert scale rather than reading and utilizing the verbiage for milestones. OBJECTIVE Our aim was to establish standardization around expected levels for each milestone based on resident year to create a more robust and valid resident evaluation process and produce more useful information for the CCC to assign milestone levels. METHODS Twelve CCC members (9 faculty members, nurse manager, chief resident, and program coordinator/manager) participated in the study. Each member was asked to consider the verbiage and rate each milestone level as action plan needed (red), area for improvement (yellow), or on target/excelling (green) based on training year. The data were averaged, and based on rich discussion and a modified Delphi method of review, norms were agreed upon. RESULTS Overall, there was high correlation by the CCC participants and the Delphi method of establishing norms was seamless. Not surprisingly, the pattern of expectations did vary by milestone and training year. Many subcompetencies had no red/action plan level for interns while for others (PROF and ICS domains), even a level 1 milestone was considered cause for an action plan. Attainment of midpoint milestone (level 3) was considered successful for third year residents in some subcompetencies. A few levels were designated orange, inferring that at the beginning of a training year it may be an area of concern, but by the end of the year it would be an area for an action plan. CONCLUSIONS Our CCC was successful in establishing a set of standard expectations of resident performance by training year using the subcompetency milestones. These standards are now being used for faculty development in resident assessment. We anticipate more accurate and efficient use of the subcompetency milestones in resident evaluation and feedback. Finally, we hope to submit this body of work to be considered for a national LEARN collaborative.

50. A CURRICULUM TO IMPROVE PEDIATRIC BOARD PERFORMANCE BASED ON SMALL GROUP TEACHING METHODOLOGY
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Background: Resident performance on the pediatric board exam is a major focus and concern of residency programs and is used by the ACGME as a marker of quality. The Cohen Children’s Medical Center’s faculty, after a series of sub-optimal resident pass rates, sort to create a curriculum based on small group teaching methodology to improve their resident’s performance on the boards. Objective: To create a longitudinal 3 year curriculum to enhance board performance. Methods: In 2009, the faculty created a 3 year, small group curriculum in an attempt to improve the resident’s knowledge as reflected on a board exam. This program included the following components. (1) A requirement that all residents read the journal “Pediatrics in Review” and complete the associated questions. (2) All
PGY2 residents participated in weekly 1 hour, “Teaching at Two” small group review session facilitated by a faculty mentor. These weekly sessions followed the ABP curriculum and included a pre-reading assignment, a pretest, and 40 topical PREP questions. The sessions were led by a resident team leader. The sessions met every day to allow universal attendance. (3) All PGY3 residents met twice/week for 1 hour, in lieu of morning report, with the PD to review the topics covered on the ITE for the past 3 years. During each session a resident provided a written overview of 10 topics featured on the ITE before the session and led an interactive discussion during the session.

Results: The board performance improved significantly following the institution of this program. The pass rate at CCMC for the past 5 years (3 years without the curriculum and 2 years with the curriculum) were: 2009-72%, 2010-64%, 2011-72%, 2012-90%, 2013-93%. The first residents who participated in the program took the boards in 2012. Approximately 30 residents took the exam each year. In 2012 & 2013 only 2 residents failed the boards. Conclusion: A 3 year focused board preparation program which centers on small group teaching, the ABP curriculum, PREP and previous ITE topics can enhance a residency program’s board pass rate.

51. TOO MANY APPLICANTS, TOO LITTLE TIME; USE OF SHORT VIDEOS IN THE APPLICANT BREAK ROOM TO HIGHLIGHT UNIQUE RESIDENCY TRAINING OPPORTUNITIES
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Background: Three of the most frequently asked questions by Medical College of Wisconsin pediatric intern applicants are about global health, advocacy and research opportunities. The faculty in charge of these areas are not always able to meet with each interested applicant. Further, attempts to provide all faculty interviewers with sufficiently detailed information about the opportunities have been met with mixed success. Objectives: To use technology to more efficiently and effectively share key information about the residency program’s unique global health, advocacy and research opportunities. Methods: Given the need to target a large audience (280 applicants) with limited faculty resources, we worked with the leaders in these three areas to create brief videos describing their respective training programs (a 3-year Global Health Track; a 1-month Community Advocacy rotation; and research support through the Children’s Research Institute). These videos ran in a continuous loop in the applicant break room allowing intern applicants to virtually meet key faculty and contact them via email if desired. Results: We invited all MCW intern applicants to complete a post-match survey. A total of 68 applicants (24%) responded to the question, “Did the videos provide you with useful information about these programs?” 78% responded yes and 22% responded no. Applicants were polled regarding the biggest influence(s) to them going into the particular program they matched: 82% cited specific training opportunities (global health, advocacy, and research). Conclusion: Showing videos that answer frequently asked questions provides intern applicants with a novel and virtual way to learn about unique training opportunities and meet the affiliated faculty. Based on initial data, using video presentations appears to enhance the interview experience, and potentially promote intern recruitment.

52. USING OBSERVATION TO IMPROVE SAFETY AND THE PATIENT EXPERIENCE
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Improving patient safety and experience is integral for providing high quality care. Physicians underreport errors and inefficiencies in part due to poor role modeling and inexperience. To enhance pediatric residents’ understanding of patients’ experiences and increase identification of errors and inefficiencies, a direct observation exercise was piloted. Methods: During the 2014-2015 academic year, pediatric interns at Phoenix Children’s Hospital observed patients during outpatient primary care visits. Patients were randomly selected to participate; participation was voluntary. An observation tool guided observers to identify factors related to communication, work- arounds/errors, efficiency, and professionalism at each phase of the encounter. Residents were prompted to identify quality improvement steps based on their observations. Results: After piloting the curriculum for 2 months, 8 patient encounters were directly observed at each phase of the visit: mood upon arrival, registration, intake, trainee and supervising interviews, waiting intervals, and the discharge process. Many factors contributed to both positive and negative experiences. While no sentinel events were reported, several inefficiencies and miscommunications were. Examples include a 40 minute interval between resident and supervising interview, inability to determine home medications, inefficiencies related to translation services, and a discrepancy in desired and available follow up. Each resident clearly communicated quality improvement steps based on their observations. Conclusions: Direct observation of a patient encounter is feasible in a primary care teaching practice. Residents, even early in training, are able to identify positive and negative factors affecting patient experience and safety. Using a structured yet open-ended approach, interns can reflect on observations to determine quality improvement steps. After further implementation, this curriculum may raise awareness for the many aspects affecting a patient’s experience and foster an environment where reporting errors and barriers is encouraged as a means for improvement.
53. EXPLORING THE VALUE OF JUST-IN-TIME TEACHING ON A BUSY INPATIENT PEDIATRICS ROTATION
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BACKGROUND Just-in-Time Teaching (JiTT) is a teaching and learning strategy currently utilized in classroom-based settings. JiTT focuses on independent web-based study completed shortly before class, allowing more active learning during the class period. In current graduate medical training, duty hour restrictions decrease opportunities for face-to-face, lecture-based education for residents by experienced physicians. There is no literature describing JiTT in a clinical setting. OBJECTIVE Our objective was to explore resident perception of a JiTT model on a busy, high-acuity inpatient pediatric hematology/oncology (H/O) ward. METHODS Four e-learning modules were created using Articulate software. Modules focused on high-yield, clinically relevant topics likely to be encountered and were limited to 15 minutes in length. Modules were not mandatory, but offered as supplemental learning tools. 13 weeks (three rotations) after introduction of the modules, electronic surveys evaluating resident perceptions were given to all residents who completed at least one module. Narrative feedback was also solicited. RESULTS 18 residents (12 PGY-1, 6 PGY-2) completed the 4-week service during the trial period. 12 residents (11 PGY-1, 1 PGY-2) voluntarily completed at least one module. 8 residents responded to the survey. 7/8 residents found modules useful, and worthy of recommendation to others. 7/8 residents found this learning strategy worthy of expansion to other rotations. 1 resident identified other learning methods as preferable to e-learning modules. 6/8 residents found modules easy-to-use, with 2 residents having technical difficulties. 5/8 residents found modules feasible, while 3 had concerns about time for completion during working hours. CONCLUSIONS We concluded that JiTT was more utilized by first-year than senior residents, was favorably received and viewed as a valuable learning resource. This pilot data supports the expansion of this resource to include more modules on clinically relevant topics in H/O as well as in other resident rotations.

54. IMPROVING THE TRANSITION FROM RESIDENCY TO FELLOWSHIP: RECOMMENDATIONS FOR A DELAYED START DATE BY THE COUNCIL OF PEDIATRIC SUBSPECIALTIES (COPS)
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INTRODUCTION: Residents are under contract until June 30, yet fellowships typically begin July 1, creating great difficulty for those who must relocate to another city. Furthermore, many residents are required to attend orientation before July 1, leading to scheduling problems and anxiety for residents and categorical program directors (PD). METHODS: CoPS convened a multi-specialty Action Team (AT) to address these problems. The AT was comprised of individuals representing residency and fellowship program director (FPD) organizations from internal medicine, pediatrics and surgery and DIOs. The group held monthly calls, conducted surveys and discussed potential solutions. RESULTS: In addressing the issue for pediatrics and with APPD collaboration, surveys of graduating residents entering fellowship (n=439) and FPDs (n=495) were conducted. Most residents (68%) were moving to a new city and 39% were required to attend orientation before June 30. Residents were divided in preferring a July 7 (38%) and July 15 (39%) start date, with fewer selecting July 1 (8%) and August 1 (17%). Half of the FPDs did not think the current date was an issue and 28% initially selected July 1. However, when provided with the resident preferences, only 18% favored July 1 and 82% preferred July 7 or later. As a result, the AT recommends: 1) beginning with the 2017 appointment year, pediatric subspecialty fellowships should start no earlier than July 7, 2) orientation for new fellows should not be scheduled before July 5, and 3) implementation should involve an educational campaign that increases FPD awareness of the problem and clearly communicates the desires of the trainees. CONCLUSIONS: Upon implementation, these recommendations should alleviate the difficulties faced by trainees and residency PDs without adversely affecting trainee income or health insurance (available retroactively through COBRA, if needed). Although most FPDs favor a July 7 date or later, no single organization regulates the start date, so implementation will require support of the pediatric GME community.

55. IMPLEMENTATION OF A 4+1 MODEL IN PEDIATRIC RESIDENT EDUCATION
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Background: In traditional Pediatric Residency training, residents attend continuity clinic (CC) one half-day per week. They spend half their day on inpatient and elective duties then leave for CC. This does not imitate work duties of primary care attendings and can be in direct conflict with training recommendations to minimize transitions in patient care, decrease signouts and maximize primary care exposure. This is disruptive to resident work flow, increases transitions of care and can lead to a fragmented educational experience. While the intention of the half-day per week CC model was to improve resident education and experience in primary care, it actually leads to increased signouts, cross-coverage, and disruption of electives and CC. Internal Medicine programs have implemented a 4+1 schedule, which addresses these issues. This model could be beneficial for Pediatric education also. Objectives: Implement a 4+1 model to: 1. Increase number of CC sessions to improve primary care experience 2. Decrease number of signouts to improve patient safety 3. Maximize time in electives Methods: We redesigned our schedule to a 4+1 block model. Residents do 4 week inpatient or elective blocks followed by 1 week of CC. Interns have 6 CC sessions, 1 downtime session and 2 other (i.e. subspecialty clinic) sessions per CC week. PL2/PL3s have 5 CC sessions and 4 sessions in Adolescent Medicine or Behavior/Development as a longitudinal experience. All residents attend a half day lecture weekly. We compared schedules from 2013-2014 to 2014-2015. Results: Total CC sessions increased by 28%. Adolescent and Behavior/Developmental sessions increased by 35%. Signout due to CC was reduced by 84.5%, leading a 12% total decrease in signouts. Cross coverage was reduced by 100% and post call days decreased by 97%, leading to 10% increase in elective time. Conclusion: 4+1 block scheduling is an efficient...
model that 1. Significantly increased total CC sessions/year. 2. Increased exposure to Developmental and Adolescent Medicine. 3. Significantly increased elective time. 4. Significantly decreased transitions of care. We are currently assessing resident satisfaction and tracking continuity of CC patient care.

56. PEDIATRIC AND PSYCHIATRIC COLLABORATIVE CARE CLINIC: TRAINING PEDIATRICS RESIDENTS
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Objectives: Collaborative care between pediatricians and child and adolescent psychiatrists (CAPs) is critical, given the shortage of CAPs and resulting need for pediatricians to provide mental health care. At University of Michigan, we sought to improve comfort with diagnosing and treating psychiatric illness by providing a training opportunity in which pediatric residents evaluate patients with mental health issues under direct supervision of a CAP. We also aimed to decrease wait time from referral to evaluation, compared to that in the psychiatric ambulatory clinic. Methods: Residents took pre- and post-rotation surveys to determine prior experience with mental health and comfort level in diagnosing and treating ADHD, depression, and anxiety. Patients, referred by UMHS pediatricians, were evaluated by pediatric residents and staffed by a CAP within one of our general pediatric continuity clinics. Residents rotate through this clinic once a week for a month to allow for initial evaluations as well as opportunities for follow up visits with the same patients. Since December 2013, 17 residents have rotated through this clinic, providing initial evaluation and follow up for forty patients. Results: Pre-test survey revealed low prior experience with mental illness and comfort level diagnosing ADHD of 37%, depression of 27%, and anxiety of 14%. Post-test survey revealed increased feeling of expertise and increased comfort level with diagnosis: ADHD (75%), depression (75%), and anxiety (50%). Time from referral to evaluation was 1-3 weeks, compared to 2-3 months in the ambulatory psychiatric clinic. Conclusions: We present a unique collaborative clinic between Child Psychiatry and Pediatrics, in which patients with suspected mental illness are seen by Pediatrics residents while supervised by a CAP. Although the clinic is still quite new, preliminary results from pre- and post-clinic surveys demonstrate increased comfort and experience with diagnosing ADHD, depression, and anxiety after the rotation. Wait time to be seen was decreased from 2-3 months to 1-3 weeks.

57. CARE OF THE CHILD WITH MEDICAL COMPLEXITY: A MULTIMEDIA, WEB-BASED CURRICULUM FOR PEDIATRIC RESIDENTS
Background: Recent literature demonstrates increased prevalence of children with medical complexity (CMC) in US hospitals. Providing quality care to CMC requires that pediatric residents receive relevant education as part of their training. However, with multiple competing educational priorities and few resources that are specific to inpatient care of CMC, it may be difficult to incorporate this into training. Objective: To administer and evaluate a curriculum composed of multimedia learning modules and virtual simulation focused on care of CMC. Methods: This is a randomized controlled study of pediatric residents supported by the APPD 2014 Special Project Grant and will be conducted 12/2014-3/2015. The curriculum is composed of 6 self-paced, interactive multimedia modules and topic-specific literature all housed on a virtual learning platform (VLP). Participants will be randomized to 1 of 2 groups; each group will be asked to complete 3 modules and 3 sets of readings that are mutually exclusive covering the following topics: dysautonomia, spasticity, ventriculoperitoneal shunts, tracheostomy tubes, enteric feeding tubes and pressure ulcers. Knowledge-based pre- and post-tests will be administered immediately before and after as well as 6 months after the end of the study period through the VLP. In addition, each participant will review the medical record of a fictional CMC, record a verbal hand-off, write a medical progress note and respond to a device-related emergency in a virtual simulation exercise prior to and after curriculum completion. Validated custom checklists will be utilized to assess performance during these simulated activities. Results: The modules were created using PowerPoint (Microsoft, Inc.), but were converted to Sharable Content Object Reference Model (SCORM) packages in order to allow for meaningful data capture and transfer between the online content and the VLP. Additionally, use of audio voice capture plug-in and Vignette Builder (Vignette, Inc.) allowed for a more interactive and realistic simulation of patient handoff and management of a device-related emergency. We expect preliminary data to be available for presentation. Conclusions: We anticipate high levels of satisfaction, significant impact on knowledge, and improvement in competence with this curriculum, and specifically more improvement with the interactive web-based modules when compared to the more traditional format of readings.

58. UTILITY OF A BOARD EXAM SIMULATION EXERCISE FOR PEDIATRIC RESIDENT BOARD PREPARATION
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Background: While quizzes are often used for summative assessment, increasing literature suggests quizzes used as a formative assessment can improve content retention. With the goal of helping residents acquire knowledge required to pass the American Board of Pediatrics (ABP) Certifying Examination (CE), in 2011 we implemented a series of online quizzes known as the Board Exam Simulation Exercise (BESE), now utilized at Nationwide Children’s (NCH), UT-Houston and Kosair Children’s Hospital. Our objectives are to demonstrate an association between BESE participation and scores and performance on the In-Training Exam (ITE) and ABP CE. Methods: Quiz topics consist of the ABP Content Outline divided into 23 sections covered over the academic year. Quizzes available at 2-week intervals contain 20 randomly selected multiple choice questions to be completed within 25 minutes, mimicking the format and time/question of the ABP CE. This initial analysis includes NCH residents with the opportunity to complete at least 2 years of BESE. Data collection included BESE participation and scores, ITE scores, and ABP CE scores. Results:
Data were available for 135 residents. Median number of quizzes completed per year was 15 [IQR 10-20] and yearly average BESE scores were 11.9/20 [IQR 11.2-12.8]. The prior year average BESE score significantly correlated with the final ITE score (n=79; r=0.68, p<0.0001). The total average BESE score significantly correlated with the ABP CE score (n=33; r=0.48, p=0.005). Completion of 50% or less of quizzes offered had a sensitivity of 100% and specificity of 65% for ABP CE failure (AUC=0.84). Discussion: Resident BESE scores significantly correlated with both the final year ITE score and ABP CE score. Additionally, completion of 50% or less of available quizzes showed high sensitivity but low specificity for failure of the ABP CE. The incorporation of BESE into the curriculum also resulted in increased attention and discussion about board preparation among our residents. Though additional data is needed, BESE may be a beneficial tool for pediatric resident board preparation and learning.

59. TEACHING DEVELOPMENTAL-BEHAVIORAL PEDIATRICS (DBP) TO RESIDENTS: BUILDING A FOUNDATION AND STRENGTHENING KNOWLEDGE THROUGH THE USE OF A LONGITUDINAL CURRICULUM
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Background: Research shows that 25% of pediatric clinic visits involve DBP concerns, however most residency programs only offer 1 month of DBP training. Surveys of pediatricians have consistently reported insufficient DBP training during residency relative to DBP demands in general practice. Our training program was contributing to this knowledge gap with below average DBP subtest scores on the American Board of Pediatrics (ABP) certifying exam over a 15 year time period. Objectives: To improve resident knowledge of DBP through a stronger foundation during the core rotation and to strengthen this knowledge through a longitudinal curriculum across residency. Methods: Changes were made to the core DBP rotation in 2011 to fill knowledge gaps. A resident portfolio was added. This consisted of structured observation forms for clinical encounters and field trips, a critical review of primary care DBP screens, a resident journal club, an end of rotation exam, and pre/post-rotation self assessments. An electronic longitudinal curriculum was developed and emailed monthly throughout residency. Electronic modules included 18 DBP topics. Monthly DBP case conferences were added to the resident noon conference schedule. Subtest scores on the ABP certifying exam, PREP Self Assessment (SA) scores, and rotation self assessments were reviewed 1 year following these changes. Results: 64 pre- and 41 post-rotation self assessments were completed. Ratings of DBP knowledge improved from a mean of 1.65 (SD 0.46) to 2.65 (SD 0.38) (4 point Likert scale, p<0.001). Residents scored 77% correct on DBP topics on the 2012 PREP SA compared to an overall pediatric topic average of 60%. DBP subtest scores on the ABP certifying exam improved to 2% above the mean in 2012 and increased to the second highest among all subtest scores for our residents in 2013. Conclusions: Teaching tools that dovetail with clinical experience during the core DBP rotation along with longitudinal curricula across residency improve resident DBP knowledge.

60. DOCUMENTING RESIDENT COMPETENCE IN LEVEL-SPECIFIC CORE ENTRUSTABLE PROFESSIONAL ACTIVITIES
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Background: The ACGME procedure tracking system enables self-reported electronic quantification of procedures performed by residents, but does not provide program directors a means to ensure resident competence in the performance of those procedures. Objective: We sought a means to document resident competence in level-specific core entrustable procedural and patient care activities (EPAs) by direct faculty observation as a requirement for successful completion of each year of training. Methods: Through a consensus of resident and faculty members of the resident education committee, 27 ACGME-required procedural competencies and 30 core patient care competencies were mapped to the appropriate level of training for the New Jersey Medical School pediatric and med-peds residency programs and printed on cards color-coded for each training level. Faculty development was undertaken to ensure an understanding of the process for and significance of this assessment. Cards are distributed and discussed at orientation for each entering class of residents. Faculty attest: I have directly observed the above-named resident and certify by my signature that he/she can competently perform the documented procedure/patient care competency. Progress toward card completion is documented at the mid-year individual performance assessment by the respective Program Director. Results: Submission of the completed level-specific card is a requirement for advancement to the next PL level or, for PL-3s, successful completion of the program. With the exception of intraosseous line placement and thoracentesis, 100% of program graduates have been certified as competent in performance of all required EPAs. Completed cards are maintained in resident personnel files and submitted to hospital administration when requested to support resident performance of those activities without direct supervision. Conclusion: Documentation of competence in level-specific core EPAs by direct faculty observation is achievable and an important component of assuring resident readiness for increased supervisory responsibility and independent practice.

61. DEVELOPING VALIDITY FOR A DREYFUS-BASED ‘NOVICE-TO-EXPERT’ ENTRUSTMENT SCALE
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BACKGROUND Numerous scales have been developed to describe a learner’s performance for assessment and evaluation. Many of these scales have been based on some variation of Dreyfus’ levels of ‘novice-to-expert,’ and cover the domains of knowledge, autonomy, and coping with complexity, to name a few. While there has been a movement to adopt Entrustable Professional Activities as a means to assess a resident’s entrustment toward proficiency with the hope that these will map reliably to Subcompetency Milestones, there exists no validated Dreyfus scale equivalent for entrustment. OBJECTIVE Our primary objective was to establish a Dreyfus-based ‘novice-to-expert’ entrustment scale that could be used to map EPAs to Competency-based Milestones. METHODS We reviewed the literature of Dreyfus-based scales to establish content validity. Using a Delphi method, we further refined the content by surveying Program Directors and Rotation Directors across three pediatric institutions to determine a five-level entrustment scale.
that was felt to best reflect the progression ‘novice-to-expert.’ We then established response validity by having the directors articulate their reason for rating resident according to the entrustment scale. RESULTS The following Dreyfus-based ‘novice-to-expert’ five-level entrustment scale represents the final product: 1. Resident trusted to perform this activity as an observer and/or assistant 2. Resident trusted to perform this activity under proactive, ongoing, and direct supervision 3. Resident trusted to perform this activity under indirect or reactive supervision 4. Resident trusted to perform this activity mostly independently & supervise more junior learners 5. Resident trusted to perform this activity completely independently & teach/model at level of master clinician CONCLUSION We were able to establish content and response validity for a Dreyfus-based ‘novice-to-expert’ entrustment scale using the Delphi method. This scale can be utilized as a means to map EPAs to Subcompetency Milestones.

62. A QUALITY EXPERIENCE TO IMPROVE THE PGY-1 GENERAL PEDIATRIC CLINIC EXPERIENCE
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Background: Traditionally continuity clinics train all levels of residents simultaneously under faculty supervision. Pediatric interns at CCMC, during focus group discussions in 2010-2011, reported they felt ill prepared to engage in concerns raised by parents during well child care visits. Objective: The faculty at CCMC sought to improve intern satisfaction with a continuity clinic with the use of a 1:1 mentorship model during their intern year. Methods: At the conclusion of the 20120-2011 academic year interns were surveyed on their satisfaction with their continuity clinic experience. 19 residents (of 33 total) responded. Only 21% of the respondents were satisfied with their continuity clinic. Our aim was to improve resident satisfaction in the hospital based continuity clinic by 50% within one academic year 2011-2012. We sought to improve the intern experience by adopting a 1:1 mentorship model. During 2011-2012 academic year we instituted a revised longitudinal general pediatric clinic experience. Interns were paired with a faculty mentor 1:1 for their half day general pediatric clinic. As second year residents they joined the resident group practice which encompasses only second and third year residents with faculty supervision. Results: Upon completion of the academic year 2011-2012 interns were surveyed in regards to their clinic experience. 19 interns (of 33 total) responded. 73% of interns were satisfied with their clinic experience. 68% of interns in the previous traditional model believed that their education was compromised by pace versus 33% in the 1:1 model (p = 0.002). In addition, interns in the traditional model were less comfortable discussing general pediatric issues (breastfeeding, introduction to solids, car seat safety, child proofing home, oral hygiene, toilet training and behavioral issues) with patients and families versus interns in the 1:1 model (p = 0.001). Finally, interns in both models preferred (or would have preferred) the 1:1 mentor model in comparison to the traditional model. Conclusion: Traditionally hospital based clinic models have residents of all levels working side by side. A 1:1 general pediatric clinic experience for intern can improve resident satisfaction as well as better prepare them to independently discuss general pediatric issues with patients and families.

63. BEYOND PATIENT CARE: IMPLEMENTATION OF A TRANSITION TO PRACTICE ROTATION FOR GRADUATING PEDIATRIC RESIDENTS
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Introduction: Shifts in residency education due to duty hour and other training limitations over the past decade have led to concerns about the ability of junior physicians to successfully transition to post-residency careers. Residency programs must balance providing sufficient clinical patient care experiences with time spent teaching non-clinical, “real world” issues. Many specialties, especially in the surgical realm, have implemented various programs to better prepare trainees for life after graduation. METHODS: Our pediatric residency program designed a mandatory four-week Transition to Practice rotation which all of our graduating residents completed during June, 2014. Program leaders, residents, and faculty collaborated on the curriculum outline which centered on five main categories of experiences: military unique medical issues, the business of medicine, quality improvement/patient safety, personal/professional development, and general pediatric board preparation. All 12 residents that completed the rotation were surveyed afterwards to determine resident satisfaction with the rotation and potential areas for improvement for future classes. RESULTS: Overall, the new rotation was well received by residents with 25% rating it “above average” and 75% “outstanding” (4 and 5, respectively, on a 5 point Likert scale). CONCLUSIONS: Dedicated end of pediatric residency training in Transition to Practice topics provides timely education to those preparing to enter the workforce at a time when they are the most motivated to receive such training. Our rotation was rated highly by our trainees and considered a beneficial use of their final month of residency. Our experience provides a framework for other programs interested in implementing a similar rotation.

64. THE WELL RESIDENT: A NOVEL CURRICULUM ADDRESSING RESIDENT BURNOUT.
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BACKGROUND: Doctors at every stage of training face significant burnout due to chronic stress and minimal self-care. Despite this, there are limited opportunities to help trainees make space for wellness during residency. The long-term consequences are alarming, including substance abuse, depression and suicide. The Well Resident Program at Oregon Health & Sciences University (OHSU) is a large-scale attempt to prevent burnout by integrating a wellness curriculum across primary care residencies emphasizing balance and personal health. DESIGN/METHODS: The program began in 2014 in the primary care residencies only. There were five, one-hour long lectures given during the work day on sleep, nutrition for high intensity lifestyles, cooking and food culture, yoga, and mindfulness based stress reduction. Topics were selected based on local professional expertise along with
identification of modalities that would best serve residents. Presenters were intentionally chosen to provide a unique perspective from outside of the medical community. Each lecture included take home gifts donated by local companies (bedtime tea, Fuel bands, and granola). A validated wellness survey was used with the pediatric intern class pre, mid and post curriculum. Additional surveys for quality monitoring were given at each lecture, in each department, to provide specialty specific data to inform future program development. RESULTS: Pilot lecture survey results showed very enthusiastic responses with attendance exceeding usual conference numbers. Lectures scored 4-5/5 on a Likert scale for overall value of the presentation. Almost 100% of residents wished to have the lecture repeated in the future. Resident comments included: “She provided useful information for our lives, but also good information that we can give to patients” and “It was great to have time in the day to receive, practice, stretch and breathe”. CONCLUSIONS: Physician burnout is inadequately addressed in medical training. Early intervention is the key to change. The Well Resident is an innovative solution with profound potential implications including significant improvement in resident happiness, improved job satisfaction, and better patient care. This model can easily be replicated at other institutions.

65. A DAY IN THE LIFE: A NEIGHBORHOOD TOUR IMPACTS PEDIATRIC RESIDENTS’ PERSPECTIVES

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BACKGROUND: Poverty is widespread in the United States, adversely affecting health outcomes. Impoverished neighborhoods are often characterized by social, economic, and environmental risk factors for health inequalities, yet residents know little about their patients’ neighborhoods. Developing effective training strategies for this educational gap are critical. Objective: Assessment of residents’ familiarity with the daily experiences of families living in an impoverished neighborhood following an innovative educational intervention. Methods: A neighborhood-based immersion experience developed de novo included a self-guided 3-hour tour of a local community. The neighborhood was selected given its close proximity to the medical center and its high rate of poverty. Sites visited during the tour included: a family’s apartment building, local elementary school, pediatric primary care office, pharmacy, corner store, outdoor playground, and recreation center. The experience included a written guide, mobile viewing of simulated clinical encounter, discussion with the school’s principal, and concluded with a 1-hour debriefing session. Impact of the curriculum was assessed through completion of anchored response pre-post competency-based self-assessments, open-ended questions, and facilitated group discussion. Change in self-assessment was assessed using McNemar test statistics. Results: Forty-one pediatric residents participated. After completion of the neighborhood tour, self-assessed recognition of community assets and barriers, knowledge of resources, and recognition of hardships experienced by impoverished families all significantly increased (all p<0.01). Residents’ self-perceived competence in providing tailored anticipatory guidance significantly improved as well (9.8% to 61%, p<0.01). Conclusions: Research is increasingly demonstrating a link between neighborhood factors rooted in poverty and health outcomes. Educational experiences such as this neighborhood-based immersion curriculum may be an effective introduction to community assets and barriers and highlight the link between neighborhood and health.

66. LEGISLATIVE ADVOCACY CURRICULUM FOR PEDIATRIC TRAINEES

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BACKGROUND: Advocacy at the legislative level is critical in improving child health. Training aids in the creation of lifelong advocates. ACGME mandates residency advocacy training; however limited evidence exists for the most effective approaches to providing these training experiences. OBJECTIVE: To implement and evaluate a legislative advocacy curriculum for pediatric residents. INTERVENTION: A longitudinal curriculum in pediatric legislative advocacy which included various legislative experiences was implemented over the course of an academic year. Experiences included: monthly legislative updates, online AAP Advocacy Training Modules, legislative advocacy journal club and noon conference lectures. A portion of residents also participated in hands on advocacy experiences; Texas Pediatric Society Legislative Advocacy Day and a community lecture series. EVALUATION: A likert scale assessment survey measured self-reported pediatric legislative advocacy knowledge, attitudes, and practices pre and post intervention. In addition, evaluation surveys were conducted exploring the impact of individual experiences. RESULTS: There was a 27% increase in self reported understanding of legislative advocacy as well as a 28% increase in insight into the role of the pediatrician. There was a smaller increase in self-reported likelihood of participating in legislative advocacy during training and beyond, self-reported comfort contacting legislative officials and utilizing media. There was also an overall increase in reported legislative advocacy participation. Residents who participated in the hands-on advocacy experiences expressed even greater understanding of legislative advocacy and the role of the pediatrician. They also reported being more comfortable contacting government officials and more likely to participate in legislative advocacy during training. CONCLUSIONS: A longitudinal curriculum in legislative advocacy has a positive impact on pediatric residents. Hands-on legislative experiences are particularly influential and should be incorporated into pediatric residency training.

67. RESIDENTS WITH PHYSICAL DISABILITIES: REMOVING BARRIERS THROUGH AN ADAPTED CURRICULUM

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INTRODUCTION: Most programs lack experience with residents who have identified disabilities causing generalized uncertainty about outcomes. Yet, more trainees with disabilities are joining residency programs. These residents may need reasonable accommodations to meet the ACGME’s six core competencies. However, the ACGME does not outline strategies for an adapted curriculum. INTERVENTION: We have identified guidelines based on current literature and the personal experiences of several young physicians with physical challenges, including one of our second year residents who uses a power wheelchair for all mobility:

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1. Establish a GME Disability Services Coordinator trained to oversee all accommodations.
2. Provide ADA-compliant teaching and patient care areas, including call rooms.
3. Perform a walkthrough with trainee of patient care/work areas to identify accommodations needed prior to the start of each clinical block.
4. Provide special supplies needed, such as lowered procedure stands and a wireless phone.
5. Provide environmental modifications needed, such as powered door openers.
6. Ensure available inpatient staff to assist with simple tasks, such as positioning of crib rails, especially as teams prepare for morning rounds.
7. Modify procedural competency skills pertinent to trainee’s long-term goals and allow for physical assistance; independent knowledge of all skills is to be shown.
8. Awareness of potential for increased fatigability when creating work schedules.

OUTCOME: Our second year resident successfully completed her intern year with many of these interventions. However, ongoing challenges exist. A coordinator to oversee disability accommodations for trainees has not been established; and due to budget restrictions, some environmental modifications have been delayed. CONCLUSION: A formalized curriculum for residents with disabilities would ensure needs are met and that the ACGME’s six core competencies are fulfilled. Also, a national mentoring network that focuses on career counseling for trainees with disabilities is greatly needed.

68. DEVELOPING A DELIBERATE PRACTICE MODULE FOR ACCELERATING FORMATION OF ORGANIZED KNOWLEDGE AMONG TRAINEES
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Two significant ACGME changes have been duty hour restrictions and the transition to milestones as a measure of a trainee’s trajectory towards competence. Both will have a substantial impact on a trainee’s timely development of the crucial skills required for the diagnostic expertise critical to providing quality and safe patient care. Cognitive and expertise research have delineated two means to this end: deliberate practice (DP) and the development of organized knowledge i.e. illness scripts. Successful DP is effortful, repetitive training of key skills with immediate and corrective feedback. Trainees should engage in DP by undertaking clinical encounters and subsequent feedback from supervising faculty. In the setting of limited duty hours and decreased patient encounters, the opportunities for successful DP have diminished and need to be attained by novel modes of learning. An illness script is an efficient cognitive structure which organizes the epidemiology, salient features, and temporality for a given disease. This form of organized knowledge defines diagnostic superiority among expert clinicians. Illness scripts, however, must be constructed by an individual learner and cannot be transmitted mind to mind via traditional educational methods. We have created a novel, computer-assisted DP module based on pediatric diseases resulting in respiratory distress. For each case, the learner selects a diagnosis, receives standardized feedback on the correct diagnosis, and then creates an illness script with a subsequent expert script for comparison. In addition to this real-time feedback, the module provides learning curves, a graphical relationship between the learner’s effort and learning achievement, to promote self-directed learning. Learning curves have often been used in education research but not in day-to-day clinical learning. The analyses of group learning curves (i.e. effort, rate, direction and maximal potential of learning) can be beneficial to education management by instructors. We will pilot, evaluate, refine, and study this DP module as a prototype for broader clinical context.

69. ENGAGING RESIDENTS IN PATIENT SAFETY & QUALITY IMPROVEMENT: CHANGING THE CULTURE
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In order for a healthcare organization to have a robust patient safety culture, staff at all levels must be invested in creating a safe patient care environment. Residents are at the frontlines of patient care, ideally positioned to recognize errors and improve shortcomings, but successfully integrating graduate medical trainees into this work has not been well described. We instituted a multifaceted strategy to engage our residents in patient safety and quality improvement work, and to empower them to recognize and report errors. Our strategy hinged on the integration of patient safety and quality improvement into regular daily activities. This included instituting a longitudinal curriculum of didactic sessions and workshops focused on patient safety and quality improvement, discussing safety events at sign-outs and daily rounds, designating a chief resident for patient safety to serve as a liaison between the patient safety team, hospital leadership, and residents, creating interdisciplinary resident conferences to discuss safety issues and experiences with errors, integrating residents into hospital-wide quality improvement projects and initiatives, and the creation of an easy-to-use error reporting system. We used event reporting by residents as our primary outcome measure. Before the implementation of this strategy, there were 2-4 event reports per year filed by residents. We began implementation with our didactic curriculum in July 2010, and we expanded the strategy to include all of the components described above by July 2013. There were 386 event reports filed by residents at our institution between July 1, 2013, and June 30, 2014. As a result of our efforts, we have greatly improved the patient safety culture at our institution. Institutions must reach out to trainees in patient safety and quality improvement work. Trainees value this exposure, and can become ambassadors for patient safety.

70. RESIDENT SCHOOL: TRANSITIONING A SMALL COMMUNITY-BASED PEDIATRIC RESIDENCY FROM DAILY NOON CONFERENCE TO A BLOCK DIDACTIC FORMAT
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The pediatric residency program at Jersey Shore University Medical Center is a community hospital-based program comprised of eight residents per year and no fellows. Prior to July 2014, our major resident didactic sessions were daily one hour noon
conferences. Due to increasing patient care responsibilities, a survey of housestaff showed that approximately 78% felt that residents were missing noon lectures due to inpatient clinical obligations. Additionally, 92% of housestaff felt that they were late to afternoon clinics due to these sessions. To ensure protected educational time and improve quality and satisfaction, we transitioned to a four hour block didactic format (Resident School) during which our faculty, outpatient nurse practitioner, and PGY4 chief resident assumed all clinical responsibilities. This allowed us to conduct expanded educational activities/dedicated board review with more resident participation. After six months, we surveyed our residents to evaluate any change in their perspective with this new curriculum. Outcomes: 14 of our PGY-2 and PGY-3 pediatric residents who participated in both noon conferences and Resident School prior to and after July 2014 were eligible for this study. All 14 residents completed both pre-block and post-block didactic surveys. One resident (7%) felt the new didactic sessions interfered with inpatient clinical care. Residents were also more satisfied with faculty presentations (88%) and participation (79%) in Resident School. Since starting Resident School, 93% of residents felt they were never/rarely late to afternoon continuity clinic and only one resident (7%) reported missing their block lectures, all or most of the time, due to inpatient clinical obligations. Further data will be collected to evaluate change in the perception of this curriculum by our faculty as well as any improvement in the medical knowledge of our residents. We believe this is one of the first descriptions of this format implemented successfully in a small, community-based pediatric residency program with positive feedback from our residents.

71. MAKE A DECISION CONFERENCE: FACILITATING AUTONOMOUS PATIENT CARE
Kevin Overmann MD, Keith Ponitz MD, Martha Wright MD, Ross Myers MD, Allayne Stephens MD, Michael Platt MD, Rainbow Babies & Children’s Hospital, Case Western Reserve University School of Medicine, Cleveland, OH

Background: National standards for pediatric residency training specify that residents should progressively develop autonomous patient care skills, ultimately leading to proficient independent clinical practice. Recent literature suggests that work hour limitations, coupled with increased supervision in clinical realms, may be leading to decreased opportunities for residents to make independent clinical decisions and critically appraise their own management. Purpose: We describe an innovative educational activity designed to improve resident progression to independent practice. This activity creates a supportive environment in which residents exercise simulated autonomous decision-making and are held accountable for real-time peer review and faculty comments. Description: This activity consists of a weekly small group session composed of five residents and a faculty facilitator. The facilitator presents a particular case that highlights a diagnostic dilemma or challenging management decision. Simulating unsupervised clinical care, residents are prompted to commit to a detailed independent diagnostic and management plan based on the case. Subsequently, each resident shares their plan with the group and justifies their decisions which are critiqued by peer and facilitator review. The facilitator concludes the session by emphasizing salient learning points. Implications: By simulating the accountable autonomy of clinical rounding in a didactic session, this activity fosters skills that lead to proficiency in independent clinical practice and at the same time fulfills several aspects of ACGME program requirements. These include working towards proficiency in patient care, medical knowledge, practice-based learning, regularly scheduled didactic sessions, and improved ability for meaningful peer to peer evaluation. Unlike many other types of didactic sessions relying on passive learning or limited participation, this activity requires each resident to fully engage in critical clinical thinking. This activity is adaptable to multiple educational settings and to multiple levels of learners.

72. AN EVIDENCE-BASED RESOURCE UTILIZATION RESIDENT CURRICULUM
Binny Chokshi MD, Children’s National Health System, Washington, District Of Columbia

Background: Despite an Accreditation Council for Graduate Medical Education (ACGME) directive to incorporate considerations of cost awareness into the training of new physicians, it is estimated that fewer than 70% of graduate medical education (GME) programs have formalized training in stewardship of finite resources. Design/Methods: The curriculum consists of monthly hour-long diagnosis and case-based sessions during Pediatric Residency noon conference. In small groups, trained facilitators guide residents through a patient case calling attention to evidence-based guidelines as residents make management decisions. Costs from the hospital’s charge master are assigned to each medical decision made. Then facilitators compare total costs across concordance testing (SCT) assesses for changes in clinical reasoning based on the interactive conference. A panel of reference experts also completes the SCT assessments, serving as baseline comparison. Post-session feedback forms evaluate learners attitudes to the sessions and toward individual awareness about costs of care via Likert scale (1 to 5, 5 being strongly agree) and free text response. Results: In a pilot session on bronchiolitis, participants (n=38) felt the conference promoted awareness about costs of medical care (mean Likert score 4.69), encouraging critical thinking about management decisions (mean 4.69). Comments noted desire to increase use of evidence-based guidelines and that the information might influence future decision-making. Data analysis of the SCT assessments is in process to determine the session’s effect on resident clinical decisions. Discussion: With rising costs of medical care, GME curricula must incorporate cost awareness considerations. Trainees demonstrate positive attitudes toward an interactive evidence-based conference focusing on concepts of resource utilization and high value care. Further study is needed to determine the effect of such a curriculum on changes in trainee practice.

73. EMPOWERING LEARNERS WITH PATIENT SAFETY SKILLS: AN INTEGRATED CURRICULUM FOR RESIDENT ENGAGEMENT AND EDUCATION
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Residency programs must provide experiences that train learners and entrust graduates to deliver safe and high quality care. Evidence suggests that engaging residents in hospital patient safety activities remain a challenge. We introduced a resident curriculum, aligned with the Clinical Learning Environment Review Pathways to Excellence, offering a platform for senior
residents to contribute to hospital activities and disseminate patient safety principles to peers. All senior residents attend monthly meetings of our hospital’s patient safety committee, which includes faculty, administrators, and interprofessionals. Committee activities include root cause analysis discussions, high level investigation reports, and strategies for systemic improvement. Each resident delivers a brief patient safety topic presentation and receives direct feedback relevant to ongoing hospital activities from committee members. The resident subsequently shares the presentation with peers and reviews systemic patient safety principles, cultivating further discussion and familiarity among learners. A questionnaire assessing the experience was distributed to residents and committee members. Our results showed that while the majority of residents have participated in patient care that may have involved a medical error, only half have ever formally reported an error. Residents who have participated in the curriculum felt more comfortable analyzing the cause of an error, reporting an error, and disclosing errors to families. Committee members noted that resident participation contributed to a culture of safety at our medical center and that residents needed additional training in patient safety reporting. An integrative experience involving committee participation and peer discussion was a successful method of empowering learners to become future leaders and stewards of high quality care and of attaining patient safety knowledge, skills, and attitudes. Areas needing improvement include engaging more junior learners and faculty, simulation based training, and strengthening education on error reporting mechanisms.

74. TEACHING CHILD ABUSE PREVENTION STRATEGIES TO RESIDENT PHYSICIANS


Background: Child abuse is a ubiquitous problem with personal, interpersonal and social consequences. Risk factors for child abuse are well established, and preventive strategies have been effective in decreasing abusive parenting behaviors and child maltreatment incident reports. Curriculum tools are needed to incorporate these strategies into training programs so physicians are adequately trained to prevent and identify child maltreatment at the earliest possible opportunity. Design/Methods: Literature review established core content for the curriculum. Resident learning needs were assessed with an online survey sent to graduating residents and teaching faculty to estimate residents’ knowledge, skills and attitudes related to child abuse prevention. Curriculum objectives were composed to target the core content and to address the learning needs of the residents. Adult learning theories were applied to design interactive workshops to meet the curriculum objectives. A qualitative assessment tool was distributed to participating residents pre- and post-curriculum. Evaluators were blinded to pre-/post-status. Follow-up surveys 3 months after the curriculum evaluated for retention of the material, and for application of the content into clinical practice. Results: After participating in the workshop, residents show greater tendency to 1) recall multiple child abuse risk factors, 2) associate a variety of somatic complaints with potential toxic stress or abuse, and 3) demonstrate an understanding of ongoing needs and risks in families affected by abuse. Follow-up surveys indicate the same trends, and most residents self-report progress toward incorporating preventive strategies into clinical practice. Conclusions: Residents became more familiar with risk factors and early symptoms of toxic stress. At 3-month follow-up, knowledge is retained and residents report some self-directed clinical practice in this area. Areas for Improvement: Concepts of 1) “trigger events” of child abuse, and 2) how age affects evaluation protocol, need to be clarified and re-evaluated in future workshops.

75. IMPLEMENTATION OF A GRADUATED, SYSTEMS-BASED DIDACTIC CURRICULUM

Jun Zhao DO, Adam H. Rosenbloom MD, Lynn Thoresen DO, UT Austin Dell Medical School Pediatric Residency Program, Austin, Texas

Background: Didactic sessions have long been a part of resident learning, although often hindered by shift-work schedules, timely attendance, discussions appropriate to level of training and interrupted learning due to service obligations. We proposed and executed an innovative approach to didactics at our program. We had 3 main goals: 1) improve resident satisfaction 2) improve resident attendance and 3) improve the quality of resident didactics. The new format changes from noon to 7 am, and involves a two hour morning didactic session, free from clinical obligations. Interns and seniors were separated to different mornings, and allows for a graduated curriculum for different resident training levels. Objective: To assess resident satisfaction, quality, and attendance for a novel protected didactics curriculum. Methods: We conducted an online cross-sectional survey pre and post-intervention that focused on residents perceptions of their attendance, appropriateness of the curriculum for board preparation and clinical work, and overall satisfaction with the new didactic schedule. The 10 question survey was graded on a five-point Likert scale. Resident attendance for the new didactics was gathered through a sign-in system, compiled and analyzed. Attendance for the 10 months of noon conference before the intervention were compared against attendance during the 5 months of the new didactic schedule. Results: 47 (88%) residents participated in the pre-survey and 38 (71%) residents participated in the post-survey. The pre-survey score for satisfaction was 2.72 (CI: 2.58-3.00) and post-survey score was 3.92 (CI: 3.70-4.14, p < 0.05). Ability to attend lectures on time rose from 2.12 (CI: 2.05-2.21) to 3.66 (CI: 3.33-3.98, p < 0.05). Perception that lectures were appropriate for level of training, and feelings that didactics would prepare residents well for their career also rose about 0.75 points on a 5 point scale (p<0.05). Total resident attendance pre-intervention was 75% (CI: 71-78%), and post-intervention it was 87% (CI: 84-89%, p<0.05), a total improvement of 12% (CI: 9-15%). This was an improvement of 14% (CI: 8-20%, p<0.05) and 9% (CI: 6-13%, p<0.05) for the 2015 and 2016 graduating classes respectively. The class of 2017 residents have a post intervention didactic attendance at 95% (95% CI 93-97%). Conclusion: A protected didactic format and curriculum substantially increased resident satisfaction, overall quality, and attendance for a protected didactics program. The results of this format, novel at our program, reflects a national trend of the success of this model. Additional research should look at system wide effects of the change, including discharge timing and morning round length. A longer prospective study may capture better in-training exam and board pass rates. Further
interventions can improve didactic quality through a more focused curriculum and lecture material development to foster active and participatory learning.

76. IT'S CLEARLY ONE THING AND ONE THING ONLY: AN EVALUATION OF A UNIQUE PEDIATRIC MORNING REPORT EXPERIENCE
Lindsay R. Kaldor MD, Sarah E. McAndrew MD, Elizabeth Groothuis MD MPH, Robert Listerick MD, Sharon M. Unti MD, Northwestern University/Ann & Robert H. Lurie Children's Hospital of Chicago, Chicago, IL

Background: An important component of the educational content of many resident training programs is the morning report experience. Rather than planned didactic sessions, our unique format consists of spontaneous case-based presentations initiated by residents. The chief resident facilitates discussion amongst residents as well as attendings from varied subspecialties.

Objectives: Evaluate the demographics and comprehensiveness of the educational content within our morning report structure and assess resident perspective of its value. Methods: For the 2014-2015 academic year, each case presented was logged in real-time by a chief resident into a database which included: year of training of resident presenting, service from which the case originated, framework for discussion (differential diagnosis, management, visual puzzler, etc.), current diagnosis, and educational topics discussed. A retrospective chart review was performed after discharge to obtain final or ongoing diagnoses. Both diagnoses and topics discussed were coded into 1 of 35 general content categories used by the American Board of Pediatrics (ABP). Residents were surveyed about conference format and content. Results: Preliminary data from a 3-month period included 125 cases. The majority of cases were presented by a senior resident (89%). Cases originated from the general inpatient service (32%), outpatient clinic (15%), and the combined subspecialty inpatient services (53%). Framework for the cases was predominantly differential diagnosis (60%) and management (28%). 77% of ABP categories were addressed among final diagnoses and 85% were addressed in the topics discussed surrounding the cases. Preliminary survey results show a 36% response rate (n=38) with residents indicating high/very high satisfaction with the content (97%) and format (94%) of the conference. Conclusions: This unique morning report format successfully provides residents with education on the majority of general pediatric educational categories outlined by the ABP while generating a high degree of satisfaction with the format.

77. FACILITATING GRANT-WRITING EXPERIENCE IN PEDIATRIC PATHWAYS

Background: Focused pathways/tracks can provide residents with individualized learning opportunities. Grant-writing is an important component of many careers, but is not often incorporated in residency curricula. The University of Washington Global Health and Community Pediatric and Advocacy Pathways include a 4 week block early in the R2 year with a two hour session about grants designed to highlight funding opportunities and develop project ideas. The pathway month also offers structured mentor support and dedicated time to facilitate resident projects. Evaluated Attitude and Practice: We surveyed former and graduating Pathway residents from 2009-2015 to assess their experiences with grant-writing. 45 of 48 (94%) eligible residents participated. Seventy percent had no grant writing experience prior to residency. During residency, 10 of the 45 residents applied for grants, 8 of which were related to Pathway projects. Seven of the 10 grants were funded. Among funded projects, 2 papers have been published in peer-reviewed journals, 3 papers are in process or review, 5 abstracts have been presented at national conferences, and two at local conferences. Nine out of 10 of those who applied for grants responded to a question regarding influences in pursuing a grant. The most important factors they reported in pursuing grants were having a topic area of interest, project time during the Pathways, and a close collaborative relationship with a community. All survey respondents reported the grant writing session as influential. All considered the grant writing experience to be a positive educational experience. Over half of respondents consider it likely or very likely that grant-writing will be part of their career. Of the 36 former residents, 11 have applied for grants since graduation. Conclusions: Offering time, exposure and mentorship for grant-writing has allowed residents to be successful in applying for, being awarded, executing, and presenting work on grant-funded projects during residency. This approach provides a valuable educational opportunity and is important for career development for the majority of residents.

78. LEAN DAILY MANAGEMENT: DAILY RESIDENT-DRIVEN QUALITY IMPROVEMENT

Introduction: Lean Daily Management (LDM) is a process improvement strategy that engages personnel to identify and solve system-wide problems utilizing a data-driven methodology. St. Christopher’s Hospital for Children has implemented LDM hospital-wide to maximize efficiency and ensure patient safety. This innovative curriculum provides residents access to advanced training in quality improvement (QI) and integrates them into multidisciplinary hospital teams. Methods: The opportunity to integrate residents into the LDM process was realized when multiple hospital departments began their LDM efforts. A group of resident and attending physician leaders met with the process improvement team and performed a needs assessment. Two resident-led subgroups formed and developed educational and implementation strategies. Education on the principles and process of LDM was delivered through global and just-in-time training. Initial problems were identified through a survey of the residents. Implementation occurred in the fall of 2014 with goals of improving resident attendance at educational sessions and decreasing the errors in medication ordering. Results: Thus far, 32 residents have participated in daily data collection which they present on run and Pareto charts to hospital administration on the Gemba walks. During serial meetings with the leadership team, further data analysis utilizing the “5 Why” process led to revision of the key questions, thus narrowing their scope and focus. Root cause analysis promoted the development of action plans to prevent additional occurrences. Conclusions: LDM offers a unique opportunity for residents to actively participate in QI and enhance their...
personal development related to the Pediatric Milestones. This curriculum highlights efforts to promote and establish LDM within a residency program and to create a lasting paradigm shift toward patient safety and QI.

79. ASSESSING RESIDENT RECOMMENDATIONS AND PATIENT OUTCOMES IN AN AFTER-HOURS PEDIATRIC TELEPHONE TRIAGE SERVICE
Cristina E. Wedin MD, Emily Wong MD, Sarada Panchanathan MD, Phoenix Children's Hospital/Maricopa Medical Center, Phoenix, Arizona

Purpose: After-hours triage services play an integral role in residency programs, yet there is little research evaluating resident recommendations. The purpose of this study was to determine patient disposition following an after-hours call and to assess the appropriateness of the resident's recommendation based on final outcomes. Methods: Between July 2014 and January 2015, a chart review was performed for patients with after-hours calls to the triage service. Information assessed included presence of documentation, recommended disposition and presence or absence of follow-up. On a convenient sample of months, follow-up calls were conducted and included a questionnaire to determine ultimate disposition and outcome. Recommended and final disposition were compared and outcomes were assessed by determining whether treatment was required. Cases in which disposition could not be determined were excluded. Results: A total of 179 charts were reviewed. 58 of 98 families were reached by phone. Resident advice was defined as correct if advice was appropriate, incorrect for resource utilization if follow-up was recommended but not necessary and incorrect for clinical care if follow-up was necessary but not recommended. Patient outcomes were defined as optimal if intervention was not necessary or was received in a timely manner, sub-optimal in the case of overuse of resources and poor if there was a delay in care or harm to the patient. Recommended and actual disposition were the same in 81% of cases with 84% optimal, 16% sub-optimal and no poor outcomes. Disposition differed in 19% of cases with 71% optimal, 15% sub-optimal and 14% poor outcomes. Conclusion: Resident advice was correct in 76% of cases and, of these, the majority (92%) resulted in optimal outcomes. Resident advice was incorrect for clinical care in 2% of cases, yet all resulted in optimal outcomes as treatment was sought in a timely manner. In summary, the majority of the time, residents are giving correct advice, resident recommendations are followed and outcomes are optimal. However, in 22% of cases, resident advice was incorrect for resource utilization and thus represents an important focus for future improvement.

80. THE EVOLUTION OF THE RESIDENT LONGITUDINAL EXPERIENCE TO ENHANCE INDIVIDUALIZED EDUCATION: ONE PROGRAM'S PERSPECTIVE OVER THE LAST 10 YEARS
James Wilkinson MD, Vasudha Bhavaraju MD, Sara Bode MD, Brett Hurliman MD, Jon McGreevy MD, MSPH, Phoenix Children's Hospital, Phoenix, AZ

Background: In 2013, the ACGME announced new requirements for individualized education; however the pediatric residency program at Phoenix Children's Hospital Maricopa Medical Center has had a long-standing resident longitudinal experience (RLE) that has been further adapted to meet this goal. This curriculum began as an opportunity for senior pediatric residents to spend an additional half-day per week to experience primary care in a setting distinct from their hospital-based continuity clinics. Over time, fellowship-bound residents wanted the ability to use the RLE for subspecialty exposure. Here we describe the evolution of this unique experience over the past 10 years. Methods: RLE data from 2005-2015 were reviewed and analyzed. Results: Over 99% of senior residents elected to participate in an RLE. In AY 2005-06, 26 (90%) of our 29 senior pediatric residents had an RLE with a community pediatrician and 3 chose subspecialty RLEs. In the last decade, our pediatric residency program has expanded to 32 categorical spots per year, and there has been a brisk up-trend in the number of residents interested in subspecialty care. In 2015, of the current 64 senior pediatric residents, there are 17 (26%) with an RLE in community pediatrics, 3 (5%) with no RLE, and 44 (69%) in a field other than community pediatrics. The specialty RLEs themselves have progressed from purely clinical time to a combination of clinical, research, administrative, and mentorship opportunities. We have also seen further individualization and diversification of the RLE, with residents choosing areas such as pathology, palliative care, clinical informatics, public health, and refugee medicine. With the expanded RLEs has come greater oversight, including clear expectations, goals and objectives, and assessments. Conclusion: Over the past decade and now, the RLE continues to be a noted strength of our program by our residents and a highlight during recruitment. We are in the process of studying the impact the RLE has had on the ultimate career path of our graduates.

81. THE PRE-TENDING EXPERIENCE: A CURRICULUM IN SENIOR RESIDENT AUTONOMY

Objectives: Design a curriculum within the new ACGME-required Individualized Education Units (IEUs) that fosters an autonomous PL3 Senior Resident experience and increases opportunities for faculty mentorship and direct observation. Description: This IEU rotation for PL3 residents takes place on a 15-bed general pediatrics unit where PL2 residents work as the front-line ordering clinicians (FLOCs). The PL3 residents serve as a “Pre-tending” rather than in a traditional Supervisory resident role. We established a system of progressive autonomy with a portion of each week's rounds being led by the Pre-tending with Attending support and then run independently by the Pre-tending with no Attending present. On the last day of each week, the Attending observed the Pre-tending leading rounds using a Direct Observation Tool1,2 and then gave feedback. To foster mentorship, Pre-tendings worked closely with Attending Physicians through rounds, patient interactions, and General Pediatrics Divisional Conferences and hospital-wide meetings. Evaluation Data: Resident evaluation of the new curriculum (intervention, n= 5) was compared to the traditional supervisory rotation (non-intervention, n =37) using a seven question survey consisting of a 5 point Likert Scale assessing degree of agreement. Likert scale scores were treated as interval data. Welch's t-test was used to compare groups. A p-value of 0.05 was used for statistical significance. Preliminary results show the intervention group, the Pre-tendings, as compared to the
non-intervention group showed a significant difference in the following realms: increased comfort leading rounds, increased autonomy, and increased faculty mentorship. They also reported increased direct observation performing physical exams and counseling families. Lessons Learned/Generalizability: Initially, the PL3 Pre-tendings struggled with teaching to the level of the PL2 residents. Orientations with each PL3 Pre-tending helped them develop teaching techniques, and discussions with the PL2 residents encouraged their directed learning. An improvement to our current model would be more attending physician continuity during the rotation as currently they are only scheduled for 1 week of service. We believe most institutions could design a rotation to model this level of autonomy on a general pediatrics only unit. Staffing considerations include the use of PL2 residents, instead of PL1 residents, as FLOCs to elevate the role of the PL3 from supervisory resident to the Pre-tending role. Faculty development related to the modified roles of the Attending and Pre-tending physicians were key to the perceived success of this rotation, as well as regular feedback from our Attendings and General Pediatrics Physician and Nursing Leadership. 1. Newman LR, Roberts DH, Schwartzstein RM. Peer Observation of Teaching Handbook. Shapiro Institute for Education and Research at Harvard Medical School and Beth Israel Deaconess Medical Center. 2. Zenni EA, Hageman H, Palmer Hafler J, Gusic ME. Peer Feedback Tool for Clinical Teaching.

82. IMPLEMENTATION OF A RESIDENT-LED QUALITY AND SAFETY CONFERENCE

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Background: Residents are often the frontline caretakers for patients and are directly involved in providing safe and quality care, yet they are not always included in review or implementation of measures to improve quality and safety within their institutions. The ACGME CLER program has called for resident engagement in quality and safety endeavors as two of the six components which affect patient outcomes and determine residency accreditation. Quality and safety initiatives have been found to be most effective when interdisciplinary teams are involved, faculty are engaged, and residents are encouraged to take a leadership role in execution of the initiative. Methods: A monthly Pediatric Quality and Safety Conference, intended to review and analyze safety events identified on the pediatric inpatient services, was introduced in July 2014. During each rotation, all residents on the inpatient team are tasked with identifying at least one safety event in which they were involved or that they witnessed, and entering the event into a system-wide online safety net program. During the Quality and Safety conference held at the end of each rotation, residents present the events they’ve identified to their peers, medical students, and attendings. One senior resident from each rotation is designated to focus on one event in detail, and describe an intervention that has been or could be implemented to improve safety on the pediatric inpatient service. Reported events are tabulated by the Chief Residents and Program Director and stratified into error types, according to the Institute of Medicine. Results: To date, 59 residents report that they have submitted at least one error to the online safety net program and have presented their events verbally, representing 100% participation of residents assigned to the inpatient service. The event types identified most commonly include communication errors (18), avoidable delay in treatment or in responding to an abnormal test (12) and failure to employ indicated tests (8). Significance: As a result of the Pediatric Quality and Safety conference, residents on the pediatric inpatient service have quickly become engaged in recognizing and reporting patient safety events, and are motivated to become involved in the process of quality and safety improvement. As increasing numbers of events are identified and shared with residents, medical students, and attendings, there has been a “ripple effect” of increased discussion of errors in other pediatric areas of the hospital, including the ICUs, newborn care areas, and outpatient clinics. Next steps include identifying potential solutions to reported errors, re-examining implemented solutions to determine efficacy, and extending conference involvement to include residents from other clinical service areas. The Pediatric Quality and Safety Conference format has been presented at the institution’s Quality Improvement meeting and to the Graduate Medical Education Committee, and other departments are being encouraged to institute similar programs for their trainees.

83. IMPROVING CONSULTATION COMMUNICATION WITH SUBSPECIALISTS

Samantha Dallefeld, UT Austin Pediatrics, Austin, Texas, Lynn Thoreson DO, UT Austin Pediatrics, Austin, TX, Gemma Daly MD, UT Austin Pediatrics, Austin, Texas

Background: With the adoption of the Pediatrics Milestone Project 1, there is increased emphasis on communication between healthcare professionals. Effective interprofessional communication has been linked to patient safety and is an important subcompetency. Feedback from consulting physicians at our institution indicated a need to improve the quality of consult calls by pediatric resident physicians. Objective: Improve resident performance in interprofessional communication as it relates to performing consultation requests. Methods: A short survey was designed to assess consultant satisfaction with the quality of consult calls from pediatric residents and how often a specific consult question was provided. Pertinent information for effective consultation calls was collected and used to create an easy to remember mnemonic, iBrief represents introduction, background, reason for consult, (case) information, (diagnostic) evaluation and assessment, and follow up details. An educational workshop for interns was conducted and included a pre-intervention survey. Results: A 6-month post-intervention consult survey indicated an improvement in the perceived quality of consults, 14% of consults were unacceptable versus 28% prior to the intervention. There was a 9% increase in consult requests containing a clearly defined clinical question. Three-quarters of the interns surveyed felt the didactic session improved their confidence in completing a consult. Conclusion: Results indicate a structured mnemonic and dedicated intern workshop to address consult calls are helpful tools to improve interprofessional communication and improve consultants perceptions of information received during consult calls. The mnemonic provides a simple reminder for the details needed for an effective consult call. References: 1 Pediatrics Milestone Project Working Group. The Pediatrics Milestone Project. 2012. Available at: http://www.acgme.org/acgmeweb/Portals/0/PDFs/Milestones/320_PedsMilestonesProject.pdf. Accessed February 2, 2015.
84. IMPLEMENTATION AND PRELIMINARY EVALUATION OF A MULTIFACETED RESIDENT-DRIVEN WELLNESS COMMITTEE
Zoabe Hafeez MD, Andrew Wu MD, Angela Kim MD, John DeGiorno MD, Rebecca Purcell MD, Jodi Schaffer MSW, Mario Cruz MD, St. Christopher’s Hospital for Children, Philadelphia, PA

BACKGROUND: Residents have reported high rates of burnout, depression, anxiety, and suicide risk. Research is lacking regarding most effective interventions to minimize resident burnout. We report on our experience with a multifaceted resident-driven wellness committee. OBJECTIVE: To describe the format of our wellness committee, the wellness-related needs of our residents, and the preliminary assessment of the efficacy of our interventions

METHODS: Established in early 2014, our wellness committee, mentored by a program director, developed monthly activities addressing each of the following wellness areas: social (outings/gatherings), physical (sports competitions), emotional (debriefings/reflection), spiritual (mindfulness/meditation), and financial (debt reduction/budgeting). We administered a monthly, well-validated, 7-item survey (Brief Resident Wellness Profile) to 78 pediatric residents. Residents also identified two areas of wellness in which they had greatest needs. RESULTS: 58% of the residents responded to the survey. 12% had results concerning for burnout. There was no significant change in enthusiasm about career goals (75%-78% often/always enthusiastic), stress (31%-42% never/rarely stress-free), and feelings about life overall (69%-73% often/always pleased) during our initial 4-month study period. Residents were most interested in physical (60%) and emotional (49%) wellness activities. Half (51%) of PL2s and PL3s reported that the wellness committee activities improved their overall wellness, compared to only a third (36%) of PL1s. CONCLUSION: A multifaceted, low-resource, resident-driven wellness committee may improve resident wellness and mitigate burnout although results thus far are inconclusive. Senior residents seemed to benefit most from wellness committee activities. First year residents may have needs that are either not currently being met or are beyond the scope of a wellness committee. We will continue to respond to serial needs assessments and tailor specific interventions in an effort to optimize resident wellness.

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