

Example of a Highly Rated APPD Educational Scholarship Abstracts

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

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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 (26%). 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.

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.

CONCLUSIONS: 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.

Example of a Highly Rated APPD QI abstract

TEACHING TEAM INTEGRATION IN THE RECOGNITION AND REPORTING OF PATIENT SAFETY EVENTS

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Background: Medical errors are a public health problem in the United States. In addition, errors in pediatric patients are significantly underreported, particularly by physicians. The ACGME CLER patient safety pathways emphasize the role of residents and faculty in recognizing and reporting safety events. Our baseline data demonstrated that physician entries accounted for 4% of all pediatric events entered into our hospitals electronic event reporting system.

Aim Statement: We planned to increase physician recognition and reporting of safety events on pediatric services by 50% over a 9 month period.

Methods: We used the model for improvement and serial PDSA cycles to test changes that we predicted would improve physician recognition and reporting of events. The primary outcome measure was the percentage of total pediatric event reports entered in the electronic event reporting system by physicians (residents or faculty). Individual PDSA cycles studied secondary or process measures to assess tests of change or inform subsequent change cycles. Initial teaching team process changes included text

message prompted Patient Safety Rounds on teaching services and an inpatient ward Superintendent rotation with core patient safety responsibilities. We predicted that routine patient safety rounds would improve event recognition by improving communication around patient safety topics and that the superintendent rotation would improve event reporting through the integration of reporting in resident workflow. The IHI assessment scale for collaboratives has been used to track progress throughout the project.

Results: Physician reporting increased significantly in the initial 5 months of the project exceeding the improvement goal set in our aim statement (5 month mean 16%; range 2% [month 1] to 27% [month 5]). Patient Safety rounds and the superintendent rotation were tested in months 1 and 2, and the superintendent rotation was implemented in month 3. Process measures indicate continued patient safety discussions on rounds (38 to 58%) after initial test cycle, a significant increase in resident event reporting in the electronic event reporting system, but unchanged faculty reporting rates. Qualitative data collected during cycles suggest that accessibility, complexity, and knowledge of the electronic reporting system may be a barrier to physician reporting. After 5 months the project scores a 3.0 to 3.5 (modest improvement to improvement) out of 5 on the IHI assessment scale due to completion initial PDSA cycles and change in outcome measure.

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).

*This excellent QI abstract submission was selected for oral presentation at the APPD 2015 Annual Meeting in Orlando.