2019 Annual Meeting

APPD 2019
Annual Spring Meeting
including the MPPDA Annual Meeting

March 26 - 29, 2019

Expanding the Possibilities

New Orleans, Louisiana
New Orleans Marriott

*This activity has been approved for AMA PRA Category 1 Credit™
Welcome to the 2019 APPD Annual Spring Meeting!

On behalf of the Board of Directors and Spring Meeting Planning Committee, we are delighted to welcome you to our community's annual spring gathering, this year in the charming city of New Orleans. In particular, we welcome the more than 400 first time attendees and all MPPDA members who, for the first time, have incorporated their own meeting within the full APPD Meeting.

Careful and thoughtful preparation has gone into this year’s meeting planning. Recognizing that funds and time for travel to national meetings have become increasingly scarce, we have worked to highlight meeting activities that must occur in person. Our theme this year of Expanding the Possibilities strives to build on the momentum from last year’s meeting to maximize opportunity for in-person connection, collaboration and inspiration. We also continue to learn from your feedback and have worked to offer the content you have found valuable as efficiently as possible.

During our opening Plenary, our Keynote speaker will introduce “The 2020 Census: The Importance of Ensuring All Kids Are Counted”. Be sure to attend and learn how we, as educators, can help in this important process.

You will notice that we have continued to offer ample time for networking with your colleagues and content experts in all aspects of Pediatric medical education. For the first time, we have added a Grassroots Forum for our Chief Residents, joining existing Grassroots sessions for other member sections. And, recognizing that exciting work happens when people come together around shared interests, we will present an improved and more efficient Table to Able session this year (Thursday morning). This activity will feature informal discussions led by content experts on a variety of topics related to best practices. In addition, APPD’s popular Facilitated Mentoring Session, scheduled during the Facilitated Networking Lunch period on Wednesday, will provide opportunities to connect with mentors around the topics of Professional Development, Leadership Development and Personal Wellbeing.

There will be 4 time slots spread over each meeting day in which to enjoy our Enhanced Learning Sessions. These offerings will continue to allow variable formats, with a goal this year of having actionable items to take home to your individual programs.

In addition, in collaboration with Key Stakeholder organizations, we incorporated specific topics and processes of importance to our programs, our trainees and the community of patients and families we care for.

We look forward to continuing to hear your thoughts as we diligently strive to improve our program every year.

In our vital work to train future pediatricians to promote the health of all children, our community is a critical source of knowledge, expertise, friendship, support and inspiration. Our annual spring gathering is essential to our mission, and we hope and expect you to find plenty of each of these over the next few exciting days here in New Orleans.

<table>
<thead>
<tr>
<th>MISSION</th>
<th>VISION</th>
<th>VALUES</th>
</tr>
</thead>
<tbody>
<tr>
<td>The Association of Pediatric Program Directors (APPD) serves pediatric programs by leading the advancement of education to ensure the health and well-being of children.</td>
<td>Exemplary pediatric education.</td>
<td>The leadership is governed by these principles: ✓ Leadership ✓ Innovation ✓ Engagement</td>
</tr>
<tr>
<td>✓ Scholarship ✓ Collaboration</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Schedule-At-A-Glance

APPD 2019 Annual Spring Meeting
MPPDA Annual Meeting
March 26 – 29, 2019 ‣ New Orleans, Louisiana

**Monday, March 25, 2019**
8:00am-5:00pm  APPD LEAD Meeting *(LEAD Cohort Only)* Riverview II
10:00am-6:00pm  APPD Board of Directors Meeting Board Room

**Tuesday, March 26, 2019**
7:30am-12:15pm  APPD LEAD Meeting *(LEAD Cohort Only)* Riverview I
9:00am-12:30pm  APPD Board of Directors Meeting Board Room
9:30am-4:45pm  Coordinators’ Session Galerie 1-3
9:30am-5:00pm  Forum for Chief Residents Preservation Hall
12:15pm-3:00pm  APPD LEAD Council Meeting Audubon
1:00pm-5:30pm  Pre-Conference Workshops *(choice of 3 - additional fee)* (see pages 21-22)
5:30pm-6:30pm  SPIN Meeting Audubon
6:30pm-7:30pm  APPD Leadership Orientation and Reception *(invitation only)* Riverview Prefunction

**Wednesday, March 27, 2019**
7:00am-8:00am  Wellness Activity (see page 22)
8:00am-9:00am  Continental Breakfast Acadia Foyer Lounge
   LEAD Council and LC Chairs Beauregard
   MPPDA Committee Meetings I (see page 22)
   AMPPA Meeting Studio 9-10
9:00am-10:00am  Plenary Session Acadia/Bissonet
10:15am-1:15pm  Grassroots Forum for APDs Salon A-D
   Grassroots Forum for Chief Residents Acadia/Bissonet
   Grassroots Forum for Coordinators Carondelet
   Grassroots Forum for Fellowship Program Directors Salon F-H
   Grassroots Forum for Program Directors Galerie 4-5
10:15am-1:45pm  MPPDA Plenary and Town Hall with Award Ceremony *(Tunnessen and Kelley Awards) and Presidential Address* Salon E
   Facilitated Mentoring Session Acadia/Bissonet
12:30pm-1:45pm  Forum for Directors of Small Programs and Affiliate Chairs Galerie 4-5
   Coordinators’ Table Talks and Networking Lunch Carondelet
   Council of Regional Chairs Lunch Meeting Board Room
   AAMC/NRMP Focus Group *(Residency Explorer) for PDs* Studio 1-2
### Schedule-At-A-Glance

<table>
<thead>
<tr>
<th>Time</th>
<th>Event</th>
<th>Location</th>
</tr>
</thead>
<tbody>
<tr>
<td>12:30pm-1:45pm</td>
<td>Council of Learning Community Chairs Lunch Meeting</td>
<td>Balcony I</td>
</tr>
<tr>
<td>2:00pm-3:30pm</td>
<td>Enhanced Learning Sessions I (choice of 11) (see pages 25-28)</td>
<td></td>
</tr>
<tr>
<td>3:45pm-5:15pm</td>
<td>Enhanced Learning Sessions II (choice of 11) (see pages 28-32)</td>
<td></td>
</tr>
<tr>
<td>5:30pm-6:30pm</td>
<td>Networking Reception</td>
<td>Acadia/Bissonet</td>
</tr>
<tr>
<td>7:00pm-9:00pm</td>
<td>MPPDA Dinner (off-site; additional fee) (see pages 32)</td>
<td></td>
</tr>
<tr>
<td>12:30pm-1:45pm</td>
<td>Council of Learning Community Chairs Lunch Meeting</td>
<td>Balcony I</td>
</tr>
<tr>
<td>2:00pm-3:30pm</td>
<td>Enhanced Learning Sessions I (choice of 11) (see pages 25-28)</td>
<td></td>
</tr>
<tr>
<td>3:45pm-5:15pm</td>
<td>Enhanced Learning Sessions II (choice of 11) (see pages 28-32)</td>
<td></td>
</tr>
<tr>
<td>5:30pm-6:30pm</td>
<td>Networking Reception</td>
<td>Acadia/Bissonet</td>
</tr>
<tr>
<td>7:00pm-9:00pm</td>
<td>MPPDA Dinner (off-site; additional fee) (see pages 32)</td>
<td></td>
</tr>
</tbody>
</table>

### Thursday, March 28, 2019

<table>
<thead>
<tr>
<th>Time</th>
<th>Event</th>
<th>Location</th>
</tr>
</thead>
<tbody>
<tr>
<td>7:00am-8:00am</td>
<td>Wellness Activity</td>
<td></td>
</tr>
<tr>
<td>8:00am-9:00am</td>
<td>Continental Breakfast</td>
<td>Acadia Foyer Lounge</td>
</tr>
<tr>
<td></td>
<td>ABP Demo of new Online Tracking System for PDs and Coordinators</td>
<td>Carondelet</td>
</tr>
<tr>
<td></td>
<td>Share Warehouse Team Breakfast Meeting</td>
<td>Salon F-H</td>
</tr>
<tr>
<td></td>
<td>Consortium Group Meeting</td>
<td>Galerie 1</td>
</tr>
<tr>
<td></td>
<td>LEARN Advisory Committee Meeting</td>
<td>Galvez</td>
</tr>
<tr>
<td></td>
<td>Fellowship Program Directors’ Executive Committee Meeting</td>
<td>Audubon</td>
</tr>
<tr>
<td></td>
<td>LEAD Council and LC Chairs</td>
<td>Beauregard</td>
</tr>
<tr>
<td></td>
<td>MPPDA Committee Meetings II (see page 32)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>MPPDA Committee Meetings II (see page 32)</td>
<td></td>
</tr>
<tr>
<td>9:00am-10:00am</td>
<td>Plenary Session</td>
<td>Acadia/Bissonet</td>
</tr>
<tr>
<td>10:15am-11:45am</td>
<td>Table to Able Session</td>
<td>Acadia/Bissonet</td>
</tr>
<tr>
<td>12:00pm-1:15pm</td>
<td>Regional Lunch Meetings</td>
<td>(see page 33)</td>
</tr>
<tr>
<td></td>
<td>MPPDA Business Meeting</td>
<td>Galerie 4-5</td>
</tr>
<tr>
<td></td>
<td>(includes AMPPA and Med-Peds Leadership Awards)</td>
<td></td>
</tr>
<tr>
<td>1:30pm-3:00pm</td>
<td>Enhanced Learning Sessions III (choice of 11) (see pages 34-37)</td>
<td></td>
</tr>
<tr>
<td>3:15pm-4:45pm</td>
<td>Learning Community Meetings</td>
<td>(see page 37)</td>
</tr>
<tr>
<td></td>
<td>MPPDA: RRC/ABIM/ABP Panel Discussion</td>
<td>Galerie 4-5</td>
</tr>
<tr>
<td>5:00pm-6:00pm</td>
<td>Poster Session - Educational Scholarship and QI Projects (posters will be on display earlier in the day, starting at 12:00noon)</td>
<td>Preservation Hall</td>
</tr>
<tr>
<td>6:00pm-7:00pm</td>
<td>APPD LEAD Reunion</td>
<td>St Charles/Lafayette/ Napoleon</td>
</tr>
</tbody>
</table>

### Friday, March 29, 2019

<table>
<thead>
<tr>
<th>Time</th>
<th>Event</th>
<th>Location</th>
</tr>
</thead>
<tbody>
<tr>
<td>7:00am-8:00am</td>
<td>Continental Breakfast</td>
<td>Acadia Foyer Lounge</td>
</tr>
<tr>
<td>8:00am-9:00am</td>
<td>Plenary Session (Please note earlier start time!)</td>
<td>Acadia/Bissonet</td>
</tr>
<tr>
<td>9:00am-10:30am</td>
<td>Platform Presentations - Top Educational Scholarship/QI Abstracts</td>
<td>Acadia/Bissonet</td>
</tr>
<tr>
<td></td>
<td>AMPPA Session: My 1st Recruitment Season: Lessons Learned</td>
<td>Salon E</td>
</tr>
<tr>
<td>10:45am-12:15pm</td>
<td>Enhanced Learning Sessions IV (choice of 8) (see pages 41-44)</td>
<td></td>
</tr>
</tbody>
</table>
CME Information

CME credit for physicians for the APPD program is included in your registration fee.

**Satisfactory Completion:** Learners must complete an evaluation form to receive a certificate of completion. Your chosen sessions must be attended in their entirety. Partial credit of individual sessions is not available. If you are seeking continuing education credit for a specialty not listed below, it is your responsibility to contact your licensing/certification board to determine course eligibility for your licensing/certification requirement.

**Physicians:** In support of improving patient care, this activity has been planned and implemented by Amedco LLC and the Association of Pediatric Program Directors. Amedco LLC is jointly accredited by the Accreditation Council for Continuing Medical Education (ACCME), the Accreditation Council for Pharmacy Education (ACPE), and the American Nurses Credentialing Center (ANCC), to provide continuing education for the healthcare team.

**Credit Designation Statement** – Amedco LLC designates this live activity for a maximum of 20 *AMA PRA Category 1 Credits™*. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

<table>
<thead>
<tr>
<th>APPD</th>
<th>Session Time</th>
<th>Session Title</th>
<th>Credit Hours</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Tuesday, March 26 - 3.25 hours</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>1:30pm-5:00pm</td>
<td>Pre-Conference Workshops</td>
<td>3.25</td>
</tr>
<tr>
<td></td>
<td>Wednesday, March 27 - 7.25 hours</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>9:00am-10:00am</td>
<td>Plenary Session</td>
<td>1.00</td>
</tr>
<tr>
<td></td>
<td>10:15am-12:15pm</td>
<td>APPD Grassroots Forum for PDs, APDs or FPDs</td>
<td>2.00</td>
</tr>
<tr>
<td></td>
<td>12:30pm-1:45pm</td>
<td>Facilitated Networking Session/Forum for Directors of Small Programs &amp; Affiliate Chairs</td>
<td>1.25</td>
</tr>
<tr>
<td></td>
<td>2:00pm-3:30pm</td>
<td>Enhanced Learning Sessions I</td>
<td>1.50</td>
</tr>
<tr>
<td></td>
<td>3:45pm-5:15pm</td>
<td>Enhanced Learning Sessions II</td>
<td>1.50</td>
</tr>
<tr>
<td></td>
<td>Thursday, March 28 – 5.50 hours</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>9:00am-10:00am</td>
<td>Plenary Session</td>
<td>1.00</td>
</tr>
<tr>
<td></td>
<td>10:15am-11:45am</td>
<td>“Table to Able” Session</td>
<td>1.50</td>
</tr>
<tr>
<td></td>
<td>1:30pm-3:00pm</td>
<td>Enhanced Learning Sessions III</td>
<td>1.50</td>
</tr>
<tr>
<td></td>
<td>3:15pm-4:45pm</td>
<td>Learning Community Meetings</td>
<td>1.50</td>
</tr>
<tr>
<td></td>
<td>Friday, March 29 – 4.00 hours</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>8:00am-9:00am</td>
<td>Plenary Session</td>
<td>1.00</td>
</tr>
<tr>
<td></td>
<td>9:00am-10:30am</td>
<td>Platform Presentations of Top Educational Scholarship and QI Abstracts</td>
<td>1.50</td>
</tr>
<tr>
<td></td>
<td>10:45am-12:15pm</td>
<td>Enhanced Learning Sessions IV</td>
<td>1.50</td>
</tr>
<tr>
<td></td>
<td><strong>TOTAL</strong></td>
<td></td>
<td><strong>20.00</strong></td>
</tr>
</tbody>
</table>
## APPD Leadership

### President
Javier Gonzalez del Rey, MD, MEd (2018 - 2020)  
*Cincinnati Children's Hospital Medical Center*

### President-Elect
Rebecca Blankenburg, MD, MPH (2018 - 2020)  
*Stanford University*

### Past-President
Franklin Trimm, MD (2018-2020)  
*University of South Alabama*

### Executive Director - Laura Degnon, CAE

### Associate Director - Kathy Haynes Johnson

### Board of Directors - At Large Members
- **Sharon Calaman, MD (2017-2020)**  
  *St. Christopher's Hospital for Children*
- **John Frohna, MD, MPH (2018 - 2021)**  
  *University of Wisconsin*
- **Patricia Poitevien, MD, MSc (2018 – 2019)**  
  *Brown University/Hasbro Children's Hospital*
- **R. Franklin Trimm, MD, Chair**  
  *University of South Alabama*
- **Bruce Herman, MD (2017-2019)**  
  *University of Utah*
- **Shannon Scott-Vernaglia (2018-2020)**  
  *Massachusetts General Hospital*

### Coordinators’ Executive Committee
- **Michelle Brooks, C-TAGME, Chair (2018-2019)**  
  *Stanford University*
- **Amy Gaug, C-TAGME, Chair-Elect (2018-2019)**  
  *University of Minnesota*
- **Pamela Carpenter, MEd, C-TAGME, Past Chair (2018-2019)**  
  *University of Utah*
- **Tammy Bleeker, BS, MEd (2017-2020)**  
  *University of Florida*
- **Francisco Hernandez, BAHSA, MBAHM (2018 - 2021)**  
  *Children’s National Medical Center*
- **Cassandra Shorter, BS (2017 - 2019)**  
  *BCM/Children's Hospital of San Antonio*

### Associate Program Directors’ Executive Committee
- **Ndidi Unaka, MD, MEd, Chair (2018-2019)**  
  *Cincinnati Children's Hospital Med Center*
- **Ariel Winn, MD, Chair-Elect (2018-2019)**  
  *Boston Children's Hospital*
- **Brian Lurie, MD, MPH, FAAP, Past Chair (2018-2019)**  
  *Carolinas Medical Center/LCH*
- **Mollie Grow, MD, MPH (2018-2021)**  
  *University of Washington/Seattle Children's Hospital*
- **Rhett Lieberman, MD, MPH (2017-2020)**  
  *Children's Hospital of Pittsburgh of UPMC*
- **Ross Myers, MD (2018-2019)**  
  *UH Rainbow Babies & Children's Hospital*

### Fellowship Program Directors’ Executive Committee
- **Kathleen McGann, MD, Chair (2018-2019)**  
  *Duke University Medical Center*
- **Katherine Mason, MD, Chair-Elect (2018-2019)**  
  *Brown University/Hasbro Children's Hospital*
- **Pnina Weiss, MD, Past Chair (2018–2019)**  
  *Yale University School of Medicine*
- **Christine Barron, MD (2017-2020)**  
  *Lawrence A. Rubin Sr. Child Protection Center*
- **Jennifer Duncan MD (2018-2021)**  
  *Washington University School of Medicine*
- **Jennifer Kesselheim, MD, MEd, MBE (2016-2019)**  
  *Children’s Hospital/Boston Medical Center*

### APPD Fund Contributors
*APPD thanks the following for generous donations to the APPD Fund between July 1, 2018 and the 2019 Annual Meeting:*

#### APPD Patron ($1,000 or more)
- R. Franklin Trimm, MD  
  *Becky Blankenburg, MD, MPH*

#### APPD Sponsor ($500-$999)
- Linda Waggoner-Fountain, MD  
  *Javier Gonzalez del Rey, MD, MEd*

#### APPD Supporter ($250-$499)
- John G. Frohna, MD, MPH  
  *APPD Friend (up to $249)*

- Sharon Calaman, MD, CHSE  
  - Susan Bostwick, MD  
  - Jill Leavens-Maurer, MD  
  - Charlene Rotandi, AB, C-TAGME
APPD 2019 Annual Meeting Program Committee

Executive Planning Committee

Adam Rosenberg, MD, Program Chair
University of Colorado/Children’s Hospital of Colorado

Adam Wolfe, MD, PhD, Program Co-Chair
Baylor College of Medicine (San Antonio)

Michelle Brooks, C-TAGME
Stanford University

Jennifer Kesselheim, MD, MEd, MBE
Children’s Hospital/Boston Medical Center

Andrea Asnes, MD, Past Program Chair
Yale-New Haven Medical Center

Ross Myers, MD
UH Rainbow Babies & Children’s Hospital

Michael Aylward, MD, FACP, MPPDA Program Chair
University of Minnesota

Program Committee Members

Mark Atlas, MD
Hofstra Northwell School of Medicine
at Cohen Children’s Medical Center

Eric Ayers
Wayne State University School of Medicine

Megan Aylor, MD
Oregon Health and Science University

Christine Barron, MD
Brown University

Tammy Bleeker, BS, MEd
University of Florida

Robert Brooker, MD
St. Louis University School of Medicine

Stefanie Brown, MD
University of Miami, School of Medicine/Jackson Memorial
Hospital/Jackson Health System

Audrea Burns, PhD
Baylor College of Medicine (Houston)

Heather Burrows, MD, PhD
University of Michigan

Pamela Carpenter, MEd, C-TAGME
University of Utah

Savanna Carson, PhD
UCLA Medical Center

Megan Christoffersen
Stanford University

Princess Dennar, MD
Tulane University

Katie Diamond-Falk, MD
Maine Medical Center

Jennifer DiPace, MD
New York Presbyterian Hospital
(Cornell Campus)

Benjamin Doolittle, MD
Yale-New Haven Medical Center

Angie Etzenhouser, MD
Children’s Mercy Hospital

Mackenzie Frost, MD
University of Texas Southwestern Medical School

Amy Gaug, C-TAGME
University of Minnesota

Claudia Halaby, MD
Winthrop-University Hospital

Francisco Hernandez, MBA, BA
Children’s National Medical Center

Casey Hester, MD
University of Oklahoma Health Sciences Center

Maya Iyer, MD
Nationwide Children’s Hospital/Ohio State University

Carrie Johnson
Stanford University

Alice Kuo, MD, PhD
UCLA Medical Center

Katherine Mason, MD
Brown University

Suzanne McLaughlin, MD
Brown University

Heather McPhillips, MD, MPH
University of Washington

Renuka Mehta, MBBS
Medical College of Georgia

Catherine Michelson, MD
Children’s Hospital/Boston Medical Center

Ayesha Mirza, MD
University of Florida College of Medicine-Jacksonville

Sandra Moutsios, MD
Vanderbilt University

Sara Multerer, MD
University of Louisville

Angela Myers, MD, MPH
Children’s Mercy Hospital

Monique Naifeh, MD
University of Oklahoma Health Sciences Center

Elizabeth Nelsen, MD
SUNY Upstate Medical University

Adin Nelson, MD
Rutgers New Jersey Medical School

Mike Pitt, MD
University of Minnesota

Sue Poynter Wong, MD, MEd
Cincinnati Children’s Hospital Medical Center/University of
Cincinnati College of Medicine
APPD 2019 Annual Meeting Program Committee

Program Committee Members, continued

Suzanne Reed, MD
Nationwide Children’s Hospital/Ohio State University

Brett Robbins, MD
University of Rochester

Charlene Larson Rotandi, AB, C-TAGME
Stanford University

Christina Russ, MD

Children’s Hospital/Boston Medical Center

Cassandra Shorter, BS
Baylor College of Medicine (Houston)

Dan Sklansky, MD
University of Wisconsin

Jessie Skriner
University of Utah

Meghan Stawitcke, BA
Stanford University

Sarah Steen, BS
University of Kentucky College of Medicine

Ronald Sutsko, MD
Carolina Medical Center

Jonathan Tolentino, MD
Stony Brook Medicine/University Hospital

Teri Turner, MD, MPH, MEd
Baylor College of Medicine (Houston)

Angela Veesenmeyer, MD, MPH
Valley Children’s Healthcare

Rebecca Wallihan, MD
Nationwide Children’s Hospital/Ohio State University

Anne Warwick, MD, MPH
National Capital Consortium

Amber Wells
Valley Children’s Healthcare

Special Thanks To:
Erika Abramson, MD
New York Presbyterian - Weill Cornell
Debra Boyer, MD
Boston Children’s Hospital
Jason Custer, MD
University of Maryland Medical System
Sanaz Devlin, MD
Children’s Hospital of the King’s Daughters
Candice Dye, MD
University of Alabama at Birmingham
Kimberly Gifford, MD
Dartmouth-Hitchcock Medical Center
Cynthia Katz, MD
Icahn School of Medicine at Mount Sinai
Su-Ting Li, MD, MPH
University of California (Davis) Health System
Sahar Rooholamini, MD
University of Washington/Seattle Children’s Hospital
Allison Rose, MD
Emory University School of Medicine
Christine Skurkis, MD
Connecticut Children’s Medical Center
## APPD Regions

In addition to the national organization, pediatric programs in APPD are divided into regions. These regional groups have leadership opportunities, meetings, and activities which are a vital part of the APPD. All attendees are welcome to attend Regional Lunch Meetings on Thursday, March 28 from 12:00pm-1:15pm (see page 33 for location of your region’s meeting).

[www.appd.org/activities/regions.cfm](http://www.appd.org/activities/regions.cfm)

## APPD Council of Regional Chairs

<table>
<thead>
<tr>
<th>Chair, Council of Regional Chairs</th>
<th>Midwest Region</th>
<th>Southwest Region</th>
</tr>
</thead>
<tbody>
<tr>
<td>Program Director, Mayo School of Graduate Medical Education</td>
<td>Program Director/Clinical Assoc Prof University of Iowa Children’s Hospital <a href="mailto:amy-stier@uiowa.edu">amy-stier@uiowa.edu</a></td>
<td>Pediatric Residency Program Director Texas Tech University Health Sciences Center <a href="mailto:tammy.camp@ttuhsc.edu">tammy.camp@ttuhsc.edu</a></td>
</tr>
<tr>
<td><a href="mailto:homem.jason@mayo.edu">homem.jason@mayo.edu</a></td>
<td>Daniel Sklansky, MD (2018-2021)</td>
<td>Alisa Acosta, MD, MPH (2017-2020)</td>
</tr>
<tr>
<td>Sue Poynter Wong, MD (2018 - 2021)</td>
<td>Associate Program Director University of Wisconsin <a href="mailto:djsklansky@pediatrics.wisc.edu">djsklansky@pediatrics.wisc.edu</a></td>
<td>Associate Program Director, Texas Children’s Hospital <a href="mailto:alisa.acosta@bcm.edu">alisa.acosta@bcm.edu</a></td>
</tr>
<tr>
<td>Director, Pediatric Residency Program, Cincinnati Children’s Hospital Medical Center</td>
<td>Sarah Braet, MBA, C-TAGME (2016-2019)</td>
<td>Mary Matus (2016-2019)</td>
</tr>
<tr>
<td><a href="mailto:sue.poynter@cchmc.org">sue.poynter@cchmc.org</a></td>
<td>Visiting Learning Coordinator Children’s Mercy Hospital <a href="mailto:skbraet@cmh.edu">skbraet@cmh.edu</a></td>
<td>Program Manager UT Austin Dell Medical School Pediatrics <a href="mailto:mkmatus@seton.org">mkmatus@seton.org</a></td>
</tr>
<tr>
<td>Director, Pediatrics Residency Program, Rainbow Babies &amp; Children’s Hospital</td>
<td>Pediatric Residency Coordinator Children’s Mercy Hospital <a href="mailto:jedwards3@cmh.edu">jedwards3@cmh.edu</a></td>
<td>Associate Fellowship Program Director, Stanford University <a href="mailto:lynne.huffman@stanford.edu">lynne.huffman@stanford.edu</a></td>
</tr>
<tr>
<td><a href="mailto:keith.ponitz@uhhospitals.org">keith.ponitz@uhhospitals.org</a></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Residency Program Coordinator University of Toledo College of Medicine</td>
<td></td>
<td>Associate Pediatric Program Director Umass Memorial <a href="mailto:christina.hermos@umassmemorial.org">christina.hermos@umassmemorial.org</a></td>
</tr>
<tr>
<td><a href="mailto:edith.reynolds@utoledo.edu">edith.reynolds@utoledo.edu</a></td>
<td></td>
<td>Marianne Custer, BS (2017-2020)</td>
</tr>
<tr>
<td>Program Director/DIO/Chief Academic Officer</td>
<td>Program Director, Maria Fareri Children’s Hospital</td>
<td></td>
</tr>
<tr>
<td>Crozer-Chester Medical Center</td>
<td><a href="mailto:matthew_kapklein@nymc.edu">matthew_kapklein@nymc.edu</a></td>
<td></td>
</tr>
<tr>
<td><a href="mailto:stephen.higgins@crozer.org">stephen.higgins@crozer.org</a></td>
<td>Aesha Diggs, BA (2017 - 2020)</td>
<td>Meghan Stawitcke, BA (2017-2019)</td>
</tr>
<tr>
<td>David Rappaport, MD (2017-2020)</td>
<td>Fellowship Coordinator, Maimonides Infants and Childrens’ Hospital of Brooklyn</td>
<td>Program Director, Stanford Children’s/Stanford Pediatrics <a href="mailto:meghans4@stanford.edu">meghans4@stanford.edu</a></td>
</tr>
<tr>
<td>Assoc Program Dir/Thomas Jefferson Univ, AI duPont Hospital for Children</td>
<td><a href="mailto:adiggs@maimonidesmed.org">adiggs@maimonidesmed.org</a></td>
<td>Sylvia Yeh, MD (2015-2019)</td>
</tr>
<tr>
<td><a href="mailto:David.Rappaport@nemours.org">David.Rappaport@nemours.org</a></td>
<td>Southeast Region Kenya McNeal-Trice, MD (2016-2019)</td>
<td>Program Director, Los Angeles County-Harbor UCLA Medical Center <a href="mailto:syeh@uclavcr.labimed.org">syeh@uclavcr.labimed.org</a></td>
</tr>
<tr>
<td></td>
<td>Director, Pediatric Residency Training Program, UNC Pediatrics <a href="mailto:kmtrice@med.unc.edu">kmtrice@med.unc.edu</a></td>
<td></td>
</tr>
<tr>
<td>Jennifer Crotty, MD, FAAP (2016-2019)</td>
<td>Jennifer Crotty, MD, FAAP (2016-2019)</td>
<td>Associate Program Director Vidant Medical Center/East Carolina University <a href="mailto:crottyj@ecu.edu">crottyj@ecu.edu</a></td>
</tr>
</tbody>
</table>
Join an APPD Learning Community!

Learning Community meetings will be held on Thursday, March 22 from 1:30pm-3:00pm. Come and see what the learning communities are all about (see page 37 for room locations). All are welcome!

www.appd.org/activities/learningCommunities.cfm

ASSessment
The Assessment Learning Community is a group of program directors, associate program directors, coordinators, and other educational leaders seeking to improve assessment practices for trainees, faculty and programs. Areas of focus include improving or standardizing current assessment methods and developing novel assessment methods that meet the goals of outcomes-based evaluation. We welcome newcomers and returning members alike. During our Learning Communities session at APPD Spring 2019, we will break into our four working groups to continue current projects and brainstorm new/additional directions. The four working groups include: Assessment of Learners focusing on Learner Communication, Assessment of Learners focusing on Peer Assessment, Assessment of Faculty, and Evaluation of Programs. These groups are working to meet our Learning Community’s three main goals for 2017-2019: 1) To engage and develop members through project-based working groups. 2) To promote research and scholarship through the study of processes and procedures in the project-based working groups. 3) To foster leadership and collaboration through partnerships with other Learning Communities.

Behavioral and Mental Health
The Behavioral and Mental Health Learning Community is excited to welcome anyone interested in improving pediatric training experiences in the areas of mental/behavioral health to join us at the 2019 APPD Annual Spring Meeting in New Orleans. We are planning an interactive session where participants and attendees will become familiar with the needs assessment and background supporting the original creation of this community. This session will include presentations and a panel discussion by members of the learning community who are currently working on developing best practices for building new curricula in this area. In addition, program directors will provide insight on the successes and challenges with assessment of resident competency in behavioral and mental health. The ABP Roadmap Project, a piece of the ABP mental health initiative that illustrates supporting the mental health of patients and families along a continuum, will also be highlighted and discussed with the group. Attendees will then work in facilitated small groups focused on identifying the needs of Behavioral and Mental Health training and plans for implementation to share with the larger group. Please join us!

Community Health and Advocacy Training
The Community Health & Advocacy Learning Community is open to program directors, associate program directors, chief residents, coordinators and other educational leaders seeking to share ideas and resources with the goal of strengthening community health and advocacy education in their programs. Through this LC, we aim to foster collaboration among leaders in community health and advocacy education within pediatric residency and fellowship programs. The session will include presentations by leaders in community pediatrics education from around the country who will discuss curricular strategies and innovations that they have implemented in their own programs. LC leaders will solicit input from participants to better understand how the LC can support their needs and goals for their programs. Participants will leave with new resources and ideas to enhance their community pediatrics curricula, and they will make connections with other leaders around the country to facilitate collaboration in the educational work that we do. We hope you can join us to help us plan for the upcoming year!

Curriculum
The Curriculum Learning Community is a group of program directors, associate program directors, residents and other educational leaders that seek to improve the development, sharing and collaboration of curriculum development across programs. We encourage all those with an interest in curricula (i.e., development, research, revision, innovation, collaboration), regardless of level of experience, to join us. During our session at the APPD annual meeting, we will briefly review our past accomplishments and then set to work on our future directions. We will be hosting small break out session and table talks to provide advisement and collaboration on key ACGME 2019 Program Requirements. We will be utilizing abstract submission from the general submission for potential table talk experts who can share their knowledge and experience. We encourage members to submit curricula in progress.
EDUCATIONAL TECHNOLOGY
The APPD Educational Technology Learning Community will host an interactive table talk session, describing best practices and showcasing the latest technology used by program leadership. Participants will rotate from table to table as hosts demonstrate various tech or programs they have implemented or found useful in program administration or medical education. We hope to provide an opportunity for APPD members to share best practices and to create new applications for technology to enhance trainee learning, while responding to the needs, challenges and opportunities of the digital age.

FACULTY AND PROFESSIONAL DEVELOPMENT
The Faculty and Professional Development Learning Community provides opportunities for collaboration among APPD members interested in faculty development. To meet these goals, our learning community has four subsections, each with a focal project.

- The Educator Development subgroup manages the production and publication of “Nuts and Bolts” publications—short tip sheets on common education topics to be used as a resource for faculty development at the home programs of APPD members.
- The Chief Resident Forum subgroup plans and runs the APPD Forum for Chief Residents at the APPD annual spring meeting, designed to support and develop the Chief Resident roles at member programs.
- The Mentoring subgroup organizes mentoring activities for APPD members.
- The Professional Development subgroup plans the longitudinal pre-conference workshop series Professional Development 101 for APPD members.

Our leadership structure, with chairs of each subgroup, creates many opportunities for leadership roles within APPD. We encourage participation by any new APPD members in the subgroups to bring innovative ideas toward the aim of meeting the professional development needs of APPD and our home programs.

HEALTHCARE SIMULATION IN PEDIATRICS
The Healthcare Simulation in Pediatrics Learning Community welcomes you to join us in a discussion of the use of simulation in pediatric education. We will begin by providing an update on projects our Learning Community has been working on since the last national APPD meeting including an Enhanced Learning Session about a nighttime simulation curriculum that we are presenting at this meeting and a survey of the APPD community to determine what programs are currently doing in simulation and how we can provide simulation resources and mentorship for the APPD community at large. We will then have people present their work in simulation to both offer ideas to and get feedback from members of the learning community. Following those presentations we will have time for small group discussions for attendees to talk about work they are doing, brainstorm ideas for future projects, and ask questions of other members. We hope you will join us in learning about what others are doing in simulation, networking with colleagues involved in simulation education, and helping us to plan our next series of projects for the coming year!

LGBTQA+ LEARNING COMMUNITY
The LGBTQA+ Learning Community will hold its annual spring meeting in New Orleans, and we are excited to meet those of you who are new and reconnect with old friends! We plan to discuss with the group relevant topics in medical education, including on the national level, as well as have a guest speaker from the NOLA area. In addition, we will report out on the realignment of our three subgroups: curriculum, recruitment, and advocacy as well as our combined goals with the Underrepresented Minorities in Pediatric GME LC as we begin to work in tandem with the APPD Vision 2020 plans to better serve our members and APPD. Please join us if you are a member of the LGBTQA+ community or have a passion for serving marginalized communities - we hope to see you there!
PEDIATRIC GLOBAL HEALTH EDUCATORS
The APPD Global Health Learning Community’s mission is to work collaboratively with pediatric faculty in the US and abroad to advance the science and implementation of global health education for pediatric trainees, to prepare them to better serve children in resource-limited settings locally and globally. Come join us for our annual meeting during which we will welcome our global health education scholarship recipients (this year joining us from Malawi and Mozambique), share abstract presentations about global health education, and discuss ways to get involved in the group’s efforts.

RESEARCH AND SCHOLARSHIP
Come join us for the APPD Research & Scholarship Learning Community session! At this session, we will review accomplishments of our learning community over the past year, including surveys reviewed, workshops submitted, and scholarship from members of the group. Next, we will brainstorm as a large group how our learning community can continue to best support scholarship for all APPD members. The majority of our session will be spent in small working groups that mix experienced and new learning community members based on individual areas of interest. These working groups typically focus on topics such as workshop submissions for future meetings and policies and processes to support scholarship. Members often collaborate with each other on great projects throughout the year following this session. We welcome all APPD members, regardless of whether you are a novice or expert at educational research scholarship.

UNDER REPRESENTED MINORITIES IN PEDIATRIC GRADUATE MEDICAL EDUCATION
The Underrepresented Minorities in Pediatric GME Learning Community was created in response to a lack of representation in academic pediatrics. The goal of the learning community is to improve diversity, inclusion, and equity practices within pediatric GME. The overarching goals of the learning community are addressed through four sub-committees: recruitment, retention and support, curriculum, and mentorship. During our session at the APPD Spring Meeting, we will review our learning community structure, updates on our goals and objectives related to Vision 2020, and breakout in our sub-committees to continue current projects and brainstorm further ideas for the upcoming year. Additionally, to share and learn from each other, we will have selected peer-reviewed oral presentations by members of our learning community related to innovative work they are doing within diversity and inclusion. We welcome anyone with a passion for this topic to join us.
APPD Council of Learning Community Chairs
Rebecca Blankenburg, MD, MPH, Chair CoLCC (2016-2019)
Stanford Children’s/Stanford Pediatrics

Assessment Learning Community
Caroline Rassbach, MD
Chair (2017-2019)
Stanford Children’s/Stanford Pediatrics

Jennifer DiPace, MD
Vice Chair (2017-2019)
New York Presbyterian - Weill Cornell

Behavioral and Mental Health Learning Community
Kenya McNeal-Trice, MD
Chair (2018-2020)
University of North Carolina Hospitals

Sue Poynter Wong, MD, MEd
Vice Chair (2018-2020)
Cincinnati Children’s Hospital Medical Center/
University of Cincinnati College of Medicine

Community Health & Advocacy Training Learning Community
Michelle Barnes, MD
Co-Chair (2017-2019)
University of Illinois College of Medicine at Chicago

Sarah Garwood, MD
Co-Chair (2017-2019)
Washington University/B-JH/SLCH Consortium

Curriculum Learning Community
Steve Paik, MD, EdM
Chair (2018-2020)
NYP Morgan Stanley Children’s Hospital/Columbia University Medical Center

Christine Skurkis, MD
Vice Chair (2018-2020)
Connecticut Children’s Medical Center

Educational Technology Learning Community
Pamela Carpenter, MEd, C-TAGME
Chair (2017-2019)
University of Utah

Michelle Miner, MD
Vice Chair (2017-2019)
Southern Illinois University SOM

Faculty and Professional Development Learning Community
Erin Giudice, MD
Chair (2017-2019)
University of Maryland

Healthcare Simulation in Pediatrics Learning Community
Ariel Frey-Vogel, MD
Chair (2014-2019)
Massachusetts General Hospital

Amanda Rogers, MD
Vice Chair (2017-2019)
Medical College of Wisconsin

Lesbian-Gay-Bisexual-Transgender-Queer/Questioning- Ally (LGBTQA+) Learning Community
Michelle Brooks, C-TAGME
Chair (2014-2019)
Stanford Children’s/Stanford Pediatrics

Beth Payne, MAEd, C-TAGME
Vice Chair (2016-2019)
UTHSCSA

Pediatric Global Health Educators Learning Community
Tania Condurache, MD, MSc
Chair (2018-2020)
University of Louisville School of Medicine

Heather Crouse, MD
Vice Chair (2018-2020)
Baylor College of Medicine

Research and Scholarship Learning Community
Erika Abramson, MD
Chair (2018-2020)
New York Presbyterian - Weill Cornell

Monique Naifeh, MD
Vice Chair (2018-2020)
Oklahoma University Health Sciences Center

Under Represented Minorities in Pediatric Graduate Medical Education Learning Community
Lahia Yemane, MD
Chair (2018-2020)
Stanford Children’s/Stanford Pediatrics

Emma Omoruyi, MD, MPH
Vice-Chair (2018-2020)
McGovern Medical School
APPD Share Warehouse

The APPD Share Warehouse is a unique opportunity for members to collectively share and use content that supports the mission of pediatric residency education. The APPD Share Warehouse is a web-based collaborative project that provides a place for APPD members to browse, search, use, and share resources, including policies, curricula and evaluation tools. It’s a perfect place to submit workshop materials, poster presentations, and resources for APPD Learning Communities. Learners, leaders, and all team members will benefit from a rich repository of information and practical applications for our diverse needs.

The APPD Share Warehouse is emblematic of our community of members: innovative, collaborative, and scholarly. Learning together from our shared work cultivates great new solutions and ignites innovation. Members may share their work and report its use as part of their portfolio of scholarship. Explore the APPD Share Warehouse and submit materials to the site. And let us know how we can adapt the site to meet your needs. When we share and innovate together, all members benefit.

Share Warehouse Design and Editorial Team

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

Giovanna Alvarado, BS
University of California-Los Angeles

Emily Borman-Shoap, MD
University of Minnesota

Cindy Colpitts
Creighton Nebraska Pediatric Residency Program

Alice Del Rosario, BS
University of California-Los Angeles

Ashweena Gonuguntla, MD
Hurley Medical Center / Michigan State University

Howard Hsu, MD
University of Nebraska Medical Center College of Medicine

Hannah Kinoshita, MD
University of Hawaii

Robert Lee, DO, MS
Winthrop University Hospital

Tara McKinley, MA
University of Louisville

Michelle Miner, MD
University of Minnesota

Maren Olson, MD
University of Minnesota

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

Thea Stranger-Najjar
University of Chicago

Candice Taylor Lucas, MD, MPH, FAAP
University of California (Irvine)/CHOC

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

SHARE Your Work!

We are excited to announce a Share Warehouse contest! Between now and April 26, every person who submits/uploads to *or* downloads from the APPD Share Warehouse will be eligible for a drawing for a free registration to the APPD 2020 Spring Meeting. We encourage you to please submit to www.appd.org/shareWarehouse/index.cfm. Your colleagues will benefit from your contributions, as you will benefit from theirs. (And, you may win the contest!)
APPD LEAD
APPD Leadership in Educational Academic Development

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 8 is underway and the application deadline is April 19, 2019. Visit www.appd.org/leadapp/begin.cfm for details and look for “Ask Me About APPD LEAD” buttons worn by attendees, LEAD brochures and further information on page 103.

LEAD Council Members / Faculty

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

Marsha Anderson, MD  University of Colorado

Hilary Haftel, MD, MHPE  University of Michigan

Richard Mink, MD, MACM  Harbor-UCLA Medical Center

Richmond Shugerman, MD  Seattle Children’s Hospital / University of Washington

Rebecca Swan, MD  Vanderbilt University School of Medicine

Linda Waggoner-Fountain, MD, MEd  University of Virginia

Robert Vinci, MD  Boston Medical Center

Incoming LEAD Council Members:

Bruce Herman MD  University of Utah

Ingrid Walker-Desertes MD, MPH, MBA  Maimonides Infants & Child’s Hospital of Brooklyn

APPD LEARN
APPD Longitudinal Educational Assessment Research Network

APPD LEARN is APPD’s research network, open to all member programs, with 149 currently participating. During the past year, APPD LEARN has begun or continued several active collaborative studies, including the Pediatrics Milestones Assessment Collaborative (with the American Board of Pediatrics and National Board of Medical Examiners) and assessment of the relationships between entrustable professional activities and milestones in the Pediatric subspecialties (with the Council of Pediatric Subspecialties, the American Board of Pediatrics, and the Subspecialty Pediatrics Investigator Network) and in general Pediatrics (with the American Board of Pediatrics). Please visit with us during the meeting to learn more about your educational research network and how you can become involved! In addition, please look for more information on the APPD LEARN web site at http://learn.appd.org

Alan Schwartz, PhD, APPD LEARN Director

Beth King, APPD LEARN Program Manager
The seventh APPD LEAD Cohort (see list below) was selected from among a highly qualified group of applicants. This seventh Cohort, an energetic and focused group of educational leaders, will graduate from the program during the Plenary Session on Thursday morning.
Meeting Schedule

Monday, March 25

8:00am - 5:00pm  APPD LEAD Meeting (LEAD Cohort Only)  
Riverview II

10:00am - 6:00pm  APPD Board Meeting  
Board Room

Tuesday, March 26

7:30am - 12:15pm  APPD LEAD Meeting (LEAD Cohort Only)  
Riverview I

8:00am-6:00pm  Registration / Information Desk Open  
Preservation Booth

9:00am - 12:30pm  APPD Board Meeting  
Board Room

9:30am - 4:45pm  Coordinators’ Session (lunch provided)  
Galerie 1-3

9:30-11:00am  OWN IT, EARN IT, AND SPEAK UP AS A LEADER IN GRADUATE MEDICAL EDUCATION

Pamela Carpenter, MEd, C-TAGME, University of Utah, Salt Lake City, UT; Michelle Brooks, C-TAGME, Stanford University, Palo Alto, CA; Amy Gaug, C-TAGME, University of Minnesota, Minneapolis, MN; Jessie Skriner, University of Utah, Salt Lake City, UT; Roberta Johnson, Advocate Lutheran General Hospital, Park Ridge, IL

The role of the program coordinator has evolved over the last two decades from strictly clerical to increasingly more management, development, and leadership responsibilities. Many coordinators aspire to further their careers and pursue leadership opportunities in GME. The first step in this process involves taking ownership and accountability, and often coordinators are not encouraged to do so. In addition, due to the power gradient present between faculty and administration, assertiveness skills are needed to effectively speak out on one’s own behalf and participate in leadership activities. This workshop will present the novel Oz Principle method of taking ownership and accountability of an institution’s mission in order to accomplish personal/professional and program-wide goals alike. Much like a rising tide lifts all boats, a good leader employs self-awareness, intuitiveness, and follow through to ensure that the goals of all are met. We will discuss common barriers to accomplishing this and assist the audience in developing tools to combat those barriers, such as power imbalances, lack of time, and communication difficulties. We will also discuss in small and large group venues ways to trust your gut, take risks, and gain expertise in aspects that interest each audience member the most.

11:00-12:00pm  ERAS PRESENTATION
12:00-1:30 pm  FACILITATED MENTORING SESSION (LUNCH PROVIDED BY APPD)
This session will be presented by the APPD Coordinators’ Mentoring Workgroup, led by Francisco Hernandez and Cassandra Shorter of the Coordinators’ Executive Committee. Our goal is to re-introduce the Mentoring Workgroup that is available to all coordinators/administrators. Our intent is to pair mentors and mentees to individual and group mentoring based on your needs. Our focus is to assist and develop new and seasoned coordinators/administrators in all areas of residency and fellowship programs.

1:30-3:00 pm  PUBLIC SPEAKING: FRIEND OR FOE
Anne Broadbent, MM, C-TAGME, Johns Hopkins All Children’s Hospital, St Petersburg, FL
Public speaking is one of the top anxiety creating events for most people, regardless of the situation. This anxiety is evident whether the public speaking is planned or spontaneous. Competency in public speaking can have a direct positive correlation to career advancement. With that same viewpoint, poor speaking skills can close doors for advancement. The confidence level of the speaker has a tendency to affect the perceived competency of the speaker. The majority of those in graduate medical education administration will not rise to the skill level or have the required responsibility as that of a professional public speaker. On the flip side, we all will be called on to speak publicly in a meeting asked to deliver a planned presentation. In fact, everyone is regularly called on in meetings to “speak off the cuff” or provide “on-the-spot” additional information. There are far more regular incidents of spontaneous public speaking vs. planned public speaking. This presentation is NOT about presentation skills in creating better slides. This presentation will NOT detail specific steps in the actual event of the public presentation. This presentation WILL look at the thoughts, emotions and processes in becoming a confident, effective and competent public speaker. This learning session will provide each participant with a self-assessment of thoughts and emotions surrounding public speaking, an opportunity for a non-threatening activity in public speaking and will also leave with a list of resources. Ms. Broadbent is the current President of the Toastmasters International club that meets at Johns Hopkins All Children’s Hospital.

3:00-4:30 pm  APPLYING THE BASICS OF QUALITY IMPROVEMENT IN YOUR ADMINISTRATIVE ROLE
Lindsey M. Gurganious, BSHA, Baylor College of Medicine (Houston), Houston, TX
Dr. Peter Batalden defined Quality Improvement as “The combined and unceasing efforts of everyone “health care professionals, patients and families, researchers, payers, planners, educators” to make changes that will lead to better outcome, better system performance, and better professional development’. Quality improvement does not simply aim to improve patient care, but rather can be used by any professional in their role to improve how they function and/or provide a service. A coordinator’s role is often inclusive of a long list of tasks that vary greatly, are required by various entities, and serve varying purposes. Coordinators support both a program, sometimes more than one, and people in a very process-oriented way. Processes over time, with changes in practice, become cumbersome and less effective. In this session, problems will be developed into a problem statement and opportunities to utilize QI tools in making a change for improvement in the coordinator's daily work life will be explored in small groups. Tools to be reviewed include: 1. Process Mapping 2. Fishbone/Key Driver 3. Kanbans. Large group discussion will then focus on measuring the outcome of the change made and methods of maintaining the change. Groups will discuss in the open forum their identified problems, tools used, and how they plan to measure and maintain the change. Tools to be reviewed will include: 1. PDSA Cycle 2. SWOT analysis. Learners should leave the session with a problem statement, a plan of tools to use in addressing their problem, a plan of how to measure the change they will implement and how they hope to maintain the change. Reference 1Batalden, P.B., & Davidoff, F. (2007). What is “quality improvement” and how can it transform healthcare? Quality & safety in health care, 16(1), 2-3.

4:30-4:45 pm  COORDINATORS’ GROUP PHOTO
9:30am - 5:00pm  Forum for Chief Residents (lunch provided)  Preservation Hall

**Coordinated by:** Blair Dickinson, MD, MS, Associate Program Director, St. Christopher’s Hospital for Children, Co-Chair, Jay Homme, MD, Program Director, Mayo Clinic, Co-Chair, Edwin Zalneraitis, MD, Program Director, University of Connecticut, Senior Mentor, and the Chief Resident Forum Planning Committee (below)

**Faculty:** Erin Giudice, MD, Program Director, University of Maryland, Bahareh Gordon, MD, Associate Program Director, UCLA, Sophia Goslings, MD, Associate Program Director, University of South Alabama, Sarah Gustafson, MD, Faculty, Harbor-UCLA Medical Center, Ross Myers, MD, Associate Program Director, UH Rainbow Babies & Children’s Hospital, Lisa Pomeroy, MD, Associate Program Director, Texas Tech Health Science Center – Lubbock, Maria Ramundo, MD, Program Director, Akron Children’s Hospital, Glenn Rosenbluth, MD, Associate Program Director, University of California, San Francisco, Sharon Smith, MD, Associate Program Director, University of Connecticut, Cheryl Taurassi, MD, Associate Program Director, Cohen Children’s Medical Center, Eric Zwemer, MD, Associate Program Director, University of North Carolina

**Chief Residents:** Christine Bacha, MD, Akron Children’s Hospital, Courtney Brantley, MD, Levine Children’s Hospital/ Carolinas Medical Center, Ali Carroll, MD, Chief, University of North Carolina, Adriana Cline, MD, Chief, University of North Carolina, Grace Fisler, MD, Cohen Children’s Medical Center, Brian Gavan, MD, Chief, University of South Alabama, Lisa Grady, DO, University of Massachusetts Medical School-Baystate, Matthew Grant, MD, University of Maryland, Joanna Hales, MD, Chief, University of North Carolina, Will Hochgertel, MD, Chief, St. Christopher’s Hospital for Children, Awab Ibrahim, MD, Chief, University of South Alabama, Morgan Khawaja, MD, Medical University of South Carolina, Jacqui Klicka-Skeels, MD, St. Christopher’s Hospital for Children, Jonah Mandell, DO, University of Connecticut, Gretchen Metzenberg, DO, St. Christopher’s Hospital for Children, Justine Mrosak, MD, University of Connecticut, Melinda Palma, MD, Harbor-UCLA Medical Center, Jessica Penney, MD, University of Massachusetts Medical School-Baystate, Patrice Pryce, MD, Cohen Children’s Medical Center, Emily Reeves, MD, University of Maryland, Emily Sampino, MD, University of Connecticut, Andrea Scioscia, MD, UH Rainbow Babies & Children’s Hospital, Mark Siegel, MD, Medical University of South Carolina, Christine Thang, MD, UCLA Mattel Children’s Hospital, Stephanie Vander-Plas, MD, Texas Tech University Health Sciences Center, Jami Zaretsky, MD, Cohen Children’s Medical Center

9:30-9:45 Welcome and Introductions ~ Blair Dickinson, MD, MS, Jay Homme, MD
Welcome from Chief Residents of New Orleans ~ Rachel Herdes, DO/MA and Leah Nuss, MD, LSUHSC Pediatrics - Children’s Hospital of New Orleans, Katie Laycock, MD and Vy Anh Mai, MD, MSc, Tulane/Ochsner Pediatric Residency Program

9:45-10:15 The Chief Handoff ~ Jay Homme, MD

10:15-10:30 Move to breakout tracks

10:30-12:30 Breakout Tracks

**Rising Chief Track**  Preservation Hall

10:30-11:45 Not Your Average Morning Report ~ Grace Fisler, MD, Will Hochgertel, MD, Jacqui Klicka-Skeels, MD, Gretchen Metzenberg, DO, Patrice Pryce, MD, Jami Zaretsky, MD, Blair Dickinson, MD, MS

11:45-12:30 Planning the Chief Year ~ Courtney Brantley, MD, Adriana Cline, MD, Ali Carroll, MD, Joanna Hales, MD, Melinda Palma, MD, Sophia Goslings, MD, Edwin Zalneraitis, MD

**Graduating Chief Track**  Galerie 4-6

10:30-11:30 Professional Development Planning & Mentoring ~ Christine Bacha, MD, Erin Giudice, MD, Maria Ramundo, MD, Cheryl Taurassi, MD

11:30-12:30 Debriefing the Chief Year ~ Jay Homme, MD, Ross Myers, MD, Glenn Rosenbluth, MD

12:30-1:30 Lunch and Poster Viewing  Preservation Hall

Authors will stand by posters from 12:30 – 1:00pm

*Please see below for accepted abstracts*

1:30-3:45 Speed Chiefing ~ Lisa Grady, DO, Matthew Grant, MD, Will Hochgertel, MD, Morgan, Khawaja, MD, Jacqui Klicka-Skeels, MD, Jonah Mandell, DO, Gretchen Metzenberg, DO, Justine Mrosak, MD, Jessica Penney, MD, Emily Reeves, MD, Emily Sampino, MD, Andrea Scioscia, MD, Mark Siegel, MD, Stephanie Vander-Plas, MD

3:45 – 4:30 Implementing Change ~ Christine Thang, MD, Jonah Mandell, DO, Justine Mrosak, MD, Emily Sampino, MD, Sophia Goslings, MD, Edwin Zalneraitis, MD

4:30 – 4:45 Top 10 Things About Chief Year ~ Ross Myers, MD

4:45 – 5:00 Wrap-Up & Evaluations ~ Blair Dickinson, MD, MS, Jay Homme, MD
Preservation Hall

9:30am - 5:00pm Forum for Chief Residents, continued

Accepted Abstracts (Listed authors include Chief Residents and other trainees)

Curriculum
- Beyond the ACGME Requirements: Cultivating a Culture of Advocacy within a Large Pediatric Residency Program (Catherine Clay McClure, MD, MPH, University of Colorado)
- Breaking Bad News: A Novel Educational Curriculum for Pediatric Residents (Jessica Penney, MD, UMMS-Baystate)
- Career Focused Training: Successfully Individualizing Curriculum. (Jennifer Walker, MD and Courtney Brantley, MD, Carolinas Medical Center/Levine Children's Hospital)
- Early exposure to behavioral, mental, and adolescent health in general pediatrics (Beau Gilmore, MD, Colin Fisher, MD, Monica Saladik, MD, Oregon Health Sciences University)
- Early impact of a Health Equity, Diversity, and Inclusion curricula on resident knowledge, attitudes, and skill in cross-cultural care (Patrice A. Pryce, MD, Cohen Children's Medical Center)
- Educating Pediatric Trainees to Navigate Medical Uncertainty: The Answer Isn’t Always “C” (Elizabeth E. Bil, MD, Kristin M. Kalita, MD, Catherine C. McClure, MD, MPH, University of Colorado)
- Increased exposure to procedural training in residency (Monica Saladik, MD, Beau Gilmore, MD, Colin Fisher, MD, Laura Waagmeester, MD, Oregon Health Sciences University)
- Low-Fidelity Simulation Curriculum Improving Resident Patient Care (Jacob Anderson, MD, SUNY Upstate Medical University)
- The Use of Board Preparation Workshop and Individualized Unit to Advance Residents in board Study Preparation (Emily R. Reeves, MD, Matthew J. Grant, MD, University of Maryland)

Education
- A Novel Approach to Promoting Resident Engagement in Educational Curricula (Patrice Pryce, MD, Cohen Children's Medical Center)
- Impact of Academic Half Day: Resident and Faculty Perceptions Post-Implementation (Jillian Hagerman, DO, Michelle Blanco, MD, University of South Florida)
- Instilling a commitment to lifelong learning and evidence-based practice through spirited competition among inpatient teams (Kristin Streiler, MD, James Odum, MD, Charley Spear, MD, Children's Mercy Kansas City)
- Nighttime Chalk Talks: A Novel Approach to Developing Residents as Educators and Improving Didactic Education on Night Shifts (Aditi Vasan, MD, Nina Fainberg, MD, Betsy Salazar, MD, Children's Hospital of Philadelphia)
- PHM Night CAP: A New Structure for the Night Tea Educational Experience (Jillian Mador, MD, Sara Serbin, MD, Heath Bernard, MD, Alanna Brickley, MD, UPMC Children's Hospital of Pittsburgh)

Miscellaneous
- Does My Team Really Need Our Attending? Perceived Autonomy of Attending-less Rounds (Rustin A. Meister, MD, Alicia Williams, MD, Vanderbilt University)
- Establishing the Resident Academic Project to Promote Scholastic Activity Among Pediatric Residents (Ashley Martinez, MD, University of California, San Diego)
- Improvement of the Resident Inpatient Experience Through Initiatives Created by an Interprofessional, Multidisciplinary Task Force (Amy Buczkowski, MD, Maine Medical Center)
- Improving the Frequency and Quality of Feedback Received by Residents Through Education, Reminders, and Incentives (Anne Kimball, MD, MPH, Emory)
- Innovative Strategies to Address Residency Wide Program Concerns through Competition, Gamification and Positive Reinforcement (Jasmine Weiss, MD, Emory)
- “Intern Check-In Tool” to improve early identification of struggling interns and facilitate feedback (Krista Allen, MD, Stefan Malin, MD, Alyssa Swick, MD)
- Resident Autonomy: Are Attendings Around Too Much? (Rustin A. Meister, MD, Alicia Williams, MD, Vanderbilt University)
- Welcome to the Family! Acclimating New Interns to Life as a Resident (Courtney Brantley, MD, Jennifer Walker, MD, Carolinas Medical Center/Levine Children’s Hospital)

Quality Improvement and Safety
- Pediatric Resident Safety Council: Fostering the Next Generation of Safety Leaders (Julie Bishop Aldrich, MD, Sarah Kappa, MD, Elizabeth Rhinesmith, MD, Allison Waller, MD, Children's National Medical Center)
- Promotion of Resident Participation in Quality Improvement By Creation of a Resident Quality Council (Grace Fisler, MD, Patrice Pryce, MD, Jami Zaretsky, MD, Joseph Castiglione MD, Stephanie Sayres, DO, Melissa Buchan MD, Joshua Belfer, MD, Lance Feld MD, Cohen Children's Medical Center)
- Resident Great Catches: Recognizing resident physicians who promote a safe environment for patients (Kristin Streiler, MD, James Odum, MD, Charley Spear, MD, Children's Mercy Kansas City)

Scheduling
- +Y Modification in X+Y Schedule to Improve Overall Residency Experience (Eric S. Mull, DO, MA, Javier Bonilla, MD, Matthew Davis, MD, University at Buffalo)
- Full-Day Continuity Clinics: Resident and Attending Perspectives on Balancing Obligations, Patient Ownership, Continuity of Care, and Satisfaction (Thomas Bertagnoli, DO, Korre Fairman, DO, Erica Bautista, DO, Wright State University Boonshoft School of Medicine/Wright Patterson Air Force Base)
- The Implementation of an X+Y Scheduling Model in a Pediatric Residency Program: 18 Month Follow Up (Archana Shukla, DO, Emily Dudek, DO, Advocate Children's Hospital-Park Ridge)
9:30am - 5:00pm  Forum for Chief Residents, continued  Preservation Hall

**Technology**
- iMessage Medicine: When Everyone Can “Text a Friend” (Alicia Williams, MD, Rustin A. Meister, MD, Vanderbilt University Medical Center)
- Instituting Note Templates to Improve Resident Efficiency with Inpatient Documentation (Kayla Bronder Phelps, MD, MPH, Allison Sheuwmake, MD)
- Making Morning Reports Digestible (Joseph Woolley, DO, Joanna Ekstrom, MD, Meghan Fanta, MD, Sarah Raatz, MD, University of Minnesota)
- Using resident teams for shared EMR in-baskets to improve timeliness of test result review (Adriana Cline, MD, Joanna Hales, MD, University of North Carolina Hospitals)

**Wellness and Resilience**
- Addressing resident wellness during the darkest months (Beau Gilmore, MD, Monica Saladik, MD, Colin Fisher, MD, Oregon Health Sciences University)
- Breaking Down the Myth of Work-Life Balance: A Residency Program’s Novel Approach to Combating Burnout and Promoting Wellbeing (Reem Itani, MD, Anna Rodenburgh, MD, Cesar Menchaca, MD, University of Chicago)
- Grief Debriefs: Providing Debriefs for Residents after Pediatric Patient Deaths (Joanna Ekstrom, MD, Sarah Raatz, MD, Rachel Cafferty, MD Meghan Fanta, MD, Joseph Woolley, DO, Erin Gutowski, DO, University of Minnesota)
- Instituting a Wellness curriculum from the Ground Up (Margaret Mou, DO, NYU Winthrop Hospital)
- Kaiser Permanente Pediatric Residency Wellness Culture: Building an Integrative Culture Based on the Belief that Wellness is not a Weekly Activity but a Permanent Mindset (Ruby Patel, MD, Arielle Randolph, MD, Kaiser Permanente Northern California)
- Resident Wellness Through Resiliency (Lisa Grady, DO, Jessica Penney, MD, UMMS-Baystate)
- Supporting Resident Parents (Jenna Erickson, MD, Phoenix Children’s Hospital)
- Use of a Modified Nominal Group Technique to Evaluate a Pediatric Residency Wellness Curriculum (Grace Fisler, MD, Jami Zaretsky, MD, Patrice Pryce, MD, Cohen Children’s Medical Center)

12:15pm - 3:00pm  APPD LEAD Council Meeting  Audubon

1:00pm - 5:30pm  Pre-Conference Workshops (choice of 3 - additional fee)  Beauregard

**PC1 - The Do’s and Don’ts of Survey Development**
*Bonnie Halpern-Felsher, PhD, FSAHM, Stanford University and Erika Abramson, MD, New York Presbyterian Hospital (Cornell Campus)*
This workshop is designed to provide skills necessary to develop, validate, and administer surveys. The workshop will provide information on: creating valid measures; ensuring that the measures used address and apply to the research questions, design and samples; determining when to use standardized measures or develop new ones; instrument validation techniques; and survey administration, including determining the most effective way of administering measures (e.g., online, paper-and-pencil, Qualtrics) and the best way to design a survey. At the end of the workshop, attendees will be able to:
- Understand key principles and strategies for survey development;
- Identify problematic versus good survey questions;
- Locate and develop reliable and valid measures;
- Determine measurement reliability and validity

**PC2 – Professional Development 101: Getting to Where You Want to Be**
*Jackson*
*Jerri Rose, MD, Rainbow Babies and Children’s Hospital; Linda Waggoner-Fountain, MD, University of Virginia; Alisa Acosta, MD, Baylor College of Medicine; Elizabeth Chawla, MD, Georgetown University; Mary Beth Wroblewski, MD, University of Toledo; Hayley Altman-Gans, MD, Stanford University; Meg McNamara, MD, University of San Francisco; Maria Ramundo, MD, Akron Children’s; Adam Wolfe, MD, Baylor College of Medicine San Antonio; Erika Friehling, MD, University of Pittsburgh; Teri Turner, MD, Baylor College of Medicine; Meredith Bone, MD, Northwestern University, Erin Giudice, MD, University of Maryland; Kim Gifford, MD, Dartmouth University*
Dedicating time to your professional growth and development is a key to reaching your goals and improving the ways you support learners and colleagues. This session is for anyone who has recently joined APPD, assumed a new educational role, or is interested in honing their career planning. The focus of this interactive, half-day session will be on self-management as an element of professional development. The first part of the session will concentrate on skills of Emotional Intelligence, including self-awareness and self-regulation. Then in the second section, participants will explore and define their own core values and professional goals. These goals will be the basis for workshop activities aimed at learning when to say “yes” to professional and personal commitments. The final portion of this session will delve into skills of self-advocacy and creating professional growth opportunities. Participants will have the opportunity to connect with other members and leaders of APPD on the challenges and strategies of their own professional development. This pre-conference session is part 2 of a 3 part annual series, which do not need to be done in order. All are welcome; prior attendance at a Professional Development 101 workshop is not necessary or required.
PC3 - Expanding the Availability of High Quality Pediatric Global Health Education

Tania Condurache MD, MSc, University of Louisville, Chuck Schubert, MD, Cincinnati Children’s Medical Center, Christiana Russ MD, DTMH, Boston Children’s Hospital, Heather Crouse MD, Texas Children’s Hospital, Jennifer Watts, MD, MPH, Children’s Mercy Kansas City, Heather Lukolyo MD, MHS, Baylor College of Medicine, Joanne Mendoza MD, University of Virginia, Adelaide Barnes MD, Children’s Hospital Philadelphia, Elizabeth Keating, MD, University of Utah/Primary Children’s Hospital, Amy Rule, MD, Cincinnati Children’s Medical Center

Whether you are a program director, program coordinator, chief resident, or GH educator, and whether you are seeking guidance for starting a program or for optimizing GH education in your well-established program, join us on Tuesday March 26th from 1:30 to 5:00 PM for the Global Health Learning Community Pre-Conference Session, titled Expanding the Availability of High Quality Pediatric Global Health Education. Participants will also have the opportunity to work with facilitators at navigating available resources to create strategies for expanding available GH resources to smaller programs, from curricula, mentorship, and faculty development, to elective site sharing.

6:30pm - 7:30pm  APPD Leadership Orientation and Reception  
(invitation only)  
Riverview Prefunction

Wednesday, March 27

6:30am-6:30pm  Registration / Information Desk Open  
Preservation Booth

7:00am - 8:00am  Wellness Activity  
New Orleans Walk

Join your fellow attendees on a beautiful scenic 1.2 mile route – wending by Woldenberg Park and the Mississippi River, strolling through Jackson Square, and walking down the scenic route of Chartres Street on the way back to the Marriott. Meet in the hotel lobby at 6:45am for a prompt 7:00am start. (In the event of inclement weather, the walk may be rescheduled to the same time Thursday morning or held indoors.)

8:00am - 9:00am  Continental Breakfast  
Acadia Foyer Lounge

MPPDA Committee Meetings I

Accreditation Committee  
Curriculum Committee  
Recruitment Committee  
Research Committee  
Transitions Committee

AMPPA Meeting: New Common Program Requirements  
Kelli DaSilva, C-TAGME – Prisma Health Upstate

Studio 9-10

9:00am - 10:00am  Plenary Session  
Acadia/Bissonet

9:00-9:10am  Welcome ~ Javier Gonzalez del Rey, MD, APPD President

9:10-9:15am  Introduction and APPD Updates

9:15-9:20am  Presentation of Robert S. Holm, MD Leadership Award ~ Franklin Trimm, MD, APPD Immediate Past President

9:20-9:50am  The 2020 Census: The Importance of Ensuring All Kids Are Counted ~ Timothy P. Olson, Associate Director for Field Operations, United States Census Bureau

Timothy P. Olson will provide a brief overview on the 2020 Census, the Undercount of Young Children, and how pediatricians and pediatric program directors can serve as trusted voices in their communities to support an accurate 2020 Census count

9:50-9:55am  Orientation to the day ~ Adam Rosenberg, MD, APPD Program Chair
10:15am - 12:15pm Grassroots Forum for Associate Program Directors

Salon A-D

The Forum for Associate Program Directors will review timely and important topics of interest to the APPD and will discuss organizational and career development needs specific to our group. As in previous years, the highlight of our session will be peer-reviewed presentations from Associate Program Directors around the country on innovative projects that they are working on currently in their programs. We invite you to bring your ideas and questions to this energetic group session to add to our discussion. Leaders: Nicola Orlov, MD (University of Chicago Medicine), Dan Sklansky, MD (University of Wisconsin School of Medicine and Public Health), Ben Miller, MD (University of Pittsburgh School of Medicine), and Monique Naifeh, MD, MFH (Oklahoma University School of Medicine)

10:15-10:20 Welcome and outline of session
10:20-10:30 APD Executive Committee Update
10:30-10:45 “Pediatric Education Didactic Series” ~ Ronen Zipkin, Children’s Hospital Los Angeles
10:45-10:55 ABP Roadmap Update ~ Carole Lannon and Javier Gonzalez del Rey
10:55-11:00 Curriculum Learning Community Survey ~ Sarah Hilgenberg, Caren Gellin, and Becky Blankenburg
11:00-11:15 “Exploring Structural Racism & Health Disparities: An Immersive Experience in the American South for Pediatric Residents” ~ Jyothi Marbin, UCSF
11:15-11:30 “Development and Application of an Attending Peer Coaching Program” ~ Erin King, University of Minnesota
11:30-11:45 X+Y Collaborative: “Immersion Scheduling to Promote Cohort Education” ~ Lynn Thoreson, The University of Texas at Austin
11:45-12:00 “Mental and Behavioral Health Learning and OSCEs” ~ Elizabeth Chawla, Georgetown University
12:00-12:15 “Story Slam: Experimenting with a Community Storytelling Night to Promote Resilience” ~ Maren Olson, University of Minnesota

Grassroots Forum for Chief Residents

Acadia/Bissonet

In this inaugural Grassroots Forum for Chief Residents, content will be focused on motivating residents, maintaining Chief Resident wellness, and identifying ways in which Chief Residents can continue networking throughout the year. We will also feature platform presentations selected from submitted abstracts that highlight the excellent work of Chiefs from around the country.

10:15-10:30 Introduction
10:30-10:40 Platform Presentation #1
Safely Promoting Autonomy? Understanding the Impact of Independent Rounding on Medical Students, Residents, and Faculty, presented by Jessica Moriarty, MD, Lee Trope, MD, MS, and Sindu Vellanki, MD, Chief Residents, Stanford School of Medicine
10:40-10:50 Platform Presentation #2
Using a resident readiness board to facilitate a brief daily safety huddle, presented by Kristin Streiler MD, James Odum MD, and Charley Spear, MD, Chief Residents, Children’s Mercy Kansas City
10:50-11:10 Group Discussion on Motivating Residents
11:10-11:15 Mini-Platform Presentation #1
Digital Didactics: An Innovative Approach to Pediatric Board Review, presented by Carolina Bautista Vallderuten, MD, and Claudia Puerto, MD, Nicklaus Children’s Hospital
11:15-11:25 Wellness Break
Chief Bootcamp – Milestone special: Develop your muscles AND your milestones, presented by Awab Ali Ibrahim, MD, and Brian Gavan, MD, Chief Residents, Jacqueline Garavito, MD, Resident Physician, University of South Alabama
11:25-11:30 Mini-Platform Presentation #2
Encouraging Jeopardy Usage for Mental Health and Fatigue, and its Impact on Resident Wellness: Considerations for a High Volume Tertiary Pediatric Training Program, presented by Jillian Mador MD, Sara Serbin, MD, Heather Bernard, MD, and Alanna Brickley, MD, Chief Residents, UPMC Children’s Hospital of Pittsburgh
11:30-11:40 Platform Presentation #3
PRO-PER: A Professional & Personal Development Rotation for Second Year Residents, presented by Tiana Won, MD, Weston Powell, MD, PhD, Kelly Dunford, MD, Melissa Hewson, MD, Chief Residents, Dia Hazra, MD, Paul Morales, MD, Resident Physicians, University of Washington
11:40-12:00 Idea Sharing – Chief Wellness
12:00-12:10 Planning Future Grassroots Forums
12:10-12:15 Wrap Up
This session was developed by: Blair Dickinson, MD, MS, Associate Program Director, St. Christopher’s Hospital for Children, Jay Homme, MD, Program Director, Mayo Clinic, Sophia Goslings, Associate Program Director, University of South Alabama, Cheryl Taurassi, Associate Program Director, Cohen Children’s Medical Center, Eric Zwemer, MD, University of North Carolina, Christine Bacha, MD, Akron Children’s Hospital, Gretchen Metzenberg, DO, St. Christopher’s Hospital for Children, Andrea Scioscia, MD, UH Rainbow Babies & Children’s Hospital, and Stephanie Vander-Plas, MD, Texas Tech University Health Sciences Center.

10:15am - 12:15pm Grassroots Forum for Coordinators Carondelet

This session will be an interactive question and answer forum, allowing coordinators to share common challenges, innovative solutions to problems, and best practices. Dr. Suzanne Woods, Executive Vice President of the American Board of Pediatrics, will also provide important updates to the coordinator membership. Coordinators will have the opportunity to break off into two groups: fellowship and residency coordinators. This will allow them to address obstacles and ideas unique to their program type. At the conclusion of this session, both seasoned and new fellowship and residency coordinators will gain insightful information from their peers. This session is facilitated by Pamela Carpenter, MEd, C-TAGME and Tammy Bleeker, BS, MEd, members of the Coordinators’ Executive Committee.

Grassroots Forum for Fellowship Program Directors Salon F-H

This moderated open forum is designed specifically for subspecialty fellowship directors and coordinators to discuss a variety of current trends and important updates in fellowship education. We anticipate your active participation. Leaders are the APPD Fellowship Directors’ Executive Committee: Kathleen McGann, MD, Kathy Mason, MD, Pnina Weiss, MD, Jennifer Kesselheim, MD, MEd, MBE, Christine Barron, MD, and Jennifer Duncan, MD. Special Guests include the following:
- ABP Road Map – Carole Lannon, MD MPH, Senior Quality Advisor, American Board of Pediatrics
- American Board of Pediatrics (ABP) – Suzanne Woods, MD, Executive Vice President, Credentialing & Initial Certification
- Accreditation Council for Graduate Medical Education (ACGME) – Susie Buchter, MD, Chair, Review Committee for Pediatrics and Caroline Fischer, MBA, Executive Director, Review Committee for Pediatrics
- Subspecialty Pediatric Investigator Network (SPIN) – Richard Mink, MD MACM
- Council on Pediatric Subspecialties (CoPS) – Debra Boyer, MD, Chair

Grassroots Forum for Program Directors Galerie 4-5

The Grassroots Forum for Program Directors will focus on timely topics of interest to Program Directors. This year’s facilitators will be Vasu Bhavaraju, MD (Phoenix Children’s Hospital/Maricopa Medical Center), Suzanne Wright, MD (Marshfield Clinic), and Lorna Fitzpatrick, MD (University at Buffalo).

10:15am-1:45pm MPPDA Plenary and Town Hall with Award Ceremony Salon E

(Tunnessen and Kelley Awards) and Presidential Address

10:15-10:30 MPPDA Opening and Welcome
10:30-11:45 MPPDA Plenary
- “Organizing for Change: A Call to Action”
  Aarti Bhatt, MD, Assistant Professor of Medicine and Pediatrics, University of Minnesota; Michael Aylward, MD, Associate Professor of Medicine and Pediatrics, University of Minnesota; Antonia Eyssallenne, Assistant Professor of Medicine, Pediatrics and Public Health, University of Miami

11:45-12:00 Break for Lunch
12:00-12:15 MPPDA Presidential Address
- Brett Robbins, MD, Professor of Medicine and Pediatrics, University of Rochester School of Medicine

12:15-12:55 MPPDA Award Ceremony
- Tunnessen and Kelley Awards
- Outgoing Leadership and Member Appreciation

1:00-1:45 MPPDA Town Hall

12:30pm-1:45pm Facilitated Networking Lunch Sessions Acadia/Bissonet

Facilitated Mentoring Session
Please enjoy the company of wonderful APPD members at the Facilitated Mentoring Session. Join colleagues to share experiences and discuss topics specific to your own professional development as educators and program leaders. Participants will have time to visit two tables of their choice, each facilitated by a faculty mentor. Open to all APPD attendees. Discussion topics include:
1) Academic Advancement (i.e. education scholarship, development of an educator’s portfolio)
2) Mentoring/Sponsoring (i.e. identifying one’s own mentor/sponsor)
3) Personal Wellbeing
4) Organizational & Time Management Strategies
COMMUNICATIONS COURSE WITH ROLE PLAY TO PREPARE RESIDENTS TO ADDRESS PREJUDICE (TRMP): USE OF AN EXPERIENTIAL COMMUNICATIONS COURSE WITH ROLE PLAY TO PREPARE RESIDENTS TO ADDRESS PREJUDICE IN THE WORKPLACE

Sylvia Choi, MD, Stephanie Dewar, MD, UPMC Medical Education, Pittsburgh, PA

The ACGME is committed to the principle that discrimination and harassment is unacceptable and must not be tolerated and that the environment for trainees will discourage discrimination and harassment by colleagues, supervisors, teachers, peers, other staff members, and patients. The AAP supports measures to improve culturally effective health care through training at all levels and increase diversity amongst pediatric providers. Neither organization address how providers can be trained to respond to discrimination from patients as the workforce becomes more heterogeneous. Clinicians may encounter discriminatory comments directed at themselves or others in the workplace and feel ill-equipped to respond. This creates conflict and can negatively impact patient care and resident well-being. We have developed a communication course for pediatric residents focused on practicing skills to address expressions of prejudice during Family Centered Rounds. This course uses clinical scenarios and simulated parents for experiential learning. The residents can choose to practice responding to intolerant views directed at themselves or a teammate, using the hospital’s Code of Conduct or focusing on shared decision making. The process of learning is experiential and uses guided self-reflection, discussion among peers, and feedback from the simulator and faculty. Following participation in this course, residents felt better prepared to respond to
discriminatory comments on rounds. During this interactive workshop we will demonstrate the Primary Teaching Method of guided facilitation and self-reflection, training of faculty facilitators, creating a safe learning environment for role play, and the specifics on essential resources will be reviewed. We will share the specific scenarios for the role plays. Participants will be given the opportunity to practice these scenarios using role plays so they can receive real-time feedback from the course directors. Lastly, we will discuss how to create similar courses at other institutions.

3. ADVERSE CHILDHOOD EXPERIENCES: PREVENTION, IDENTIFICATION AND TREATMENT

Galerie 6

Stephen DiGiovanni, MD, Brian Youth, MD, Pamela M. Dietz, MD, Dory Hacker, LCSW, Maine Medical Center, Portland, ME

Adverse childhood experiences (ACEs) such as exposure to violence, abuse or neglect, parental substance abuse, incarceration, mental illness or separation/divorce significantly impact a child’s developing brain-body and affect long-term health. Children with greater than or equal to four ACEs have a 70% chance of developmental delay by age 3, a 50% lifetime risk of depression, a 20% lifetime risk of a suicide attempt, in addition to multiple other negative health outcomes. According to the AAP a pediatrician will see an average of 2 to 4 children a day with 4 or more ACEs. This 90-minute educational session will provide participants with foundational understanding and tools to start addressing ACEs in a pediatric resident continuity clinic. We will discuss how a trauma informed lens is an essential component to providing pediatric care and to staff/provider/learner well-being. Key pieces of our program including behavioral health collaboration, educational methods, data utilization, and community partnerships will be highlighted. We will focus on methods to engage resident learners and incorporate this education and screening into a pediatric resident continuity clinic. Participants will be provided with the MaineHealth ACEs Toolkit which includes screening tools for trauma exposure, ACEs number, food insecurity, and PTSD symptoms. For each screen, participants will learn how to introduce, score and respond to the answers in a trauma informed manner. Participants will practice the skills and tools that have been presented. Session will end with will questions and the development of action steps one can bring back to their program.

4. PAGE TO STAGE: DELIVERING THE SCIENCE OF EARLY CHILD DEVELOPMENT THROUGH AN ONLINE, ANIMATED RESIDENCY CURRICULUM

Studio 6

Carrie A. Quinn, MD, Icahn School of Medicine at Mount Sinai, New York, NY, Blair S. Hammond, MD, Icahn School of Medicine at Mount Sinai, New York, NY, Gwen Raphan, MD, Icahn School of Medicine at Mount Sinai (Elmhurst), Elmhurst, NY, Joel S. Forman, MD, Icahn School of Medicine at Mount Sinai, New York, NY, Myo Thwin Myint, MD, Tulane University, New Orleans, LA

This workshop will explore a free, online curriculum, Keystones of Development, that trains pediatric residents to promote parent-child relationships and early child development. The curriculum consists of 6 animated modules which teach residents how to weave the promotion of attachment, autonomy, and executive function into well visits and 6 modules which focus on the science behind these concepts. We will begin the workshop by having participants take a “pre-curriculum survey” that is being used to evaluate residents’ knowledge, attitudes, and behavior regarding counseling parents on behaviors that promote child development and strong parent-child relationships. We will then review a needs assessment of 173 members of the APPD about current practices, barriers, and desires for training pediatric residents on how to promote positive parenting behaviors that foster optimal development. Participants will break into small groups and discuss current resident education in this area at their institution. We will follow up with each table sharing with the large group the different teaching modalities used in their programs to train learners on promoting development. As a large group, participants will then view a few clips from different modules of the Keystones of Development curriculum which is currently being pilot site tested at 7 residency programs. After viewing some of the modules, participants will again break into small groups to brainstorm possible ways they might implement the curriculum at their program, including identifying where in resident training the curriculum should be integrated, potential barriers, and solutions. We will ask participants to consider faculty development that might be helpful and other ideas to make the learning most impactful. We will wrap up with a large group share of creative strategies to implement the online curriculum into resident training. Pilot site directors from other programs will then discuss with the whole group how they have integrated the curriculum at their institutions and preliminary resident evaluation data looking at the impact the curriculum has had on residents’ knowledge, attitudes, and behavior.

5. IMPLEMENTING A SPIRITUAL CARE CURRICULUM INTO PEDIATRIC RESIDENCY TRAINING

Studio 7-8

Paige Stevens, MD, Travis White, MD, Children’s Hospital of Los Angeles, Los Angeles, CA

An important aspect of caring for the biopsychosocial needs of patients is addressing their spirituality and many pediatricians feel that faith plays an important role in healing. Despite this, few curricula have been developed to teach pediatricians how to incorporate spiritual care into their practice. This workshop teaches pediatricians how to implement spiritual care into their clinical practice through showcasing a spiritual care curriculum that was designed and implemented in a pediatric residency training program at a large, urban, academic Children’s hospital. Participants will engage in three interactive sessions designed to teach the following: the importance of providing spiritual care for pediatric patients and their families, how to incorporate a spiritual history into the biopsychosocial assessment of a pediatric patient, and how to utilize hospital-wide, interdisciplinary spiritual care resources. In the first session, workshop leaders will provide didactic education about literature supporting the importance of spiritual care in medical practice. Leaders will then facilitate small-group discussions about clinical cases highlighting several world religions frequently encountered in medical care. Discussion will help participants identify how beliefs of patients and family members may affect medical decision-making and how to identify resources available for patients and families in various clinical settings. In the second session, workshop leaders will teach an evidence-based tool, the HOPE model, as a means of obtaining a spiritual history. Participants will then work as dyads to practice utilizing the HOPE model through role-play activities. In the third session, participants will engage in small group discussions...
Participants will develop a plan for implementation of a specific well-being initiative for their own program, targeting work-life balance, goal-setting, mindfulness, stress-reduction, and personal reflection to enhance resiliency. Systems-level reforms that are known to improve physician well-being, 3) discuss and practice evidence-based interventions systems improvement approach to address wellness, 2) describe and share best practices for organizational factors and through two of three interactive stations to 1) draft questions for their own program-specific needs assessment to inform their overview of evidence-based interventions to improve individual resiliency. Participants will then have the option to rotate developing a program-specific needs assessment, highlight organizational factors that influence well-being, and give a brief to promote well-being and meet this challenge. The session will begin with a panel discussion to provide a framework for institutions engaged in training residents and fellows are struggling to make meaningful changes since the Accreditation Council for Graduate Medical Education (ACGME) issued new program requirements in 2017 related to physician wellness, institutions engaged in training residents and fellows are struggling to make meaningful changes and meet this challenge. The session will begin with a panel discussion to provide a framework for developing a program-specific needs assessment, highlight organizational factors that influence well-being, and give a brief overview of evidence-based interventions to improve individual resiliency. Participants will then have the option to rotate through two of three interactive stations to 1) draft questions for their own program-specific needs assessment to inform their systems improvement approach to address wellness, 2) describe and share best practices for organizational factors and systems-level reforms that are known to improve physician well-being, 3) discuss and practice evidence-based interventions targeting work-life balance, goal-setting, mindfulness, stress-reduction, and personal reflection to enhance resiliency. Participants will develop a plan for implementation of a specific well-being initiative for their own program.
9. WITH OR WITHOUT YOU: PROMOTING RESIDENT AND MEDICAL STUDENT AUTONOMY

ACROSS CLINICAL SETTINGS

Jessica Moriarity, MD, Sindu Vellangi, MD, Lee Trope, MD, Stanford Pediatrics – Stanford School of Medicine; Kelly Dundon, MD, Melissa Hewson, MD, Weston Powell, MD, Tiana Won, MD, Heather McPhillips, MD, Seattle Children’s Hospital – University of Washington; Caren Gellin, MD, University of Rochester Medical Center; Michael Weisgerber, MD, Patrick McCarthy, MD, Children’s Hospital of Wisconsin – Medical College of Wisconsin; Sarah Hilgenberg, MD, Becky Blankenburg, MD, MPH, Stanford Pediatrics – Stanford School of Medicine

According to the American College of Graduate Medical Education (ACGME), a residency training program must foster in residents the skills, knowledge, and attitudes required to enter the unsupervised practice of medicine. This development is highly dependent on allocation of progressive and graded responsibility. Over the last several decades, the appropriate balance of autonomy and supervision has been questioned, particularly in the light of heightened patient safety concerns, increased complexity of the healthcare system, and 24/7 hospitalist coverage in many teaching hospitals. In this highly interactive workshop, participants will complete a force field analysis to highlight facilitating factors and barriers to promoting autonomy in various clinical settings. Facilitators will then present a brief overview of the theories supporting autonomy, as described in self-determination theory, educational scaffolding, and entrustment decision making. In facilitated small groups, participants will actively apply these concepts to clinical scenarios presented through video clips or clinical skits. Participants will next develop strategies that individuals can employ to optimize the balance between autonomy and supervision at resident and/or fellow levels across clinical settings. Participants will then brainstorm programmatic structural changes and create an action plan that both faculty and trainees can implement to safely promote autonomy in their home institutions. In an interactive Gallery Walk, participants will review each other’s action plans and give each other feedback. A final large group discussion will clarify any remaining questions and allow participants to commit to meaningful change.

10. NEW OPPORTUNITIES FOR LEARNING ABOUT ADVOCACY (NOLA)

Julie A. Venci, MD, Anne Frank, MD, Amy Beeson, MD, University of Colorado, Denver, CO, Brian Hilliard, MD, University of Minnesota, Minneapolis, MN, Christopher Bruti, MD, Rush University Medical Center, Chicago, IL

The ACGME program requirements for Internal Medicine–Pediatrics (Med-Peds) residency training includes two educational units of ambulatory experiences which include elements of community pediatrics and child advocacy. At last year’s national meeting, the Med-Peds Program Directors Association (MPPDA) identified that residencies want improved resources and information on how to incorporate advocacy into their training programs. Through an online survey conducted by the National Med-Peds Residents Association (NMPRA), Med-Peds programs were asked to describe their advocacy curricula. The survey results identified great variability in how Med-Peds programs are currently meeting the ACGME requirement. This workshop will encourage a collaborative approach to development and enhancement of advocacy curricula. Current state will be described by highlighting the survey results and a gallery walk of program exemplars. Attendees will utilize structured worksheets to reflect on opportunities and barriers to creating or updating an advocacy curriculum at their home institution. These ideas will be further refined through interactive small group sessions. Attendees will leave with 2 SMART goals for development or modification of an advocacy curriculum. Finally, participants will have an opportunity to join a Med-Peds advocacy committee and listserv.

11. WE CAN DO IT! HOW TO EFFECTIVELY MANAGE AN EDUCATIONAL PROGRAM WITHOUT AUTHORITY

Gretchen Shawver, BS, Stanford University, Palo Alto, CA, Carrie Johnson, MBA, Alexandra “AJ” Fletcher, BA, Megan Christofferson, BA, C-TAGME, Charlene Larson Rotandi, AB, C-TAGME, Stanford University, Stanford, CA

A central portion of the program coordinator role is to ensure that the program requirements are being fulfilled, including soliciting essential documentation from trainees, faculty, and staff. But what is a coordinator to do when they feel as though they do not have the authority to hold others accountable for failing to follow through? Managing without authority is essential to the very practice of a coordinator, and often many are frustrated and struggle with getting other stakeholders to comply, especially in a timely manner, to program requests. Often program coordinators are told to find someone with more authority (e.g., program director, division chief, DIO, etc.) to exert it on their behalf. However, not all program coordinators are fortunate to have an effective ally in their program to whom they can turn. In the absence of support, there are techniques and strategies that can help a program coordinator get the job done. The workshop will include case-based examples of management challenges and solutions program coordinators commonly face. Participants are expected to contribute to the discussions, drawing from their own experiences, and help brainstorm as many potential solutions as possible since no one technique will work for all programs. Following the session, all participants will receive a toolkit that will include a summary of the ideas generated during the session, as well as additional resources compiled by the facilitators.

3:45pm - 5:15pm Enhanced Learning Session II (choice of 11)

12. MEDICAID (AND HOW TO TEACH IT) MADE CLEAR

Cara Lichtenstein, MD, MPH, Children’s National Medical Center, Washington, DC, Elizabeth Hanson, MD, University of Texas Health Science Center School of Medicine at San Antonio, San Antonio, TX, Natalie J. Burman, MD, Naval Medical Center (San Diego), San Diego, CA

Did you know that Medicaid provides health insurance coverage to more people in the US than any other single program covering nearly half of all births in a typical state, 76% of poor children, and 48% of children with special health care needs? Medicaid is essential for providing quality care to children in the US and improved understanding of the program allows residents to better advocate for quality patient care and optimal patient care systems as required by the ACGME. Pediatric
The Accreditation Council for Graduate Medical Education (ACGME) has made advocacy training and experience a requirement for all pediatric residents. Pediatric residency programs have adapted a variety of approaches to integrating advocacy into their formal curricula, including advocacy rotations and electives. The components to effective advocacy are to identify a problem, gather information, commit to action, collaborate with others, mobilize resources, and sustain the effort. In this highly interactive workshop, we will orient participants to a novel Advocacy Action Plan tool, which can be used to prime residents and fellows to develop and meet personalized advocacy goals and delineated steps to meet those goals. Participants will develop their own individualized advocacy action plans to familiarize themselves with the tool.

We will present a framework of advocacy at interpersonal, organizational, health system, and policy levels, based on the social-ecological model of public health, to encourage participants to think broadly about advocacy opportunities for learners. Pediatric residents are already familiar with the concept of developing asthma action plans for our patients; in this workshop participants will learn how to guide residents and fellows to develop their own personalized advocacy action plan.

### 13. LIGHTING THE FIRE: ACTIVATING ADVOCACY SKILLS AND ACTION IN LEARNERS

**Salon F-H**

**Heather Lukolyo, MD, MHS, Baylor College of Medicine (Houston), Houston, TX, Amy Rule, MD, MPH, Cincinnati Children’s Hospital Medical Center/University of Cincinnati College of Medicine, Cincinnati, OH, Tania Condurache, MD, University of Louisville, Louisville, KY, Michelle Lopez, MD, MPH, Julieanna Nichols, MD, Claire Bocchini, MD, Baylor College of Medicine (Houston), Houston, TX**

There is widespread acceptance among physicians’ organizations and medical educators that advocacy is a core component of medical professionalism. The Accreditation Council for Graduate Medical Education (ACGME) has made advocacy training and experience a requirement for all pediatric residents. Pediatric residency programs have adapted a variety of approaches to integrating advocacy into their formal curricula, including advocacy rotations and electives. The components to effective advocacy are to identify a problem, gather information, commit to action, collaborate with others, mobilize resources, and sustain the effort. In this highly interactive workshop, we will orient participants to a novel Advocacy Action Plan tool, which can be used to prime residents and fellows to develop and meet personalized advocacy goals and delineated steps to meet those goals. Participants will develop their own individualized advocacy action plans to familiarize themselves with the tool.

We will present a framework of advocacy at interpersonal, organizational, health system, and policy levels, based on the social-ecological model of public health, to encourage participants to think broadly about advocacy opportunities for learners. Pediatric residents are already familiar with the concept of developing asthma action plans for our patients; in this workshop participants will learn how to guide residents and fellows to develop their own personalized advocacy action plan.

### 14. DEVELOPING PHYSICIAN SCIENTISTS DURING PEDIATRIC RESIDENCY

**Studio 9-10**

**Caroline Rassbach, MD, Stanford University, Stanford, CA, Debra Boyer, MD, Children’s Hospital/Boston Medical Center, Boston, MA, Rebecca Blankenburg, MD, MPH, Stanford University, Palo Alto, CA, Heather McPhillips, MD, Weston Powell, MD, PhD, University of Washington, Seattle, WA, Pnina Weiss, MD, Yale-New Haven Medical Center, New Haven, CT, Steven Levitte, MD, PhD, Stanford University, Palo Alto, CA, Mark Ward, MD, Andrea Burns, PhD, Baylor College of Medicine (Houston), Houston, TX**

Physician-scientists dedicate their careers to research advancing our understanding of diseases and developing new therapies and preventative measures to improve health. Physician-scientists areas of research may include basic science, translational research, clinical research, and occasionally other areas. Residency programs have an important mission to train physician scientists who face numerous opportunities, challenges and threats throughout their careers. Pathways to train physician scientists during residency include alternative pathways such as the American Board of Pediatrics Integrated Research Pathway (IRP) and Accelerated Research Pathway (ARP). Developing physician-scientists requires attention to their clinical training, research training, work-life integration and wellness. This workshop seeks to bring together experts and key stakeholders to discuss best practices in residency training for physician-scientists. This highly interactive workshop will begin with a pair-share activity where participants will discuss successes and challenges their own institutions face in supporting physician-scientists-in-training. Facilitators will then present a short didactic on the definition and roles of physician scientists and recent literature on physician scientist training. Next, facilitators will share physician-scientist residency training models from a few of their own institutions, which include Baylor, Stanford, Seattle, Harvard, and Yale. Participants will then have the opportunity to rotate through two out of four expert-facilitated tables to discuss the following elements of physician-scientist residency training: 1) mentorship, peer mentorship and personal support, 2) clinical training and the ARP and IRP pathways, 3) goals and objectives for research training in residency, and 4) considerations for small vs large programs with focus on infrastructure and funding. The structure of the small groups will include facilitated discussion and prompting questions around core issues for expert facilitators to address key questions in the topic area followed by a chance for participants to share experiences from their own institutions and to ask additional questions. Small groups will then report-out to the larger group so that all participants hear about all four topic areas. The workshop will conclude with facilitators sharing take-home points and resources followed by participants having the chance to ask questions and share additional insights.
15. SIMMING AFTER SUNDOWN: INTERACTIVE THINK TANK TO LAUNCH THE DEVELOPMENT OF A NIGHTTIME SIMULATION EDUCATION CURRICULUM

Amanda J. Rogers, MD, Medical College of Wisconsin Affiliated Hospitals, Milwaukee, WI, Ariel Frey-Vogel, MD, Massachusetts General Hospital, Boston, MA, Madhuri Dave, DO, Carmen Cobb, MD, Lauren Castaneda, MD, Michael Weisgerber, MD, Medical College of Wisconsin Affiliated Hospitals, Milwaukee, WI

With changes in work hours, night rotations have become a staple in most residency programs. There is valuable learning that occurs at night, but residents often miss formal didactics, rounds, and opportunities to talk in depth about their patients. At the same time, night emergencies are in the hands of residents without their usual daytime support system. Given these realities, a resident-run nighttime simulation curriculum, focusing on night emergencies, could address two issues at once: increasing formal education for residents working at night and increasing resident competency handling emergencies at night. So let's all start simming after sundown! While this idea has a lot of potential, there are challenges to creating, implementing, and sustaining a nighttime simulation curriculum. That's why we need your help - to make this idea a reality! This highly interactive session will allow interested participants to join members of the APPD Healthcare Simulation in Pediatrics Learning Community in a multi-institutional project to develop, implement, and assess a nighttime simulation curriculum. We will begin working through Kern’s six steps of curriculum design to develop the proposed curriculum. We will start by conducting a multi-institutional needs assessment regarding high yield content to include and barriers to implementation. Next, we will use Bloom’s taxonomy to develop curricular goals and objectives. Participants will then divide into three groups to begin developing 1) session content with case templates, 2) educational strategies and implementation approach, and 3) methods for curriculum evaluation. At the end, participants interested in remaining involved will develop action items and a timeline to continue project development. We welcome residents, chiefs, and faculty in all roles to join us regardless of whether you are able to continue with the project outside the meeting! We hope this will be an opportunity to gather perspectives and lay the groundwork for a meaningful project while also allowing participants who are interested mentorship in scholarship.

16. MANO A MANO: HOT TOPICS IN MEDICAL EDUCATION

Salon A-D

Rebecca Wallihan, MD, Nationwide Children’s Hospital/Ohio State University, Columbus, OH, Emily Borman-Shoap, MD, University of Minnesota, Minneapolis, MN, Ndidi Unaka, MD, Cincinnati Children’s Hospital Medical Center/University of Cincinnati College of Medicine, Cincinnati, OH, John Mahan, MD, Nationwide Children’s Hospital/Ohio State University, Columbus, OH, Javier Gonzalez del Rey, MD, Cincinnati Children’s Hospital Medical Center/University of Cincinnati College of Medicine, Cincinnati, OH, Teri Turner, MD, Baylor College of Medicine (Houston), Houston, TX, Heather McPhillips, MD, University of Washington, Seattle, WA, Alan Chin, MD, University of California, Los Angeles, Los Angeles, CA, Sabrina Ben-Zion, MD, Children’s Hospital Medical Center of Akron/NEOMED, Akron, OH

In this interactive, debate-style session, attendees will hear leaders in the field face off to address emerging issues in medical education. Three hot topics will be discussed with an affirmative and negative speaker for each. After opening remarks and framing by the moderator, each debater will present briefly her/his major points, address follow-up questions from the moderator, and then respond to audience questions. The debate is then ended by closing remarks by each debater. Audience response will be used to poll attendees on their stance prior to and at the conclusion of each topic. The three proposed topics for 2019 are: 1) Current interview practices: Is it time for a new system? 2) Social media persona: Is it mine or the program’s? 3) Trainee wellness: Individual or program responsibility?

17. DO I HAVE TO? EXAMINING THE DEBATE ABOUT MANDATORY SCHOLARLY ACTIVITY DURING RESIDENCY TRAINING

Studio 7-8

Mackenzie S. Frost, MD, University of Texas Southwestern Medical School, Dallas, TX, Blair Dickinson, MD, St. Christopher’s Hospital for Children, Betsy Maxwell, MD, Children’s Hospital of Philadelphia, Philadelphia, PA, Meredith Monaco-Brown, MD, Albany Medical Center, Albany, NY, Andrew Yu, MD, University of Texas Southwestern Medical School, Dallas, TX

Requiring participation in scholarly activity for trainees is a source of debate for many programs. Successful scholarly experiences can improve trainees’ critical thinking skills, further their understanding of the medical literature, foster an interest in a sub-specialty area, and help strengthen fellowship and job applications. However, meaningful participation in scholarly activity during residency training can be difficult to achieve. Simply reaching a consensus about which resident activities constitute “scholarship” can be hard. Scheduling challenges, inadequate mentorship, and changing career goals can negatively impact scholarly pursuits. Thus, programs may feel challenged in supporting residents who wish to complete scholarly projects and are then unlikely to mandate it as part of residents’ educational experience. This session will focus on the debate of the role of scholarly activity during residency training. The session will be led by a multidisciplinary group of residency and fellowship associate program directors from across the country. First, the panel of session moderators will debate the pros and cons of mandatory scholarly activity for residents. Session participants will have an opportunity to ask the panel questions to further the debate discussion. Then session leaders will present ways that scholarly activity is integrated into their programs: experiences at programs that both require and do not require scholarship will be highlighted. Facilitated small groups will then discuss ways that participants can integrate similar approaches into their home institutions. Finally, the impact of scholarly activity on career choices after residency will be discussed. Small groups will develop strategies to help ensure that trainees appropriately emphasize their residency scholarship on their CVs and applications.
Evaluations are an essential part of medical training for all levels of learners, yet numerous studies show that bias is pervasive. Many consider this as it relates to resuscitation training, but SBE extends beyond prepping for emergencies. We aim to provide educators with practical tools they can use to enhance multiple areas of resident and fellow training. Multi-disciplinary and multi-specialty facilitators represent a variety of institutional sizes with a range of simulation experience, equipment and funding. Our goal is to share techniques that may be incorporated easily and quickly in the absence of high technology or budgets. We will provide an overview of SBE and a review of programs at 3 institutions. Majority of time will be in interactive sessions with participants rotating through stations.

One of the stations will focus on creative ways to construct procedural models for task training. Participants will interact with several task-training models: from suturing to higher-level procedures like pericardiocentesis. We will review cost-effective ways to enhance procedural training by creating models from simple materials. Station 2 will focus on the use of rapid cycle deliberate practice. This technique is an adaptation of SBE where learners practice a specific skill/scenario, quickly debrief, and repeat the process until mastery is achieved. This method allows practice of specific skills, while providing in-the-moment feedback. This technique can improve technical skills, leadership, and communication. Station 3 will focus on the use of low-fidelity models to enhance trainee night team education. Many learners have less exposure to formal educational sessions while they are working overnight, yet encounter many high acuity situations. The use of low-fidelity simulation can enhance clinical reasoning skills for commonly encountered events and increase exposure to managing critical situations.

The conclusion of the workshop will engage participants to reflect on ways to implement strategies at their programs. We will provide materials that help participants apply SBE methodologies reviewed during the workshop.

19. MOLDING THE MILLENNIAL MIND: INSTAGRAM AS A MEDIUM FOR GRADUATE MEDICAL EDUCATION

Stephanie A. Raymundo, MD, University of California (Irvine)/CHOC, Long Beach, CA, Niharika Goparaju, MD, Daniel Kang, MD, Candace Taylor Lucas, MD, MPH, University of California (Irvine)/CHOC, Irvine, CA

The millennial generation has access to an innumerable amount of resources but is faced with the daunting task of navigating them. In recognition of this, innovative strategies utilizing social media are increasingly common in graduate medical education. Residency programs often capitalize on resident use of common media platforms such as Facebook and Twitter for resource dissemination, recruitment, and advocacy. Instagram is a smartphone application that focuses on mobile sharing of images and videos and builds on recent trends in mobile photography. It is unique in that it is simple, quick and fun. With more than 500 million active users, Instagram rivals other popular platforms such as Facebook and Twitter. If your program has ever experienced difficulty connecting with your millennial residents, this session will inspire you to incorporate Instagram in your residency training program. Instagram offers novel teaching opportunities, can enhance messaging during recruitment, support advocacy efforts, and foster a sense of resilience and belonging by highlighting resident and faculty achievement.

During the first part of this session, you will learn about the main features of this social media platform as well as how to utilize them to target specific residency program needs. The second part of the session will involve workshop time to practice these skills with peers...and the presenting millennial herself!

20. JOHN IS CONFIDENT, JADA IS TOO ASSERTIVE: HOW TO RECOGNIZE AND MINIMIZE BIAS IN WRITTEN TRAINEE EVALUATIONS

Hannah Keppler, MD, Kamaal Jones, MD, Maria de Lourdes Eguiguren, MD, Emily Earl-Royal, MD MPH, Jonathan Updike, MD MPH, Xinshu Shi, MD, Quynh Dierickx, MD, Joseph Perales, DrPh LCSW, Lahia Yemane, MD, Stanford University, Palo Alto, CA

Evaluations are an essential part of medical training for all levels of learners, yet numerous studies show that bias is pervasive throughout evaluations of trainees across all specialties and can have longstanding implications. In emergency medicine, the rate of resident milestone evaluation attainment throughout residency was higher for males than females across all sub-competencies despite receiving similar evaluations at the beginning of residency(1). Another study with medical students showed white students were more likely to be described using “standout” words whereas black students were described as “competent”(2). The effects of bias in evaluations can create differences in opportunities for advancement among different groups, such as selection into AOA, residency and fellowship programs, and leadership positions in academics. For these reasons, it is imperative that medical educators have the knowledge and skills to recognize and minimize bias in written evaluations so that we do not continue to perpetuate these disparities. This interactive workshop will teach participants how to identify potential bias in evaluations and practice how to minimize bias in their own written evaluations. The session will begin with a pair-share activity and reflection on a sample trainee evaluation that will be referenced throughout the session as new concepts are introduced. The presenters will then review literature in business and across the medical education continuum to build the case for the enduring negative effects of bias and current best practices to reduce its effects on an individual, programmatic, and institutional level. Participants will then use what they have learned to actively practice analyzing and editing additional sample evaluations as part of a group activity and then large group de-briefing. By the end of the workshop, participants will leave with new knowledge and skills to reduce bias in written evaluations.
21. TOGETHER BUT NOT EQUAL: CAN WE MITIGATE THE EFFECTS OF BIAS AND DISCRIMINATION IN THE LEARNING ENVIRONMENT?

Mumtaz Mustapha, MD, University of Minnesota, Minneapolis, MN, Alda M. Gonzaga, MD, UPMC Medical Education, Pittsburgh, PA

Imagine this scenario: you are an intern and about to perform a lumbar puncture. You excelled in the simulation and are feeling confident but anxious. As you’re prepping the patient, the nurse says, “Women usually have a harder time with this procedure, but you seem to be doing quite well.” Could that ‘compliment’ negatively affect your performance? Research says it could. Stereotype threat, the fear of being evaluated based on stereotype, can lead to under-performance of learners. Though non-white trainees, religious minorities, and women are more prone to stereotype threat, stereotype threat can affect anyone, creating a cognitive burden detrimental to learning in the clinical environment. In this workshop, we explore three examples of the impact of unconscious bias prevalent in academic medicine: stereotype threat, diversity tax, and surplus visibility. We based this workshop on our prior successful work designed to improve the effectiveness and confidence of established educators working in today’s increasingly diverse learning climate. We have seen that this thoughtful and deliberate work leads to personal and institutional change. We begin by introducing core topics and vocabulary used throughout the workshop, and the adult learning theory upon which the workshop is based. We invite participants to share personal experience with stereotype and bias. Using interactive cases, participants explore the topics, and learn strategies to mitigate the effect of bias on individual learners and the learning environment. Participants leave with a toolkit including articles, vignettes and a slide set for faculty development.

22. THE SEVEN HABITS OF HIGHLY EFFECTIVE PROGRAM COORDINATORS

Elizabeth Wueste, MAEd, C-TAGME, University of Texas Health Science Center School of Medicine at San Antonio, San Antonio, TX, Charlene Larson Rotandi, AB, C-TAGME, Stanford University, Stanford, CA

The last several years have brought significant change to the ACGME program requirements and how Program Coordinators effectively manage these programs. Broad-based accreditation improvements have allowed for a positive shift in mindset, culture and overall programmatic outcomes. However, change in itself brings unease and discomfort to which implies a need for self-reflection and personal growth to remain effective in attaining both personal and professional goals. The role of program coordinators in graduate medical education embodies that of a community of leaders and learners that personifies a commitment to lifelong learning and improvement. By participating in personal and professional development, program coordinators will be able to create ideas and opportunities to drive innovative learning environments and foster relationships with the broader graduate medical education community. The workshop is based on the well-known text by Stephen Covey, The Seven Habits of Highly Effective People, first published in 1989. Participants will be introduced to foundational ideas of these seven habits and apply the concept of a paradigm shift to facilitate change in mindset from the graduate medical education perspective. Session participants will go through a self-reflection exercise and learn to apply techniques and strategies to improve their personal effectiveness. “Habit is the intersection of knowledge (what to do), skill (how to do), and desire (want to do).”

7:00pm - 9:00pm MPPDA Dinner (off-site; additional fee required)
Crescent City Brewhouse, 527 Decatur Street, New Orleans, Louisiana 70130
www.crescentcitybrewhouse.com
8:00am - 9:00am  AMPPA Meeting: Professional Development  

9:00am - 10:00am  Plenary Session  

**Acadia/Bissonet**

9:00-9:05am  Welcome ~ Javier Gonzalez del Rey, MD, APPD President

9:05-9:10am  Presentation of Carol Berkowitz Award for Advocacy and Leadership in Pediatric Medical Education ~ Franklin Trimm, MD, APPD Immediate Past President

9:10-9:20am  APPD LEAD Graduation ~ Su-Ting Li, MD, APPD LEAD Council Chair

9:20-9:50am  Update from the Accreditation Council of Graduate Medical Education (ACGME) with Q&A ~ Susie Buchter, MD, Chair, Review Committee for Pediatrics and Caroline Fischer, MBA, Executive Director, Review Committee for Pediatrics

9:50-9:55am  Orientation to the day ~ Adam Rosenberg, MD, APPD Program Chair

10:15am - 11:45am  Table to Able Session  

This year we are again offering the popular Table to Able session. The theme of this session is Best Practices. The format of the session will consist of tables covering a variety of topics, with one topic and a specific question related to that topic at each table. There will be an expert Table Leader who will address the question and topic and facilitate discussion. Each table session will be 25 minutes in length with the opportunity to participate in three table topics during the session.

**Curricular Issues**

- Developing Cultural Humility and Structural Competency
- Board Preparation
- Education
- Global Health
- Mental Health Curriculum

**Program and Accreditation**

- Recruitment and the Match Frenzy
- Milestones
- Community Based Programs
- Chief Resident Role

**Personal and Professional Development**

- Wellness
- Promoting Resilience
- Developing Mentorship in your training program

**Regional Lunch 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

12:00pm - 1:15pm  Regional Lunch Meetings  

MPPDA Business Meeting  

(includes AMPPA and Med-Peds Leadership Awards)  

- MPPDA Leadership Award
- AMPAA Administrator Award
- Committee Reports
- NMPRA Presidential Update
- AAP Section on Med-Peds Update
Consultation Requests

Sara J. Pavitt, MD, Kim Hoang, MD, Stanford University, Palo Alto, CA, Ross Myers, MD, Case Western Reserve University/University Hospital Case Medical Center/Rainbow Babies, Cleveland, OH, Jessica Moriarty, MD, Lee Tropo, MD, Sindu Vellanki, MD, Nivedita Srinivas, MD, Stanford University, Palo Alto, CA

Communication failures are the leading cause of medical errors. Previous studies have shown lack of communication standardization leads to delays and errors in patient care, as well as increased health care costs. For this reason, the Accreditation Council for Graduate Medical Education has identified communication skills as a competency equal in importance to clinical skill and medical knowledge for residents and fellows. Regardless of provider training level, effective consult communication is important to ensure that timely and pertinent recommendations are made. However, most health care providers do not receive formal training on effective consult communication. In an ongoing study at Lucile Packard Children’s Hospital at Stanford examining the current state of consult communication, pediatric subspecialty fellows felt that 50% of consult questions posed by residents were either unclear or very unclear. Miscommunication during consults was reported by residents and fellows (98% and 96%, respectively). Furthermore, residents and fellows reported a number of these miscommunications lead to patient safety errors (86% and 88%, respectively). Based on focus groups of residents and fellows, a novel modified SBAR tool was developed to standardize and improve verbal consult communication. SBAR is a communication tool that is currently used in various healthcare settings. A recent systematic review of SBAR demonstrated its overall effectiveness on improving patient outcomes. In this highly interactive workshop, we will help participants learn and apply a modified SBAR as a standardized communication tool to facilitate learners’ communication around consult requests that can be applied at their home institutions. Participants will reflect on prior experiences and challenges in facilitated small-group exercises and large group discussions. Participants will then apply the SBAR tool in role-play scenarios. All participants will leave with an implementation plan as well as a practical tool kit to improve their own practice and to teach others how to initiate a standardized consult workflow at their home institutions.

24. The Educator Portfolio Demystified: Building a Tool for Reflecting on Your Work and Advancing Your Career

Karen A. Mangold, MD, MEd, Zarina Norton, MD, Michael Spewak, MD, Robyn A. Bockrath, MD, MEd, Priya G. Jain, MD, McGaw Medical Center of Northwestern University, Chicago, IL, Sarada Panchanathan, MD, MS, University of Arizona, Phoenix, AZ, Deborah A. Alliston, MD, MEd, University of Kansas School of Medicine, Wichita, KS, Elizabeth K. Nelsen, MD, SUNY Upstate Medical University, Syracuse, NY, Kevin Kuo, MD, MHPE, Stanford University, Palo Alto, CA

Educator portfolios act as tool for assessment of performance and to stimulate learning from experience. However, the time and effort needed to develop a portfolio can lead to frustration. Promotion of portfolio development and mitigation of negative reactions can be achieved by using a flexible learner-centered format with structure and guidance. Such guidance will be provided in this workshop through a step-wise approach to portfolio development with reflective exercise for learner-centered application. This will be an interactive workshop co-taught with faculty from multiple institutions who have expertise in developing educator portfolios for various purposes. We will first use an audience response system to determine the background and goals of participants. Next, there will be a brief didactic overview of the history of educator portfolios and how they are used today. Participants will be able to explore various portfolio platforms online and determine which formats best fit their individual needs. Using worksheets and feedback from partners and small groups, participants will develop their own goals and an outline for their own portfolio. Faculty will continue to give insight during group discussion on their own experiences with format, content and usefulness of portfolios. Attendees are encouraged to bring their own laptops to allow them to view different sites online.

25. Understanding SI2025: Preparing Programs and Sponsoring Institutions to Meet Future Challenges in Health Care

Abdulla Ghori, MD, Amy Zack, MD, Mammen Puliyel, MD, Case Western Reserve University (MetroHealth), Cleveland, OH

It is every GME educator’s responsibility to understand the future challenges and plan proactive steps possible within their program and institution to modify curriculum and training practices to prepare trainees for a successful future. The presenters are experienced in the model of change, have spent a considerable amount of time understanding the concept of SI2025 and planned strategies feasible even in resource limited institutions. The lessons learnt, and the practice of developing strategies experienced during the workshop session will enable participants to implement innovations within their programs and institutions and mitigate the fear of facing the future challenges in graduate medical education, projected in SI2025. Session Takeaways: The presentation will educate the participants on the concept of SI2025 and provide an overview of the 9 thematic categories, 52 findings, and the current view and projected view with concrete examples. Practically feasible number of selected thematic categories and findings will be shared in print on tables for workshop discussion. Following presentation of examples of proactive steps composed by the presenters for select findings, participants will have the opportunity to work on their plans to address the findings shared on their table. The plans proposed by each table will be presented to the audience for discussion, and comments. The final set of plans will be collated and shared with all participants. Post conference the participants will be given the option of future communications among the group to bounce off ideas. Presenters will also be available as advisors.
The Accreditation Council of Graduate Medical Education (ACGME) has expanded requirements for residencies and fellowships specifying that programs must provide a supportive, educational environment that is free of mistreatment. Faculty must role model humanistic behaviors and promote joy of curiosity, problem-solving, intellectual rigor, and discovery. Despite these goals, recent data show that medical learning environments are not consistently providing optimal learning climates for trainees. In this interactive learning session using collaborative activities, facilitated small groups, and large group discussions, participants will identify the value of a positive learning climate and the impact that suboptimal environments have on trainee well-being, professional satisfaction, and development. Working in small groups followed by large group discussions, participants will explore key drivers resulting in substandard environments within their institutions. Presenters represent a diversity of intuitions including both residency and fellowship leadership. Data from the presenting institutions will be shared also highlighting proposed solutions and methods to monitor and enhance the learning climate. Participants will work in pairs to develop plans for ways to measure the learning climates in their institutions and propose solutions to identified issues. Action plans will be shared in a pair-share format to maximize feedback. Participants will leave the workshop understanding the current challenges that exist within their institutional learning climate and with concrete, actionable plans and tools to improve and enhance the learning environment, which will meet the ACGME requirements.

27. HELPING OUR TRAINEES BECOME THE PEDIATRICIANS THEY ALWAYS WANTED TO BE: CAREER DEVELOPMENT AND CARING FOR UNDERSERVED AND GLOBAL POPULATIONS

Amy R. Rule, MD MPH, Cincinnati Children’s Hospital Medical Center/University of Cincinnati College of Medicine, Cincinnati, OH, Heather Lukoylo, MD MHS, Baylor College of Medicine (Houston), Houston, TX, Meghan Hofo, MD MPH, University of Alabama Medical Center, Birmingham, AL, Joanne Mendoza, MD, University of Virginia, Charlottesville, VA, Tania Condurache, MD MSc, University of Louisville, Louisville, KY, Chuck Schubert, MD, Cincinnati Children’s Hospital Medical Center/University of Cincinnati College of Medicine, Cincinnati, OH, Heather Crouse, MD, Baylor College of Medicine (Houston), Houston, TX

Remember when you decided to become a pediatrician and educator because you wanted to make a difference and help your trainees do the same? Studies show that increasing numbers of medical students, pediatrics residents and fellows are passionate about Global Health and caring for the underserved, but far fewer are successful at incorporating that into their careers. Common barriers include time and financial constraints, family and personal obligations, lack of institutional or administrative buy-in, lack of mentorship, medical education requirements, and lack of protected time to be away. In this interactive workshop, you will learn about five global health/underserved medicine-pediatrics career pathways that incorporate international or domestic global health care and education with underserved populations. Building on the five pathways and using the new ABP guide, Global Health in Pediatric Education: An Implementation Guide for Program Directors, small groups of educators will work collaboratively with successful global health pediatricians as facilitators, to work through the issues and challenges to help trainees develop plans for ways to measure the learning climates in their institutions and propose solutions to identified issues. Action plans will be shared in a pair-share format to maximize feedback. Participants will leave the workshop understanding the current challenges that exist within their institutional learning climate and with concrete, actionable plans and tools to improve and enhance the learning environment, which will meet the ACGME requirements.

28. TAKING DIAGNOSTIC REASONING TO VEGAS: APPLICATION AND EVALUATION OF PROBABILISTIC THINKING USING A NOVEL EDUCATIONAL GAME

Nathan R. Stehouwer, MD, Lukasz Weiner, MD, Collin Swafford, MD, Michael Dell, MD, Case Western Reserve University/University Hospital Case Medical Center/Rainbow Babies, Cleveland, OH

Diagnostic reasoning exercises requiring learners to describe their degree of confidence in their differential diagnosis have many potential benefits, including (1) encouraging meta-cognition (“how well do I know what I know?”); (2) correcting overconfident or under-confident learners; (3) developing the ability to more accurately apply likelihood ratios to select and interpret diagnostic testing; (4) assessing learners’ readiness for increased independence. In this session, we will discuss benefits of probabilistic thinking and explore methodologies for teaching and assessing probabilistic thinking. The key innovation we will apply to diagnostic reasoning is the use of Brier scores to evaluate participants’ differential diagnoses. Brier scores evaluate forecasts compared with actual outcomes. A maximum score is obtained by accurately describing degree of uncertainty, and overconfidence is strongly penalized. Applied to differential diagnoses, this score rewards both naming the correct diagnosis and accurately appraising one’s level of confidence. To gain familiarity with the scoring methodology, attendees will participate in a short exercise in which they predict a series of 10 events based on card drawing. For example, “what is the probability that you will draw 4 black cards in this hand of 5 cards?” Each participant will predict scores, and then we will conduct actual scoring together. This exercise will demonstrate how accurate assessment of likelihood, not just prediction of the actual outcome, results in the highest score. Approximately half of our session will consist of attendees participating in a diagnostic reasoning game which they can later choose to adapt and apply at their own institutions. In this session participants will be given a series of 10 brief cases with a similar chief complaint, such as child with fever for 5 days.
For each case, the participants will list the top 3 diagnoses on the differential, and assign a numerical probability to each diagnosis. These cases will then be scored relative to real-life outcomes using Brier scores, giving participants immediate feedback on their ability to accurately describe their level of confidence in their diagnoses. After this exercise we will discuss didactic and bedside applications for teaching probabilistic diagnosis, and participants will plan uses for probabilistic reasoning in teaching sessions at their home institutions.

29. NOT YOUR TYPICAL REMEDIATION WORKSHOP: LEVERAGING THE PYGMALION

**SALON E**

**EFFECT TO SET LEARNERS UP FOR SUCCESS**

*Andria Tatem, MD, Baylor College of Medicine (Houston), Houston, TX, Rupa Kapoor, MD, Phillip Thomas, MD, Eastern Virginia Medical School, Norfolk, VA, Teri Turner, MD, MPH, MEd, Baylor College of Medicine (Houston), Houston, TX*

“The difference between a flower girl and a lady is not in way she acts, but in way she is treated.” Eliza Doolittle, My Fair Lady (also called The Pygmalion Effect). What if the difference between a successful and an unsuccessful trainee in remediation was more about whether or not the teacher(s) believed the trainee would be successful? We have all dealt with learners in difficulty and multiple workshops, articles and books which focus on the mechanics of remediation. In a landmark educational article from the 1960’s, researchers demonstrated that teacher attitudes and behaviors have a significant impact on student outcomes. They called this the Pygmalion effect. This workshop will highlight the importance of faculty attitudes and behaviors in remediation planning. It will also challenge the current model of remediation planning by using literature from the fields of business, K-12 education, and psychology to put a greater emphasis on the biopsychosocial aspects of remediation within the clinical training environment. Participants will be actively engaged in large group discussions, role-playing exercises, and small group activities which focus on both the mechanics and the emotions of remediation. Topics covered will include the impact of (1) labeling; (2) self-fulfilling prophecies; (3) group think; (4) implicit bias; (5) mindset; and (6) unrealistic expectations. In small groups, attendees will review real-life cases and remediation plans and identify psychological strategies that could be employed by front-line faculty, supervising residents, and program leadership to enhance the likelihood of success. Participants will then practice delivering information to a learner-in-difficulty, using verbal and non-verbal communication strategies that facilitate both positive expectations in the learner and clearly articulate appropriate learner actions. Attendees will leave with a toolkit of both the mechanics of common remediation plans and a repertoire of scripted responses to be used in difficult conversations with learners. Target Audience: Chief residents, residency program directors, fellowship program directors, individuals involved in faculty development and program coordinators.

30. I’VE GOTTEN YOUR BACK: WHAT CAN WE DO WHEN WE WITNESS PATIENTS, FAMILIES OR STAFF DISCRIMINATE OR HARASS RESIDENTS?

**GALERIE 2**

*Mumtaz Mustapha, MD, University of Minnesota, Minneapolis, MN, Alda M. Gonzaga, MD, UPMC Medical Education, Pittsburgh, PA*

Every day, a small but significant proportion of patients implicitly or explicitly express their preference for a physician who looks like their ideal of a physician - a white physician, a non-Muslim, a man or woman. Many attendings do not know how to support residents who are belittled, or rightly discriminated against, or have inappropriately sexual comments directed toward them. Oftentimes, these slights or microaggressions happen in the presence of the entire medical team. However, the team, led by the attending, often to not discuss the incident either to check in with the emotional wellbeing of the resident or to discuss how to handle such situations in the future. Rather, the team disperses from the bedside to do the day's work, and the resident who was subjected to discrimination or harassment is left feeling isolated, not knowing if their attending and team realized how hurtful it was to them. Perhaps the most common form of discrimination for physicians of color and for female physicians is being mistaken for a nonphysician; residents of diverse backgrounds report being mistaken for the nurse, food service workers, or housekeepers. Participants will develop skills to support residents experiencing race, religious, or gender discrimination in the clinical environment. Through small group case discussion, participants will learn strategies to create a safe environment in clinical educational settings to openly discuss discrimination and harassment with the resident team. Participants will leave with a detailed toolkit of strategies to accomplish these goals including articles, case vignettes, and a slide set to be used for faculty development around supporting residents of diverse backgrounds.

31. NOW YOU’RE SPEAKING MY LANGUAGE! A WORKSHOP ON HEALTH LITERACY

**SALON A-C**

**INFORMED ORAL COMMUNICATION**

*Joy L. Solano, MD, Kathleen Berg, MD, Kadiyre O. Lewis, Ed D, Jacqueline M. Walker, MD, Children's Mercy Hospital, Kansas City, MO*

This interactive workshop will provide participants with strategies on how to use plain language when speaking with patients and caregivers. Learning will be augmented further when participants take on a teaching role and practice giving peer/learner feedback. With this, participants will be equipped to further address the following competencies set by the Accreditation Council for Graduate Medical Education: “communicate effectively with patients, families, and the public, as appropriate, across a broad range of socioeconomic and culture backgrounds” and “demonstrate the insight and understanding into emotion and human response to emotion that allows one to appropriately develop and management human interactions.” The overall goals of the workshop are: 1) To instill new knowledge, skills and attitudes about health literacy informed oral communication into the attendees of the workshop. 2) To provide a replicable sample of instructional activities that each attendee can put into action in their own workplace with medical students, residents and faculty educators as well as nursing staff. To achieve this, the educational activities in this workshop are specifically designed to promote a learner-centered experience. We will employ a variety of educational strategies using elements of game-based learning theory to enhance learner motivation and interactivity. Participants will practice skills through role play, reinforce new knowledge through small group reflection and discussion and serve as educators by providing peer feedback. Ideally, the new
knowledge, skills and attitudes adapted by learners at this workshop will be taken back to home institutions for integration into patient care and educational dissemination.

32. KNOW THYSELF: BRANDING YOUR PROGRAM TO GET THE TRAINEES YOU ARE LOOKING FOR!
Sharon Wretzel, MD, Stewart Mackie, MD, UMMS-Baystate, Springfield, MA, Ronald Magliola, MD, Case Western Reserve University (MetroHealth), Cleveland, OH, Emily Borman-Shoap, MD, University of Minnesota, Minneapolis, MN
Branding is a well-known tactic used by many Fortune 500 companies to enhance their product, promote a sense of high quality and value and influence an individual’s perception and behavior. The application of branding to a training program is important in allowing prospective trainees to understand what differentiates your training program from others and ultimately can help to recruit the trainees who are the best fit for your program. Adapting the branding conceptual framework of Botti, this interactive workshop will use facilitated small group work, collaborative activities, and large group discussions to help identify a program’s identity, develop a clear message, and ensure alignment of identity with messaging in creating experiences that promote the brand throughout the program’s department. Participants will develop their brand identity by reflecting on their program’s purpose, values and strengths - topics often developed in the ACGME self-study process. Participants will then develop a clear message with the goal of learning how to use this to facilitate aligning your brand image (how others view you) with your identity. The workshop will conclude with discussing the importance of continuous reflection on a program’s brand and a discussion on how to facilitate culture change to create your desired brand image. A program leadership toolkit to help identify key components of your training program’s brand will be distributed and started during the session to bring back to participant’s home institution.

33. THE AUTHENTIC YOU: CREATIVE WAYS TO OVERCOME IMPOSTOR SYNDROME
Alexandra J. Fletcher, BA, Stanford University, Stanford, CA, Megan K. Christofferson, BA, C-TAGME, Meghan Stawitcke, BA, Stanford University, Palo Alto, CA
Much scholarly work has been dedicated to the concept of impostor syndrome, and the variety of professionals for whom this takes a toll. However, it continues to be a source of anxiety and stress for many, including graduate medical education professionals. As medical professionals and academics, it has taken countless hours filled with trials, frustrations, tireless work, and dedication to get to where we are. So why do many high achievers (such as yourself) struggle to take credit for that? How is it possible that we still feel like frauds after all we’ve accomplished? As educators and learners in our pediatric subspecialties, we are no doubt achieving wonderful feats in childcare. This is why we are likely targets of Impostor Syndrome. In The Authentic You: Creative ways to overcome impostor syndrome, we plan to open a dialogue that takes a deeper look into what impostor syndrome is and how it manifests in our daily professional lives. More importantly with this workshop, we will walk away with fun and creative steps to reduce the feelings of impostor syndrome in ourselves and learn to identify symptoms in others so that we can all learn to acknowledge the work we put into our programs.

3:15pm - 4:45pm Learning Community Meetings (choose one)

ASSESSMENT LEARNING COMMUNITY
BEHAVIORAL & MENTAL HEALTH LEARNING COMMUNITY
COMMUNITY HEALTH & ADVOCACY TRAINING LEARNING COMMUNITY
CURRICULUM LEARNING COMMUNITY
EDUCATIONAL TECHNOLOGY LEARNING COMMUNITY
FACULTY & PROFESSIONAL DEVELOPMENT LEARNING COMMUNITY
HEALTHCARE SIMULATION IN PEDIATRICS LEARNING COMMUNITY
LGBTQA+ LEARNING COMMUNITY
PEDIATRIC GLOBAL HEALTH EDUCATORS LEARNING COMMUNITY
RESEARCH & SCHOLARSHIP LEARNING COMMUNITY
UNDERREPRESENTED MINORITIES IN PEDIATRIC GRADUATE MEDICAL EDUCATION LEARNING COMMUNITY
3:15pm - 4:45pm  MPPDA: RRC/ABIM/ABP Panel Discussion  
Galerie 4-5  
Moderators:  
Jane Trinh, MD, Associate Professor of Internal Medicine and Pediatrics, Program Director, Duke University School of Medicine;  
Michael Aylward, MD, Associate Professor of Medicine and Pediatrics, Program Director, University of Minnesota  
Panelists:  
Furman McDonald, MD, MPH, Senior Vice President for Academic and Medical Affairs, American Board of Internal Medicine  
Suzanne Woods, MD, Executive Vice President, Credentialing and Initial Certification, American Board of Pediatrics  
Jerry Vasilias, PhD, Executive Director Review Committee for Internal Medicine, Accreditation Council for Graduate Medical Education  
Caroline Fischer, MBA, Executive Director Review Committee for Pediatrics, Accreditation Council for Graduate Medical Education  
5:00pm - 6:00pm  Poster Session – Educational Scholarship and QI Projects  
Preservation Hall  
(posters will be on display beginning at 12:00pm)  
See page 45 for poster details  
6:00pm - 7:00pm  APPD LEAD Reunion  
St. Charles/Lafayette/Napoleon  
(LEAD Graduates only)  
Friday, March 29  
7:00am-12:00pm  Registration / Information Desk Open  
Preservation Booth  
7:00am - 8:00am  Continental Breakfast  
Acadia Foyer Lounge  
8:00am - 9:00am  Plenary Session (**Please note earlier start time!**)  
Acadia/Bissonet  
8:00-8:05am  Welcome ~ Javier Gonzalez del Rey, MD, APPD President  
8:05-8:10am  Special Project Awards ~ Rebecca Blankenburg, MD, APPD President-Elect  
8:10-8:15am  Presentation of Walter W. Tunnessen, Jr. MD Award for the Advancement of Pediatric Resident Education ~ Franklin Trimm, MD, APPD Immediate Past President  
8:15-8:45am  Update from the American Board of Pediatrics (ABP) with Q&A ~ Suzanne K. Woods, MD, Executive Vice President, American Board of Pediatrics  
8:45-8:55am  APPD LEARN Update (Longitudinal Educational Assessment Research Network) ~ Alan Schwartz, PhD, APPD LEARN Director  
8:55-9:00am  Orientation to the day ~ Adam Rosenberg, MD, APPD Program Chair  
9:00am - 10:30am  Platform Presentations from Top Educational Scholarship/QI Abstracts and Presentation of APPD Research Awards  
Acadia/Bissonet  
9:00-9:05  Presentation of Research Awards ~ Presented by Adam Rosenberg, MD, APPD Program Chair  
APPD QI Project Award: Sara Pavitt, MD, Stanford University, Palo Alto, CA – Platform Presentation # 5  
APPD Research Award: John Mahan, MD, Nationwide Children’s Hospital/Ohio State University, Columbus, OH – Platform Presentation # 4
1. IMPLEMENTATION AND EVALUATION OF A STRUCTURED EXPERIENCE IN MENTAL AND BEHAVIORAL HEALTH

Rebecca Sanders MD, PhD, Melissa Adams MD, David S. Wolf MD, PhD, Susie Buchter MD, Emory University, Atlanta, GA

Background: Mental and behavioral health (MBH) is an underserved area in pediatrics. Increasingly, pediatricians are called upon to be first line providers for children with MBH needs, and the ABP has charged residency programs with meeting this need by bolstering educational initiatives in MBH. Objective: Create an MBH rotation to improve residents’ ability to evaluate and treat ADHD, anxiety, and depression. Methods: A 2-week rotation in MBH was added to the PL-1 year, with experiences on an inpatient psychiatric consult service, in community psychiatry clinics, in subspecialty clinics with psychologists, and in continuity clinic with a behavioral health coordinator. Supplemental readings and online modules in psychopharmacology, depression, anxiety and ADHD were available for self-study. PL-1s were surveyed at the start of residency to determine baseline knowledge and confidence in MBH, and they completed the same survey after the rotation. PL-3 residents who did not participate in the rotation were also surveyed. Survey responses were compared by t-test. Results: After the rotation, a significantly higher proportion of PL-1s answered questions regarding evaluation and treatment of ADHD, anxiety, and depression correctly compared to before the rotation; self-reported facility with management of these conditions also significantly increased (Fig. 1A). PL-1s’ post-rotation knowledge of ADHD management was equal to that of PL-3s’, and PL-1s’ knowledge of anxiety and depression management was significantly higher than PL-3s’. Similarly, self-reported ability to manage ADHD was equivalent between the 2 groups and statistically higher for PL-1s with respect to anxiety and depression (Fig. 1B). Conclusions: Our PL-1s’ ability to manage common pediatric mental health conditions was increased by participation in a structured MBH rotation. These gains were equivalent or superior to knowledge acquired longitudinally by senior residents through incidental clinical experiences, suggesting that structured experiences in mental and behavioral health may be more effective.

2. A PROGRAM’S EXPERIENCE WITH HEALER’S ART: FOSTERING COMPASSIONATE HEALING AND HUMAN CONNECTION

Korre Fairman DO, Miriam Lader MD, Ann E. Burke MD, Wright State University, Dayton, OH, Evangeline C. Andarsio MD, Wright State University

Background: Resident well-being is a crucial issue in Pediatric Graduate Medical Education (GME). Many programs are seeking educational strategies and experiences that will foster resilience and well-being. Healer’s Art (HA) is a program from the Remen Institute for the Study of Health and Illness (RISHI) used to provide professional formation for medical students who aspire to bring their passions and hearts into their work. Our residency is the first pediatric program to utilize this experimental curriculum in GME to our knowledge. Objective: Determine new interns’ perceptions of the usefulness of participation in HA to their practice of medicine. Methods: Interns, over each of the last two years, from our program participated in five 3-hour HA workshops during orientation and the first month of internship. Sessions explored “nurturing your wholeness”, “sharing grief and honoring loss”, “mystery and awe” and “service as a way of life”. Course evaluations validated in the literature in medical students were completed by the interns. Evaluations included ratings of the course and statements about course impact (from 1 = Strongly Disagree to 5 = Strongly Agree). We used mean (SD) to summarize responses and conducted thematic analysis of written comments. Results: Twenty-four of thirty-one (77.4%) interns who participated completed evaluations. Quality of course faculty was rated highly overall at 4.6 with a SD of 0.7. Interns felt the course provided important content not available elsewhere in their training (4.3 [0.6]). As a result of the course they felt more committed to patient centered care (4.0 [0.8]), were more certain they belong in the profession (4.1 [0.7]), and felt more supportive of peers and colleagues (4.5 [0.7]). Themes included learning about ones’ emotions and recognizing that everyone struggles with similar feelings. The biggest challenges were time and returning to patient care after sessions. Conclusions: HA in a residency program has perceived value to interns in the broad areas of empathy, patient centeredness and connectedness.
3. DEVELOPMENT AND EVALUATION OF A COMPREHENSIVE VACCINE HESITANCY CURRICULUM
Zarina Norton MD, Sandra Sanguino MD, McGaw Medical Center of Northwestern University, Chicago, IL

Background: Vaccine hesitancy may lead to delayed or incomplete vaccination, increased risk of vaccine-preventable disease and distrust between pediatricians and families. Studies have shown many pediatric providers are uncomfortable addressing parental concerns and educating hesitant parents on vaccine safety, necessity and misconceptions, yet few curricula to fill this need have been published. We developed and implemented a comprehensive longitudinal curriculum for pediatric residents on vaccine hesitancy and evaluated its efficacy via randomized controlled trial, hypothesizing that residents undergoing the curriculum would demonstrate improved knowledge, comfort and communication skills with vaccine hesitant families compared to a control group. Methods: Using Kern’s curriculum design framework, we designed and implemented didactic sessions for each pediatric vaccine and interactive role-playing sessions on communication skills. Half the pediatric residents were randomized to the intervention group (IG) and received the curriculum over 1 year; the control group (CG) received standard education only. Residents completed written pre and posttests and a standardized patient (SP) assessment at the end of the study period; group differences were evaluated using independent t-tests. Results: 35 residents were randomized to IG and 35 to CG. Pre-test scores did not differ significantly between the 2 groups. The CG did not show a significant difference between pre and posttest scores for didactic knowledge or reported comfort level. The IG showed a significant increase in both knowledge and comfort level post curriculum. IG pretest knowledge score increased from 47% to 66%, p=0.00. IG pretest comfort level increased from 2.9/5 to 3.76/5, p=0.00. IG group SP score was significantly higher than the CG: 78% vs. 52%, p=0.00. Conclusion: Implementation of a comprehensive curriculum on vaccine hesitancy resulted in improvements in vaccine knowledge base, communication skills and comfort level with vaccine hesitancy discussions in pediatric residents. Studies should be done to assess the impact of such a curriculum on patients and vaccination rates.

* Winner – APPD Research Award *

4. BURNOUT IN PEDIATRIC RESIDENTS: INSIGHTS FROM THREE YEARS OF LONGITUDINAL NATIONAL SURVEY DATA
John D. Mahan MD, Kathi Kemper MD, MPH, Nationwide Children’s Hospital/Ohio State University, Columbus, OH, Paria M. Wilson MD, MEd, UPMC Medical Education, Pittsburgh, PA, Betty B. Staples MD, Duke University Hospital, Durham, NC, Hilary McClaflerty MD, University of Arizona for Medical Sciences, Little Rock, AR, Chuck J. Schubert MD, Cincinnati Childrens Hospital Medical Center/University of Cincinnati College of Medicine, Cincinnati, OH, Alan Schwartz PhD, University of Illinois College of Medicine at Chicago, Chicago, IL, Janet R. Serwint MD, Johns Hopkins University, Baltimore, MD, Maneesh Batra MD, University of Washington, Seattle, WA

Background: Burnout is highly prevalent among residents and associated with poor personal health and worse patient outcomes. Little is known about the factors which impact burnout longitudinally. Objectives: 1) Define burnout prevalence (via Maslach Burnout Inventory) from 2016-2018 among pediatric residents; 2) Explore demographic factors and experiences related to burnout over time; and 3) Elucidate factors that predict future burnout, stress, and confidence in providing compassionate care (CPCC). Methods: The Pediatric Residency Burnout-Resilience Consortium, a national sample of 34 programs in 2016, 43 programs in 2017, and 49 programs in 2018, conducted an annual anonymous survey of residents for 3 years via APPD LEARN. The survey included personal qualities (quality of life, sleepiness, mindfulness, self-compassion, empathy); experiences (current rotation, recent errors/patient deaths and time off, special learning tracks), satisfaction (career, work/life balance, support, learning environment) and measures of burnout, stress, and CPCC. Cross-sectional and longitudinal regression analyses for these measures were performed. Results: >60% of eligible residents participated each year; burnout rates (54%-56%) were similar all 3 years and not associated with any specified demographic characteristic. In each year burnout was associated with stress, sleepiness, dissatisfaction with work/life balance, and reporting a recent medical error; burnout was inversely associated with higher levels of empathy, self-compassion, quality of life, and CPCC. Higher self-compassion in 2017 correlated with lower stress in 2018. Mindfulness and satisfaction with learning environment and pediatrics as a career in 2017 correlated with higher CPCC in 2018. Conclusion: Nationally, burnout prevalence in pediatric residents consistently exceeds 50%. We identified modifiable factors associated with lower burnout including empathy, mindfulness, self-compassion and stress and programmatic interventions which may mitigate burnout such as training in medical errors response, and healthy scheduling paradigms.
Background Communication failures are the most common root cause of patient safety events. Consults provide a significant opportunity for miscommunications to occur; however, trainees receive little education on how to effectively convey consult requests. Based on literature review and needs assessment of pediatric residents and fellows at Stanford, we identified essential consult elements (ECE) for optimal consult communication. 54 consult requests were audited, and our baseline data showed that only 9% included all ECE. At our institution, 98% of residents (n=56) and 95% of fellows (n=41) reported miscommunication around consults, 85% of which led to perceived patient safety errors. Only 13% of residents reported receiving teaching from fellows during the consultation. Aim Statement 1) Develop a standardized consult communication tool that includes all ECE 2) Increase consult requests containing all ECE by pediatric residents from 9% to 40% within a 6-month period. Interventions A consult communication tool containing ECE was developed using modified SBAR (Situation, Background, Assessment, Recommendations) and taught to pediatric residents from July-Aug 2018 through a series of workshops. Multimedia interventions (flyers, screen savers, name badge cards) were disseminated throughout the hospital. During the initial PDSA cycle, residents and fellows were queried to inform subsequent cycle changes, such as targeting faculty engagement and monthly reminder emails. Measures The primary outcome measure was the percentage of inpatient consult requests containing all ECE by pediatric residents. The process measure was adherence to the modified SBAR tool. Secondary outcomes included clarity of consult question, perceived teaching and learning, and communication. Resident and fellow satisfaction was used as a balancing measure. Results Post intervention from Sep-Dec 2018, 51 consults were audited and 35% containing ECE increased from 9% to 49%. SBAR was used in 76% of consultations. With SBAR, 98% of consult questions were clear/very clear and 100% of fellows reported being satisfied/very satisfied with communication. Conclusions and Next Steps Our modified SBAR tool resulted in increased inclusion of essential elements for consult communication. It led to greater clarity of consult question and satisfaction by pediatric fellows. Data regarding its effect on teaching, learning, and patient safety will be available in March 2019.

**AMPPA Session: My 1st Recruitment Season: Lessons Learned**

*Erica King, University of Minnesota*

Includes Recruitment Roundtable: Best Practices

10:45am - 12:15pm Enhanced Learning Session IV (choice of 8)

34. **“WE CAN HELP YOU WITH THAT!” BUILDING A CASE FOR A RESIDENT**

**ASSISTANT PROGRAM**

Heather Burrows, MD PhD, University of Michigan, Ann Arbor, MI, John D. Mahan, MD, Michael A. Perry, MD, Nationwide Children's Hospital/Ohio State University, Columbus, OH, David A. Stewart, MD, University of Michigan, Ann Arbor, MI, Roy Takei, MD, Nicole R. Washington, MD, Children's Hospital of Philadelphia, Philadelphia, PA

Residency training requires juggling of a multitude of tasks including direct patient care, documentation, didactic activities, and teaching of peers and other learners. Finding an appropriate balance between service and education can be a challenge. Identifying tasks of lower learning potential that can be allocated to someone else within the health care team is important for resident wellbeing, work hour requirements, and efficiency of practice. The University of Michigan, Nationwide Children's Hospital, and Children's Hospital of Philadelphia pediatric residencies have each implemented a Resident Assistant (RA) program for inpatient teaching services. Once incorporated on teams, RAs become experts in facilitating patient care coordination within the hospital, creating more time at the bedside for providers, ensuring proper patient follow-up, allowing more education time for learners, and so much more! RAs can also serve as an additional support network, identifying residents who are struggling or otherwise suffering burnout symptoms. This workshop will review our experiences with RAs, discuss applicable ways they can be utilized at your institution, and then assist as you create an elevator pitch to request similar support for your program.
36. IMAGINARY BOUNDARIES: BRINGING THE SUBCONSCIOUS TO THE CONSCIOUS
Linessa M. Zuniga, MD, Baylor College of Medicine (Houston), Houston, TX, Adam Wolfe, MD, Baylor College of Medicine (San Antonio), San Antonio, TX, Teri L. Turner, MD, MED, MPH, Baylor College of Medicine (Houston), Houston, TX
This innovative workshop will explore the novel concept of imaginary boundaries, defined as perceived obstacles to success. The workshop will first introduce the concept of imaginary boundaries and then encourage reflection about one’s own imaginary boundaries and strategies to mitigate them. While these boundaries may be personal, we anticipate commonality of some boundaries amongst participants. One well-known example is imposter syndrome, which has been known to affect individuals in the healthcare field. Utilizing concepts such as grit, growth mindset, desirable difficulty and emotional intelligence, we will explore recommendations from the literature, which will be heavily drawn from outside of medicine. First, we will encourage participants to identify their own boundaries and then provide them with tools to overcome these boundaries. We anticipate that by bringing the subconscious to the conscious and inspiring participants to be aware of their own imaginary boundaries, they can then help to identify these barriers in their trainees and devise plans to support their trainees to lead them to success and fulfillment in their work. Through unique workshop activities and small group work, the workshop will be interactive and fast-paced. By the end of the workshop, participants will have outlined strategies to take this concept back to their institutions.

36. INNOVATIVE CURRICULA FOR TEACHING PEDIATRIC RESIDENTS/FELLOWS
BEHAVIORAL AND MENTAL HEALTH
Kenya McNeal-Trice, MD, University of North Carolina Hospitals, Chapel Hill, NC, Sue Poynter, MD, Cincinnati Children’s Hospital Medical Center/University of Cincinnati College of Medicine, Cincinnati, OH, Keith Ponitz, MD, Case Western Reserve University/University Hospital Case Medical Center/Rainbow Babies, Cleveland, OH, Elizabeth Chawla, MD, Georgetown University Hospital, Washington, DC, Jennifer DiPace, MD, New York Presbyterian Hospital (Cornell Campus), New York, NY, Heather McPhillips, MD, University of Washington, Seattle, WA, Ann E. Burke, MD, Wright State University, Dayton, OH, Joseph Zenel, MD, University of South Dakota, Sioux Falls, SD
The prevalence of behavioral and mental health issues in our pediatric population is currently at an all-time high. In 2013, 66% of pediatricians surveyed by the AAP reported that they lacked training in recognizing and treating basic mental health problems. A national pediatric resident survey in 2010 reported that less than half of residents rated their competence in this area as good to excellent. The American Board of Pediatrics (ABP), along with the Association of Pediatric Program Directors (APPD), have deemed improving mental and behavioral health curricula for pediatric trainees as one of the most pressing issues facing training programs to ensure that patients have access to providers who are competent in the diagnosis and treatment of the most common disorders. A survey of Pediatric Program Directors at the 2018 Annual Meeting identified that preparing residents to treat mental health conditions as one of the most pressing issues facing program directors. Of 130 program directors surveyed, only 7% identified their graduates were very well prepared to diagnose and manage mental health issues; while 93% responded their graduates were only somewhat or not at all prepared. Recognition of pediatric patients at greater risk of developing mental health problems is also lacking. Although great progress has been made in the medical care of children with chronic illness, there has been slower recognition of the need to build resilience and address mental health and emotional well-being in this patient group. During this highly interactive workshop, a multi-institutional group of medical educators will share their experience in innovative implementation of the learning concepts outlined in EPA #9 focused on behavioral and mental health issues. Presenters will highlight successes and challenges encountered during the implementation process of their behavioral and mental health curricula in a variety of inpatient and ambulatory rotations. In small groups, participants will complete a blueprint outlining educational strategies for establishing a comprehensive mental and behavioral health curriculum at their home institutions, including generating buy-in, identifying essential content, designing assessment platforms to ascertain resident competency.

37. BLUEPRINT FOR EQUITY: NAVIGATING THE NEW ACGME REQUIREMENT FOR RECRUITMENT AND RETENTION OF A DIVERSE AND INCLUSIVE WORKFORCE IN RESIDENCIES AND FELLOWSHIPS
Lahia Yemane, MD, Carmin Powell, MD, Michelle Brooks, C-TAGME, Carrie Johnson, MBA, Stanford University, Palo Alto, CA, Sahar Rooholamini, MD, MPH, Maya Jones, MD, MPH, Mollie Grow, MD, MPH, Heather McPhillips, MD, MPH, University of Washington, Seattle, WA, Patricia Poitevien, MD, MSc, Brown University, Providence, RI, Brian Lurie, MD, MPH, Carolinas Medical Center, Charlotte, NC, Rebecca Blankenburg, MD, MPH, Stanford University, Palo Alto, CA
The pediatric patient population in the United States is rapidly becoming more diverse. However, the pediatric workforce, more specifically within academic medicine, does not reflect those we care for. Effective July 2019, ACGME common program requirements will ask programs to include an annual assessment of their efforts to recruit and retain a diverse and inclusive workforce. It is critical that programs begin to plan strategically to meet these requirements. In this highly interactive workshop, participants will review the new ACGME requirements, discuss ways to leverage support from their institutions, and create action plans to improve efforts to recruit and retain a diverse and inclusive workforce. Participants will perform a SWOT analysis of their own program to assess their abilities to meet the ACGME requirements. Four institutions will present their current efforts, successes, and lessons learned. Afterwards, participants will work in small groups to create action plans around topics of (1) recruitment practices, (2) building community, (3) learning environment. The session will conclude with a small group report out of action plans to receive feedback from participants and discussion of next steps to ensure success in implementation.
We have all sat through multiple workshops about feedback in the hopes that this will be the one to allow for ground-breaking change at our institutions. And yet, time and again we have faced the same challenges—our faculty don’t feel comfortable giving honest feedback to trainees, our trainees don’t feel comfortable giving feedback to each other (never mind faculty), everyone wants more actionable feedback, and problems we thought we addressed with feedback persist. How do we break out of this cycle?

In this workshop we will explore how to approach feedback in a novel way to allow for real change utilizing the “good judgment” model developed by Dr. Jenny Rudolph of the Center for Medical Simulation. Much of the problem with the feedback culture within which we currently operate is that as feedback providers, we start from a place of believing we know what the “lesion” in performance is and that our role is to partner with the feedback recipient to figure out ways to “fix the lesion.” We contend that the premise of this argument—that we know the “lesion”—is all wrong. The “good judgment” model was initially designed to help faculty debrief simulation participants; here, we will apply it to feedback more broadly. We will discuss the importance of using curiosity to understand the frame, or mindset, of the feedback recipient so that we can truly understand the underlying “lesion” and figure out ways to address it. We will actively practice this technique and apply it to feedback scenarios generated by workshop participants.

We realize that a new feedback model needs to fit with the culture and workflow at your institution in order to effect real change. Workshop leaders and participants will discuss barriers to implementation and brainstorm strategies to overcome them together, as well as outline a plan for how to introduce this model to trainees and faculty. You will leave with resources about the “good judgement” model and its efficacy, a plan for how to share this model at your institution, and educational materials that will help you teach this model. We promise that by the end, like us, you too will be asking “WTF?”

40. LAUNCHING INTO THE OP-ED SPACE: AN ADVOCACY CURRICULUM FOR HOUSE STAFF  Studio 9-10

Hannah G. Rosenblum, MD, Emily Pinto Taylor, MD, Christine Ngaruuya, MD, MSc, DTMH, Jaideep Talwalkar, MD, Yale-New Haven Medical Center, New Haven, CT

Public advocacy by physicians is a core component of medical professionalism and is among the top competencies for which Med/Peds Program Directors request assistance in curriculum development. Writing and publishing Op-Ed pieces is an achievable and impactful advocacy modality for physicians. To equip resident physicians with both writing and advocacy skills, we developed an evening series teaching Op-Ed writing to house staff. The course debuted in fall 2017, was popular again in spring 2018, and is in the works for 2019. Each of four evening sessions consisted of a one-hour interactive didactic with an expert Yale scholar-writer, followed by an hour of small group workshop time, in which participants brought their own pieces. Thirty-five residents have participated in the course, and preliminary survey data shows an increase in self-rated confidence in Op-Ed writing abilities and understanding of publication logistics. So far, over 30 Op-Eds have been drafted; seven have been published in local and state media. This Enhanced Learning Session will provide attendees with an interactive overview of this innovative curricular program geared towards trainees. During the workshop, attendees will explore our curriculum by participating in an abbreviated version of the didactic sessions. Concepts that will be highlighted are: anatomy of an Op-Ed, choosing topics and identifying expertise, logistics of pitching, and troubleshooting. At the start of the session, attendees will select an issue to use as a focus for interactive writing exercises. Participants will leave with a skeleton version of their own Op-Ed and with tools to deploy similar workshops at their own institutions. Faculty and chief residents interested in creating an advocacy curriculum or enhancing an existing curriculum may find this workshop to be particularly helpful. With the increasing politicization of healthcare, physician advocacy writing skills are a vital part of trainee education. Our Op-Ed course arms attendees with tools to influence public debate on important topics in an innovative curriculum that could be tailored to fit the needs at participants’ home institutions.
Abdulla Ghori, MD, Nancy Phuong, BA, Case Western Reserve University (MetroHealth), Cleveland, OH

The program coordinator can greatly influence the success of the program by tracking performance data of the program and the residents. Fully understanding the Collecting meaningful and accurate data is one of the most daunting tasks for a program coordinator. The program coordinator is a one stop inquiry station when any data for residency administration is required for Residents, Program Directors and even graduates. The inquiry not uncommonly occurs at the last minute. Consider a program administration with a living document of Master Data Tracking that includes a complete predetermined list of data that needs to be tracked for compliance, accreditation, performance, assessment, and evaluation. The program coordinator can greatly influence the success of the program by maintaining the data up to date and making it accessible to the program director or designee in the event of the coordinator being away for any reason. This workshop session will walk participants through the steps involved in preparing a transparent and customized list of data required for program requirements, webADS reporting, clinical competency committee, annual program evaluation, and some of the program specific needs to build the Master Data Tracking document. Time saving technology based, practically tested strategies, will be shared to reduce redundancy and improve efficiency in how to collect the data and how to tabulate and track. Participants will learn to develop a color-coded electronic dashboard customized to program needs for Program Evaluation and CCC reporting. A tracking method minimizing redundancy will be demonstrated that will assist in analysis as well as preparation of graphs for reporting. A sample electronic document containing all the common requirements applicable to any pediatric program will be shared as deliverable for the participants to further build upon to their local needs.
THURSDAY, MARCH 28, 5:00PM-6:00PM
Preservation Hall
PLEASE NOTE THAT POSTERS WILL BE ON DISPLAY BEGINNING AT 12:00PM

Posters will be separated in the following topic areas in the Poster Session:
- Wellness / Resilience / Burnout: Posters 1-16
- Trainee Scholarship: Posters 17-22
- Curriculum / Procedures: Posters 23-36
- Exam Preparation: Posters 37-41
- Assessment / Feedback: Posters 42-54
- Entrustment / EPAs / Milestones: Posters 55-62
- Program Issues / Recruitment: Posters 63-78
- Trainee Autonomy: Posters 79-82
- Diversity / Social Determinants / Poverty / Advocacy: Posters 83-93
- QI / Safety: Posters 94-109
- MPPDA Committee Posters will be on boards 110-114
- MPPDA Transitions Learning Collaborative Posters will be on boards 115-126

APPD 2019 Research Award winners:
- APPD QI Project Award: Sara Pavitt, MD, Stanford University, Palo Alto, CA – Platform Presentation # 5 (see page 41)
- APPD Research Award: John Mahan, MD, Nationwide Children’s Hospital/Ohio State University, Columbus, OH – Platform Presentation # 4 (see page 40)
- APPD Trainee Research Award: Madhuri G. Dave, DO, Medical College of Wisconsin Affiliated Hospitals, Milwaukee, WI – Poster # 103 (see page 92)

WELLNESS/RESILIENCE/BURNOUT

1. ASSESSMENT OF WELLBEING AND PHYSICAL ACTIVITY AMONG RESIDENTS
Naomi O’Sullivan, MD, Irene Paoakonstadopoulos, MD, Inna Kaminecki, MD, Brunetto Jacqueline, MD, Renuka Verma, MD, Prasiksha Sitaula, MD, Monmouth Medical Center, Long Branch, NJ

Background: Burnout is common among residents, occurring in 40-75% of trainees across multiple disciplines. Studies demonstrate that regular physical activity correlates with improved sense of well-being, increased empathy, decreased burnout and increased career satisfaction. Evidence suggest that the level of physical activity of physicians can be correlated directly with physician counselling patterns. Methods: This prospective observational study was conducted at Monmouth Medical Center and included categorical residents from the following residency programs: Dentistry, Internal Medicine, Obstetrics and Gynecology, Orthopedic Surgery, Pediatrics, Radiology and Surgery. Residents completed pre-participation questionnaire and PWBI questionnaire. All residents were provided a wearable physical activity tracker. The data was collected over the 3 months period. Results: 83 residents participated in the study: 6 from Dentistry, 27 from Internal Medicine, 14 from Obstetrics and Gynecology, 8 from Orthopedic Surgery, 15 from Pediatrics, 4 from Radiology, and 9 from Surgery. Results of pre-participation questionnaire showed that 96% of residents believed that physical activity improves wellness, 77% counsel patients on physical activity, and 59% counsel patients on intensity of physical activity. 28% participants were identified as having risk of burnout using PWBI. Total of 45 residents (54%) uploaded their activity data during the study period. The average amount of steps by month per resident presented on Figure. Step counts of residents in Internal Medicine, Pediatrics, Orthopedics, & Obstetrics and Gynecology were similar, and averaged 5817 steps/day. The average amount of steps by residents in Radiology was 7345 steps/day and in Surgery was 7937 steps/day. However, it did not reach statistical significance in comparison with other specialties. There was weak negative correlation between PWBI and physical activity (r =-0.03) Conclusion: Residents among multiple specialties in this study are not achieving CDC recommendations regarding physical activity level. More than a quarter of residents were identified as having risk of burnout using PWBI. Additional interventions designed to improve residents' physical activity and wellbeing should be encouraged
2. BURNOUT AND EMPATHY DURING THE FIRST QUARTER OF PEDIATRIC INTERNSHIP
Colin M. Sox, MD, MS, Christine M. Cheston, MD, Children’s Hospital/Boston Medical Center, Boston, MA, Celeste Allen, MD, Children’s Hospital-Oakland, Oakland, CA, Andrea G. Asnes, MD, MSW, Yale-New Haven Medical Center, New Haven, CT, Jefferson M. Barrett, MD, MPH, Tufts Medical Center, Boston, MA, Maneesh Batra, MD, MPH, University of Washington, Seattle, WA, William Bernstein, MD, St. Peter’s University Hospital, New Brunswick, NJ, Tammy Bleeker, MEd, University of Florida, Gainesville, FL, Pam M. Dietz, MD, Maine Medical Center, Portland, ME, Joanna Lewis, MD, Advocate Christ Medical Center, Park Ridge, IL, Su-Ting Li, MD, MPH, University of California (Davis) Health System, Sacramento, CA, T. M. Ma, MD, Loyola University, Maywood, IL, John D. Mahan, MD, Nationwide Children’s Hospital/Ohio State University, Columbus, OH, Catherine D. Michelson, MD, MMSc, Children’s Hospital/Boston Medical Center, Boston, MA, Sue E. Poynter, MD, MEd, Cincinnati Children’s Hospital Medical Center/University of Cincinnati College of Medicine, Cincinnati, OH, Mark A. Vining, MD, University of Massachusetts, Worcester, MA, Katherine Watson, DO, UPMC Medical Education, Pittsburgh, PA, Yarden S. Fraiman, MD, Children’s Hospital/Boston Medical Center, Boston, MA

Background: Epidemic among trainees, physician burnout has been associated with delivery of unsafe care. Little is known about early markers of burnout in pediatric interns. Objectives: To determine the rates of and factors associated with burnout during the first quarter of pediatric internship. Methods: From June through September 2017, we invited a cross-section of pediatric interns training at 15 programs to complete the Maslach Burnout Inventory (MBI) and an empathy index. Burnout was defined as an Emotional Exhaustion score ≥ 27 and a Depersonalization score ≥ 10. Empathy was measured using a continuous index (higher scores indicate greater empathy). We conducted bivariate logistic and linear regressions clustered on program to determine if between-group differences were statistically significant. Results: Of the 365 interns invited, 213 responded in June, 51 in July, and 76 in late August and September, for a 93% response. Most participants were >28 years old (58%), female (75%), and training in programs with >16 interns (78%). Thirty percent of participants were in the Midwest, 42% in the East, 24% in the West, and 4% in the South. Emotional exhaustion scores were high for 90 participants (25%) and depersonalization scores were high for 99 (28%); of these, 44 (13%) met MBI criteria for burnout. Burnout was significantly less common in June (7%) than July (16%) or August and September (29%, p = 0.001). Among interns who were not burned out, emotional exhaustion and depersonalization increased over this timeframe at similar rates (both p < 0.0005). Participants’ mean empathy score was 51.3 (SD = 3.9; range 40-64). Empathy was significantly lower among burned out interns (50.1) than those who were not burned out (51.5, p < 0.0005), and was lower among interns who had begun clinical work (50.5) compared to those who completed the survey during orientation in June (51.8, p < 0.02). Conclusion: Burnout early in pediatric internship is associated with lower empathy and the onset of clinical responsibilities. Some pediatric interns enter training with burnout. Interventions are needed early in training to decrease burnout.

3. EMPATHY AND SELF-COMPASSION CORRELATE WITH PERFORMANCE IN PEDIATRIC RESIDENTS
Maren E. Olson, MD, MPH, University of Minnesota, Saint Paul, MN, Michael B. Pitt, MD, University of Minnesota, Minneapolis, MN, H. Mollie Grow, MD, MPH, Maneesh Batra, MD, MPH, University of Washington, Seattle, WA, Alan Schwartz, PhD, University of Illinois College of Medicine at Chicago, Chicago, IL

Background: Empathy and self compassion have emerged as strong, potentially modifiable corollaries with burnout, though little is known about how these correlate with resident performance over time. Objectives: Assess residents' empathy and self-compassion during residency over time, and how these correlate with pediatric milestone scores. Methods: As part of the Pediatric Resident Burnout - Resilience Study Consortium, we performed a subanalysis of a prospective cohort including all residents from 55 institutions. In each of the 3 data cycles, residents completed online cross-sectional surveys which included validated assessments of burnout (Maslach), empathic concern (EC; Interpersonal Reactivity Index), and self-compassion (SC; Neff’s Self Compassion). Programs provided linked milestone data for each respondent. We fit linear mixed model growth curves predicting competency domain scores (mean milestones within each of the ACGME competencies) from EC, SC, POY level, data cycle, interaction of data cycle x PGY, and with random intercepts and PGY slopes within learner and within program. Results: 432/4946 residents had responses for all variables. For all 6 competency areas (Medical Knowledge-MK, Patient Care-PC, Interpersonal Communication Skills-ICS, Problem Based Learning Improvement-PBLI, Systems-Based Practice-SBP, Professionalism-PROF), domain scores increased with POY, as expected. EC and SC were associated with ICS and PROF domain scores; SC was associated with MK and PC; EC was associated with PBLI and SBP; (p < 0.05 for all comparisons) All significant associations had small magnitudes of difference, with changes of 1 SD in EC (~4.5 points on its 0-28 scale) or SC (~0.61 points on its 1-5 scale) associated with changes of 0.01-0.03 points in mean scores. Mediation analysis found the effects of SC on MK and PC domain scores were entirely mediated by burnout, but effects on other domains persisted when controlling for burnout. Conclusion: In a national longitudinal sample of pediatric residents, empathy and/or self-compassion were correlated with all ACGME core competencies. Targeting interventions to modify empathy and self-compassion may support efforts to mitigate burnout and improve performance.
4. DEVELOPMENT AND IMPLEMENTATION OF THE NATIONAL PEDIATRIC RESIDENT BURNOUT-RESILIENCE STUDY CONSORTIUM (PRBRSC)

Maneesh Batra, MD, MPH, University of Washington, Seattle, WA, Paria M. Wilson, MD, MEd, UPMC Medical Education, Pittsburgh, PA, Janet R. Serwint, MD, Johns Hopkins University, Baltimore, MD, Charles J. Schubert, MD, Cincinnati Children’s Hospital Medical Center/University of Cincinnati College of Medicine, Cincinnati, OH, Kathi J. Kemper, MD, MPH, Nationwide Children’s Hospital/Ohio State University, Columbus, OH, Betty B. Staples, MD, Duke University Hospital, Durham, NC, John D. Mahan, MD, Nationwide Children’s Hospital/Ohio State University, Columbus, OH

Background: The ACGME requires residency programs to monitor & address burnout. Previous studies of prevalence and interventions to address burnout are limited by small number of participants and cross-sectional designs. Objective: Develop a national consortium of pediatric residency programs to characterize, monitor, and address resident burnout and well-being through research and advocacy. Methods: The Pediatric Residency Burnout-Resilience Study Consortium (PRBRSC) was founded in 2015 by 8 members from 6 institutions, who continue to serve as a steering committee (SC). Activities include assessing residency efforts to monitor/improve well-being, and assessing the prevalence, natural history, and protective/risk factors for burnout longitudinally. Membership was solicited through discussions at APPD meetings and email invitation to programs. In collaboration with APPD LEARN, the SC developed an anonymous annual online resident survey including standard measures of burnout and attributes of well-being based on literature review and consensus. A subcommittee developed a program report template so that aggregate results could be provided annually for each participating program to monitor their well-being. Proposed sub-analyses of the dataset can be submitted by any site investigator, requires involvement of investigators from >1 program and a SC member. Results: The PRBRSC has grown from 34 residency programs (2723 residents) in 2016, to 43 (3273 residents) in 2017, and 49 (3657 residents) in 2018. Annual survey response rates were >60% in all 3 years. Program reports were distributed annually to each participating program. The PRBRSC has had 7 presentations at national meetings, 5 published manuscripts and 4 proposals for additional studies. Additional manuscripts are in preparation or have been submitted. Conclusion: After 3 years, the PRBRSC has established a nationally representative sample of programs to characterize prevalence and associated risk/protective factors and is poised to develop and study interventions to promote well-being and reduce burnout among residents.

5. DO WELLNESS INTERVENTIONS IN A LARGE PEDIATRIC RESIDENCY PROGRAM IMPACT RESIDENT BURNOUT?

Allison F. Wise, MD, Katherine I. Watson, DO, Jessica M. Brown, MBA, MM, UPMC Medical Education, Pittsburgh, PA

Background: The ACGME has called upon programs to more directly address resident physician well-being. In recent years, the pediatric residency program at Children’s Hospital of Pittsburgh (CHP) has implemented multiple interventions aimed at improving resident wellness. Examples include the addition of an elective to the intern year, incorporation of wellness weeks, and visits for interns with a clinical therapist. The program monitors individual resident burnout biannually using the Maslach Burnout Inventory (MBI), a validated survey which evaluates three domains: emotional exhaustion, depersonalization and personal accomplishment. The aim of this study was to evaluate the prevalence of burnout in pediatric residents, and to examine changes in burnout rates over time as the program has implemented wellness interventions. Methods: Retrospective analysis of MBIs completed by pediatric residents at CHP between July 2015 and July 2018 was performed. Burnout was defined as a high score in either emotional exhaustion or depersonalization. Data was analyzed using descriptive statistics. Results: 92 pediatric residents were included. Residents were excluded from sub-analyses if they did not complete MBIs for all the terms being analyzed. During the 2017-2018 academic year, 42% of residents experienced burnout. Following a cohort from the 2015 PGY-1 class (N=16), 80% of residents who were burned out during their intern year had burnout at later points in residency. Between 2015-2018, there was a decrease in PGY-1 burnout rates. Prevalence of burnout in PGY1s during the fall and spring terms was 40% and 45% in 2015/2016 (N=20), 27% and 40% in 2016/2017 (N=30), 22% and 28% in 2017/2018 (N=32). Conclusions: The prevalence of burnout in pediatric residents at CHP was comparable to rates reported in the literature. When following a cohort of individuals through their residency, burnout seemed to persist over time. Burnout rates were higher for interns in the spring compared to the fall. With an increase in wellness interventions the program has seen a decrease in intern burnout over the past three years.

6. ENCOURAGING JEOPARDY USE FOR MENTAL HEALTH AND FATIGUE, AND ITS IMPACT ON RESIDENT WELLNESS

Jillian Mador, MD, Sara Serbin, MD, Alanna Brickley, MD, Heather Bernard, MD, Andrew Nowalk, MD, PhD, Stephanie Dewar, MD, Allison Wise, MD, Katherine Watson, DO, UPMC Medical Education, Pittsburgh, PA

Background: Residents who require absence from clinical duties due to illness, emergency, or fatigue are covered at our program through a jeopardy system. The pool of residents is composed of 3 to 4 senior-level residents. In response to 2017 ACGME survey data, program leadership updated our Fatigue Management Policy to include Jeopardy as an option.
Leadership attempted to impact residency culture with a “wellness-inclusive Jeopardy policy” by encouraging the use of Jeopardy for mental health, wellness, and management of fatigue. Objective: Assess the impact of a wellness-inclusive Jeopardy policy by measuring number of calls, reason, and burnout scores. Methods: A database of Jeopardy use maintained by Chief Residents from 2014-2018 was reviewed, including number of calls per year and the reasons provided for calls. Maslach Burnout Inventory scores and the ACGME Resident Survey data were reviewed and compared before and after the adoption of a wellness-inclusive Jeopardy policy. Results: In the 3 years prior to the adoption of the new Jeopardy policy, residents cited mental health or wellness needs 3.3% of the time. In the 1.5 years since residents cited mental health or wellness needs 9.5% of the time. The number of total calls increased significantly over 4 years from 81 calls in 2014-15 to 169 calls in 2017-18, a 109% increase. Resident complement increased 13% in the same period. PGY-1 end of year burnout inventory scores from 2016-2018 decreased from 45% to 28%. ACGME survey scores on providing fatigue transitions improved from 3.3 to 4.4 between 2017 and 2018 surveys. Conclusions: While multiple initiatives within our program may have driven improvement in burnout scores, residents responded to wellness-inclusive Jeopardy policy with increased utilization of Jeopardy as a whole for wellness or mental health reasons. Residents reported more awareness of options to transition care when fatigued. Increased utilization of Jeopardy as a tool for decreasing burnout warrants further discussion regarding improved experience for the residents providing coverage given this increased frequency.

7. PROFESSIONAL FULFILLMENT IN PEDIATRIC RESIDENTS
Elizabeth K. Nelsen, MD, SUNY Upstate Medical University, Syracuse, NY
Knowledge about physician burnout is vast, but little is known about professional fulfillment. It is defined as satisfaction and meaningfulness with self-efficacy at work. The purpose of this study was to examine professional fulfillment and burnout among pediatric residents at SUNY Upstate using the Stanford Professional Fulfillment Index (SPFI). It is a 16-item survey that has been previously validated. It has been recognized by the National Academy of Medicine as an important resource for assessing clinician well-being. The survey with additional demographic questions was distributed to residents in November 2018. Data were collected and managed using REDCap electronic data capture tools hosted at SUNY Upstate. Residents received a unique link to the index to maintain confidentiality. This study was determined to be exempt from IRB review. 76% of residents completed the survey. Responses to many questions were similar across training levels. There is a positive sense of professional fulfillment; at least 2/3 selected moderately/very true for these questions. 92% of PL-1s indicated feeling happy at work to be moderately/very true, compared to 81% of senior residents (PL-2/3/4). On feeling in control when dealing with difficult problems at work, 52% of PL-1s said this was moderately/very true vs. 81% of seniors. At least 1/3 indicated responses of “moderately” on questions about burnout. One-fifth responded they felt a lot of emotional exhaustion at work; 8% of PL-1s vs. 29% of seniors. 40% of all residents indicated they were moderately less empathetic with colleagues - 15% of PL-1s vs. 52% of seniors. This is a small sample at a single site and results may not be generalized to other programs at our institution or other pediatric programs. There are no published reports using the SPFI exclusively in pediatric residents and therefore we lack other data for comparison. We will use these results to develop resources aimed at mitigating burnout, focusing on improving empathy and decreasing emotional exhaustion. We will use the SPFI quarterly to gauge the impact of changes on professional fulfillment.

8. LEARNERS, TEACHING, & EDUCATION SYSTEMS FACTORS: PEDIATRIC FACULTY PERSPECTIVES OF IMPACT ON WELLBEING
Jessica C. Babal, Kristin A. Shadman, MD, Megan A. Moreno, MD, MSeD, MPH, Sarah A. Webber, MD, University of Wisconsin, Madison, WI
Introduction: Many pediatricians report burnout and low professional fulfillment. While it is assumed that academic pediatricians garner professional fulfillment from teaching, little is known about the perceived intersection of teaching and pediatrician well-being. Methods: In June 2018, pediatric faculty focus groups were conducted at a university-based pediatrics department, addressing work-related factors with greatest impact on wellbeing. Focus groups were audio recorded, transcribed, and de-identified. All excerpts about learners and teaching were manually coded using the constant comparative method. Results: Participants included 47 faculty in 8 focus groups, of whom 55% were female. A small number of comments described positive impact of teaching on wellbeing. “It’s a great privilege to be around young learners that are energized to extract as much as they possibly can...[teaching] helps sustain most of us.” A larger subset described negative impact of teaching. Four themes emerged: (1) Perceived institutional devaluation of teaching as an academic pursuit, “If teaching doesn’t get you promoted, I don’t know what should...I know that it really stresses me out just thinking about it and having to come up with things to do that count because what I’m already doing, I don’t think counts enough.” (2) Perceived decline in trainee work ethos, “The patients have to be cared for. You’re the one answering [pages], and [the residents are] gone. Then they don’t have the ownership that you may have had during your training.” (3) Perceived disparity in work hour protection and wellness support for faculty as compared to trainees, “I would love to have work-hour restrictions and all those sorts of things...I’m not angry or bitter at [trainees], but...everyone just makes the assumption that you’re in charge and you’ve already figured out
how to cope with your 80-hour work weeks." (4) Perceived burdens of teaching, "There’s fewer and fewer faculty involved with teaching because of a lack of rewards and more administrative [workload] when you do teach, like the 20-page evaluations of a medical student you spend an hour with." Conclusion: Teaching may be both protective and detrimental to pediatrician wellbeing. Future studies should further explore teaching-related factors that contribute to a sense of fulfillment and burnout to ensure faculty remain engaged and fulfilled in their work.

9. BURNOUT IN PEDIATRIC HEMATOLOGY ONCOLOGY FELLOWS, CROSS-SECTIONAL EXTENT AND OUTCOMES
Scott Moerdler, MD, Rutgers Cancer Institute of New Jersey, New Brunswick, NJ, Shicheng Weng, MS, Jennifer Kesselheim, MD, Children’s Hospital/Boston Medical Center, Boston, MA

Background: Burnout is plaguing doctors at all levels with severe consequences. Despite high emotional intensity, burnout rates among pediatric hematology-oncology (PHO) faculty have been less than previously described (Roth, PBC, 2011). The landscape of burnout among PHO fellows remains unknown. Objectives: Describe the prevalence, determinants, and associated outcomes of burnout among PHO fellows. Methods: 115 PHO fellows enrolled in a humanism curriculum study were administering the Maslach burnout inventory, empowerment at work scale, patient-provider orientation scale (PPOS), and satisfaction in training scale. Secondary analyses were performed using chi square analysis for demographic risk factors, and t-test for the continuous outcome variables. Results: A total of 45/115 fellows (39.1%) met criteria for high level of burnout. No demographic variables were identified as statistically significant risk factors to predict high levels of burnout, including year of fellowship. The prevalence of high-level burnout among 2nd and 3rd year fellows was not significantly lower than that of 1st year fellows (36% vs 46%, p=0.3), revealing burnout to be an issue across the full fellowship experience. Program size was not significantly associated with level of burnout, though there was a trend towards large programs contributing a higher proportion of fellows with high levels of burnout (62.2% of fellows with high burnout trained in large programs vs 47.1% of those without high burnout). Those who met criteria for high burnout were associated with poor outcomes (Table 1). Conclusions: This study identified more than 1/3 of current PHO trainees experiencing high levels of burnout. Interestingly, research years may not be as protective as thought and those at larger programs might be at higher risk, though more data is required. High level burnout is associated with decreased satisfaction with training, poor empowerment, and less patient-centered care. These data beg the need for longitudinal investigation of burnout in PHO fellows, both for their own well-being but also for the possible impact on patient care.

10. GRIEF DEBRIEFS: PROVIDING DEBRIEFS FOR RESIDENTS AFTER PEDIATRIC PATIENT DEATHS
Joanna C. Ekstrom, MD, Sarah Raatz, MD, Rachel Cafferty, MD, Meghan Fanta, MD, Joseph Woolley, DO, Erin Gutowski, DO, Emily Borman-Shoap, MD, University of Minnesota, Minneapolis, MN

Background: The inability to process grief in response to the death of a patient contributes to burnout in medicine. Pediatric residents are directly involved in caring for children with life-limiting disease. A 2017 survey of pediatric residents at the University of Minnesota revealed shared reactions to patient death including work avoidance, decreased productivity, questioned decision-making, loss of confidence, depression, and anxiety. Formal debriefs for our residents were infrequent. Methods: A secure email account was used to notify residents of a patient death. Chief residents aimed to facilitate an optional debrief for all trainees within 72 hours. During the debriefs, an additional chief resident held all pagers to ensure protected time with limited distractions. We followed a published bereavement debriefing template. When possible, a chaplain or palliative care attending was present. Results: To date, we have held 24 debriefs for 31 patients. Themes discussed included futility of care, personal guilt, helplessness or the sense of providing unfounded optimism, communication breakdown, medical ambiguity, self-care, and honoring the memory of our patients. When surveyed in December 2018, 47% of residents had attended a debrief, and 100% found them helpful or extremely helpful in processing patient deaths. Residents reported that the debriefs promoted "long term wellness", "insight into emotions", and "practical ways to process grief". Time and location of debriefs were factors that both facilitated and prevented attendance. Conclusions: We have held a debrief after the majority of inpatient pediatric deaths. Debriefs enable residents to process grief together and enhance community in our program. Since our residents train at four different hospitals, we will continue to identify times and locations that promote attendance. We will continue to gather data from residents on process improvement and effects on well-being in medicine in the hopes that interventions such as these can positively impact the culture of medicine.
11. MISTREATMENT OF PEDIATRIC RESIDENTS BY PATIENTS AND THEIR FAMILIES IS COMMON AND REQUIRES MORE EFFECTIVE INTERVENTIONS
Henna Shaikh, MD, Marianne Hatfield, MSN, RN, CENP, Rebecca Ciaburri, RN, Kirsten Wilkins, MD, Kurt Bjorkman, MD, Matthew Goldenberg, MD, MSc, Pnina Weiss, MD, Yale-New Haven Medical Center, New Haven, CT

Background: Mistreatment of trainees adversely impacts their learning and wellbeing and can lead to medical errors and preventable adverse outcomes. However, few studies have examined mistreatment of trainees by patients and their families. We hypothesized that pediatric residents commonly experience mistreatment from patients and their families and lack training to effectively intervene. Methods: We created an anonymous Qualtrics survey to assess resident experiences of mistreatment based on the AAMC Graduation Questionnaire, review by departmental and hospital leadership, and pilot testing. We emailed the survey to all categorical pediatrics (60), combined internal medicine-pediatrics (16), and child psychiatry residents (2). Results: Of 78 residents, 45 completed the survey (58%). Ninety-eight percent reported experiencing mistreatment from patients or their families over the last year. While 44% and 40% felt that they intervened effectively when they or their colleagues were mistreated, respectively, 13% reported having received training on how to intervene. Verbal threats or intimidation, threats of physical harm, or actual physical harm were reported by 89%, 24%, and 9%, respectively. Eighty percent of residents were targets of offensive behavior or remarks. Remarks based on age and gender were reported by 69% and 49%, followed by appearance (27%), race/ethnicity (18%), language proficiency (9%) and sexual orientation (2%). Seventeen percent of residents reported these events; the most common reasons for not reporting were that the incident did not seem important enough (71%) or that the resident thought nothing would be done about it (49%). Conclusions: Pediatric residents commonly experience mistreatment from patients and their families. Effective intervention is limited by lack of training, self-efficacy, and perceived institutional responsiveness. Based on these results, we are now implementing and evaluating educational and systems-based interventions to address this mistreatment and optimize resident learning, wellness, and patient care.

12. AN INNOVATIVE WELLNESS ROTATION DECREASES RATES OF RESIDENT BURNOUT
Kelsey Kaneshiro, MD, Jean Aschkenasy, PhD, Bridget Voigt, MD, Jane Kramer, MD, Varun Shetty, MD, Alice Hackett, MD, Margaret Scotellaro, MD, Jean Silvestri, MD, Rush University Medical Center, Chicago, IL

Background: Burnout, depression, and risk of suicide are pressing issues in pediatric residency programs. Novel strategies to mitigate burnout and promote resiliency are needed. Objective: To reduce rates of burnout in our program at Rush University Medical Center, we initiated a multi-faceted approach in July, 2017, including a Wellness/Study Rotation in the PL-2 year, widely acknowledged as the most taxing year of training. Ultimately, our aim is to promote a more resilient workforce, serving the well-being of both the residents and their patients. Design Methods: A number of wellness activities were enhanced or initiated. A Wellness/Study rotation was created for PL-2s that includes: scheduling appointments with healthcare providers, covering for other residents who have important healthcare appointments, check-in with staff psychologist, defined Board review, self-care (exercise, meditation), scheduled meetings with academic and QI advisors, and jeopardy call. Before and after the creation of the rotation, we participated in the Pediatric Resident Burnout-Resilience Study Consortium (PRB-RSC) survey, which includes multiple scales of stress and resilience including the Maslach Burnout Inventory (MBI). Results: In 2017 (pre-intervention), 55% of pediatric residents completed the PRB-RSC survey, compared to 90% in 2018. The percent of residents experiencing burnout, defined as scoring high on the emotional exhaustion and/or depersonalization scale of the MBI, fell from 59% (2017 survey) to 39% (2018 survey) after the implementation of the Wellness/Study rotation. PL2 residents experienced the greatest improvement. Their rates of burnout fell from 80% to 30%. Conclusions: The Rush Pediatrics Wellness Curriculum includes multiple interventions to prevent and mitigate burnout and promote resiliency. This innovative model, including the Wellness/Study rotation, appears to have decreased our rate of burnout. Future challenges include decreasing burnout rates among all residents, defining the most effective interventions, and creating a culture of wellness among both residents and faculty.
13. EVALUATING THE RELATIONSHIP BETWEEN TEAMWORK, ORGANIZATION, CULTURE AND BURNOUT AMONG RESIDENTS

Sonia Ruparell MD and Jane Nestler, MD, New York Presbyterian Hospital (Cornell Campus), New York, NY, Erika Abramson, MD MSc, Victoria Cooley, MS, Linda Gerber, PhD MA, Timothy Clapper, PhD, New York Presbyterian Hospital (Cornell Campus), Manhattan, NY

Rationale: Little research has explored in depth the relationship between organizational, individual, and program factors contributing to burnout, and the resident perspective on how best to address burnout. Objective: The Maslach Burnout Inventory (MBI) was administered to residents and focus groups were conducted to explore how organizational, individual and program factors affect burnout in a medium sized, urban, academic pediatric residency program. Methods: A constant comparison analysis was used to derive themes from focus groups until achieving thematic saturation. Residents completed the MBI following a department wide saturation in training model of the Strategies and Tools to Enhance Performance and Patient Safety program. Burnout was defined as a high subscale score for the burnout domain (>27) and/or the depersonalization domain (>10) on the MBI. Results: 3 focus groups of 10 total residents were conducted and 31 residents completed the MBI. 4 themes were identified from the focus groups. First, at a program level, offering an individualized approach to wellness is important. Second, ensuring residents feel appreciated prevents feelings of lack of personal achievement. Third, from an organization perspective, teamwork training boosts interdepartmental relationships, but may not provide adequate reinforcement and should be supported by frequent debriefings to promote positive team culture. Lastly, getting residents back to the bedside and reducing documentation burden is key. Quantitative data supported qualitative findings, with 61% of residents meeting criteria for burnout. Conclusions: A multifactorial approach to addressing burnout in pediatric residents requires the development of organizational infrastructure and program level interventions to support residents. It is essential to create a culture that ensures residents can prioritize clinical education, develops effective communication and reflective skills through team training and debriefing, and gets residents back to the bedside. Program interventions should give residents autonomy around wellness and educational activities.

14. BURNOUT IN PEDIATRIC RESIDENTS: WHEN IS BURNOUT MOST LIKELY TO OCCUR DURING AN INPATIENT SERVICE MONTH AND WHAT ARE ITS ASSOCIATED FACTORS

Maria J. Skorey, MD, Valerie H. Rinehart, MD, Hao Hsu, MD, Kortany McCauley, MD, Robin High, MBA, MA, Katie Greenwood, MD, University of Nebraska Medical Center College of Medicine, Omaha, NE

Background: Burnout is a work-related syndrome characterized by emotional exhaustion (EE), depersonalization (DP), and a sense of lack of personal accomplishment (PA). Data shows those in medical training suffer from burnout, but neither the timing of burnout in a narrower timeframe nor its associations are known. Objective: A single center prospective study was conducted to establish the prevalence of burnout in pediatric residents during an inpatient month, monitor the pattern of burnout progression throughout the month, and ascertain what factors may be associated with that burnout. Methods: Surveys assessing burnout, symptoms of depression, quality of life, fatigue, clinical and personal experiences were distributed to pediatric residents every week for a total of five weeks during an inpatient service month. Surveys included the Maslach Burnout Inventory (MBI), considered the gold-standard for measuring burnout, and the McCauley Survey, a survey created by one of our authors to measure burnout. Inpatient service months included a rotation on the wards, pediatric intensive care unit (PICU) and neonatal intensive care unit (NICU). First, second and third year pediatric residents were included in the study. A washout period of at least one month was required before a resident was surveyed a second time. Results: Mean values of EE had statistically significant worsening between the start and end of an inpatient month. Similarly, the prevalence of burnout increased from 71% to 83%. 71% of residents had positive screens for depression. 38% of residents had answered “yes” to the question “have you doubted your career choice in the last week.” The McCauley Survey results for burnout correlated well with the standard MBI surveys. Conclusions: A large majority of pediatric residents are burned out and burnout increases during an inpatient rotation. Many pediatric residents trigger positive screens for depression and question their career choice during an inpatient rotation. Intervention is warranted in this center and is currently underway. Future multi-center studies are needed to validate this data, as well as follow-up studies to evaluate the possible impact of current interventions at this center.
Background: Wellness is a hot topic in GME, with many pediatric residency programs adopting formalized curricula. Significant literature describes these efforts but little exists on their evaluation. A modified nominal group technique (MNGT) involves semi-quantitative rank-ordered evaluation on learner perceptions of curricular elements. MNGT has not previously been used to evaluate a residency wellness curriculum. Methods: A wellness curriculum was designed and implemented during the 2017-2018 year. Elements included structured didactics meant to grow resiliency and well-being, improvement of retreats to promote team-building, weekly resident recognition, and resident coverage for the annual graduation party. In June, a session was held with about 50% of the residents to evaluate the curriculum. Participants were divided into groups of 6-10 learners. The session was facilitated by two experienced educators not affiliated with the residency program. After MNGT steps were performed, facilitators asked groups to list one item to improve the curriculum. Results: Elements that scored highest included coverage for all residents to attend the end-of-year graduation party (score 94) and the resident retreats focused on team-building (score 76). Of didactics, the session on approaching difficult conversations with families scored highest (score 19). Elements residents identified as most negatively impacting their wellness included inability to attend sessions if on certain rotations (score 67) and lack of protected time (score 50). Residents identified having more free time while at work and increased ability of residents to attend sessions as the greatest areas for improvement. Conclusions: Evaluation of our wellness program via a MNGT elucidated unexpected findings; many formalized sessions were not viewed as important. Residents valued elements that allow teambuilding and socialization. This leaves the question as to whether the formal sessions are truly not advantageous or are undervalued by residents despite long-term benefit.

16. STRESS, BURNOUT, AND HELP-SEEKING BEHAVIOR AMONG PEDIATRIC FELLOWS

Anna K. Weiss, MD MEd, Sheila Quinn, DO, Children's Hospital of Philadelphia, Philadelphia, PA, Amy L. Danley, MBA EdD, Not Affiliated with Program/Institution listed above, Wilmington, DE, Kandi Wiens, MBA EdD, Not Affiliated with Program/Institution listed above, Jay Mehta, MD MEd, Children’s Hospital of Philadelphia, Philadelphia, PA

Burnout is highly prevalent among graduate medical trainees and is often associated with serious personal and professional consequences. While burnout among medical students and residents has been studied, few studies have examined burnout among fellowship trainees. We measured rates of stress and burnout among fellows in our freestanding children’s hospital and evaluated fellows' perceptions of stigma around, and willingness to seek treatment for, mental illness. Objectives: 1) To measure burnout among pediatric fellowship trainees using the Maslach Burnout Inventory (MBI) 2) To assess fellows' perceptions of stigma around help-seeking for mental illness 3) To examine the relationship between burnout and willingness to seek help for emotional distress. Methods: We distributed a 48-item inventory to all 288 fellows in our pediatric center. Survey items included the MBI in addition to questions measuring professional fulfillment and attitudes toward mental health treatment. Stress, burnout, and professional fulfillment were measured with descriptive statistics. Pearson correlations were used to associate burnout variables with willingness to seek mental health treatment. Results: 152 fellows (52%) responded to the inventory in its entirety. Fellows reported high levels of stress (7 on a 10-point scale). On the MBI, they reported moderate levels of exhaustion, low levels of cynicism, and high levels of personal accomplishment. They did not perceive stigma around seeking mental health treatment, and most noted that they would “probably go” to a mental health professional if needed. However, high scores in the domains of exhaustion and cynicism were associated with lower likelihood of help-seeking, while high scores in the domain of personal accomplishment were associated with a higher likelihood of help-seeking. Conclusion: High levels of stress alone are not directly correlated to high rates of burnout among fellowship trainees in our center. Our findings also indicate that fellows who score highly in the negative domains of the MBI are less likely to seek help for their distress, making them a particularly at-risk population.
18. INCREASING SCHOLARLY OUTPUT THROUGH A FORMALIZED CURRICULUM IN A SMALL PEDIATRIC RESIDENCY PROGRAM
Samantha A. House, DO, MPH, Carol Lynn O’Dea, MD, Catherine D. Shubkin, MD, Sholeen T. Nett, MD, PhD, Dartmouth-Hitchcock Medical Center, Lebanon, NH

Background: The ACGME requires pediatric residents to be exposed to principles of research and participate in scholarly activity. In small departments, development of a rigorous scholarly activity curriculum can be difficult due to competing educational requirements and fewer faculty. In 2016 we instituted a scholarly activity curriculum focused on longitudinal knowledge acquisition and close mentorship. Aim: To measure the impact of a structured scholarly activity curriculum on resident scholarly output. Methods: Our curriculum consists of a longitudinal educational component, comprised of individual tasks and group didactics (Fig 1) and completion of a scholarly project. Projects receive direct faculty mentorship; additionally, residents meet with the curricular co-directors twice annually to track scholarly progress and steps toward presentation/publication. To assess early outcomes, we measured resident scholarly output (defined as regional/national presentations or publications) from 2016-2018 and compared to baseline data (2013-2015). We also measured percent of graduating residents with scholarly output and faculty mentorship of resident scholarship as reported on the annual ACGME survey beginning at curricular implementation. T-test and chi-squared tests were used for statistical comparisons. Results: From 2016-2018, 21 residents produced an average of 9.7 pieces of scholarly output annually as compared to 3.0 from 2013-2015 (p=0.03). Graduates producing scholarly output has increased incrementally (40% in 2016, 43% in 2017, 57% in 2018, not statistically significant (NS)). Additionally, faculty reporting working on a trainee scholarly project has increased from 57% in 2015-2016 to 68% in 2017-2018 (NS). Conclusions: A structured curriculum with close faculty mentorship increased scholarly output in our small program. Though other measured trends did not reach statistical significance, they support increasing resident and faculty engagement in resident scholarly activity. Future work will focus on curricular refinement and qualitative assessment of resident comfort with scholarship.

19. DESIGN AND IMPLEMENTATION OF A FLEXIBLE PEDIATRIC SCIENTIST DEVELOPMENT TRACK
Andrew J. Nowalk, MD PhD, Jackie Ho, MD, Jessica Brown, MBA, UPMC Medical Education, Pittsburgh, PA

Background: Curricula for pediatric scientist development are not standardized in pediatric residency and fellowship, despite the dire need for pediatric physician scientists. We examined existing educational models and developed an integrated residency/fellowship pediatric scientist training program (PedSDP). Objective: Our primary objective was the development of an integrated six-year program, spanning residency and fellowship, for training of pediatric physician scientists. Methods: We reviewed 20 existing pediatric residency tracks for scientist development. An integrated six-year program was constructed using the non-standard American Board of Pediatric pathways (Accelerated and Integrated Research Pathways) and individual components modeled on programs from other residencies. We formed a steering committee comprised of departmental leadership to support and provide input into our curriculum development. With the support of the Chair, we were able obtain approval for acceptance into fellowship programs at time of residency selection as a key obstacle to overcome. We also developed internal educational activities to support scientist development. (See Figure for overall design) Results: From 2014-2018, our PedSDP recruited 8 residents, improving our overall MD PhD recruitment to 3 per year. While six of eight PedSDP trainees were MD PhD, we also recruited two MD only residents into our program. Residents have pursued fellowship in Infectious Disease and Allergy/Immunology (2 each), and Neonatology, Rheumatology, Critical Care Medicine and Cardiology (1 each). All residents have average milestones in the top half of their class. Discussion: We successfully implemented a training program which has increased both MD PhD recruitment but also has provided opportunity for MD residents to pursue research careers. We have found new strategies for recruitment (adding a dedicated ERAS track) but continue to struggle to identify and attract MD/DO only resident applicants interested in being physician-scientists to the program. URL: http://www.chp.edu/health-care-professionals/education/residencies/pedsdp
20. 4+1 AMBULATORY WEEK MODIFICATION TO ENHANCE OVERALL RESIDENCY EXPERIENCE
Eric S. Mull, DO, Javier A. Bonilla, MD, Matthew J. Davis, MD, University at Buffalo, Buffalo, NY

Purpose: The University at Buffalo Pediatrics 4+1 block schedule format was well-received by residents. Striving to advance
our residents 3 year training experience, the chief residents adjusted the schedule based on the residents’ feedback.
These adjustments were in light of a growing national concern of physician burnout. Burnout is defined as a syndrome of
psychological problems experienced due to chronic work stress. There is a link between work stress and lower levels of
well-being. In a recent poll of pediatricians, 41% reported some degree of burnout. Objective: The goals of the schedule
modification to the +1 ambulatory week aimed to establish meaningful mentor vs. mentee relationships, improve the ability
to complete scholarly activities, allow time for board preparations, and improve residents’ wellness. Design: Historically, the
+1 ambulatory week was comprised of 5 half-day sessions of continuity clinic mixed with half-day sessions of adolescent
clinic in the second year and developmental clinic in the third year. Based on residents’ feedback during the 2017-18 year, the
adolescent and developmental half-days were transferred into the traditional month long block. The unfilled half-day sessions
were repurposed for research, clinical administration time, resident wellness, and board preparations. Results: Data collected
in the spring of 2019 will be compared to the program specific ACGME survey results of 2018. In the spring 2018 survey, 50% of
residents felt the program assisted with their development of individual learning plans, showing 21.4% in strong agreement.
As of Jan. 2019, the Copenhagen Burnout Inventory (CBI) will be implemented biannually to assess residents’ wellness.
Discussion: We remain optimistic that these changes will allow for greater access to research and scholarly activities, as well as
improved wellness scores. To date, the feedback has been overwhelmingly positive and adjustments to the Interns’ schedules
for research sessions occurred. We remain confident that improvement in the annual ACGME survey and biannual CBI results
will be witnessed.

21. ESTABLISHING THE RESIDENT ACADEMIC PROJECT TO INCREASE SCHOLASTIC ACTIVITY AMONG
PEDIATRIC RESIDENTS
Ashley R. Martinez, MD, University of California (San Diego), San Diego, CA

Introduction: Participation in scholarly activity is a critical element of clinicians’ training. Required research projects are
becoming increasingly more common amongst medical schools and residency programs. The University of California, San
Diego (UCSD) pediatric residency program aims to increase research participation amongst its residents by launching and
evaluating a new Resident Academic Project (RAP Project). Methods: The RAP Project will be initiated starting with the UCSD
pediatric residency class of 2021. The RAP Project is introduced during the fall of their first year. In the spring of their first
year, residents will attend an afternoon-long research session that will connect them to potential mentors within each available
research area (basic science, clinical, quality improvement (QI), education, and advocacy/global health research). Residents
will select a project chair and two committee members and, with the help of their chosen mentor, develop a research proposal.
Proposals will be approved by each trainee’s research committee as well as the RAP oversight board by the beginning of their
second year of residency. Residents will complete their project within the two months prior to graduation, submitting a yearly
update at the end of their second year. Residents will present their work at an annual research day at the end of residency.
Conclusions: A pediatric and adult neurology residency program found that requiring residents to participate in mentored
projects aimed at producing peer-reviewed publications or conference presentations increased research productivity
amongst residents as well as expanded its pool of research mentors.1 We will use baseline data from previous residency
classes to determine if the Resident Academic Project increases scholastic activity (peer-reviewed publications, conference
participation, ongoing projects) among UCSD pediatric residents and if it increases residents’ satisfaction with their research
opportunities during training. We will also create a database of research opportunities, funding sources, and mentors to

22. NATIONAL SURVEY OF RESEARCH OUTCOMES FOR PEDIATRIC HOSPITAL MEDICINE FELLOWSHIP
GRADUATES
Caroline E. Rassbach, MD, Stanford University, Stanford, CA, Darren Fiore, MD, University of California (San Francisco),
San Francisco, CA

Background: Pediatric Hospital Medicine (PHM) fellowships were developed between the 1990s and early 2000s and have
advanced to meet established goals and forthcoming accreditation standards. Few studies have evaluated the research
outcomes of PHM fellowship graduates. Objective: To describe research outcomes of PHM fellowship graduates. Methods: IRB-
approved, cohort study using an electronic survey emailed to all PHM Fellowship graduates in July-December 2018. Questions
were modified from an existing survey and developed by expert consensus to address study objectives, and were pilot tested.
The 88-item survey addressed demographics, characteristics of fellowship training, and research and leadership outcomes.
Results: 143/228 (63%) PHM fellowship graduates completed the survey, representing 20 states in the US and Canada
(graduate dates, 2000-2018). Of the 143 respondents, 127 (89%) graduated from dedicated PHM fellowship programs, 13
(9%) from academic general pediatrics programs with inpatient clinical experience, and 3 (2%) from combined programs.
The median fellowship duration was 2 years. Among the graduates, 67 (47%) hold a Masters’ or Doctoral degree in addition to
their medical degree. Participants were on average very satisfied with their decision to do PHM fellowship (mean 4.4/5, st dev
0.77). Nearly half (45%) are currently employed by their fellowship institution. 112 (78%) now practice primarily at a university
or children’s hospital, 7 (5%) at a community hospital, and 24 (17%) at both. The most common types of research conducted
during fellowship were clinical, (N=74, 52%), quality improvement (N=57, 40%), health services (N=34, 24%) and medical
education (N=27, 19%), with some fellows reporting multiple categories of research. 48 (34%) applied for a grant during
fellowship, and 30 (21%) received a grant during fellowship. 63 (44%) published their primary fellowship research. 110 (77%)
fellowship graduates continued to do research after graduation. 90 (63%) published during fellowship or after graduation, with
24. EARLY EXPOSURE TO BEHAVIORAL, MENTAL, AND ADOLESCENT HEALTH IN GENERAL PEDIATRICS
William Gilmore, MD, Colin Fisher, MD, Monica Saladik, Melissa Weddle, MD, Megan Aylor, MD, Oregon Health and Science University, Portland, OR
Background: For residents entering general pediatrics, graduate surveys revealed a desire for increased behavioral health and psychiatry exposure early in training. Moreover, current residents requested earlier adolescent experience to better prepare them for continuity. Presently, interns spend 9-12 weeks in general pediatrics providing exclusive acute, newborn, and well child care. The majority of adolescent training is during third year, and there is no dedicated time spent with psychology nor psychiatry. Given the many competing interests in residency training, implementing a robust curriculum to better prepare residents for all aspects of general pediatrics is imperative. Objective: Increase early exposure to behavioral psychology, psychiatry, and adolescent health in general pediatrics without compromising other educational priorities nor patient access. Methods: We developed multiple half day experiences for interns during general pediatrics rotations while ensuring adequate clinic staffing for patient access. Over the course of the year, each intern spends approximately 4-6 half days in each of the following clinics: behavioral health, psychiatry, and adolescent health. To ensure that the experiences were useful and adequate patient access was maintained, we surveyed faculty and residents after each rotation. Results: For those exposed to the new curriculum, all 18 interns, 3 of 6 senior residents, and 10 of 16 faculty members responded to surveys. For interns, 40% found outpatient psychiatry useful; 90% found the behavioral health clinic useful; and 94% found the adolescent clinic useful. Of all interns, 81% felt that these experiences did not jeopardize other learning in general pediatrics. For faculty and senior residents, 100% felt that having interns intermittently missing from clinic did not adversely affect the educational priorities of clinic nor clinic staffing. Conclusion: The early addition of experiences such as behavioral health, outpatient psychiatry, and adolescent training is valued by residents and does not jeopardize patient access nor other educational priorities.
there was a large statistically significant increase in the counseling behaviors that promote positive parenting, specifically, discussing (p < 0.01; δ = 1.03), modeling (p < 0.01; δ = 0.97), and praising (p < 0.05; δ = 0.64). A statistically significant decrease in perceived barriers (p < 0.01) and an increase in knowledge (p < 0.01) was seen. There was a ceiling effect for attitudes. Self-efficacy to perform each respective behavior increased significantly (p < 0.01). Residents liked the curriculum (4.2/5) and found it useful in practice (4.3/5). Conclusion: The Keystones of Development online curriculum was well received by pediatric residents and resulted in increased promotion of positive parenting practices during well-child visits. This study yields promising results that suggest benefits to the field through wider dissemination and use.

26. PEDIATRIC RESIDENCY LEADERSHIPS’ ATTITUDES AND CURRENT PRACTICES TOWARD PARENTING-FOCUSED CURricula

Lianna Lipton, MD, Blair S. Hammond, MD, Carrie A. Quinn, MD, Joel Forman, MD, Mariel S. Benjamin, MSW, Aliza S. Pressman, PhD, Icahn School of Medicine at Mount Sinai, New York, NY

Background: Pediatricians are uniquely well-positioned to promote strong parent-child relationships and optimal child development, however, they may be less likely to do so if they receive no formal training in this area. No study has evaluated current resident education on parenting or pediatric residency leaderships’ view on the importance of training residents on parenting. Objective: To assess pediatric residency leaders' attitudes about educating residents on parenting skills and current training and desired curricula on parenting. Methods: A 21-item survey was sent to the members of the Association for Pediatric Program Directors via email in May, 2017. Results: 53 of the 206 program directors (26%) and 85 of the 418 Associate Program Directors (20%) completed the survey. 100% of respondents reported it was important to train residents about parenting skills, with 58% reporting it was “very important.” However, only 11% reported training residents “very well” and 24% reported educating residents “not very well” in this area. Chi-square tests showed no significant difference in response to these two questions based on respondent’s role, specialist vs generalist, or type of program. No statistically significant association was seen between the importance respondents accorded parenting education and the perceived quality of their program’s training on parenting. Curricula most often used by programs included Bright Futures (91%) and Healthy Steps (28%). Among those who reported that their programs did not train residents very well on parenting, 88% reported one barrier was not having a curriculum. Desired parenting topics were discipline (95%), promoting self-regulation in children (82%), sleep training (82%), tantrums (79%), promoting language development (71%), toilet training (70%), promoting secure attachment (66%), promoting school readiness skills (64%), and promoting literacy (53%). Conclusion: Pediatric leadership values training residents on parenting, however few report educating residents very well in this area, with lack of curricula as a major barrier.

27. EFFECTIVENESS OF DELIVERING DIFFICULT NEWS TRAINING: IMPROVED SKILLS AND SELF-EFFICACY OF PEDIATRIC TRAINEES

Tanya D. Murtha, MD, MPH, Emily Pinto Taylor, Joana Tala, Andrea Asnes, Janet Hafler, Stephanie Massaro, Sarah Kandil, Yale-New Haven Medical Center, New Haven, CT

Background: Delivering difficult news to patients and families is an essential but challenging communication skill. Pediatric trainees report limited training, competence, or comfort in this skill, and when tested, perform poorly. Objective: To assess the effectiveness of a modified American Academy of Pediatrics (AAP) Resiliency Curriculum (Part B) to improve skills and self-efficacy of pediatric trainees in delivering bad news. Methods: A quantitative research design was used to study the impact of the modified curriculum, offered at one institution with 78 residents and 48 fellows. The course consisted of interactive didactics with faculty role modeling. Fellows also participated in role playing and in novel simulations and self-reflection activities. Self-efficacy surveys were used to assess knowledge, confidence, and comfort with delivering difficult news. Objective performance was assessed during simulations with standardized patients using a bad news delivery framework checklist (“SPIKES”) and the mini Master Interview Rating Scale (mMIRS). Self-efficacy was analyzed using hierarchical mixed effects linear modeling and simulation performance was evaluated using Wilcoxon signed-rank tests. Results: Pediatric trainees (n = 67, 29 residents, 38 fellows) improved their scores on each of the 13 self-efficacy items (p = 0.007 to <0.001), as well as in the skill categories of displaying empathy (3.8 to 4.0, p = 0.016), managing emotions (3 to 3.8, p < 0.001), and conversation skills (3.4 to 3.8, p < 0.001). For fellows (n = 19), objective skill in delivering bad news improved; the median score on the “SPIKES” checklist improved from 78% to 90% completion (p < 0.001; Fig. 1) and mMIRS from 4.2 to 4.6 (p < 0.001; Fig. 1). Conclusion: Pediatric residents had significant improvement in self-efficacy and fellows in both self-efficacy and observable skill in delivering difficult news after participation in an AAP modified Resiliency course, with the use of simulation for fellows. These learning activities could serve as a model for other institutions to address gaps in training for difficult news delivery.

Fig. 1. Fellow improvement in delivery of difficult news during pre and post simulations

Participants consisted of 19 pediatric fellows. The SPIKES checklist contains 17 items and is scored: 0 – not done, 1 – partially done, and 2 – done well. The percent complete score was determined by the total points scored out of 34 possible points. The mMIRS contains 9 items and is scored on a 5-point behavior-anchored Likert scale. The participant mMIRS average scores were generated from the scores for each item.
28. PEDIALITE: A REFRESHING WAY TO KEEP UP WITH PEDIATRIC RESEARCH
Elizabeth I. Landzberg, MD, Tiffany S. Yang, MD, Caitlin R. McNamara, MD, Tony Tarchichi, MD, UPMC Medical Education, Pittsburgh, PA

Background: A major challenge in resident education is the efficient use of limited time. As self-directed learners, residents need to find pragmatic ways to keep up to date on current literature. In February 2018, a survey of 80 pediatric residents revealed that most were unsatisfied with the amount of literature they were reading. While all residents received daily emails about current research, most rarely or never read them because the emails were too frequent, too long, and visually unappealing. Design/Methods: PediaLITE was created in March 2018 with the goal of providing monthly updates on current pediatric research that entertain and stimulate residents to read further. Each email contains concise summaries (three paragraphs or fewer) of two recent studies accompanied by links to the original articles, and a review of a general pediatrics topic. They are emailed via Mailchimp to pediatric residents at UPMC Children’s Hospital of Pittsburgh and individuals who have subscribed online. A second survey was administered nine months later to assess residents’ perception and utilization of PediaLITE. The survey responses were compared using a Mann Whitney U test. Results: Monthly readership ranges from 40-70% as tracked through Mailchimp. Fifty-seven residents completed the follow-up survey and 68% had read at least half of the emails. All of those who read PediaLITE found it interesting and relevant; 95% enjoyed the emails and 92% felt more up-to-date. Fifty-four percent believed that they were reading more primary literature because of PediaLITE. Of those who did not read the emails, most cited a lack of time or not finding it in their inboxes as barriers. As a whole, residents have read more articles (Figure 1). Furthermore they are more satisfied with their reading habits after receiving nine months of PediaLITE (mean Likert value 2.05 versus 2.64, p = 0.003; Figure 2). Conclusion: PediaLITE is an effective, entertaining educational tool that helps residents stay more up-to-date with pediatric literature.

29. FELLOWS ABROAD: NATIONAL LANDSCAPE OF GLOBAL HEALTH OPPORTUNITIES IN PEDIATRIC FELLOWSHIPS
Heather L. Crouse, MD, Baylor College of Medicine (Houston), Houston, TX, Jennifer Watts, MD, MPH, Children’s Mercy Hospital, Kansas City, MO, Nicole E. St. Clair, MD, University of Wisconsin, Madison, WI, Maneesh Batra, MD, MPH, University of Washington, Seattle, WA, Gail McGuinness, MD, Not Affiliated with Program/Institution listed above, Chapel Hill, NC, Elizabeth M. Keating, MD, University of Utah, Salt Lake City, UT, Christiana M. Russ, MD, Children’s Hospital/Boston Medical Center, Boston, MA, Kimberly M. Farr, MD, Baylor College of Medicine (Houston), Houston, TX, Andrew P. Steenhoff, MD, Children’s Hospital of Philadelphia, Philadelphia, PA, Charles J. Schubert, MD, Cincinnati Children’s Hospital Medical Center/University of Cincinnati College of Medicine, Cincinnati, OH, Laure K. Leslie, MD, MPH, Suzanne K. Woods, MD, Not Affiliated with Program/Institution listed above, Chapel Hill, NC, Elizabeth A. Camp, PhD, Baylor College of Medicine (Houston), Houston, TX, Sabrina M. Butteris, MD, University of Wisconsin, Madison, WI

Background: In the past decade, interest in global health (GH) among graduating pediatric residents has grown. The availability of these opportunities can influence their ranking of fellowship programs. Current GH opportunities in pediatric fellowship programs in the United States (US) are not well described. Methods: This was a cross-sectional study by pediatric GH educators including representatives from the Association of Pediatric Program Directors (APPD) GH Learning Community and the American Board of Pediatrics. Program directors and GH educators at US pediatric fellowship programs were surveyed using REDCap®. Data were analyzed using standard descriptive statistics. Results: Data were collected from 473 of 819 (58%) eligible US pediatric fellowship programs representing 111 institutions across all APPD regions and ABP subspecialties. 47% offered GH training opportunities as either GH electives (n=209, 44%) or formal GH fellowships (n=15, 3%). There was variable pretravel preparation (Table 1) and supervision for research projects, with almost 20% of programs indicating a lack of GH faculty on fellows’ scholarship oversight committees. Programs offering any GH opportunities, compared to those without, were more likely to report that available GH training improves fellow education (82% vs. 38%, p<0.001) and recruitment (77% vs. 36%, p<0.001). Since 2005, 10 programs with formal GH fellowships have graduated 46 fellows, nearly all of whom are still working in GH. 10/14 (71%) of formal GH fellowships believe that national accreditation of GH fellowships would help define minimum programmatic requirements.

Table 1. Pretravel preparation for international rotations (N=819)

<table>
<thead>
<tr>
<th>Pretravel preparation item</th>
<th>Total N (%)</th>
<th>GH Electives N=469 (%)</th>
<th>GH Fellowships N=15 (%)</th>
<th>P-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Redeployment meeting</td>
<td>20 (4.1)</td>
<td>19 (3.1)</td>
<td>1 (6.2)</td>
<td>0.22</td>
</tr>
<tr>
<td>Not offered</td>
<td>19 (3.9)</td>
<td>17 (2.9)</td>
<td>2 (12.5)</td>
<td></td>
</tr>
<tr>
<td>Required</td>
<td>103 (20.1)</td>
<td>92 (16.0)</td>
<td>0 (0.0)</td>
<td></td>
</tr>
<tr>
<td>Redeployment counseling</td>
<td>33 (6.5)</td>
<td>31 (5.4)</td>
<td>2 (13.3)</td>
<td>0.03</td>
</tr>
<tr>
<td>Not offered</td>
<td>11 (2.1)</td>
<td>9 (1.6)</td>
<td>0 (0.0)</td>
<td></td>
</tr>
<tr>
<td>Required</td>
<td>62 (12.4)</td>
<td>54 (9.7)</td>
<td>8 (53.3)</td>
<td></td>
</tr>
<tr>
<td>Simulation sessions</td>
<td>102 (19.8)</td>
<td>100 (17.1)</td>
<td>2 (13.3)</td>
<td>0.001</td>
</tr>
<tr>
<td>Not offered</td>
<td>46 (8.9)</td>
<td>45 (7.8)</td>
<td>1 (6.7)</td>
<td></td>
</tr>
<tr>
<td>Required</td>
<td>22 (4.3)</td>
<td>19 (3.4)</td>
<td>4 (26.6)</td>
<td></td>
</tr>
<tr>
<td>Current Travel Conditions</td>
<td>34 (6.5)</td>
<td>31 (5.4)</td>
<td>3 (20.0)</td>
<td>0.03</td>
</tr>
<tr>
<td>Not offered</td>
<td>78 (15.0)</td>
<td>78 (13.8)</td>
<td>0 (0.0)</td>
<td></td>
</tr>
<tr>
<td>Required</td>
<td>78 (15.0)</td>
<td>78 (13.8)</td>
<td>0 (0.0)</td>
<td></td>
</tr>
<tr>
<td>Education on Opioid Use</td>
<td>70 (13.3)</td>
<td>65 (11.1)</td>
<td>5 (33.3)</td>
<td>0.004</td>
</tr>
<tr>
<td>Not offered</td>
<td>45 (8.8)</td>
<td>41 (7.2)</td>
<td>4 (26.7)</td>
<td></td>
</tr>
<tr>
<td>Required</td>
<td>34 (6.6)</td>
<td>31 (5.4)</td>
<td>3 (20.0)</td>
<td></td>
</tr>
<tr>
<td>Describing Focal Outcomes</td>
<td>27 (5.1)</td>
<td>26 (4.5)</td>
<td>1 (6.7)</td>
<td>0.07</td>
</tr>
<tr>
<td>Not offered</td>
<td>101 (19.6)</td>
<td>94 (16.0)</td>
<td>7 (46.7)</td>
<td></td>
</tr>
<tr>
<td>Required</td>
<td>60 (11.7)</td>
<td>58 (10.5)</td>
<td>2 (13.3)</td>
<td></td>
</tr>
<tr>
<td>Journaling or Self-Evaluation</td>
<td>52 (10.1)</td>
<td>48 (8.7)</td>
<td>4 (26.7)</td>
<td>0.04</td>
</tr>
<tr>
<td>Not offered</td>
<td>50 (9.8)</td>
<td>50 (9.0)</td>
<td>0 (0.0)</td>
<td></td>
</tr>
<tr>
<td>Required</td>
<td>41 (8.2)</td>
<td>37 (6.7)</td>
<td>4 (26.7)</td>
<td></td>
</tr>
</tbody>
</table>

* p-value: significance levels were compared with a Bonferroni correction (*p-value < 0.0001).

This variable was missing for 3 GH Elective programs and 1 GH Fellowship program.
standards and 9 (64.3%) believe it would improve recruitment and help recognize GH as a formal subspecialty. Conclusions: GH experiences are an integral part of many US fellowship programs, and programs offering GH perceive that these opportunities improve the education and recruitment of fellows. Data suggests that standards for GH opportunities during fellowship training would be useful, particularly pertaining to pre-travel preparation, supervision, and mentorship for trainees.

30. THE BENEFITS OF A TRULY INDIVIDUALIZED CURRICULUM

Punit N. Jhaveri, MD, Pooja B. Jhaveri, MD, Brandon M. Smith, MD, Penn State Milton S. Hershey Medical Center, Hershey, PA

Background: In response to the 2013 ACGME Program Requirements that mandated “a minimum of six educational units of an individualized curriculum determined by the learning needs and career plans of each resident and... developed through the guidance of a faculty mentor,” many pediatric programs developed career-based tracks. Because tracks have the potential to introduce unnecessary and potentially harmful rigidity, our program aimed for each resident to develop a truly individualized schedule. Objective: Allow each resident in our program to develop a unique individualized schedule through faculty guidance. Methods: A new position, the Director of Individualized Education (DIE) was created with 0.05 FTE departmental support, which translates to approximately 100 hours of protected time, or approximately 2.5 hours per resident in a program of approximately 40 total residents. A new resident block schedule was created that is broadly divided into three categories: A) Required rotations (94 weeks) include those mandated by ACGME requirements plus other rotations required by the program. B) Selectives (12 weeks in the third year) are chosen from a limited menu based on hospital staffing needs. C) Electives (38 weeks, available as 2- or 4-week experiences) are structured to meet ACGME requirements for “key subspecialties,” “additional educational units,” and the “individualized curriculum,” following the “double counting” rules from prior ACGME FAQs. For the 32 such weeks that occur in the PGY2 and PGY3 years, rotations are chosen after a meeting between the resident and the DIE. A flowsheet for each resident is reviewed annually by the DIE and semi-annually by the Program Director or an Associate Program Director to ensure compliance with ACGME requirements. Results: 54 residents have completed our program under the current scheduling system, and no two residents have had identical schedules. On the ACGME annual survey of PGY3 residents from 2016 to 2018: 1) 97.4% of our residents (vs. 86.8% nationally) chose Agree or Strongly Agree for the question In my training program, a portion of my training is based on my learning needs related to my career plans. 2) 94.8% of our residents (vs. 92.9% nationally) chose Agree or Strongly Agree for the question My training program provides a faculty mentor or advisor to help develop learning activities to meet my learning needs related to my career plans. Outcomes: A relatively small investment (0.05 FTE for the DIE) has been sufficient to allow each resident to receive proper mentoring in the context of thoughtful discussions about both career goals and current strengths/weaknesses. The DIE has also had time to invest in building relationships with divisions and departments throughout our children’s hospital and academic medical center, resulting in many new and innovative rotations, including GI pathology, transport (prehospital) medicine, maternal-fetal-medicine, complex primary care, and many others. Ultimately, we have been able to provide each resident with a unique schedule and a high level of satisfaction with the individualized curriculum.

31. BRINGING BACK THE CHALK TALK: A NOVEL CURRICULUM UTILIZING THE MINI CHALK TALK TO IMPROVE CLINICAL TEACHING IN A PEDIATRIC RESIDENCY PROGRAM.

Joshua Price, MD, Alexander Knee, MS, Laura Koenigs, MD, Stewart Mackie, MD, UMMS-Baystate, Springfield, MA

Background: In addition to becoming superb clinicians, residency is tasked with training residents to be excellent educators in the clinical environment for patients, peers, medical students and other learners. Our program aimed to improve our residents’ abilities to teach in the clinical environment by developing a curriculum to enhance resident teaching based on the mini chalk talk (MCT). The MCT is an old but highly applicable teaching modality that is based on a short 3-5 minute talk and is grounded in adult learning theory using both auditory and visual cues to engage learners. Objective: Improve residents’ ability to educate in the clinical setting through the use of the MCT. Methods: Instituted in September 2017, the curriculum is based on the conceptual framework of Bandura’s Social Learning Theory which highlights attention, retention, motor reproduction and motivation. The curriculum had residents read a short article on a specific topic, develop an outline for a MCT, discuss and optimize their ideas in small groups, and finally present their MCT to a different small group of colleagues. Pre and post surveys in addition to a peer-to-peer teaching evaluation rubric were used to evaluate the curriculum which was performed monthly for 6 months. Results: 76% (13/19) of residents who completed both pre and post surveys went from feeling uncomfortable to comfortable teaching and 42% (8/19) went from feeling their teaching was not adequate to the level of a role model. As Fig. 1 shows, the percentage of residents who scored at the role model level also increased on peer-to-peer evaluations in multiple assessors of quality of resident teaching over time. Medical student evaluations of residents in inpatient and outpatient settings also noted excellent chalk talks being given by residents, an observation not previously noted. Conclusions: Institution of a novel curriculum utilizing the MCT improved residents’ ability as educators based on self-perceived and peer-to-peer teaching evaluations.
32. IMPROVING EFFICIENCY OF AUTISM SCREENING

XIN TAN, MD, PhD, Ning Yang, MD, Allison Becker, MD, Muhammad Riaz, MD, Angie Matos, MD, Areej Alwahab, MD, Vipul Kothari, MD, Lewis Krata, MD, Brooklyn Hospital Center, Brooklyn, NY

Background Autism is a neurodevelopmental disability appearing before age 3. Children with autism have difficulties in verbal and non-verbal communication, social interaction and play activities. M-CHAT is a 20-question parental survey about a child’s social, verbal and emotional development. It is easy to use and validated in primary care settings with 85% sensitivity and 93% specificity. The AAP recommends that all children be screened for autism at ages 18 and 24 months, along with regular developmental surveillance. In Children’s Health Center of The Brooklyn Hospital Center, we use Office Practicum with an automated scoring system of M-CHAT. Residents ask 20 questions during the encounter and document answers in the EMR as routine practice at 18 and 24 months visits. We propose a different approach using an M-CHAT paper form to be filled out by the parent before the encounter to improve efficiency of autism screening in a busy primary care clinic. Aim Statement To decrease M-CHAT screening time by 50% and achieve a 100% completion rate at 18 and 24 months visits by May 2018.

Interventions PDSA cycle I: Residents ask parent to fill out M-CHAT before the encounter of 18 and 24 months visits. Residents review the answers and input them into the EMR with automated scoring system. Residents address any concerns parent might have. PDSA cycle II: M-CHAT handout is available in front desk with multiple language versions. Educate the front desk staff to distribute M-CHAT to parent at 18 or 24 months well child visit after registration. Measures Autism screen time using M-CHAT-R; Completion rate of documented M-CHAT in EMR at 18 and 24 months visit Results During PDSA cycle I, a significant reduction of autism screen time was noted, with the median time being 1 minute compared to 4.5 minutes without intervention. There were 2 patients with a positive screen result and the screen times were 5 and 10 minutes respectively, which we excluded from data. The average time spent in M-CHAT assessment with negative screen result continued to be 1 minute in PDSA cycle II. In the pre-intervention study from October to December 2017, the documented M-CHAT completion rate was 80% at 18 months visits and 78% at 24 months visits. In January 2018 (PDSA cycle I), the M-CHAT completion rate increased to 100% at 18 months visits and 94.7% at 24 months visits. In PDSA cycle II, the M-CHAT completion rate was 94.6% at 18 months visits and 90% at 24 months visits. Yet, the rate of M-CHAT distribution by front desk staff was 64.5%.

Conclusions and Next Steps This quality improvement study demonstrated significant reduction of autism screening time and improvement of workflow, and positive changes in completion of the M-CHAT documented on 18 and 24 months well child visits. Our intervention process excluded child with positive screens due to additional discussion regarding proper follow-up and referral. Use of the M-CHAT handout before the encounter markedly increased efficiency of autism screening, yet adaption to this practice among clinic staff likely contributed to the incompletion rate in quality metrics. Overall, we found the use of M-CHAT paper forms before the encounter helped residents incorporate information faster and assess the risk for autism more efficiently. As a result of this study, the practice leadership decided to continue using the processes introduced in this intervention.

33. DEVELOPING A BOOTCAMP TO INCREASE PEDIATRIC RESIDENTS’ COMFORT BEFORE CRITICAL CARE ROTATIONS

Anyela Duque Suarez, DO, Manu R. Varma, DO, Jackie Z. Lui, MD, Megha Thakkar, MD, Jon F. Sicat, DO, Sumon K. Das, MD, Ketan Kansagra, MD, Newark Beth Israel Medical Center, Newark, NJ

INTRODUCTION: Pediatric residents have limited exposure to critical care early in training. Orientation programs (“bootcamps”) have been described for graduating medical students and beginning fellows, but not for residents within pediatric training. We developed a bootcamp for rising senior residents beginning critical care rotations and hypothesized that the program would increase participants’ comfort with critical care. METHODS: Eleven PGY-2 pediatric residents completed the bootcamp prior to their first critical care rotation. Critical care and cardiac surgery attendings led the program and covered respiratory support including ventilation, shock including pressors, postoperative cardiac surgery care, and total parenteral nutrition. Outcomes were measured with a retrospective pre-post survey on a five-point scale, assessing residents’ comfort with initiating treatment, titrating treatment, and seeking assistance in each topic covered. Free text comments were also solicited. Data were analyzed using Wilcoxon signed-rank test with paired scores on each question and pooled data for all topics. RESULTS: Participants reported increased comfort with initiating treatment (+1.44, Z = 5.16), titrating treatment (+1.44, Z = 4.83), and seeking assistance (+1.1, Z = 3.64) following the bootcamp. Conclusions: This program improved residents’ comfort before their first critical care rotation. Future studies should explore the sustainability of this intervention.
Pediatric residents (n=26, 79% response rate) completed the pre-intervention online survey, and 23 (70%) completed the post-tool to assess progress notes. Participants completed a 22-question online survey (Qualtrics) before and after the sized pediatric residency program attended a workshop consisting of best practice didactics and small group work using the progress notes. Objective Test the efficacy of a workshop intervention on changing resident knowledge, attitudes, and beliefs guidelines give learners some direction, but may not provide adequate explanation about the importance and purposes of.

Introduction Physicians enter residency with variable proficiency in note writing and knowledge of note purpose. Best practice frame teaching experiences. The interventions planned may be useful at other institutions with similar remote supervision accountability with residents, with the strategy of incorporating Resident as Teacher training to build confidence and positively.

34. PROCEDURAL COMPETENCY: CONFIDENCE, COMPETENCE AND PREPAREDNESS ARE NOT CREATED EQUAL

Charles D. Hannum, MD, Sara L. Ross, MD, Jessica A. Bennett, MD, MPH, Abigail H. Scully, MD, Nicole B. Gendron, MD, Tufts Medical Center, Boston, MA

In response to trends on the annual ACGME Resident Survey and a recent Area for Improvement noted on our program’s 2017 ACGME Site Visit, we explored procedural competency with our recent program graduates to better provide a framework for and inform program quality improvement regarding skill-based and simulation curricula. Recent graduates (2017 and 2018, n=22, 79% response rate) were asked via our annual Recent Graduate Survey how the words “confidence,” “competence,” and “preparedness” might differ, and also asked Likert Scale questions regarding procedural confidence, procedural competence and procedural preparedness for many of the most common and also cited procedures of concern. Our Graduate Survey results show that procedural confidence, competence and preparedness are defined and interpreted in very different ways. When comparing this data to ACGME survey and site visit results, it calls into question whether the nuance among these terms leads to confusion on interpretation of the ACGME residency evaluation questions. Our graduates interpret confidence, competence and preparedness as three linked, but very different, ideas as they relate to procedural skills. It is difficult to both translate these differences to trainees and to interpret ACGME surveys with regards to this nuance. Using our PEC, which includes both core faculty and resident advisors, as a driving force for change, we are examining simulation and skill-based learning opportunities. Our goal is to provide a contextual framework for addressing the ACGME survey and site visit concerns and determine if procedure volume, re-evaluation of minimum targets and education regarding competency, confidence and preparedness impacts our outcomes. Educating our residents in the subtle, yet important, differences in confidence, competence and preparedness throughout residency will clarify true programmatic deficiencies in procedural based skills and simulation curricula, so that we may better prepare our future workforce. Anecdotally, our recent graduates feel competent, but it is unclear why this transition is not captured in our trainee data.

35. STRENGTHENING SELF-DIRECTED NIGHTTIME LEARNING THROUGH RESIDENT AS TEACHER CURRICULUM

Nisha Wadhwa, MD, Sarah Gustafson, MD, Los Angeles County–Harbor UCLA Medical Center, Torrance, CA

Background: As in many other residency programs, night rotations comprise about a significant portion of the curriculum at Harbor-UCLA. The National Pediatric Nighttime curriculum is a robust educational resource that was created to address the gap in nighttime education and has been provided to our residents through a residency website, though limited data existed about usage after implementation. In our program, there are no in-house hospitalist attendings at night, which requires residents to independently lead learning. Our residents were not formally trained in teaching methods until this year. Methods: Resident feedback about the inpatient pediatric night rotation was solicited in the form of an online survey. Respondents were asked to rate agreement with statements on a five-point scale. Prior to the implementation of changes to the nighttime curriculum, residents participated in a Resident as Teacher lecture series. Results: We obtained responses from 20 of 30 residents. 90% were not satisfied with the current state of nighttime education, and 95% did not use the nighttime curriculum. However, 80% stated that senior residents were preferred teachers. Based on these results, a strategy to increase accountability was instituted, while the Resident as Teacher intervention was ongoing. At the outset of the night rotation, expectations are now formally reviewed with assigned modules and associated questions which map to board content specifications. Completion will be tracked on the website. Resident satisfaction will be assessed in a follow-up survey at the end of the rotation, which the first set of which will be available in February 2019. Conclusions: In spite of the availability of nighttime curricula, it is not being used at our program. This may indicate the need for increased mechanisms for accountability with residents, with the strategy of incorporating Resident as Teacher training to build confidence and positively frame teaching experiences. The interventions planned may be useful at other institutions with similar remote supervision from hospitalists.

36. CHANGE IN RESIDENT KNOWLEDGE AND PERCEPTIONS OF DAILY PROGRESS NOTES FOLLOWING AN EDUCATIONAL INTERVENTION

Helen G. Waterman, DO, Nicole L. Bentley, MD, Daniel J. Sklansky, MD, Michelle M. Kelly, MD, Kirstin A. Nackers, MD, Daniel P. Gorski, MD, Kristin A. Shadman, MD, University of Wisconsin, Madison, WI

Introduction Physicians enter residency with variable proficiency in note writing and knowledge of note purpose. Best practice guidelines give learners some direction, but may not provide adequate explanation about the importance and purposes of progress notes. Objective Test the efficacy of a workshop intervention on changing resident knowledge, attitudes, and beliefs about progress notes. Methods An educational workshop was constructed by residents and faculty stakeholders based on review of the literature, institutional best practices, and a previously designed note assessment tool. Residents from a mid-sized pediatric residency program attended a workshop consisting of best practice didactics and small group work using the tool to assess example progress notes. Participants completed a 22-question online survey (Qualtrics) before and after the workshop to evaluate knowledge of progress note components and attitudes regarding note importance. Pre-post analysis was performed with Chi square testing for true/false questions and Mann-Whitney testing for Likert scale questions. Results Pediatric residents (n=26, 79% response rate) completed the pre-intervention online survey, and 23 (70%) completed the post-intervention survey. Accurate response rate improved in 15/20 of the true/false content questions, with a statistically significant
improvement in five of them (p<0.01). Overall correct answer percentage increased from 78% to 91% (insignificant change). Resident confidence in their ability to write a note and opinion of note importance increased (p=0.01, 0.04). Discussion/Conclusion This study suggests that a workshop intervention is an effective method of educating pediatric residents on progress note best practices. Further studies should assess the impact of the intervention on sustained resident knowledge and beliefs about progress notes and subsequent note quality.

EXAM PREPARATION

37. NEEDS ASSESSMENT OF BOARD PREPARATION CURRICULA AND CERTIFICATION RATES AMONG U.S. PEDIATRIC RESIDENCY PROGRAMS
Miki Nishitani, MD, Nicola Orlov, MD, MPH, University of Chicago, Chicago, IL
Background: The Accreditation Council for Graduate Medical Education (ACGME) requires pediatric residency programs to achieve an overall 70% pass rate on the American Board of Pediatrics Certification Exam. There is high variability in board preparation curricula among programs and minimal evidence showing which are the most effective in producing the highest certification rates. Objective: To gain an understanding of the current board preparation landscape across pediatric residency programs and to evaluate the need for individualized and/or focused board preparation curricula. Methods: A survey was distributed to all U.S. pediatric residency program directors by the Academic Pediatric Program Directors (n=209; response rate=35%). Programs were anonymously asked about their demographics, average in-training examination (ITE) scores and board pass rates, board preparation styles, and whether they are individualized and/or required for certain residents. Survey results were analyzed using descriptive statistics and Fisher’s exact tests. Results: Overall, board preparation consists of a combination of lectures/didactics (n=68, 100%), completion of board-style questions (n=70, 98.5%), and/or a formalized comprehensive review course (n=68, 26.5%). While almost all programs required didactics (91.2%), only about half (52.2%) of programs required completion of self-directed questions for all residents. ITE scores were the most commonly used means of identifying which residents needed an individualized curriculum. Board pass rates were divided into <70% (below goal), 70-79% (at risk), and >80% (above goal). Seven programs (10%) were considered below goal, while 13 (18.6%) were at risk. Table 1 shows that there is a statistically significant association between a requirement for completing self-directed questions and pass rates (p = 0.03). There were no statistically significant associations between other forms of board preparation and certification rates. Conclusion: Future efforts should focus on personalizing each resident’s board preparation curriculum, especially based on ITE scores.

38. PREDICTORS OF PASSING BOARD CERTIFICATION EXAMS IN A MED/PEDS RESIDENCY PROGRAM
Daniel R. Wells, MD, Shelley Ost, MD, Michael Kleinman, MD, Natascha Thompson, MD, University of Tennessee, Memphis, TN
Introduction: Combined Internal Medicine and Pediatrics (MP) residencies have primarily relied on categorical program data to predict pass rates for both the American Board of Internal Medicine Certifying Exam (ABIM-CE) and the American Board of Pediatrics Certifying Exam (ABP-CE). However, there is insufficient literature on what constitutes the best predictors of a MP resident passing each. We thus conducted a review of prior exam scores in our large MP program to determine the best predictors of passing both ABIM-CE and ABP-CE. Methods: Numeric scores from USMLE Steps 1 and 2 and In-Training Exams in Internal Medicine (ITE-IM) and Pediatrics (ITE-P) for UTHSC MP residents over 10 years (2008-2017) were retrospectively reviewed. A total of 91 residents were enrolled. First time ABIM-CE and ABP-CE numeric scores (n=65, n=71 respectively) and pass/fail results (n=91, n=71 respectively) were collected. Linear and logistic regression were applied to determine if a relationship existed between scores and whether numeric ABIM-CE and ABP-CE scores or odds of passing could be predicted based on prior exams. Results: Each prior USMLE, ITE-IM, and ITE-P score had a linear relationship with both ABIM-CE and ABP-CE scores. In the linear regression, adjusted r² values showed low to moderate predictive ability ranging from 0.10 to 0.34, with the highest predictor of ABIM-CE and ABP-CE being USMLE Step 1 (0.34) and first year ITE-IM (0.32) respectively. Logistic regression showed odds ratios of passing board-certifications ranging from 1.05 to 1.53 per point increase on the prior exam scores. The third year ITE-IM was the best predictor of passing both the ABIM-CE and ABP-CE using the c statistic for comparison (0.88 and 0.94 respectively). Conclusion: In this large MP program, USMLE Steps 1 and 2 and all years of ITE-IM and ITE-P scores were linearly related to ABIM-CE and ABP-CE scores, with third year ITE-IM scores most predictive of passing ABIM-CE and ABP-CE. These results provide MP specific data for programs to use for individualized counseling and targeted program improvements.
40. PREPARING PEDIATRIC RESIDENTS FOR THE GENERAL PEDIATRICS BOARDS USING QUARTERLY EXAMS

Kelsey Wehrenberg, DO, Betty Cheney Kelly, MD, MPH, Bertha B. Khallouq, MA, J. Gene Chen, MD, MHS, University of Florida (Orlando), Orlando, FL

Background: Graduating pediatric trainees are required to pass the American Board of Pediatrics (ABP) General Pediatrics Certifying Examination (the Boards) to be board certified in pediatrics. Many residencies use the annual ABP In-Training Exam (ITE) for preparation, but it is only given at the beginning of the academic year. Objective: To implement a series of Quarterly Exams (QEs) and explore the relationship between scores on QEs and scores on the Boards. Methods: We instituted a series of QEs in our mid-sized, community-based and university-affiliated pediatric residency. Each QE consisted of 45 board-style questions to be answered in 1 hour. QEs were created and proctored by chief residents at 3 month intervals throughout 3 years of training. QEs were mandatory; make-up sessions were held for residents who could not make the scheduled time. Each exam tested the topics covered in the previous 3 months of systems-based didactic conferences. After the exam, a program director facilitated a review session to discuss the 10 most missed questions and related testing strategies. The primary outcome of this study was the correlation between scores on QEs and scores on the Boards. Results: Residents who graduated in years 2016, 2017, and 2018 were included in the study (N=42). For each resident, the overall 3-year mean score on QEs was positively associated with their board score (r=.48, p<.001). By training year, mean scores on QEs and scores on the Boards were significant and positively associated for PL3 (r=.45, p<.001) and PL1 (r=.38, p<.05), but not PL2 (r=.09, p>0.05) residents. Scores on the ITE and scores on the Boards were significant and positively associated for PL3 (r=.70, p<.001), PL2 (r=.39, p<.05) and PL1 (r=.37, p<.05) residents. In multivariate analyses, the best predictors of Boards score were overall 3-year mean score on QEs and the score on the PL3 ITE (Bs =.74 and .61, respectively; p<.001). Conclusions: Performance on QEs correlated with performance on the Boards. QEs can help pediatric residents prepare for the Boards and identify residents at risk of failing.

41. THE EFFECT OF AN ACADEMIC HALF DAY CURRICULUM ON ITE SCORES AND RESIDENT SATISFACTION WITH BOARD PREPARATION

Deanna Chieco, MD, EdM, Children’s Hospital/Boston Medical Center, Boston, MA, Xuxin Chen, MD, Christina Thabit, MD, New York University School of Medicine, Elizabeth Kariuki, MD, New York Presbyterian Hospital (Columbia Campus), Michael Goonan, MD, Chanelle Coble-Sadaphal, MD, Hannah Famiglietti, MD, Heather Howell, MD, New York University School of Medicine, New York, NY, Patricia Poitevien, MD, MSc, Brown University, Providence, RI

Background: Resident didactics often occur during noon conferences. In 2017, the New York University School of Medicine Pediatric Residency Program transitioned from daily noon conferences to a weekly 3-hour Academic Half Day (AHD). While internal medicine residency programs have shown an association between AHD and higher in-training exam (ITE) scores, the impact of AHD on pediatric resident ITE scores or satisfaction with preparation for the General Pediatric Board Exam is not well studied.
42. WHAT DO YOU WANT TO LEARN OR WORK ON TODAY?: FEASIBILITY OF ASKING RESIDENTS FOR SELF-IDENTIFIED LEARNING GOALS IN THE PEDIATRIC EMERGENCY DEPARTMENT

**Pamela Fazio, MD, Emily Hardy, MSN, CRNP, Anna Weiss, MD, MSC, MSED, Jill Posner, MD, MSCE, MSEd, Children’s Hospital of Philadelphia, Philadelphia, PA, John Shatzer, PhD, Johns Hopkins University, Baltimore, MD, Kathy Shaw, MD, MSC, MSEd, Children’s Hospital of Philadelphia, Philadelphia, PA**

**Background:** In the unique clinical setting of the emergency department (ED), residents and preceptors may have only a short-term relationship, such as a single shift. This poses challenges to performing accurate learner assessment, selecting ideal instructional strategies, and providing substantive feedback. Objectives: The aims of this study were to determine if implementing a formal process in which residents self-identified learning goals for their ED shifts was feasible and to characterize the goals that residents self-identified. We used the conceptual framework that learner-driven goal-setting would increase engagement in learning and teaching, which would promote reflective feedback and guided discovery learning in the pediatric ED. Methods: In this prospective cohort study in the ED of an academic children’s hospital, residents were prompted to write a learning goal for their shift on a study card. At the end of the shift, residents were asked three yea/no questions to determine if they had identified, accomplished, and received feedback related to their goal. Logistic regression was used to determine if shift time, number of residents on shift, PGY level, and residency program type were predictors of goal identification, accomplishment, and receiving feedback. Goals were categorized by the six ACGME core competencies.

**Results:** During the 19-week study period, residents completed 306 end-of-shift surveys (74% response rate) and identified 358 learning goals. Residents reported that they identified a goal 54% of the time, accomplished 89% of identified goals, and received feedback related to their goal 76% of the time. Residents were less likely to identify goals on evening shifts (odds ratio [OR]=0.62, 95% confidence interval [CI] 0.41-0.94). The odds of receiving feedback were greatest on an overnight shift (OR=3.66, 95% CI 1.87-7.14) and lowest on an evening shift (OR=0.19, 95% CI 0.10-0.37). The number of residents on shift, PGY level, and program type did not influence the odds of goal identification, accomplishment, or receiving feedback. Most learning goals related to Patient Care and Procedural Skills (56%) or Medical Knowledge (41%) competencies. Conclusions: Asking residents to self-identify learning goals for their shifts in the pediatric ED is a feasible instructional strategy. Residents were able to identify, accomplish, and receive feedback related to their goals.

43. WHAT DO YOU WANT TO LEARN OR WORK ON TODAY?: BENEFITS AND BARRIERS TO ASKING RESIDENTS FOR SELF-IDENTIFIED LEARNING GOALS IN THE PEDIATRIC EMERGENCY DEPARTMENT

**Pamela Fazio, MD, Emily Hardy, MSN, CRNP; Children’s Hospital of Philadelphia, Meghan Chamberlain, Not Affiliated with Program/Institution listed above, Philadelphia, PA, Isabel Genecin, Not Affiliated with Program/Institution listed above, New York, NY, Jill Posner, MD, MSCE, MSEd, Children’s Hospital of Philadelphia, Philadelphia, PA, John Shatzer, PhD, Johns Hopkins University, Baltimore, MD, Kathy Shaw, MD, MSC, Children’s Hospital of Philadelphia, Philadelphia, PA**

**Background:** In the clinical setting of the pediatric emergency department (PED), residents and preceptors may have a short-term relationship, such as a single shift. This poses challenges to performing learner assessment, selecting instructional strategies, and providing substantive feedback. Objectives: We used the conceptual framework that learner-driven goal-setting would increase engagement in learning and teaching, which would promote reflective feedback and guided discovery learning in the PED. The purpose of this study was to determine how asking students to self-identify learning goals for their PED shifts might affect residents’ and preceptors’ experiences with learning, teaching, and feedback. Methods: This was a qualitative study with attending physicians and residents from fourteen training programs that rotate through an academic PED. Residents were asked to write a learning goal for their shift and to share it with their attending. Semi-structured interviews were conducted with a convenience sample of residents and a purposive randomized sample of attending physicians about their experience. Interviews were audio-recorded, transcribed, parallel coded, and analyzed until thematic saturation was reached. Results: During the 19-week study period, 358 unique learning goals were collected. Nineteen residents and ten attending physicians were interviewed. Major themes included: (1) Goal-setting facilitated learning. Residents and attendings reported that learning was attending-dependent and identified multiple ways in which attending facilitated accomplishing residents’ goals, such as prioritizing teaching on shift, doing verbal teaching, and directing residents to patients and resources. (2) Residents’ perceived weaknesses, future practice settings, and available patients informed their...
44. DEVELOPMENT OF A TOOL FOR FACULTY TO ASSESS RESIDENT-LED LARGE GROUP TEACHING
Ariel S. Frey-Vogel, MD, MAT, Kristina Daara, PhD, MMSc, Massachusetts General Hospital, Boston, MA, Kimberly A. Gifford, MD, Dartmouth-Hitchcock Medical Center, Hanover, NH, Erica Y. Chung, MD, Brown University, Providence, RI

Background: Residency programs are required to develop residents as teachers. Much of the formal teaching by residents occurs in group settings; the existing published tools did not collect validity evidence for assessment of resident-led large group teaching. We aim to create a tool for faculty to assess resident teaching in this setting. Methods: Initial content for the tool came from literature review and our personal experience leading resident-as-teacher curricula. Resident focus groups provided stakeholder input, informing the first round of tool revisions. A modified Delphi panel of 14 international faculty experts, over 2 rounds of revisions, provided feedback on the tool’s elements. Anchors were designed and finalized after a third Delphi round. Study investigators piloted the tool with 10 video recordings of senior residents teaching from the 3 sites. Cronbach’s alpha was calculated for internal consistency and intraclass correlation (ICC) for interrater reliability. Results: The tool has 6 domains: learning climate, goals and objectives, content, promotion of understanding and retention, session management, and closure. Each domain contains 12 sub-elements which are described by 37 observable behaviors. The Cronbach’s alpha was 0.88. The ICC was good or excellent for 13/37 sub-elements (35%), fair or poor for 22/37 sub-elements (59%) and the remaining 2 elements had no ICC score given no variability in rater scores. Conclusion: A tool for faculty assessment of resident-led large group teaching was developed using robust methodology. In the pilot study, the assessed behaviors have good internal consistency, but low interrater reliability without rater training. In the next study phase, we will develop tool utilization standards, train faculty raters, and apply the tool to a larger video sample of resident teaching. We will collect validity evidence for the tool including ability to discriminate between novice and advanced teachers and its correlation with teaching milestones.

45. “INTERN CHECK-IN TOOL” TO IMPROVE EARLY IDENTIFICATION OF STRUGGLING INTERNS AND FACILITATE FEEDBACK
Alyssa Swick, MD, Duane Allen, MD, Krista Allen, MD, Stefan Malin, MD, Mitchell Goldman, MD, Zeina Nabhan, MD, Jerry Rushton, MD, Indiana University School of Medicine, Indianapolis, IN

Background: Our current system for evaluation relies on faculty and peer evaluation of intern performance relating to general ACGME milestones. However, a program may have insufficient data to accurately identify a struggling intern until several months into the academic year. Objective: To develop a brief, objective, resident-based evaluation tool to facilitate earlier identification of struggling interns in pediatric and internal medicine programs. Methods: The intern check-in tool (ICT) consists of 18 items with a variety of observable key skills expected for interns (refer to attached form). It is scored on a 22-point scale of objective behaviors. Chief residents meet half way through each rotation and review the tool with senior residents supervising each intern. Results: We implemented the use of the ICT at the beginning of the academic year in July 2018. Mid-year data is still being analyzed. In January 2019, after completion of the clinical competency committee (CCC) meetings, we will perform statistical analysis to measure correlations between the ICT scores and the overall intern performance as assessed by the CCC. We will also calculate the sensitivity and specificity for a range of ICT scores and measure correlations between the ICT scores and the demographic data, including medical school quartile and USMLE scores, for each intern. The ICT allowed us to identify a struggling intern early on who had multiple high scores. Following focused feedback and mentoring from senior residents, the intern’s performance improved significantly prior to the CCC. The use of the tool has also identified interns struggling with wellness, who we have been able to integrate into a counseling program. Conclusions: The pilot of the ICT may supplement more general milestone evaluations. Our data is preliminary but promising. This tool might be of benefit to other programs aiming to assess intern performance. It provides a forum for residents to learn the art of giving feedback and seek strategies to help their interns improve in real time.

46. QUICK RESPONSE (QR) CODES ARE A MORE EFFECTIVE MEANS OF ELICITING FEEDBACK FROM PATIENTS AND FAMILIES
Jennifer Fishbein, MD, Kimberly Lau, MD, Stephen Barone, MD, Hofstra Northwell School of Medicine at Cohen Children’s Medical Center, New Hyde Park, NY

Background: Multisource feedback to residents is important for development and evaluation. In addition to traditional feedback from faculty, valuable feedback can be provided by patients and families. Previously, our program obtained family feedback via paper forms distributed on admission. This system resulted in a low response rate. Alternatively, Quick Response
47. DEVELOPMENT AND IMPLEMENTATION OF THE SCALABLE TOLERATING AMBIGUITY/UNCERTAINTY TOOL UTILIZING SIMULATION (STATUS) TO ASSESS THE PROF6 PEDIATRIC MILESTONE SUB-COMPETENCY: A PILOT STUDY

Charles M. Bergman, MD, Kevin M. Ching, MD, New York Presbyterian Hospital (Cornell Campus), New York, NY

Background: Uncertainty and ambiguity permeate the health care field. The Pediatrics Milestone Project identifies a sub-compentency under the “Personal and Professional Development” competency stating residents must, “recognize that ambiguity is part of clinical medicine and respond by utilizing appropriate resources in dealing with uncertainty” (PROF6). A survey of pediatric program directors and simulation experts conducted by Mallory et al., ranked PROF6 as the most difficult sub-compentency to assess using traditional methods. Objective: Proof-of-concept assessment tool pilot to evaluate PROF6 in simulation. Methods: STATUS is comprised of an “Instructors” assessment focused on direct observation of predefined skills, and a “Learners” self-assessment focused on subjective feelings towards ambiguity in practice. STATUS features items from the “Physician’s Reactions to Uncertainty” scale developed by Gerrity et al., the “Pearson Risk Attitude” index developed by Pearson et al., and novel items derived from the Pediatrics Milestone Project Domains. Pediatric interns at an urban tertiary care medical center participated in a simulation scenario where there is substantial practice variation in managing a febrile infant. A trained standardized parent actor utilized scripted lines to elicit the interns’ position on the uncertain outcome of their child’s condition. Results: 36/40 pediatric interns participated in our study. Interrater-reliability between the two instructors was calculated for our initial tool using a 5-point Likert scale (kappa = 0.705 [95% CI, 0.572-0.838]), and for modified versions of our tool using a 3-point scale (kappa=0.982 [95% CI, 0.957-1]). Conclusion: STATUS reliably assessed pediatric resident responses to ambiguity in an uncertain clinical situation. Next steps will be to incorporate the learner and instructor assessments to generate a combined appraisal of a resident's performance in PROF6. A multi-center study is planned to further validate and evaluate these assessments.

48. CONTINUITY CLINIC PRACTICE FEEDBACK: WHAT DO RESIDENTS WANT?

Chad Vercio, MD, Loma Linda University Health Education Consortium, Redlands, CA, Chris Peltier, MD, Cincinnati Children’s Hospital Medical Center/University of Cincinnati College of Medicine, Cincinnati, OH, Lori Price, MD, Indiana University School of Medicine, Indianapolis, IN, Dominick Deblasio, MD, Cincinnati Children’s Hospital Medical Center/University of Cincinnati College of Medicine, Cincinnati, OH

Continuity Clinic Practice Feedback: What Do Residents Want? Background: The Accreditation Council of Graduate Medical Education (ACGME) recommends that residents receive data on quality metrics and benchmarks related to patient care. Continuity clinic (CC) is an ideal setting to obtain practice habit data. Objective: To determine which CC practice habit data residents would find beneficial to receive during feedback. Methods: A multicenter qualitative study was conducted with pediatric continuity clinic residents at 3 academic medical centers in two different phases. During phase 1, small resident focus groups were conducted at each site. The focus groups explored preferred content feedback on CC practice habit data. The qualitative data was reviewed by all investigators to identify major themes. For the second phase of the study, the results obtained from the focus group were used to develop a survey in order to determine how strongly residents felt about the particular areas of feedback that were identified in phase one of the study. This survey, which utilized a 5-point Likert scale to determine the importance of each feedback item, was sent out electronically to all categorical residents at each academic center. Results were analyzed with the mean and standard deviation for each question calculated. Results: Focus groups were held at 3 sites with 3-10 residents per focus group. Consistent major themes which arose from the focus groups at all sites as desired areas to receive feedback on CC practice included the following categories: patient panel characteristics, quality measures, measures of efficiency in patient care, population management and information on specific patients. For the
second phase of the study, 277 residents received the survey with 92 responding (33% response rate). The mean value that residents placed on the importance of each content area is displayed (table 1) with 1 being not important at all and 5 being very important. Conclusion: Residents are interested in receiving practice habit data from continuity clinic. Presentation of the feedback described may enhance the resident continuity clinic experience and improve overall performance and enhance patient care.

49. RETHINKING FACULTY EVALUATIONS: GIVING FACULTY WHAT THEY WANT
Mark A. Vining, MD, Jennifer Berube, MSN, Patricia Meza, MS RN, Anna Cooley, MD, University of Massachusetts, Worcester, MA

Background: The ACGME requires programs to review faculty “commitment to teaching” and “teaching ability”. Research has demonstrated improvement in teaching with various new assessment tools based primarily on learner assessments. We found no studies in which authors explored how faculty perceived and used information provided by their evaluations. Objectives: 1) Understand how faculty perceive the usefulness of their evaluations in their current state; 2) Understand how faculty apply recommendations from evaluations to improve their teaching; 3) Explore the elements of evaluations faculty feel will best help them meet their educational and professional goals. Methods: As a LEAD qualitative educational project, we conducted faculty focus groups at our institution between November 2017 and January 2018. We employed a purposeful sampling approach to ensure a diversity of faculty experiences with evaluations. A semi-structured interview guide was utilized during each focus group. Focus groups were recorded and transcripts were analyzed and coded independently by three investigators. Coders re-grouped and determined common themes utilizing the methodologic approach of qualitative description, an inquiry approach that yields rich, low inference descriptions of a phenomenon as described by those who experience it. Results: Six focus groups were held with a total of 35 faculty participants. 242 minutes of discussion were transcribed and analyzed. Three major themes emerged: Process problems, How evaluations are utilized, and Components of the ideal evaluation, with several thematic subsets. While faculty find feedback provided after specific didactic sessions useful and constructive, faculty do not find the current rotation evaluations to be helpful, nor do they use these to alter their teaching. Of the themes that emerged, the most generalizable among programs was a clear desire for a more “learner-centered” evaluation. Faculty want evaluations to judge their ability to assess their learners’ needs and to in turn meet those needs. Faculty are less interested in complimentary comments endorsed on evaluations (“approachable”, “respectful”). We will present further quotes supporting these themes.

Conclusion/Implication: We created a new evaluation form that better meets faculty priorities for professional growth and promotion that is more learner-centered in focus (will be shared with audience and posted on SHARE Warehouse).

50. PARENT COACHES: A NOVEL APPROACH TO TRAINEE FEEDBACK
Michael Kim, DO, Medical College of Wisconsin Affiliated Hospitals, Wauwatosa, WI, Kelly Lynch, Serena LaBounty, Heather Toth, MD, Sarah Vepraskas, MD, Sara Lauck, MD, Jennifer Hadjiev, MD, Michael Weisgerber, MD, Medical College of Wisconsin Affiliated Hospitals, Milwaukee, WI

Conducting direct observation and providing immediate feedback can be a valuable method for training learners as effective participants in patient- and family centered rounds (PFCR). These are traditionally done by faculty and are time consuming to do consistently for a large number of trainees. A new innovative role found on some hospital interprofessional teams is the parent advisor. This role is filled by a parent of a child with complex medical needs who is an experienced user of the hospital system. We speculated a novel use of parent advisors to serve as coaches for trainees and developed a program to observe and provide feedback on PFCR performance. A parent coach was identified and trained by members of our study team in PFCR observation, family communication, and provision of feedback to medical learners. Structured tools used included the PEA-21 checklist (a validated tool for observing presenters on PFCR), a structured form for interviewing families of patients,
Microaggressions have emerged in anonymous, online resident evaluations. The types of microaggressions may inform future work on the implications and impact of microaggressions in medical education.

We established the feasibility of trained parent coaching program and reached 128 students and residents during this period. In addition the learners found the feedback sessions valuable for their training.

51. VALIDATION OF THE MAYO EVALUATION OF REFLECTION ON IMPROVEMENT TOOL (MERIT) FOR USE IN A PEDIATRIC RESIDENCY PROGRAM

MacKenzie S. Frost, MD, Asya Asghar, MD, Timothy Chow, MD, Heather Weydig, MD, Andrew Yu, MD, Charles Rosenfeld, MD, University of Texas Southwestern Medical School, Dallas, TX

Background: Quality improvement (QI) education is a requirement at all stages of medical education training. Pediatric training programs are required to assess their trainees on quality improvement reflection and knowledge as part of the Pediatric Milestones. However, there is currently no validated tool for use in pediatrics to assess reflection on quality improvement opportunities. The Mayo Evaluation of Reflection on Improvement Tool (MERIT) has been previously published with validity evidence for use in internal medicine programs, but it has not been studied for use in pediatric training programs.

Objective: To validate the MERIT assessment tool for use in pediatric residency programs to aid in quality improvement milestone evaluation.

Design/Methods: All University of Texas Southwestern (UTSW) pediatric residents completed annual improvement reflections between 2015-2017. De-identified reflections were assessed by five independent reviewers. Reviewers were oriented to the MERIT tool and compared 10 initial evaluations to ensure consistency. Completed MERIT evaluation scores were compared. Inter-rater reliability for each item on the tool was compared with intra-class correlation coefficients (ICC) and corresponding 95% confidence intervals (CI) using a mean-rating, absolute-agreement, 2-way mixed effects model.

Internal consistency for each section and the overall tool was evaluated with Cronbach's alpha and inter-item correlations. All calculations were done with SPSS statistical package version 25. Results: 150 resident reflections were evaluated yielding 749 evaluation forms for study. Item mean scores were highest for the Problem of Merit section (3.19) and lowest for the Reflection on System Characteristics of Quality Improvement (1.94). Inter-rater reliability was good for all 18 items on the MERIT tool (ICC range: 0.78 - 0.90). Inter-rater reliability was good to excellent for 13 of the 18 items on the tool when 95% CI was used.

Internal consistency was excellent (Cronbach's alpha 0.93 overall and 0.94 - 0.95 for each section). The Cronbach's alpha did not improve if any single item was removed. Inter-item correlations were high for all three sections, but highest for the Problem of Merit section (0.67 - 0.92). Conclusion(s): Validity evidence supports the use of the MERIT in pediatric residency programs to assess resident reflections on quality improvement. The pediatric validity evidence is consistent with the previously published validation study in an Internal Medicine residency program.

52. MICROAGGRESSIONS IN ROTATION EVALUATIONS BY RESIDENTS

Alisa A. Acosta, MD, MPH, Andria Tatem, MD, Mark Ward, MD, Carla N. Falco, MD, Baylor College of Medicine (Houston), Houston, TX

BACKGROUND: There seems to be an increasing sense of hostility or harshness in comments of rotation evaluations submitted by residents. There seems to be an emergence of microaggressions and even hostile comments recently. Millennials are now the largest generation in the US labor force and the prevalent generation of medical learners. This generation grew up in a digital world where expressing their opinion as online comments was the norm. When comments are anonymous, they are more likely to be uncivil, and the lack accountability contributes to writing simplistic evaluations of complicated issues.

Microaggressions are "brief and commonplace verbal, behavioral, and environmental indignities, whether intentional or unintentional, that communicate hostility, derogatory, or negative...slights and insults." Similar to online comments are online evaluations completed by residents. METHODS: We conducted a qualitative study of all free-form answers in written, electronic, anonymous resident evaluations of rotations and the program from 2 academic years: 2007-2008 and 2017-2018. Rotation evaluations asked for the (a) strengths of the rotation, (b) in what ways the rotation did not meet one's expectations, and (c) suggestions to improve the rotation. In 2007-2008, there were 2934 comments and in 2017-2018, there were 3717. A constant comparison method was used to identify codes and themes within the comments, including a focus on constructive criticism versus microaggressions.

RESULTS: The majority of negative comments were constructive criticism directed at characteristics of or, more rarely, specific behavior of personnel on the rotation. There were few microaggressions noted in 2007-2008 with the majority found in 2017-2018. Three types of microaggressions were identified. First, an insult was seen as a personal attack that ascribed a negative attribute to the person as opposed to the person's behavior. Second, the use of sarcasm was seen as a hostile response. Third, the use of powerful words that elevated the intensity of the comment (e.g. rabid, horrible, miscreant) or made generalized or absolute statements, for example, using terms like “everyone”, “everywhere”, and “all”.

CONCLUSIONS: Microaggressions have emerged in anonymous, online resident evaluations. The types of microaggressions may inform future research on the implications and impact of microaggressions in medical education.
Background: Daily progress notes are vital cross disciplinary communication tools. The electronic medical record has influenced progress note content and length. Previously developed note assessment tools, such as the Physician Documentation Quality Instrument (PDQI-9), have not focused on the assessment and plan of the note, which are often most informative. Objective: Develop a reliable and valid tool to evaluate the assessment and plan of resident daily progress notes. Methods: A committee of pediatric resident, hospitalist and critical care physicians generated a list of common pitfalls associated with daily progress notes. A standardized ideal progress note assessment and plan was developed using a cause and effect diagram, literature review, consultation with billing expert and institutional documentation best practice guidelines. From this ideal state, a progress note evaluation tool PNAPE was developed using Modified Delphi technique. Four faculty experts used PNAPE and PDQI-9 to independently review resident progress notes identified from a convenience sample from each intern on the hospitalist service in fall 2017. Inter-rater reliability of the PNAPE was assessed using intraclass correlation coefficient (ICC). External validity was assessed by correlation between mean PNAPE and PDQI-9 scores using Pearson’s coefficient. Results: PNAPE is shown in figure 1. In all, 13 Notes were assessed with an ICC of 0.85. Pearson’s r is 0.63 between mean PNAPE and PDQI-9 scores. Conclusion: These findings suggest that the PNAPE is a reliable and valid tool for evaluation of resident progress note assessment and plan by expert assessors. Next steps will include use of PNAPE to track note quality over time, provide feedback and to assess notes in other inpatient settings and specialties.

54. GENDER GAPS IN THE PEDIATRIC EMERGENCY DEPARTMENT: HOW DOES GENDER AFFECT EVALUATIONS?
Lydia M. Rabon, MD, Jon F. McGreevy, MD, MPH, Lucia Mirea, PhD, Phoenix Children's Hospital, Phoenix, AZ

Background: The emergency medicine literature reports a gender gap in milestone attainment. While residents receive similar evaluations at the start of residency, throughout training male residents receive milestone attainment at a faster rate across all EM competencies leading to a gender gap that continues until graduation. The field of both pediatrics and pediatric EM data shows that a higher percentage of female trainees and attendings are entering the specialty each year. Our study objectives were to test for gender differences in evaluations from both the learner and the evaluator and examine differences in scores between same and opposite gender evaluator-resident pairings. Methods: Pediatric residents were assessed every month that they rotated through the Pediatric Emergency Department. Evaluations assessed 8 different competencies: procedural competency (PC), prioritizing and multitasking (PC2), management plans (PC5), medical knowledge (MK), physician accountability (PROF2), reliability (PROF5), handling uncertainty in medicine (PROF6), and interdisciplinary teamwork (SBP3). Statistical comparisons of each category were performed using the Kruskal-Wallis test at the 5% level. Results: Total evaluations included 69 male and 94 female resident rotations performed by 64 male and 99 female evaluators. Female residents scored higher than male residents on PROF5 and SBP3 and PROF6. Female evaluators scored residents higher in the areas of PROF2 and PROF6. Scores from same sex pairings (92) were higher than different sex (71) pairings for PROF2, PROF6 and SBP3. Also, female evaluators scored female residents higher than male residents on PROF2, PROF6 and SBP3 while male evaluators showed no difference. Conclusion: Both the gender of evaluator and gender of resident impact evaluation scores in the areas of PROF2, PROF5, PROF6 and SBP3. This study doesn’t address the longitudinal gender gap previously reported but would suggest that, in pediatrics, female residents are evaluated with higher milestone competencies. Additional data collection and analyses will further understanding of the effect gender has on resident evaluations, and drive change towards gender-equal resident competency evaluation.

ENTRUSTMENT/EPAS/MILESTONES

55. UTILITY OF RESIDENCY MILESTONES REPORTED TO FELLOWSHIP DIRECTORS: A NATIONAL SURVEY OF PEDIATRIC FELLOWSHIP PROGRAM DIRECTORS
Suzanne Reed, MD, Nationwide Children's Hospital/Ohio State University, Columbus, OH, Richard Mink, MD, Los Angeles County-Harbor UCLA Medical Center, Los Angeles, CA, Su-Ting Li, MD, University of California (Davis) Health System, Davis, CA

Background The Accreditation Council for Graduate Medical Education (ACGME) requires milestone-based assessments of residents and fellows. The ACGME recently allowed fellowship programs access to the final residency milestones for incoming fellows through the ACGME Accreditation Data System. It is unknown if fellowship programs are downloading residency milestones and if fellowship program directors (FPDs) believe they have value. Objective Determine how many pediatric
56. PROGRAM DIRECTOR MINIMUM MILESTONE EXPECTATIONS OF PEDIATRIC RESIDENTS BEFORE READY TO SUPERVISE OTHERS AND BEFORE GRADUATION

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

Background: In 2013, the Accreditation Council for Graduate Medical Education (ACGME) began requiring program directors (PDs) to report Milestone levels for every resident semiannually. Our prior 2015 survey found that few PDs had minimum Milestone level expectations before residents were ready to supervise (20%) or ready to graduate (20%). Objective: Characterize present day model for pediatric PD minimum Milestone expectations for residents before being ready to supervise and graduate. Methods: Cross-sectional survey in Spring 2018 of pediatric PDs on their program Milestone expectations before residents are ready to supervise and graduate. At programs with no established Milestone expectations, PDs indicated expectations they considered for use in their program. Descriptive analyses were used to explore PD minimum Milestone levels before residents are ready to supervise (20%) or ready to graduate (20%).

Table 1: Pediatric Subspecialty Fellowship Program Directors’ perceptions of usefulness of residency milestones for their first-year fellows

<table>
<thead>
<tr>
<th>Theme</th>
<th>Representative quote</th>
</tr>
</thead>
<tbody>
<tr>
<td>Validity</td>
<td>&quot;Residency and Fellowship Milestones are unproven instruments towards the outcome of educating better practicing physicians. As for any unproven and investigative instrument in healthcare, evidence should be developed before implementation is required.&quot;</td>
</tr>
<tr>
<td></td>
<td>&quot;Without knowing much about the training culture of the residency program, I don’t know if the milestone scores are inflated or realistic or how honest they are.&quot;</td>
</tr>
<tr>
<td>Fellowship relevance</td>
<td>&quot;Residency milestones apply to a wide variety of settings that are not specific to [subspecialty] settings&quot;</td>
</tr>
<tr>
<td></td>
<td>&quot;As fellows they are in a different environment and different expectations of their role. The milestone behaviors are likely to change in a new context. We will determine the milestones for our fellows independent of any prior assessments.&quot;</td>
</tr>
<tr>
<td>Revision of assessment tools/reporting</td>
<td>&quot;Language is unclear and lengthy. Faculty often is uncertain as to what they mean and how to apply them&quot;</td>
</tr>
<tr>
<td></td>
<td>&quot;Many relevant skills are not measured well by milestones.&quot;</td>
</tr>
<tr>
<td>Allows for identification of trainee needs</td>
<td>&quot;It helps us know what areas of strengths and weaknesses we may or may not need to emphasize during fellowship.&quot;</td>
</tr>
<tr>
<td></td>
<td>&quot;...I would find the residency milestones useful if a fellow were struggling in a particular area and I could confirm that the same area was a problem in residency also.&quot;</td>
</tr>
<tr>
<td>Provides baseline assessment</td>
<td>&quot;Provides an estimation, albeit an estimation from other’s who may or may not be known to us, of where a fellow is starting out&quot;</td>
</tr>
<tr>
<td></td>
<td>&quot;We could use the information to guide the ILP for their first year fellowship rather than use their recall.&quot;</td>
</tr>
</tbody>
</table>

Conclusions: Most pediatric subspecialty programs do not use residency milestones to tailor education for their first-year fellows and most think they have limited usefulness. While more PDs felt that residency milestones might be useful during recruitment, there was not universal agreement. Further studies to improve validity of residency milestones may make them more useful to fellowship programs.
for trustworthiness (Prof5), professional conduct (Prof3), professionalization (Prof2), transfer of care (PC3), organize and prioritize (PC2), humanism (Prof1), and help-seeking (Prof4), where most PDs felt that Level 2.5 was the minimum expectation. PD expectations for supervising residents were lowest for learning activities (PBLI2) and advocacy (SBP2), where the majority of PDs felt that there was no minimum or that Level 1 was sufficient. Minimum expectations for graduates were highest for diagnostic/therapeutic decisions (PC4), develop management plans (PC5), gather information (PC1), organize and prioritize (PC2), professionalization (Prof2), and trustworthiness (Prof5), where >70% of PDs felt that Level 3.0 was the minimum (Figure). PD expectations for graduating residents were lowest for quality improvement (PBLI3), advocacy, learning activities, and evidence-based medicine (MI), where >40% of PDs felt that Level 2.5 was the minimum. Conclusions: Five years after the ACGME required Milestone reporting, only a minority of PDs have established minimum Milestones before residents are ready to supervise or ready to graduate. However, more PDs have minimum Milestone levels before residents are ready to graduate than in 2015 (36.6% vs 20%) and PDs recognize the relative importance of different competencies in establishing readiness to supervise and readiness to graduate.

57. A “DENVER DEVELOPMENTAL” VIEW OF RESIDENT PERFORMANCE USING AN EPA FRAMEWORK
Daniel J. Schumacher, Cincinnati Children’s Hospital Medical Center/University of Cincinnati College of Medicine, Cincinnati, OH; Alan Schwartz, University of Illinois College of Medicine at Chicago, Chicago, IL, Beth King, Not Affiliated with Program/Institution listed above, McLean, VA, Daniel West, University of California (San Francisco), San Francisco, CA, Su-Ting Li, University of California (Davis) Health System, Sacramento, CA, Sue Poynter, Javier Gonzalez del Rey, Cincinnati Children’s Hospital Medical Center/University of Cincinnati College of Medicine, Cincinnati, OH, Bruce Herman, Meghan O’Connor, Joni Hemond, University of Utah, Salt Lake City, UT, Adam Rosenberg, University of Colorado, Denver, CO, Candance Smith-King, Michigan State University, Grand Rapids, MI, Teri Turner, Baylor College of Medicine (Houston), Houston, TX, Valera Hudson, Lauren Newhall, Medical College of Georgia, Augusta, GA, Robyn Blair, Stony Brook Medicine/University Hospital, Stony Brook, NY, Christin Traba, Rutgers New Jersey Medical School, Newark, NJ, Suzanne Lavoie, Virginia Commonwealth University Health System, Richmond, VA, Kenya McNeil-Trice, University of North Carolina Hospitals, Chapel Hill, NC, Dilip Patel, Western Michigan University Homer Stryker MD School of Medicine, Kalamazoo, MI, Julie Baughn, Mayo Clinic College of Medicine (Rochester), Rochester, MN, Leah Millstein, Erin Guidace, University of Maryland, Baltimore, MD, Emily Borman-Shoap, University of Minnesota, Minneapolis, MN, Hannah Famiglietti, New York University School of Medicine, New York, NY, Keith Ponitz, Case Western Reserve University/University Hospital Case Medical Center/Rainbow Babies, Cleveland, OH, Elena Griego, University of Washington, Seattle, WA, Nicole Black, University of Florida, Gainesville, FL, Kimberly Gifford, Dartmouth-Hitchcock Medical Center, Hanover, NH, Carol Carraccio, Not Affiliated with Program/Institution listed above, Chapel Hill, NC

INTRODUCTION: The American Board of Pediatrics and pediatrics community developed entrustable professional activities (EPA) defining the foundation of general pediatrics care. We sought to determine the developmental progression of pediatric residents across 3 years of training for the 17 General Pediatrics (GP) EPAs. METHODS: Over 3 academic years (2015-18), 22 geographically representative residency programs in the APPD LEARN used scales with 5 or 8 anchors, describing levels of supervision from direct to indirect to entrustment, to assess EPAs biannually. Interns were assessed only at the end of Year 1.

We fit growth curves to ordinal supervision levels for all 17 EPAs together using a linear mixed model and developed “Denver Developmental” charts to display the proportion of learners who have reached each given level of supervision on each EPA based on the growth curves. RESULTS: Figure 1 illustrates examples of the developmental progression for 5 of the 17 EPAs. The graphic demonstrates where 25% (beginning of white box), 75% (where white and blue boxes meet), and 90% (end of blue box) of residents achieve each supervision level for the EPA with the highest ratings (handovers) and 4 EPAs with the lowest ratings (quality improvement, resuscitate/stabilize, behavioral/mental health, and transition to adult care) across 3 years of training. Some levels were achieved by all residents by the end of the intern year (e.g., levels 1-3 for EPA 18, handovers). Most EPAs had one or more advanced levels where the 25%, 75%, or 90% data extended beyond the end of training. In those instances, the percent of residents achieving these levels is indicated on the right-hand side of Figure 1 (e.g., 12% of residents achieved level 8 for EPA 8, transition to adult care, by the end of training). CONCLUSION: The GP EPA “Denver Developmental” progressions may help in early screening for underperforming residents. This is critical information for the learner and the program. For the former, providing feedback provides an opportunity for improvement and for the latter, if a number of learners are not progressing as expected this may indicate curricular gaps.
58. ASSESSMENT THAT MATTERS FOR PATIENTS: POSITIVE ASSOCIATION BETWEEN ENTRUSTMENT DECISIONS AND QUALITY CARE MEASURES FOR RESIDENTS CARING FOR PATIENTS WITH ASTHMA

Daniel J. Schumacher, MD, MEd, Terri Byczkowski, PhD, Cincinnati Children's Hospital Medical Center/University of Cincinnati College of Medicine, Cincinnati, OH, Carol Carraccio, MD, MA, Not Affiliated with Program/Institution listed above, Chapel Hill, NC, Cesie van der Vleuten, PhD, Jamui Busari, MD, PhD, MHPE, Not Affiliated with Program/Institution listed above, Maastricht, NL, Abigail Martini, BS, Cincinnati Children's Hospital Medical Center/University of Cincinnati College of Medicine, Cincinnati, OH, Eric Holmboe, MD, Not Affiliated with Program/Institution listed above, Chicago, IL

BACKGROUND: Recent focus has been placed on the entrustment construct for assessing residents; specifically, how much supervision is needed to provide safe care. This method of assessment puts the patient at its core. However, whether entrustment decisions are related to quality care is not known. OBJECTIVE: Determine the association between entrustment decisions made about pediatric residents in the pediatric emergency department (PED) caring for patients presenting with acute asthma exacerbations and resident quality measures for those patient encounters. METHODS: During the 2016–2017 academic year, we obtained the following for encounters of patients presenting with asthma exacerbation to the Cincinnati Children’s PED: 1) 6 question resident entrustment score based on Chen’s supervision scale and Kennedy’s trustworthiness construct (6 item total score: 0–6), and 2) resident quality measure score (proportion of 21 quality measures achieved). Supervising faculty and fellows completed the entrustment questions for each encounter. Quality measures were developed through expert consensus to meet two criteria (importance to asthma care and likelihood the resident, and not another team member, completes the measure) and were manually extracted from the electronic medical record. To account for nested data within residents, association of entrustment with quality was evaluated using mixed models adjusting for patient acuity and complexity. RESULTS: 59 residents provided care for 110 unique patients. Table 1 summarizes measurement descriptive statistics. Entrustment scores exhibited a significant positive linear relationship with quality scores (p-value = 0.04), with entrustment scores increasing by 0.16 (95% CI: 0.01, 0.31) for every 0.10 increase in quality. CONCLUSION: This study demonstrates a statistically significant association between resident performance assessments and quality of care for the patients treated by those residents. This offers initial validity evidence for the use of entrustment decisions as well as quality measures as resident performance assessment frameworks.

Table 1: Descriptive Statistics for the Entrustment and Quality Scores

<table>
<thead>
<tr>
<th>Measure</th>
<th>Min</th>
<th>Max</th>
<th>Mean (SD)</th>
<th>Median (IQR)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Entrustment Score (0 – 6)</td>
<td>1.58</td>
<td>6</td>
<td>4.76 (0.23)</td>
<td>4.91 (4.16 – 5.58)</td>
</tr>
<tr>
<td>Asthma Quality Score (0 – 1)</td>
<td>0.47</td>
<td>1</td>
<td>0.79 (1.11)</td>
<td>0.81 (0.71 – 0.86)</td>
</tr>
</tbody>
</table>

59. FELLOW SELF ASSESSMENT USING THE PEDIATRIC SUBSPECIALTY EPAS

Eric P. Velazquez, MD, Antoinette Moran, MD, Brandon Nathan, MD, Emily Borman-Shoap, MD, University of Minnesota, Minneapolis, MN

BACKGROUND: As an alternative to milestone based evaluations, Entrustable Professional Activities (EPAs) may provide a more specific and useful feedback tool for fellow training. Assigning a level of entrustment on an EPA coupled with qualitative comments, shows promise as a real-time feedback approach. Although the EPAs are being studied as a summative assessment tool in fellowship training, their formative assessment capabilities remain unknown. In addition, fellows self-assessment on EPAs has not been well-studied. METHODS: As part of a pilot study, we created an online EPA assessment form. Pediatric fellows from four divisions (Neonatology, Endocrinology, Adolescent Medicine, and Developmental and Behavioral Pediatrics) were recruited. As part of a needs assessment on feedback in fellowship training, the participating fellows were asked to provide self-assessment via the 6 core pediatric subspecialty EPAs using the established scoring benchmarks. RESULTS: Nine fellows completed the needs assessment survey: 3 first year, 4 second year, and 2 third year fellows. Lead Subspecialty had the lowest average score of 2.78, with Handovers having the highest average score of 3.67. Fellows rated themselves as trusted to practice without supervision for Fiscal Management and Handovers, whereas fellows at all levels of training rated themselves as needing at least indirect supervision for the EPAs related to Consultation, Public Health, and Lead Team. CONCLUSIONS: Our pilot establishes preliminary data of where fellows feel their level of entrustment is at the beginning of the academic year. Variability in self-assessment may be related to unfamiliarity with the rating scale, true variation in fellow skillset, or may represent re-appraisal of skills as fellows advance in development. Use of the EPA assessment scale and more frequent assessments we hope will increase familiarity with EPA scale and improve fellows’ ability to reflect on development. Fellows self-reported need for at least indirect supervision on most EPAs highlights the need for ongoing coaching and supervision throughout all three years of training.

60. NEEDS ASSESSMENT AND EARLY EXPERIENCE USING PEDIATRIC SUBSPECIALTY EPAS AS A FORMATIVE ASSESSMENT TOOL

Eric P Velazquez, MD, Antoinette Moran, MD, Brandon Nathan, MD, Emily Borman-Shoap, MD, University of Minnesota, Minneapolis, MN

BACKGROUND: Compared to semi-annual Milestone-based assessment models of fellowship training, Entrustable Professional Activities (EPAs) may be better at assessing fellow development. EPAs formative assessment capabilities are unknown, nor have they been adopted as a method for evaluation. The use of EPAs entrustment scales could allow for more specific, actionable feedback from faculty during training. METHODS: In a pilot study, we created a needs assessment on feedback in pediatric fellowship training and a readily accessible online EPA assessment form. Fellows use the form to ask faculty to choose EPAs to assess following a clinical experience. Fellows from Neonatology, Endocrinology, Adolescent Medicine, and Developmental & Behavioral Pediatrics were recruited. Fellows are asked to obtain a minimum of four EPA assessments monthly. Time spent completing forms and providing feedback is recorded for each encounter. RESULTS: 20 faculty, 4 program directors and 9 fellows completed the needs assessment. 77% of fellows reported current Milestone-based feedback aided
their professional development, but only 60% were satisfied with the quantity and quality of feedback received. 80% of faculty believed fellows were provided adequate feedback using Milestones, but only 50% reported they provided good feedback. Faculty identified many barriers to giving good feedback using Milestones. 85% felt use of a structured EPA template and more frequent opportunities would improve their feedback. In the first 4 months of the pilot, 27 episodes of EPA based feedback occurred. 12 different faculty members have provided feedback using the template. The most often used EPA was Lead Team while Public Health was least used. An average of 9 minutes of feedback per assessment was reported. CONCLUSIONS: Our pediatric faculty and fellows feel an opportunity exists to improve the quality and quantity of feedback from our current Milestone approach. An online EPA tool is being used by faculty and fellows to provide more frequent feedback. Future assessments will evaluate the utility and specificity of feedback provided.

61. DO PEDIATRIC FELLOWS MEET THE EXPECTED LEVEL OF SUPERVISION AT GRADUATION?
Richard Mink, MD, MACM, Los Angeles County-Harbor UCLA Medical Center, Torrance, CA; Carol Carraccio, MD, MA, American Board of Pediatrics, Chapel Hill, NC; Bruce Herman, MD, University of Utah, Salt Lake City, UT; Angela Myers, MD, MPH, Children’s Mercy Hospital, Kansas City, MO; Jill J. Fussell, MD, University of Arkansas for Medical Sciences, Little Rock, AR; David A. Turner, MD, Duke University Hospital, Durham, NC; Sarah Pitts, MD, Children’s Hospital/Boston Medical Center; Jennifer Kesselheim, MD, EdM, Dana-Farber/Boston Children’s Cancer and Blood Disorders Center, Boston, MA; Jeanne Baffa, MD, Sidney Kimmel Medical College at Thomas Jefferson University/duPont Hospital for Children, Wilmington, DE; Pnina Weiss, MD, Yale-New Haven Medical Center, New Haven, CT; Cary Sauer, MD, MSc, Emory University, Atlanta, GA; Shubhika Srivastava, MBBS, Mount Sinai Medical Center, New York, NY; Mary E. Moffatt, MD, Children’s Mercy Hospital, Kansas City, MO; Susan Halbach, MD, MPH, University of Washington, Seattle, WA; Alan Schwartz, PhD, University of Illinois College of Medicine at Chicago, Chicago, IL

Background: At the end of training, fellowship program directors (FPD) attest that graduating fellows are competent to practice without supervision, but there are no agreed upon criteria on which to base this decision. Entrustable Professional Activities (EPAs) may provide an approach to determine if fellows are meeting a set standard. We examined whether graduates from the pediatric fellowships are meeting the minimum level of supervision for 6/7 common subspecialty EPAs. Methods: The Subspecialty Pediatrics Investigator Network (SPIN) recently surveyed FPDs (response rate 82%) asking them to identify the minimum level of supervision expected for a graduating fellow for the common pediatric subspecialty EPAs (table). Consensus for the expected level was set at the 80th percentile. Achievement of these levels was then examined using data from a previous SPIN study in which Clinical Competency Committees assigned a level of supervision for graduating fellows for each EPA using 5-level scales. The number of fellows who met the minimum levels was determined and differences among subspecialties examined. Results: 331 graduating fellows of ~1275 graduates (26%) were assessed. 91% (n=302) met minimum levels for all 6 EPAs, 5% (n=16) met 5 and 4% (n=13) met 4 or less. For the Consultation and Handover EPAs, 22 (7%) and 10 (3%), respectively, did not meet minimum levels and 23 (7%) did not meet levels for both. There were differences among the subspecialties (p<0.05). 7 of 10 (70%) fellows in Adolescent Medicine, but all in Child Abuse and Endocrinology, met all minimum levels. Fellows in Emergency Medicine, Critical Care, and Neonatology were more likely to achieve all expected levels compared with those in Adolescent Medicine (reference group; p<0.05). Conclusions: These data suggest that while most fellows are meeting the expected level of supervision for 6 common subspecialty EPAs at graduation, many are not. Of concern is that some still need direct supervision for consultation and handovers. There are also differences among the subspecialties. Further study is needed to determine the source of these differences.

Table. The minimum level of supervision expected by fellow program directors at the time of graduation.

<table>
<thead>
<tr>
<th>EPA</th>
<th>Apply QI Methods</th>
<th>Provide Consultation</th>
<th>Practice Management</th>
<th>Facilitate Handovers</th>
<th>Lead Healthcare Team</th>
<th>Lead within the Profession</th>
</tr>
</thead>
<tbody>
<tr>
<td>Minimum Level at Graduation</td>
<td>2</td>
<td>4</td>
<td>2</td>
<td>4</td>
<td>3</td>
<td>2</td>
</tr>
</tbody>
</table>

| Description | Trusted to contribute with direct supervision and coaching as a member of a collaborative effort to improve care at the institutional level | Trusted to execute with indirect supervision and may require discussion of information conveyed but only for selected complex cases | Trusted to perform with direct supervision and coaching with supervisor verifying work product for accuracy | Trusted to execute with indirect supervision and coaching with supervisor verifying work product for accuracy | Trusted to lead with supervisor occasionally present to provide advice | Trusted to lead with supervisor occasionally present to provide advice |

62. CAN I TRUST YOU? DO PEDIATRIC RESIDENTS WRITE SAFE PRESCRIPTIONS?
Mary Beth Wroblewski, MD, Brian Fink, PhD, University of Toledo, Toledo, OH

Purpose: The 2014 Core Entrustable Professional Activities (EPAs) for Entering Residency state that residents should be entrusted to write prescriptions and medication orders in all settings at the start of their residency training without direct supervision. This pilot aimed to determine if Pediatric residents of all levels at The University of Toledo College of Medicine and Life Sciences (UTCOMLS) were writing safe electronic prescriptions in continuity clinic. Based on Kolb’s Experiential Learning Theory, residents’ skills should improve with increased prescription writing over time. Methods: The first ten electronic prescriptions written by each resident during continuity clinic starting in July 2017 were retrospectively reviewed (n=270). PGY level and the method of Sig entry (decision support vs free text) were recorded. Prescription components (dose, route, frequency, etc) were recorded as either correct or incorrect. Percent incorrect for each item was used to determine common errors, and Pearson chi-square analysis was used to determine statistical significance between percent incorrect versus PGY level as well as method of Sig entry. Results: Common errors found on prescriptions included PRN not tied to a reason (57% of 77 scripts) and incorrect duration of treatment (26% of 73 scripts). For weight-based medications, neither a
weight-based dosing standard nor the patient’s weight was noted on the prescription 98% of the time. There was no statistical significance in errors made by PGY level. There were significant differences in errors made based on the method of Sig entry. A route was noted less often if the Sig was written with free text (p<0.001) and a PRN reason was noted less often when using decision support (p<0.001). Conclusion: Pediatric resident prescriptions contained several errors. Upper level residents made just as many and the same type of errors as junior residents. This suggests experiential learning does not help improve prescription writing skills, and residents would benefit from education on safe prescribing guidelines and regular feedback throughout their training.

**PROGRAM ISSUES/RECRUITMENT**

63. THE NEXT MORNING: MODIFICATIONS MADE ON ROUNDS TO ORDERS PLACED BY OVERNIGHT ADMITTING RESIDENTS

Eli Freiman, MD, Laura Chiel, MD, Julia Yarahuan, MD, Chase Parsons, MD, Christopher Landrigan, MD, MPH, Ariel Winn, MD, Children’s Hospital/Boston Medical Center, Boston, MA

BACKGROUND: An increased focus on quality and safety has resulted in increased resident supervision by attending physicians. At our large pediatric academic medical center, the overnight shift is when residents admit general pediatrics patients without immediate attending supervision. As such, admission orders are not evaluated by an attending until morning rounds. To the authors’ knowledge these orders have not been previously evaluated in the academic literature. OBJECTIVES: To categorize orders placed by residents overnight that were subsequently discontinued on medical rounds the next morning and to examine the reasons for those changes. METHODS: We utilized our hospital’s Enterprise Data Warehouse to generate a report of all orders placed on newly admitted patients by residents on the general pediatrics night shift over a 12-month period that were subsequently discontinued the following morning on rounds. All charts were reviewed by two independent reviewers. Orders were categorized by type of order and perceived reason for discontinuation. Disagreements on categorization were discussed with the research team until consensus was achieved. RESULTS: 290 discontinued patient orders were included in the analysis. Inter-rater agreement was very good with a kappa of 0.91. 66% of orders were medicines, 11% were diets, 4% were diagnostic testing, and 19% were for patient care. Within medication orders, 38% were antibiotics, 17% were antiasthmatics, and 10% were non-narcotic analgesics. The reason for order discontinuation was due to a change in clinical trajectory in 44% of cases (98% of which was patient improvement), primary attending decision in 11% of cases, and due to medical errors in 8% of cases. The most common medical error was a duplicate order (37.5%). CONCLUSIONS: This study suggests that admission orders placed by pediatrics residents overnight are clinically appropriate. Medical errors were mostly common duplicate orders. This pilot identifies the need for further study to better understand the overnight care delivered by residents and to identify areas for increased resident autonomy.

64. APPLICATION FACTORS ASSOCIATED WITH CLINICAL PERFORMANCE DURING PEDIATRIC INTERNSHIP: A 5-YEAR SINGLE CENTER RETROSPECTIVE COHORT STUDY

Caroline J. Gross, MD, Conor O’Halloran, MD, Shyam Deshpande, MD, Samuel Lux, MD, Theodore Sectish, MD, Catherine Michelson, MD, Ariel Winn, MD, Colin Sox, MD, Children’s Hospital/Boston Medical Center, Boston, MA

Background: The specific components of an application to residency that predict clinical performance during training in pediatrics remain unknown. Methods: Retrospective cohort study of all pediatric interns who matched into the Boston Combined Residency Program from 2013-2017. Demographics, subspecialty track, medical school ranking, USMLE scores, advanced degrees, clerkship grades, Alpha-Omega-Alpha (AOA) and Gold Humanism Honor Society membership, interview day performance, letters of recommendation (LOR) strength, and number of publications were extracted from application materials.

The primary outcome was clinical performance at the end of internship, measured as a weighted average of existing ACGME pediatric milestones scores. Linear mixed effects modeling with random effects for grading committee and match year was used to identify factors independently associated with clinical performance. Variables with p-values <0.2 in bivariate analysis were included in the final model. Results: 223 interns were included in the study. In the model (Table 1), higher average LOR score (B=-.07, p=.01), having a master’s degree (B =.18, p=.03), and not having a PhD (B =.13, p=.03) were associated with more advanced clinical performance at the end of pediatric internship. AOA membership, medical school ranking, public medical school attendance, time off prior to medical school, number of

<table>
<thead>
<tr>
<th>Predictor</th>
<th>Estimates</th>
<th>Std. Error</th>
<th>t</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>(Intercept)</td>
<td>3.85</td>
<td>2.96</td>
<td>1.29</td>
<td>0.20</td>
</tr>
<tr>
<td>Master’s Degree</td>
<td>0.19</td>
<td>0.28</td>
<td>0.69</td>
<td>0.49</td>
</tr>
<tr>
<td>PhD Degree</td>
<td>-0.13</td>
<td>0.55</td>
<td>-0.24</td>
<td>0.81</td>
</tr>
<tr>
<td>LOR Score*</td>
<td>-0.08</td>
<td>0.08</td>
<td>-1.05</td>
<td>0.29</td>
</tr>
<tr>
<td>AOA Membership</td>
<td>-0.02</td>
<td>0.04</td>
<td>-4.85</td>
<td>&lt;0.01</td>
</tr>
<tr>
<td>as Senior</td>
<td>0.04</td>
<td>0.12</td>
<td>0.35</td>
<td>0.72</td>
</tr>
<tr>
<td>as Junior</td>
<td>0.00</td>
<td>0.13</td>
<td>-0.01</td>
<td>0.99</td>
</tr>
<tr>
<td>Medical School</td>
<td>-0.02</td>
<td>0.16</td>
<td>-0.13</td>
<td>0.89</td>
</tr>
<tr>
<td>Ranking**</td>
<td>-0.03</td>
<td>0.04</td>
<td>-0.89</td>
<td>0.38</td>
</tr>
<tr>
<td>Public Medical School</td>
<td>-0.08</td>
<td>0.04</td>
<td>-2.01</td>
<td>0.04</td>
</tr>
<tr>
<td>Time off before</td>
<td>-0.08</td>
<td>0.09</td>
<td>-1.00</td>
<td>0.27</td>
</tr>
<tr>
<td>Medical School</td>
<td>0.03</td>
<td>0.06</td>
<td>0.53</td>
<td>0.59</td>
</tr>
<tr>
<td>Number of Honors ***</td>
<td>0.02</td>
<td>0.05</td>
<td>0.35</td>
<td>0.73</td>
</tr>
<tr>
<td>Interview Score*</td>
<td>-0.02</td>
<td>0.05</td>
<td>-0.41</td>
<td>0.68</td>
</tr>
</tbody>
</table>

**Table 1: Predictors of Clinical Performance at the End of Pediatric Internship, as measured by weighted average of Milestones Scores.**

Fixed Effects

### Random Effects

<table>
<thead>
<tr>
<th>Predictor</th>
<th>Variance</th>
<th>SD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Groups</td>
<td>0.01</td>
<td>0.10</td>
</tr>
<tr>
<td>Grading Committee</td>
<td>0.01</td>
<td>0.10</td>
</tr>
<tr>
<td>Match Year</td>
<td>0.30</td>
<td>0.55</td>
</tr>
</tbody>
</table>

**Poster Abstracts**

March 26-29, New Orleans, LA www.APPD.org

**63. THE NEXT MORNING: MODIFICATIONS MADE ON ROUNDS TO ORDERS PLACED BY OVERNIGHT ADMITTING RESIDENTS**

**64. APPLICATION FACTORS ASSOCIATED WITH CLINICAL PERFORMANCE DURING PEDIATRIC INTERNSHIP: A 5-YEAR SINGLE CENTER RETROSPECTIVE COHORT STUDY**

Catherine Michelson, MD, Ariel Winn, MD, Colin Sox, MD, Children's Hospital/Boston Medical Center, Boston, MA
 Poster Abstracts

65. ARE PEDIATRIC FELLOWS FINANCIALLY LITERATE?

Kevin W. Kuo, MD, MHPE, Stanford University, Palo Alto, CA, Rebecca Swan, MD, Vanderbilt University, Nashville, TN, Rebecca Blankenburg, MD, MPH, Stanford University, Palo Alto, CA

Background: Pediatric subspecialty fellows face unique financial challenges, including significant educational debt, delayed retirement savings, and in many subspecialties, relatively lower future incomes. There are no data regarding the financial knowledge, attitudes, and behaviors of pediatric fellows. Using Bandura’s social cognitive theory as a conceptual framework, we hypothesized that pediatric fellows would have low financial literacy and lack physician role models and self-efficacy in terms of managing finances. Objective: To measure the financial attitudes, knowledge, and self-reported behaviors of pediatric fellows. Design/Methods: In August 2018, an IRB-approved survey was administered to pediatric fellows at Stanford and University of California, San Francisco. This 52-item survey included a 20 question test of financial literacy (adapted from the Vanguard Financial Literacy Test) as well questions regarding respondent demographics, financial attitudes, and self-reported financial behaviors. Results: 101 of 176 (57%) eligible pediatric fellows responded. 56% of respondents had student loans with 61% of those carrying debt burdens of more than $100,000. The median score on the financial literacy test was 35% (IQR 25-45%, range 0-75%), below the 40% average score for the general population. 14% of respondents were satisfied with their financial knowledge, with 77% dissatisfied or extremely dissatisfied. 79% had begun saving for retirement but only 28% had a savings target. Only 50% felt capable of managing their own finances and 88% reported insufficient physician role models for personal finances. 26% of respondents reported receiving financial education during medical training while 90% agreed that such education should be part of the core curriculum during medical training. Conclusion: Pediatric fellows have low financial literacy and many do not feel capable of managing their own finances. Few have received any formal financial education although the vast majority feel that such education should be included during medical training. A curriculum on personal finances should be developed and its efficacy assessed.

66. IMPROVING PRIMARY CARE PRECEPTOR EXPERIENCE

Kris Saudek, MD, Kelsey Porada, MA, Fatima Anibaba, MS, Sarah Pritchard, BA, Sara Lauck, MD, Medical College of Wisconsin Affiliated Hospitals, Milwaukee, WI

Background: At our institution the longitudinal outpatient experience for pediatric residents and third year medical students on their pediatric clerkship is predominantly community-based. Our programs rely on partnerships with physicians in these practices to provide required primary care experience. Demands on their time and the number of unique practice sites has led to challenges recruiting and retaining preceptors who may have limited time to familiarize themselves with educational goals and objectives. To address these issues we formed the Primary Care Initiative (PCI) to examine ways to ensure robust resident/student education. Objective: To measure the financial attitudes, knowledge, and self-reported behaviors of primary care preceptors. Design/Methods: A needs assessment was performed with a representative group of primary care preceptors. Based on feedback received, interventions targeted communication, teaching resources, evaluations, and appreciation. A 7-question annual survey was administered asking preceptors to rate their experience on a 5-point Likert scale (1=poor, 5=excellent) pre-intervention (2016) and 2 consecutive years post-intervention (2017 and 2018). A Chi square test of independence examined the relationship between high satisfaction responses (items rated 4 or 5 on the Likert scale) and low satisfaction responses (items rated 1, 2, or 3). Results: Response rates were: 2016 43% (28 of 65), 2017 45% (29 of 65), and 2018 37% (24 of 65). For the 7 items the percentage of respondents choosing “very good” or “excellent” increased all 3 years. The item “your feeling of appreciation for your role in resident/student education” showed significant improvement (p=0.037) (Figure 1). Communication regarding resident/student schedules remains one of the lowest rated measures. Conclusion: Initiation of a PCI has demonstrated improvements in overall preceptor experience, especially in the area of feeling appreciated. An area to direct focus is communication regarding resident and student schedules.

Figure 1: Three Year Survey Results of Primary Care Preceptors
67. YEAR ONE OF A NEW RESIDENCY PROGRAM: REFLECTIONS FROM THE INAUGURAL INTERN CLASS TO LEADERSHIP

Benjamin L. Moresco, MD, Adam D. Wolfe, MD PhD, Baylor College of Medicine (San Antonio), San Antonio, TX

BACKGROUND: As the number of graduating medical students is increasing, the number of residency positions is remaining the same. One solution to this problem is the creation and accreditation of new residency programs to help bridge the gap. However, the distinct challenges and opportunities that new training programs present for learners and faculty have not been extensively studied or described. OBJECTIVE: Determine and understand the distinctive perspective of a group of resident physicians who served as the inaugural interns in a new categorical pediatrics residency program. METHODS: We conducted a modified qualitative analysis of themes to generate resident perspectives. Seven residents (70% of the total class) agreed to answer six initial open-ended questions followed by a analysis of themes. These residents then met as a group and identified three consensus themes in each of the three topic areas: Strengths, Challenges, and Lessons Learned from a new program. In small working groups key areas were investigated and themes were consolidated, reviewed and edited for flow by faculty over a 2-month period and presented in a summarized form. RESULTS: Residents described strengths of participating in a new residency-training program as the opportunity to shape the program, individualized learning experience, and enthusiastic and available faculty. They identified challenges of training in a new program as lack of upper level residents, diverse faculty expectations, resident morale, and coping with challenges. Lessons learned included themes of resident engagement, standard expectations and feedback, and resident driven wellness. CONCLUSIONS: Our inaugural class of residents identified the key challenges and opportunities of training in a new program. These perspectives should prove informative for educators who are planning new programs in graduate medical education.

68. EVALUATING THE PERCEIVED EFFECTIVENESS OF PEDIATRIC INTERN ORIENTATION

Sabrina Ben-Zion, MD, Children’s Hospital Medical Center of Akron/NEOMED, Akron, OH, Ntidi Unaka, MD, MED, Cincinnati Children’s Hospital Medical Center/University of Cincinnati College of Medicine, Cincinnati, OH, Lori Price, MD, Indiana University School of Medicine, Indianapolis, IN, Rebecca Wallihan, MD, Nationwide Children’s Hospital/Ohio State University, Columbus, OH

Background: Effective means of preparing interns for transition to residency remains elusive. Recent studies indicate program directors perceive new interns to be underprepared for residency. While intern orientation is ubiquitous, content can vary greatly and often does not assess trainee competence. Objective: To determine the content of intern orientation across several pediatric residency programs and evaluate intern perceptions of the effectiveness of orientation. Methods: This cross-sectional study included pediatric residency programs in the Mid-America region. A survey with questions regarding orientation activities—including content, allotted time, format, and assessment—was sent to 24 program directors. Current interns at these programs were surveyed regarding their perceptions of the effectiveness of activities completed during orientation. Descriptive statistics were used to analyze survey responses. Results: Fifty-eight percent of program directors responded to the initial survey. Median time in orientation was 65.5 hours (range 30-120). Variation was noted across programs in content and format. Only 9 activities were represented among all survey participants. Additionally, 93 interns from 15 programs completed the intern survey. Approximately 80% of interns perceived the overall time spent in orientation was “just right”; however, 37% felt too little time was spent on orientation to intern roles, and 38% perceived that too little time was spent on review of clinical skills. Fifty-four percent of respondents felt electronic health record training was slightly or not at all effective. Conclusions: Pediatric intern orientation varied across the institutions surveyed and intern responses indicate that time on clinical skills and intern roles should be increased. This study is the first to characterize the activities included in pediatric orientation and their perceived value to interns. Next steps include expanding the study to additional pediatric programs and utilizing findings to help inform best practices for orientation and onboarding of pediatric residents.

69. A MILESTONE-BASED PEDIATRIC INTERN BOOT CAMP: AN EDUCATIONAL INTERVENTION TO MINIMIZE THE JULY EFFECT

Ann Novosel, MD, Monica van de Ridder, PhD, Candace Smith-King, MD, Michael McLeod, MD, MBA, Justin Triemstra, MD, FAAP, Spectrum Health/Michigan State University/Helen DeVos Children’s Hospital, Grand Rapids, MI

Intro: The transition from student to intern is difficult and highlighted by performance missteps often referred to as the July Effect. Some pediatric institutions have implemented intern boot camps (IBC) to better prepare interns at the start of residency. Such pediatric boot camps described in the literature have not specifically targeted the ACGME/ABP Pediatric Milestones. We implemented an IBC that utilized these milestones to improve the interns’ confidence, knowledge, and skills. Methods: 19 new interns participated in the IBC at the HDVCH/MSU Pediatric Residency Program. We used Kerns Six-Step Approach as a conceptual framework and targeted 3 levels of Kirkpatrick’s level of evaluation (reaction, learning, and behavior). A needs assessment from residents and faculty was used to identify specific milestones. We designed our IBC to include lectures, workshops and clinical experiences to target these milestones. A questionnaire containing 15-confidence (Likert Scale 1-5) and 10 knowledge-based questions was given before and after the IBC. The paired t-test was used to assess total confidence scores and pre/post knowledge measures. The sign test was used to compare individual confidence questions. Block 1 milestone evaluations were analyzed for pre-IBC (2016, 2017) and post-IBC interns (2018). Significance was assessed at p<0.05.
Results: Interns demonstrated a significant improvement in their overall confidence score (Pre: 47.7+/−4.1, Post: 58.6+/−5.3; p<.001). All individual confidence questions showed increases. Interns demonstrated a significant improvement in perceived pediatric knowledge on the post-IBC test (Pre: 5.2+/−1.5, Post: 6.8+/−1.3; p=0.004). Block 1 evaluations from 7/2018 did not show improved evaluations when compared to pre-IBC cohorts. Conclusions: Incoming interns demonstrated a significant improvement in confidence and perceived knowledge of the targeted pediatric milestones after participating in the IBC. Our innovative approach of targeting pediatric milestones in an IBC suggests that such a targeted curriculum helps the difficult transition for interns.

70. CHARACTERISTICS OF US GRADUATING PEDIATRIC RESIDENTS BY GENDER, 2003-2018
Daniel J. Schumacher, MD, MEd, Cincinnati Children’s Hospital Medical Center/University of Cincinnati College of Medicine, Cincinnati, OH, William Cull, PhD, Blake Sisk, PhD, Mary Pat Frintner, MSPH, Not Affiliated with Program/Institution listed above, Itasca, IL

BACKGROUND: Approximately three-quarters of pediatric residents are women. Yet, little is known about how women and men compare on family and financial characteristics and satisfaction with training. OBJECTIVE: Compare family characteristics, financial characteristics, and satisfaction of graduating pediatric residents by gender across time. METHODS: National, random samples of up to 1,000 graduating pediatric residents each year from 2003-2018; 58% completed the surveys (48-64% across years). Cross-sectional responses were pooled; chi-square tests and t-tests were used to examine the association of gender with a) family characteristics, b) financial characteristics, and c) satisfaction with residency training. Multivariable logistic regression models examined the independent effect of gender on married and have children (controlling for survey year and international medical school graduate-IMG), part-time job (controlling for year, IMG, married, and children), and satisfaction with training (controlling for year, IMG, married, children, program size and educational debt). Ordinary least squares regression models estimated the adjusted difference in graduates’ debt and starting salary between men and women.

RESULTS: Overall, 74% of residents in the sample were women (consistent across survey years, p=.23). Women were less likely than men to be married (69% vs 73%, p<.001) and have children (29% vs 38%, p<.001). They had higher educational debt (women: $162,645 vs men: $141,365, p<.001). Among residents starting primary care or hospitalist positions following residency, more women than men had part-time jobs (18% of women and 6% of men, p<.001), and full-time starting salaries were not significantly different ($147,369 vs $149,954, p=.08). Nearly all were satisfied with their training; 95% of women and 91% of men, p<.001. All bivariate relationships remained significant in multivariable models [Table]. CONCLUSION: Starting salaries for residents entering primary care or hospitalist positions do not vary by gender. Men and women do vary on several other dimensions, including that women report more educational debt than men.

71. FULL-DAY CONTINUITY CLINICS: RESIDENT AND ATTENDING PERSPECTIVES ON WORK BALANCE, PATIENT OWNERSHIP, AND CONTINUITY OF CARE
Michelle E. Kiger, MD, Thomas M. Bertagnoli, DO, Erica Bautista, MD, Korre Fairman, MD, Caitlin Hammond, MD, Kara Dickey, DO, Wright State University, Dayton, OH, Sebastian Uijtdehaage, PhD, Ting Dong, PhD, Lara Varpio, PhD, Holly Meyer, PhD, Not Affiliated with Program/Institution listed above, Bethesda, MD, Ann Burke, MD, Wright State University, Dayton, OH

Objective: Within residency programs, half-day continuity clinics can lead to difficulties transitioning between inpatient and outpatient obligations and achieving continuity of care. We examined resident and attending perceptions of a switch to full-day continuity clinics in order to determine its impact on work balance, continuity of care, patient ownership, and clinic satisfaction. Methods: In January 2018, a pediatric residency program transitioned to full-day continuity clinics. From six to eight months after the transition, we administered a retrospective pre-post implementation survey to gauge resident and attending perceptions of the change. Surveys included 20 matched pairs of 5-point Likert-style questions evaluating work volume (problems), continuity of care (satisfaction), patient ownership (subjective and objective), and work balance (ability to prepare, ability to follow up, ability to be married, ability to have children). Table 1 shows the results. Conclusions: Residents and attending physicians had significantly improved perceptions of work balance, continuity of care, patient ownership, and easier ability to prepare for lectures and follow up personally. Attending physicians noted improved perceptions of work balance, continuity of care, and patient ownership.

Table 1. Resident Perception of Full-Day Continuity Clinic Model (selected responses due to figure size constraints)

<table>
<thead>
<tr>
<th></th>
<th>Pre</th>
<th>Post</th>
<th>p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>How often had difficulty balancing inpatient &amp; outpatient obligations</td>
<td>4.13</td>
<td>1.38</td>
<td>&lt;.001</td>
</tr>
<tr>
<td>able to huddle with care team</td>
<td>2.38</td>
<td>4.72</td>
<td>&lt;.001</td>
</tr>
<tr>
<td>able to prepare for lecture</td>
<td>2.75</td>
<td>4.22</td>
<td>&lt;.001</td>
</tr>
<tr>
<td>able to pre-read on patients</td>
<td>2.25</td>
<td>4.34</td>
<td>&lt;.001</td>
</tr>
<tr>
<td>personally responded to TCONS</td>
<td>2.96</td>
<td>4.29</td>
<td>&lt;.001</td>
</tr>
<tr>
<td>personally responded to labs</td>
<td>2.56</td>
<td>3.5</td>
<td>&lt;.001</td>
</tr>
<tr>
<td>felt ownership of patient care</td>
<td>3.09</td>
<td>3.91</td>
<td>&lt;.001</td>
</tr>
<tr>
<td>personally scheduled follow up</td>
<td>2.47</td>
<td>3.33</td>
<td>&lt;.001</td>
</tr>
<tr>
<td>Overall continuity clinic satisfaction</td>
<td>2.63</td>
<td>4.08</td>
<td>&lt;.001</td>
</tr>
</tbody>
</table>
72. IMPROVING COMPLIANCE: PEDIATRIC RESIDENT ACCOUNTABILITY USING PEER PRESSURE
Avni Bhatt, PhD, Daniel Castro, MD, Sydur Rahman, MD, Sony Kuruppacherry, Tammy Bleecker, MEd, Nicole Paradise Black, MD, MEd, University of Florida, Gainesville, FL
University of Florida Pediatric Residency program developed peer groups, or collaborative professional communities (CPCs), to maintain compliance with mandatory tasks and improve overall resident wellness. Prior to 2017, residents were regularly reminded to complete mandatory tasks by the medical education staff. For the 2017-18 academic year, administrative pressure was replaced with peer pressure through the introduction of CPCs. CPCs meet monthly educational events and compete for quarterly wellness prizes awarded to the CPC with the highest compliance in various work-related tasks. Pediatric residents were compared before and after the introduction of CPCs, corresponding to Post Graduate Year (PGY) 1,2 residents in the 2016-17 year and PGY 2,3 residents in 2017-18. Compliance was determined per resident for completion of 4 faculty evaluations per academic quarter and duty hour logging within 14 days. Yearly wellness data was collected by the Pediatric Residency Burnout Resilience Study Consortium (PRBRSC). The transition from administrative to peer pressure did not significantly change resident compliance with completion of quarterly faculty evaluations (Panel A). Though a reduction in duty hour logging compliance was observed, the decrease in compliance from 88% to 76% was not of practical significance (Panel B). Overall, residents reported no significant change in metrics of cognitive and effective mindfulness, resilience, perceived stress, spirituality, or physical and mental health. A reduction in burnout scores was reported for the PGY3 residents for the 2017-18 academic year (0%) compared to 2016-17 (31%). From these data, it would suggest that CPC activities have fostered team spirit that could improve resident well-being. Additionally, the transition to CPCs reduced the burden on staff to enforce compliance, anecdotally allowing for higher staff wellness. Peer pressure was determined to be sufficient for maintaining resident compliance and CPCs will continue to be utilized at our institution. Overall, our project established the usefulness of peer groups for the betterment of medical education programs.

73. IMPLEMENTING A CARE TEAM ASSISTANT PROGRAM: LESSONS LEARNED
Elizabeth Salazar, MD, Ryosuke Takei, MD, George Dalembert, MD, Jeanine Ronan, MD MS MSEd, Nicole Washington, MD, Stuti Tank, BA, Anna Sweeney, BS, Susan Kolb, MSN CNP, Evan Fieldston, MD MBA MSHP, Children’s Hospital of Philadelphia, Philadelphia, PA
INTRODUCTION: Excessive administrative tasks have been associated with adverse consequences for doctors and their patients. Furthermore, this burden of non-clinical tasks has been linked to depersonalization, a major component of physician burnout. The Care Team Assistant (CTA) program, established in Nov 2016, provides administrative support for the inpatient medical teams to help optimize patient care and promote wellness. OBJECTIVE: To share the acceptability, feasibility, sustainability, and effectiveness of implementing a CTA program. APPROACH: The program was established in a large, urban, academic, tertiary medical center. A needs assessment included time-motion studies, resident surveys, and drafting of a key driver diagram. Highest impact goals were identified by clinicians, nursing leadership, and administrative stakeholders. A physician lead and project manager were designated, and 5 CTAs were initially hired. Once didactic/clinical training was completed, the CTAs were incorporated into inpatient resident teams and assigned various non-clinical tasks. Program leaders met regularly to discuss the program’s development and to ensure quality assurance for the CTAs. OUTCOMES: Acceptability: Resident surveys showed CTAs completing a large percentage of daily administrative tasks with promotion of job satisfaction and time spent in direct clinical care. Feasibility: Initial challenges included a lack of benchmark and guidelines for CTA training. These were iteratively refined with input from CTAs and physician partners. Some CTAs were terminated given inability to meet established markers for competency. Another major challenge was the lack of familiarity with the role and sub-optimal utilization of the CTAs, requiring significant efforts to raise awareness. Effectiveness: The initiative has shown concrete positive impacts on various measures including PCP communication and family-centered rounds. CTAs have also helped address institutional needs relating to capacity management by facilitating earlier discharges. Sustainability: CTAs have become integral members of inpatient teams with involvement in multiple interdisciplinary initiatives. The program continues to grow with 12 current CTAs and expansion to the PICU. CONCLUSIONS: CTAs provide an effective means of
74. LACK OF CORRELATION BETWEEN USMLE SCORES AND PERFORMANCE IN PEDIATRICS RESIDENCY TRAINING BASED ON ACGME MILESTONES RATINGS

Ben Miller, MD, Stephanie B. Dewar, MD, Andrew Nowalk, MD, PhD, UPMC Medical Education, Pittsburgh, PA

Introduction: The United States Medical Licensing Exam (USMLE) was designed to determine whether medical trainees are competent to become licensed physicians, not necessarily as a means of providing a comparative gradient on students' knowledge. Despite this, many residency programs use USMLE scores in the residency selection process as indicators as to whether physicians will succeed in residency. Not only is this not the intended use of the USMLE, some previous studies have suggested that USMLE scores are not effective indicators of a physician's success during residency. One method of assessing residents' progress through residency training is the Accreditation Council for Graduate Medical Education (ACGME) Milestones in the six clinical competency domains of Patient Care, Medical Knowledge, Systems Based Practice, Practice-Based Learning and Improvement, Professionalism, and Interpersonal Communications Skills. Ratings along these milestones are completed by supervising physicians who observe and assess residents in the clinical setting. No previous literature has tried to link USMLE Step scores to resident performance using Milestone ratings. Methods: USMLE Step 1 and 2 Scores and Milestones Ratings in twenty-one different competencies were collected over five years (2012 - 2017) from 187 residents enrolled in a single large pediatrics residency program. Correlations were examined using Pearson's correlation coefficients. Results: Among the residents studied, the mean score of Step 1 was 236, while the mean score of Step 2 was 250. While Step 1 and 2 had correlation (r2 = -0.628), no correlation was found between Step 1 and overall Milestones average (r2 = -0.130 and <0.001 for PGY1 and PGY3), or between Step 2 and overall Milestones average (r2 = -0.102 and 0.058 for PGY1 and PGY3). Conclusion: These results suggest that USMLE scores have no correlation to success in residency training as measured by progression along competency-based milestones. These confirm previous claims about the limited utility of USMLE scores in predicting success in residency training.

75. IN PURSUIT OF UNINTERRUPTED EDUCATION: TRANSITION FROM A NOON CONFERENCE TO AN ACADEMIC HALF DAY

Morgan H. Khawaja, MD, Mason Walgrave, MD, Mark Siegel, MD, Medical University of South Carolina, Charleston, SC, Jordan Newman, MD, Emory University/Sibley Heart Center Cardiology, Atlanta, SC, Sarah Yale, MD, Not Affiliated with Program/Institution listed above, Milwaukee, WI

Introduction: The Accreditation Council for Graduate Medical Education (ACGME) requires residency programs to provide regularly scheduled didactic sessions. The ACGME does not, however, dictate the format of these didactic sessions, and traditionally programs have opted for a daily noon conference (NC). The daily NC format often leads to poor conference attendance for a variety of reasons including resident duty hour restrictions, clinical responsibilities, and increased off-campus rotations. Without clinical coverage, conference attendees are often interrupted to answer pages and phone calls, leading to poor participation in these learning sessions. In response to resident criticism of the NC structure, our institution transitioned to a pager-protected Academic Half Day (AHD) model in which didactic sessions are delivered in a single weekly afternoon learning session. Methods: Second and third year residents (n=21) were surveyed at the start of the AHD transition and 5 months later using a five point Likert scale. Results were not statistically significant, likely due to lack of power with 21 participants. However, there was an overall trend of improvement between the two survey time intervals. Most notably,
the areas showing the greatest improvement were: ability to arrive on time, frequency of interruptions, frequency of leaving early, perception of retention of medical knowledge, and overall satisfaction [Fig 1]. In addition, overall resident attendance increased from 50% with a NC model to approximately 80% with an AHD model. Conclusion: Transitioning from a NC to an AHD model improved overall resident satisfaction and provides a better learning environment with uninterrupted time for medical education. Follow-up data will assess the AHD impact on resident wellness and knowledge retention via analysis of in-training exam scores and ultimately Pediatric Board Exam scores.

76. IMPLEMENTATION AND EVALUATION OF A COORDINATOR-LED, PEDIATRIC PROGRAM COORDINATOR MONTHLY EDUCATIONAL SERIES
Megan K. Christofferson, BA, C-TAGME, Stanford University, Palo Alto, CA, Sara L. Salem, EdM, Charlene L. Rotandi, AB, C-TAGME, Stanford University, Stanford, CA
Background: With ever expanding requirements from the Accreditation Council of Graduate Medical Education (ACGME), the role of the program coordinator has grown, necessitating updated onboarding materials for new coordinators and continuing education for experienced coordinators. While the need for coordinator education and professional development is well-established, there remains the question of who should provide such education. A needs assessment at a single institution of coordinators representing 177 programs (111 ACGME accredited residencies and fellowships, 66 non-ACGME accredited fellowships) found that although monthly meetings were provided by the Graduate Medical Education Office, gaps still existed in the knowledge and engagement of coordinators across-the-board. 88% of coordinators surveyed indicated that coordinator professional development is very important and needed. Objective: To create and assess the impact and feasibility of a coordinator-led educational series for pediatric program coordinators. Methods: The Department of Pediatrics at Stanford University School of Medicine instituted a monthly, coordinator-led educational series. Three coordinators organized the series, with a total of nine coordinators collaborating on presentation of topics. Over a period of 18 months, 20 distinct topics were delivered, with some topics being repeated (Figure 1). Participants were asked to rate the entire series as a whole at the end of the 18-month period. Descriptive statistics were used to analyze the results. Results: Of 19 pediatric coordinators, 18 completed the final survey (95%). Coordinators reported they were satisfied with the series (94%), likely to recommend to new coordinators (100%), and likely to recommend to experienced coordinators (82%). C-TAGME and opportunities for national participation were identified as topics that would be useful for future sessions. Comments underscored that rolling topics were necessary for new coordinators but would be repetitive for experienced coordinators. The time spent in organization and preparation of the series was estimated at eight hours a month. Conclusion: The implementation of a program coordinator-led educational series was found to be feasible and satisfactory, with coordinators likely to recommend the series to others. More work needs to be done to determine the best format, frequency, and topics for a coordinator-led series.

77. UTILIZATION OF HEAT-MAPPING SOFTWARE TO MATCH A RESIDENT STAFFING TEMPLATE TO ED ARRIVAL PATTERNS
Abigail Schuh, MD, MMHPE, Mark Nimmer, Amy Drendel, DO, MS, Medical College of Wisconsin Affiliated Hospitals, Milwaukee, WI
Background: Academic institutions rely on resident physicians to adequately staff emergency departments while residency programs need a steady flow of patients in order to provide trainees with a good clinical experience. Feedback from end-of-rotation evaluations suggest that residents feel competition for patients during some shifts and overworked during others. To investigate this, we utilized heat-mapping software to determine the degree of over- and under-staffing by hour of the day in the ED. Objective: Utilize heat-mapping to develop an evenly-distributed staffing model in the ED at a tertiary care children's
hospital Design/Methods: Heat-mapping software within Excel (Microsoft Corp, Seattle, WA) was utilized to overlay ED patient arrival patterns from June 2017-May 2018 on top of the potential patients per hour based on national estimates for trainees. Time-frames for under- and over-staffing were identified. A new schedule matrix was implemented in October 2018 and the same heat-mapping process was used to determine appropriateness of the staffing matrix. Given the visual nature of the study, results are presented descriptively. Results: Analysis of the heat-map revealed that the current schedule matrix significantly under-staffed in the morning between 7-11 am and over-staffed the rest of the day. A heat map representing usual staffing from October to December 2017 is shown in figure 1 and highlights the mismatch. Changes were made to the staffing matrix informed by the findings which resulted in more appropriate staffing during morning hours and evening hours for the months of October to December 2018 (figure 2). Conclusion(s): Novel use of heat-mapping software has the potential to successfully match ED patient arrival patterns to an appropriate resident staffing matrix. Future directions include incorporation of variable productivity to account for fatigue as the shift progresses.

78. APPLICANTS? WE HAVE AN APP FOR THAT!
LaGail Green, Andrea DelGiudice, BS, Elise Gross, MD, Marie Pfarr, MD, Kayla B. Phelps, MD MPH, David A. Stewart, MD, Lauren Helms, MD, Thomas Saba, MD, John Schmidt, MD, Shane Quinonez, MD, Heather L. Burrows, MD PhD, University of Michigan, Ann Arbor, MI

BACKGROUND Large amounts of information are provided to applicants during the residency interview process. It is important to share this information in an efficient, environmentally sound, and engaging manner. Preparing information packets requires significant administrative time and results in discarded paper or unused flash-drives. OBJECTIVE We sought to eliminate paper documents, minimize administrative effort, and streamline communication during interview season. METHODS With the assistance of LegitApps Company we designed an app for Android and Apple devices that allows us to communicate in real time with applicants. The app delivers all required documentation prior to the applicant’s arrival. It provides interview day schedule details and logistics, maps to their specific pre-interview dinner, and helps with navigating our city (finding hotels, identifying places to eat, highlighting fun things to do, etc). An easy to complete interview day survey is automatically pushed to all applicants at the end of the day. After initial programming, only minimal maintenance was needed by our administrative staff throughout the season. RESULTS The app was downloaded 522 times this season. Based on results from the end-of-the-day survey, almost all 353 applicants downloaded the app. They appreciated the streamlined communication and hub for information. They used it to find Uber rides, book hotels, explore the city, and to prepare for their interview day. By eliminating paper, we saved money and manpower, allowing our staff to dedicate their time to the applicant experience. Survey comments include: “I appreciated the UM Pediatrics App, as it made the resources easy to access and reference throughout the day” and “I liked the App and that you tried to save some trees and not print out all of the information.” CONCLUSION The app successfully conveyed information efficiently to applicants and decreasing the administrative workload. We plan to expand the app to include our fellowship programs and are working with other programs at our institution to develop similar apps for their programs.

TRAINEE AUTONOMY

79. RESIDENT AUTONOMY: ARE ATTENDINGS AROUND TOO MUCH?
Alicia Williams, MD, Rustin Meister, MD, Travis W. Crook, MD, Rebecca R. Swan, MD, Vanderbilt University, Nashville, TN

BACKGROUND: According to guidelines from the ACGME, residents must demonstrate progressive autonomy over the course of training that affords them the ability to act in a supervisory role under faculty guidance in preparation for independent practice. As adult learning theory supports, autonomy within a supportive climate can have a significant impact in motivating learners to expand their knowledge base and practice methods. We created a needs assessment survey to help obtain information regarding the current opinions surrounding autonomy within our own residency program. OBJECTIVE: We sought to determine residents’ perception of autonomy during their pediatric residency training with a secondary objective of preliminary assessment for an attending-less rounding experience to address autonomy and supervisory elements within the residency curriculum. METHODS: In 2018, graduating PGY3 Pediatric residents and PGY4 combined Internal Medicine/Pediatric residents were electronically sent an anonymous novel survey. The questions focused on overall level of supervision as well as how valuable they would find rounding without an attending in terms of building their own autonomy. Numerical responses were collected for statistical interpretation. RESULTS: We obtained surveys from 33/36 graduating residents within their final month of residency training. Respondents reported a mean value of 72/100 (Scale: 0/100 = significantly unsupervised, 50/100 adequately supervised, 100/100 significantly over-supervised) when asked about their level of supervision on pediatric services. This cohort also reported a mean value of 82.42/100 and 83.27/100 when asked how
81. COMFORT AND PERCEIVED VALUE: PARENT VIEWS OF TRAINEE PARTICIPATION IN PEDIATRIC CARE

Jessica C. Babal, MD, Daniel J. Sklansky, MD, Megan A. Moreno, MD, University of Wisconsin, Madison, WI

INTRO: Trainees require progressive autonomy to prepare for unsupervised practice as physicians. Studies show that patients largely accept trainee participation in their own medical care, but little is known about parental perceptions of medical student and resident engagement in pediatric care. METHODS: We conducted a national cross-sectional online survey of parents with at least one child under 18 years. The survey used 5-point Likert scale to explore acceptability, desirability, and perceived value of medical student and resident involvement in pediatric care. The survey also assessed parent comfort with progressive trainee autonomy in the clinical encounter. The Wilcoxon rank sum test was used to compare means for Likert scale responses, p<0.01. RESULTS: A total of 3,000 parents completed the survey, of whom 87.9% were female, 82.5% were white, 32.3% had at least one child under 18 years. The survey used 5-point Likert scale to explore acceptability, desirability, and perceived value of medical student and resident involvement in pediatric care. The survey also assessed parent comfort with progressive trainee autonomy in the clinical encounter. The Wilcoxon rank sum test was used to compare means for Likert scale responses, p<0.01. RESULTS: A total of 3,000 parents completed the survey, of whom 87.9% were female, 82.5% were white, 32.3% had prior experience with medical students and 38.4% had experience with residents in their child’s care. Parents appreciated the importance of trainee participation (4.0±1.1 for students, 3.9±1.0 for residents) and enjoyed having trainees present (3.8±1.0 for students, 3.9±1.0 for residents). Parents, regardless of exposure to trainees, were more comfortable with resident autonomy at each stage of the clinical encounter (p<0.001); were more comfortable having a clinic visit last longer if a resident was involved than if a student was involved (p<0.01); and perceived that residents improved pediatric care more than did students, (p<0.0001). Parents who had experience with students reported increased comfort with student autonomy at all stages of the clinical encounter compared to parents who had never experienced pediatric care with students (p<0.0001). Similarly, parents exposed to residents reported increased comfort with resident autonomy at all stages of the clinical encounter compared to parents who had never experienced care with residents (p<0.0001). CONCLUSION: Parents valued and enjoyed trainee participation in the care of their children and were more comfortable with progressive autonomy for residents than students. Prior exposure to students or residents increased parental comfort with autonomy for respective trainee types. Further studies should investigate how parent and child characteristics correlate with how parents view trainee involvement in pediatric care.

82. SAFELY PROMOTING AUTONOMY: UNDERSTANDING THE IMPACT OF INDEPENDENT ROUNDED ON STUDENTS, RESIDENTS, AND FACULTY

Jessica A. Moriarty, MD, Lee A. Trope, MD MS, Sindu Vellanki, MD, Sarah Hilgenberg, MD, Rebecca Blankenburg, MD MPH, Stanford University, Palo Alto, CA

Background: Due to heightened focus on patient safety, increased healthcare complexity, and 24/7 hospitalist coverage in many teaching institutions, the appropriate balance between resident autonomy and supervision is in question. Independent rounding as a way to promote progressive responsibility has been studied in internal medicine, but limited data exists in pediatrics. Objectives: To explore medical student, intern, resident, and faculty perspectives on independent rounding on wards at two institutions (children’s hospital and county hospital). Methods: Using Self-Determination Theory as a conceptual model, we introduced independent rounds 1-2 times a week at 2 separate training sites in July 2018. In this IRB-approved qualitative study, we conducted semi-structured focus groups with a purposive sample of junior trainees, senior trainees, and faculty between October-December 2018. Focus groups were audio-recorded, transcribed verbatim, and analyzed for themes using the constant comparative approach associated with grounded theory. Results: Focus groups included 13 junior trainees (3 MS3a, 10 PGY1s), 10 senior trainees (3 PGY2s, 7 PGY3s), and 12 faculty. Five themes emerged (Table 1): (1) independent rounds contributed to all trainees’ development; (2) senior residents described increased motivation to take full ownership of patients and educational needs of the team; (3) faculty were concerned about decreased opportunities for teaching and
feedback, however trainees reported unique learning from faculty presence on and absence from rounds; (4) no significant safety events were noted; and (5) all identified communication and patient progression concerns that can be mitigated.

Conclusion: As a result of independent rounding, trainees described increased motivation to take ownership of their patients, education, and team. They felt both rounding experiences contributed to their development as physicians. Concerns about communication and patient care progression will be important to investigate when designing interventions to promote resident autonomy in the future.

| Independent rounds contributed to all trainees’ development. | “It was a really scary opportunity to step up and have the kind of responsibility to be the doctor, but it was also really important and gave me a lot of insight into things that I need to know before I graduate residency and have to do this on my own.” – PGY3 |
|———|———|
| Senior residents described increased motivation to take full ownership of patients and educational needs of the team. | “It was one of the first times that I really felt like... my decisions were having real consequences and I was carrying the responsibility for the patient and I had to be prepared for what the outcomes of my decisions were going to be.– PGY3 |
| Though faculty were concerned about decreased opportunities for teaching and feedback, both senior and junior trainees reported unique learning from having faculty both present and absent from rounds. | “The team [felt] more relaxed and then that led to people asking more questions. I found we were having these amazing discussions about management that applied to the med students all the way to the junior and the senior. And we were teaching each other things and it was just like this really fluid learning environment that I had never experienced before.” – PGY3 |
| No significant patient safety events were noted. | “The attending is still reviewing the vitals. The attending is still examining the patient. The attending is still looking at your orders and talking about the plan. There pretty much is an attending there. You’re just not with an attending on rounds.” – PGY3 |
| All identified communication and patient progression concerns that can be mitigated. | “I felt [like there was a] lack of recognition for things that should have been progressed in the patient’s care.” – Faculty |

**DIVERSITY/SOCIAL DETERMINANTS/POVERTY/ADVOCACY**

83. **THE CAROLINAS COLLABORATIVE: HOW A PEDIATRIC RESIDENCY TRAINING PROGRAM COLLABORATIVE IMPROVED COMMUNITY HEALTH AND ADVOCACY CURRICULA**

*Margaret Ellis, DO, MSPH, Wake Forest University School of Medicine, Winston Salem, NC, Ben Hoffman, MD, Oregon Health and Science University, Portland, OR, Shivani Mehta, MD, Carolinas Medical Center, Charlotte, NC*

Background The Carolinas Collaborative (CC) is a cohesive network of advocacy leaders and representatives from all 8 pediatric academic institutions in North and South Carolina. Upon the founding of the CC, each institution had disparate levels of established advocacy curricula. Over the course of two years, the CC member programs worked together to improve their advocacy curricula via bi-weekly conference calls and quarterly meetings. Institutions saw an improvement in their curricula over time, and the advocacy programs involved in the CC became stronger and more developed through their involvement in the CC. Objective To explore the impact of a multi-state advocacy-training collaborative upon community health and advocacy curricula using the American Academy of Pediatrics Community Pediatrics Training Initiative (CPTI) Community Health and Advocacy Mapping Profile (CHAMP) Mapping tool. Our hypothesis was that the collaborative would positively impact the curricular content for each program and lead to deeper and broader learning and assessment. Design/Methods Each of the 8 training programs of the CC completed the CPTI CHAMP Mapping tool at the outset of the collaborative in August of 2016, identifying which of the 35 learning objectives for Community Health and Advocacy Training were addressed in their residency program's curriculum, and an assessment of the level of learning expected for each taught objective according to Miller’s Pyramid (Knows, Knows How, Shows How, Does). Each program repeated the CHAMP Mapping exercise in April of 2018. We assessed both changes in the number of objectives taught, and increases in the level of learning expected per Miller's Pyramid. Results Compared to the 2016, the total number of CHAMP objectives taught by each program increased by 2018, from 31 to 33 of the 35 total. This number was not statistically significant. The level of learning assessed in 2016, defined by the number of objectives that met “Shows How” or “Does” showed a statistically significant increase by 2018 whether compared to all 35 CHAMP objectives (Curriculum Index, p=0.00007), or to the specific CHAMP objectives taught by each program (Robustness Index, p=.0002) (FIGURE 1). Conclusion Involvement in a multi-institutional Residency Training Collaborative can improve the quality and depth of Community Health and Advocacy education for residents. Both the breadth and depth of curricula improved, but the changes in level of learning, as defined by Miller’s Pyramid, were the most significant.
84. TEACHING SOCIAL DETERMINANTS VIA SERVICE LEARNING AND COMMUNITY EXPLORATION
Leora Mogilner, MD, Icahn School of Medicine at Mount Sinai, Ashley B. Stevens, MD, New York Presbyterian Hospital (Columbia Campus), Cynthia Katz, MD, Icahn School of Medicine at Mount Sinai, New York, NY
BACKGROUND: Residents must be familiar with the community they serve and understand the impact of social determinants of health (SDH). Service learning is an educational approach that combines community service with reflection to achieve meaningful community engagement and understanding of SDH. We designed an intern orientation program to engage new trainees in conversations about SDH and advocacy through service learning and a team building experience.
OBJECTIVE: Assess the impact of a community tour and volunteer experience on knowledge of local community, attitudes around SDH screening, and intern bonding. METHODS: The intervention included a didactic session on SDH; a walking tour of East Harlem (EH), the hospital neighborhood; and a visit to a local food pantry/community-based organization where residents engaged in a volunteer activity (packing meals). Residents completed a mixed methods survey with retrospective pre/post questions to reflect on the impact of the activity on knowledge and attitudes regarding: patient demographics, SDH (particularly food insecurity), and familiarity with co-interns. Data was analyzed using McNemar’s test. RESULTS: 35 residents were surveyed in 2017-2018. The program was effective in increasing interns’ understanding of the demographics and health issues affecting EH children (p=0.001) as well as increasing comfort discussing food insecurity with patients (p=0.001). All respondents reported a future plan to screen patients for food security, and 100% affirmed that program participation provided tools to help their patients. 97% agreed the activity helped them get to know their fellow interns. When asked for favorite aspects of the day, “volunteering at the pantry and giving back to the community,” “learning more about the EH community” and “getting to know our co-residents,” were identified. CONCLUSION: A volunteer experience followed by a walking tour gave interns the opportunity to learn about EH while performing community service and bonding with their co-interns. Future research is needed to ascertain whether this hands-on experience inspires and sustains a program culture of advocacy.

85. TEACHING RESIDENTS TO ADDRESS CHILD POVERTY: AN INNOVATIVE MULTIMODAL CURRICULUM
Jessica Weisz, MD, Lanre O. Falusi, MD, Iana Clarence, MPH, Cara Lichtenstein, MD, MPH, Jiaxiang Gai, MS, Mary C. Ottolini, MD MPH Med, Children’s National Medical Center, Washington, DC
Background: Because children in poverty are more likely to experience adverse health outcomes it is imperative that trainees learn to identify and mitigate poverty’s negative effects. Objective: To evaluate the effectiveness of a new residency curriculum on child poverty. Design/Methods: We designed the Trainee Education in Advocacy and Community Health (TEACH) curriculum with input from trainees, educators, and community members based on objectives of the U.S. Child Poverty Curriculum. Pediatric residents were randomized to participate based on continuity clinic site. The curriculum includes 2 interactive modules, experiential learning at a government benefits application site, a museum exhibit on evictions, and a faculty debriefing. The curriculum was evaluated using a mixed methods approach including a survey assessing attitudes and experiences with child poverty, module pre/post-tests, written reflections, and qualitative analysis with inductive coding of audio-recordings of the debrief sessions to identify themes from the resident experience with the curriculum. Results: Sixteen residents completed the curriculum between June and November 2018; 9 PL-1s, 5 PL-2s, and 2 PL-3s. All increased their confidence (p<0.001) and knowledge (p=0.001) of poverty rates and how they differ by population. Pre/post module scores increased on average from 33.9% correct to 69.5% correct (p=.001). Themes from qualitative analyses included residents
recognizing socioeconomic disparities, empathizing with patients, committing to ask about social determinants of health (SDH), understanding barriers to obtaining benefits, and feeling empowered to address SDH with patients and the care team. Conclusion: The TEACH curriculum increased resident knowledge, confidence, and attitudes about child poverty. The modular format allows for reproducibility in other training programs. A community experience was key to enhancing empathy for families in poverty. Next steps include assessing a comparison group and knowledge application during a clinical encounter.

86. EARLY IMPACT OF A HEALTH EQUITY, DIVERSITY, AND INCLUSION CURRICULA ON RESIDENT KNOWLEDGE, ATTITUDES AND SKILL IN CROSS-CULTURAL CARE
Patrice A. Pryce, MD, Hofstra Northwell School of Medicine at Cohen Children’s Medical Center, Elmont, NY, Omolara Uwemedimo, MD, Pratichi Goenka, MD, Stephen Barone, MD, Hofstra Northwell School of Medicine at Cohen Children’s Medical Center, New Hyde Park, NY
Background: GME programs that provide targeted training on the care of disadvantaged populations may result in improved cross-cultural care and decreased health disparities and patient discrimination. In 2018, the ACGME highlighted lack of formal education on knowledge and strategies to address health disparities as a national priority need. Currently, many residents do not receive training on structural competencies and biases that contribute to poor health, nor are they equipped with skills to advocate for patients who disproportionately experience inequity from structural and social determinants of health (SDOH). Design: The HEDI curriculum at Cohen Children’s Medical Center expands resident training to include sessions on: implicit bias, use of interpreters, health literacy, health disparities, community engagement, LGBTQ health, mistrust, racism, SDOH, cultural and structural competency. Prior to curriculum initiation, residents completed the validated Cross-Cultural Care Survey (CCCS). Trainees engage in monthly, interactive workshops and case-based simulations. Pre and post surveys assess resident knowledge, skill, and attitudes related to each session. Descriptive analyses and Fisher’s Exact Test assess bivariate associations. Results: Of the 49 residents who completed the CCCS, 67% felt unprepared to deliver cross-cultural care. 18% identified lack of experience and 30% reported inadequate training as barriers to delivering cross-cultural care. Attendance of at least 1 HEDI session was associated with a decrease in residents personal feeling of helplessness when caring for patients of different cultures (p<0.025) and their own dismissive attitudes as a problem in the delivery of cross-cultural care (p<0.05). Conclusion: Early results from the HEDI curriculum show residents improvement in preparedness and attitudes in providing cross-cultural care. Further research is warranted to examine whether curricular elements provide a long-term, sustained impact on resident knowledge, skills, and attitudes, which are necessary to combat and eliminate health disparities.

87. TRANSFORMING ADVOCACY CURRICULA INTO ONE THAT PROMOTES TRAINEE KNOWLEDGE, SKILLS, AND ENGAGEMENT
Patrice Pryce, MD, Hofstra Northwell School of Medicine at Cohen Children’s Medical Center, Elmont, NY, Alexandra Kilinsky DO, Grace Fisler, MD, Jami Zaretsky, MD, Allison Driansky, MD, Stephen Barone, MD, Hofstra Northwell School of Medicine at Cohen Children’s Medical Center, New Hyde Park, NY
Background: Residency programs have addressed advocacy curriculum needs with various degrees of success. Program leadership at Cohen Children’s Medical Center recognized the need to enhance curricula to meet the demands of residents and communities. Design: Didactics are structured as a series of conferences, interactive workshops and web-based modules. There is education on the importance of Community Based Organizations (CBOs), health equity, vulnerable populations, legislative advocacy etc. Experiential learning is provided at CBOs, federal program sites, and schools. During this 4-week intern rotation, residents care for vulnerable populations, provide outreach, conduct health assessments, and participate in home visits in a community setting. Each intern develops an advocacy topic/campaign (gun safety, toxic stress, border separation, voter rights) to present at a resident noon conference. To further highlight the importance of this topic, a 3-week advocacy lecture series was incorporated into the core resident education curricula. Results: Enhanced understanding of advocacy topics and increased interest in engaging in advocacy initiatives was demonstrated. The mean value added score for the series was 1.52 (CI 1.35 to 1.7). There was improvement in understanding (decrease in score) within multiple topics. Pre-intervention understanding of public health insurance, school-based clinics, healthcare economics, and CBOs was 2.83, 2.67, 2.89, and 2.25 respectively. Post-intervention understanding of public health insurance, school-based clinics, healthcare economics, and CBOs was 1.61, 1.80, 2.00, and 1.55 respectively (p<0.05). 80% of residents who completed the rotation agree or strongly agree lecture content was useful and will change future practice. Conclusion: Residents yearn to learn advocacy measures. An advocacy toolkit equips residents with the knowledge and skills necessary to lead and transform future work environments. The curriculum is easily replicable for residency programs desiring to integrate advocacy training curricula without increasing the burden of utilizable resources.

88. STUDYING THE PROGRESSION OF RESIDENTS CULTURAL ATTITUDES DURING STANDARD PEDIATRIC RESIDENCY
Bindiya Bagga, Kimberlee V. Norwood, University of Tennessee, Memphis, TN
Background: Developing skills for taking care of patients from a variety of backgrounds is an important aspect in medical education as cultural differences between providers and patients can lead to miscommunication and affect patient outcomes. There is a lack of evidence in the current medical literature on the progression of residents’ cultural attitudes during pediatric residency through clinical experiences alone. The purpose of this study was to perform a cross-sectional survey of pediatric residents at different levels of training in our mid-size residency program. We hypothesized that clinical experiences attained with natural progression through standard pediatric residency training is insufficient to improve the trainees’ cultural attitudes. Methods: After obtaining IRB approval, a previously validated Health Belief Attitudes Survey (15 items scored on a
89. PEDIATRICIANS AT THE CAPITOL: PEDIATRIC RESIDENT LEGISLATIVE ADVOCACY TRAINING

Jennifer Farabaugh, BS, Michael Do, MD, Kristen Samaddar, MD, Phoenix Children’s Hospital, Phoenix, AZ

Background The Accreditation Council for Graduate Medical Education (ACGME) requires legislative advocacy education in residency. However, due to the relatively recent emergence, structure and content requirements for curriculum in advocacy training are lacking. In 2014, the residency program at Phoenix Children’s developed an annual curricular event “Pediatricians at The Capitol” to actively engage residents in advocacy training and demystify the state legislative process. Methods The event at the State Capitol includes training on interacting with legislators, overview of pediatric health issues, an opportunity to meet with individual district Representatives and attend health committee meetings. Advocacy tools and materials developed by the national AAP are utilized. Child health issues are based on local legislative priorities in collaboration with the Arizona Chapter of the AAP. Participants complete a pre- and post-event survey to assess the quality of the experience. Results To date, 169 medical professionals have participated (136 residents). Only 22% of participants knew who their local representatives were prior to the event, 100% knew after. Over 70% of participants met with at least one of their representatives and felt confident and prepared in discussing child health issues with them. Overall, the event received 4.47 out of 5 indicating it is both informative and highly valued by participants. More than 60% of participants anticipate that their engagement in advocacy activities will increase as a result of participating. Conclusion Legislative advocacy curriculum is an essential component of pediatrics residency. Adapting existing advocacy tool from the AAP and collaborating with local pediatric focused organizations to provide a structured, hands-on experience proves to be well received and leaves residents prepared and confident in ongoing legislative advocacy.

90. STRENGTHENING MEDICAL-LEGAL PARTNERSHIPS: THE ADVOCACY LETTER PROJECT

Kayla B. Phelps, MD, Leah Rappaport, MD, Priyanka Rao, MD, Debra Chopp, JD, University of Michigan, Ann Arbor, MI

Many medical problems intersect with legal issues. While medical providers may screen for such social determinants of health, they often lack the time, knowledge, tools and, agency to effectively advocate for their patients. Physicians may refer patients to a social worker or legal aid clinic, but these resources do not have sufficient capacity to address all patient needs. The Advocacy Letter Project worked with the Pediatric Advocacy Clinic (PAC), a legal aid clinic, at the University of Michigan Law School to identify important medical-legal issues and to build capacity among community providers by creating advocacy letter templates and training for their ideal utilization. This project is supported by an AAP CATCH grant. An initial needs assessment survey of providers identified which common medical-legal issues are identified during patient visits. Advocacy tools and materials developed by the national AAP are utilized. Child health issues are based on local legislative priorities in collaboration with the Arizona Chapter of the AAP. Participants complete a pre- and post-event survey to assess the quality of the experience. Results To date, 169 medical professionals have participated (136 residents). Only 22% of participants knew who their local representatives were prior to the event, 100% knew after. Over 70% of participants met with at least one of their representatives and felt confident and prepared in discussing child health issues with them. Overall, the event received 4.47 out of 5 indicating it is both informative and highly valued by participants. More than 60% of participants anticipate that their engagement in advocacy activities will increase as a result of participating. Conclusion Legislative advocacy curriculum is an essential component of pediatrics residency. Adapting existing advocacy tool from the AAP and collaborating with local pediatric focused organizations to provide a structured, hands-on experience proves to be well received and leaves residents prepared and confident in ongoing legislative advocacy.

91. ASSESSING PEDIATRIC RESIDENT READINESS TO SCREEN MOTHERS OF YOUNG CHILDREN FOR FAMILY
PLANNING NEEDS
Aisha Bobb-Semple, Natasha Ramsey, Megan D’Andrea, John Rowland, Leora Mogilner, Icahn School of Medicine at Mount Sinai, New York, NY

BACKGROUND: The postpartum period is a high risk period for unintended pregnancies which can be associated with negative outcomes for mother and infant. Effective contraception is important during this time and thus the AAP advises pediatricians to ask mothers about family planning by the two-month visit. Previous work has shown family planning screening can be implemented in a pediatric resident clinic, with residents providing referrals needed services. OBJECTIVE: To assess resident knowledge, attitudes and confidence around discussing family planning with mothers of their young patients.

METHODS: Anonymous surveys were administered to pediatric residents in an inner city pediatric residency program. Group comparisons were made using Fisher’s exact test and chi-square test. RESULTS: 39 residents completed the survey for a response rate of 65%. 39% of respondents were in their 1st year of residency, 36% were in the 2nd year, and 25% were in their third year or higher. More than half (55%) of respondents felt knowledgeable or very knowledgeable about guidelines around providing contraceptive care for adolescents. These residents were more likely to be farther along in residency (p=0.04) and to correctly identify first line contraception for adolescents (p=0.006). Respondents who felt knowledgeable about providing contraceptive care for adolescents were more likely to feel confident speaking with mothers about their contraceptive needs (p <0.001). 90% of respondents were not aware of recommendations to screen mothers for family planning needs, though 36% reported speaking with mothers about plans for having another child. Over 60% of respondents felt pediatricians should play a moderate or extensive role in such screening. CONCLUSIONS: While most residents surveyed were not aware of guidelines recommending screening mothers of young children for family planning needs, they felt pediatricians have a role in such discussions. These data highlight resident willingness to screen mothers of infants for family planning needs and the opportunity to build on their current knowledge and practices.

92. LEARNING TO LEAD (LEADERSHIP EDUCATION IN ADVANCING DIVERSITY): EMPOWERING TRAINEES THROUGH BUILDING LEADERSHIP AND SCHOLARSHIP CAPACITY IN DIVERSITY AND INCLUSION
Carmin Powell, MD, Lahia Yemane, MD, Michelle Brooks, C-TAGME, Carrie Johnson, MBA, Rebecca Blankenburg, MD, MPH, Stanford University, Palo Alto, CA

Background: Though the patient population is rapidly becoming more diverse, there has remained a low number of physicians who are under-represented in medicine, particularly in academic medicine leadership positions. Building leadership and scholarship capacity for improving diversity and inclusion should begin early during residency and fellowship training. To address these needs, we developed the LEAD (Leadership Education in Advancing Diversity) Program, a voluntary, 9-month longitudinal program for pediatric residents and fellows to provide leadership training and mentorship in creating scholarly works in diversity and inclusion topics. Objective: To evaluate participants’ knowledge, confidence and attitudes on diversity and inclusion topics and satisfaction with the LEAD Program. Methods: In 2017-2018, IRB-approved, de-identified pre- and retrospective pre/post surveys assessed learner knowledge, confidence, attitudes, and program satisfaction. Analysis included descriptive statistics and two-tailed t-tests. To measure the impact on learners’ leadership and scholarship, we measured the number of workshop presentations by LEAD scholars at local, regional, and national meetings. Results: We had 13 participants (8 residents; 5 fellows) in the LEAD Program. 100% (N=13/13) completed the pre-survey and post-survey. 100% of participants thought the LEAD Program should continue to include residents and fellows and should spread to all GME programs at Stanford. There was a statistically significant improvement in participants’ self-confidence for all learning objectives. In total, participants presented 3 local, 5 regional, and 4 national workshops stemming from the LEAD Program. Conclusions: The LEAD Program was successful in fostering leadership and promoting scholarship in diversity and inclusion. Future steps include expansion across further GME departments outside of Pediatrics, following long-term career outcomes of LEAD participants, and developing a concurrent mentor curriculum.

93. TEACHING RESIDENTS TO MITIGATE PREJUDICE
Elizabeth L. Paulsen, MD, Kimberly M. Wells, MD, Olamide Ajagbe, MD, John Ervoes, MD, SUNY Upstate Medical University, Syracuse, NY

Discrimination in the workplace is prevalent and while more residency programs are teaching residents to mitigate their own biases, research remains scant on how physicians can respond to discriminatory comments. Evidence supports that discrimination contributes to physician burnout. One institution developed a longitudinal curriculum to help residents respond to discriminatory comments using the NURSE mnemonic (Name-Understand-Respect-Support-Explore). We adapted this curriculum and created a 2-hour workshop for trainees at our pediatric residency program.

Workshop objectives were: 1. Recognize when discrimination occurs and how this affects patient care; 2. Utilize the NURSE mnemonic and hospital code of conduct; and 3. Apply these tools in simulations to enhance pediatric residents’ ability to effectively respond to discriminatory comments. Our workshop included videos from popular media, an overview of current literature, and our institution’s code of conduct. A gold standard skit demonstrated the NURSE mnemonic, and was followed by small group activity with role playing and debriefing. Pre- and post-surveys were administered to participants. All respondents reported facing

![Discrimination Towards Team Members: Resident Preparedness](image-url)
discrimination at least once with 13% reporting greater than 5 encounters. Discrimination against gender, race, and age were the most commonly faced. Prior to the workshop, 41% of respondents felt fairly well prepared to respond to discriminatory comments directed towards themselves, and 33% felt fairly well prepared when comments were directed towards a team member. After the workshop, 77% of residents felt very well prepared or fairly well prepared to respond to these comments, and no residents reported feeling very unprepared. There was also a marked difference in perceived faculty support following the workshop with 83.4% of residents reporting either fairly well or very well supported versus 55.9% pre-workshop. We found that an interactive workshop can facilitate discussion and improve residents’ self-reported preparedness to respond to discriminatory comments. Our data also demonstrate that residents in our program feel more supported following this workshop.

QI/SAFETY

94. REDUCING UNNECESSARY TESTING OF VIRAL RESPIRATORY PATHOGENS IN PEDIATRIC PATIENTS
Heather Gardiner, MD, Tina Ramo, MD, Kathryn Stockbower, MD, Mina Tahai, MD, Natalie Wilcox, MD, Megan Aylor, MD, Windy Stevenson, MD, Oregon Health and Science University, Portland, OR

Background Although advancements in respiratory viral testing allow for more timely detection of viruses, these tests are expensive and lacking clear evidence of added clinical utility. The Respiratory Pathogen Panel (RPP) used in our institution checks primarily for non-treatable viruses. It accounted for an estimated 2 million dollars in charges from 2015-2017 and was often ordered without documentation of how the test would change clinical management. This raised concern about the clinical utility and added cost of this test for our patients. Aim Statement We aimed to reduce the number of RPP tests ordered on pediatric patients in the pediatric emergency department (ED), inpatient ward and pediatric intensive care unit (PICU) by 50% over 1 year. Interventions Through retrospective chart review, we identified the common clinical divisions and indications in which the RPP was being ordered. We then met with these high utilizers as well as other key stakeholders to develop provider consensus on appropriate utilization of the RPP. Using clinical consensus, along with a focused literature review, we drafted a best practice advisory (BPA), which notably, has been approved but not yet activated in our electronic health record. Measures We used problem solving methodology and a test of change to decrease RPP test utilization. We tracked test utilization in the pediatric ED, PICU and inpatient ward. Results With development of clinical consensus, the number of RPP tests ordered decreased significantly from a median of 19 tests/week in the 2016-2017 respiratory season to a median of 10 tests/week in the 2017-2018 respiratory season in target units. This resulted in an estimated reduction of charges by 54% (from approximately $811,200 to $436,800). Conclusions and Next Steps Establishing a consensus for appropriate use of respiratory viral testing can significantly reduce test utilization and healthcare cost. We anticipate the BPA will sustain resident efforts to date and further reduce unnecessary testing. We predict creating consensus for other tests may be an effective means of ensuring appropriate utilization and reducing costs.

98. IMPROVING RESIDENT NOTE COMPLETION IN A GENERAL PEDIATRICS CLINIC
Megan Aylor, MD, Eliza Bakken, MD, Rebecca Hood, Rachel Hauser, Carrie Phillipi, MD, PhD, Oregon Health and Science University, Portland, OR

Background Timely note completion is an important part of patient care. Our hospital has standard expectations for note completion; however, pediatric residents in our program were often delinquent in their documentation, resulting in incomplete patient data in the electronic health record during return visits, elevated resident stress, and threat of suspension of clinical duties from the professional board. The vast majority of these delinquencies were from our general pediatric clinic, where residents see patients for both acute and well child care. Aim Statement Decrease number of delinquent resident notes by 80% over a 9 month period. Interventions We used problem solving methodology and serial tests of change to improve note timeliness. The primary outcome measure was the number of overall delinquent charts according to a weekly graduate medical education deficiency notification system. Tests of change included: 1-Program Director emails and pages to residents with delinquent notes (defined by the institution as >14 days for ambulatory charts) 2-General Pediatric attending consensus on note completion timeliness (same day for acute care visits, next day for well child visits) 3-Intermittent auditing and real time alerts by administrative staff for residents who failed to comply with the same day/next day clinic note completion timeline Measures Number of delinquent charts by pediatric residents according to the weekly graduate medical education deficiency notification system Results Timely note completion improved significantly over the 13 months of the project. Program Director emails/pages to residents with deficient charts resulted in a reduction of a median 26 deficient charts/week to 12 deficient charts/week. Intermittent real time alerts to residents who failed to close charts within 24 hours of an acute care visit or 48 hours of a well child visit further reduced the median from 12 charts per week to 2 charts per week. Conclusions and Next Steps Standard expectations for resident note completion in a general pediatric clinic coupled with real time feedback improved resident adherence to institutional expectations around timely note completion. While program director contact with residents who have delinquent charts demonstrated some improvement, this intervention alone was insufficient.
96. IMPLEMENTING AND MAINTAINING A PEDIATRIC NIGHT EDUCATION CURRICULUM
McKenzie Water, David Johnson, Alison Herndon, Whitney Browning, Vanderbilt University, Nashville, TN
Background Resident work hour restrictions have led to increasing night float coverage, reducing the ability of residents to attend educational conferences. A night education curriculum could help fill this void. While sample curricula exist, few have evaluated factors leading to successful implementation. Aim Statement To increase resident-led formal teaching while on ward night shifts from zero occurrences per week to at least three times weekly by December 31, 2018. Interventions Resident-completed surveys provided information on educational needs and indicated formal nighttime teaching was exceedingly rare. Key drivers were developed to identify areas for intervention, including: flexibility on timing of teaching and who is present for teaching, resident understanding of survey results, comfort with teaching skills and content, and perception of adequate time to teach. Measures Several plan, do, study and act cycles were instituted as changes were tested. Weekly data were analyzed using a run chart with six consecutive points on either side of the median line representing special cause variation indicating a shift. Results Nighttime teaching initially occurred zero times per week. Introduction of the curriculum with expectations to teach on Monday, Wednesday and Friday at 10 PM with the attending present increased teaching to a median of one session per week. Based on resident feedback and concerns, targeted interventions providing more flexibility in teaching expectations led to a shift of the median to our goal of three times per week which has been sustained for 20 weeks. These changes in teaching expectations included the flexibility on who is present for teaching, the night it occurs, the time it occurs and the duration of teaching. Other interventions such as providing results of the survey and placing a calendar as a reminder did not result in a more reliable process. Conclusions and Next Steps Simply creating night curriculum content does not ensure teaching occurs, especially when overnight workflows and workloads are variable and hectic. Implementing and sustaining a pediatric night education curriculum is possible using quality improvement methodology. Utilizing resident feedback for modifications to the curriculum and allowing more resident-ownership by testing different interventions increased the consistency at which resident-led night teaching was done at our institution.

97. RESIDENT NOON CONFERENCE FEEDBACK IN THE DIGITAL AGE: A QI PROJECT
Christina M. Abrams, MD, Jessica Wilson, MD, Kristen Bettin, MD, Emilee Dobish, MD, University of Tennessee, Memphis, TN
Background Noon conference lectures are a valuable education tool for residency programs, but feedback is difficult to obtain with many methods unsuccessful. Our program used paper and audience polling systems without meaningful responses as the feedback consisted of a numerical rating without comments. Given the availability of smartphones, Quick Response (QR) codes may provide a sustainable method for feedback. Aim Statement By December 2018, we will increase resident feedback for noon conference lectures to 75% of residents in attendance utilizing QR codes and Google Forms. Interventions PDSA cycles were completed monthly to track changes in resident response rate. In cycle 1, chief residents

*We elected to adjust the median following each test of change*
asked residents to use the QR code to complete feedback. In cycle 2, feedback results were discussed during the monthly housestaff meeting. In cycle 3, faculty presenters displayed the QR code and asked residents to participate. In cycle 4, QR codes were placed in the conference hall. In cycle 5, QR codes were displayed Friday before conference. In cycle 6, faculty were provided education on the QR code process. Measures Following the model for improvement, we reviewed prior attempts to obtain resident feedback and compiled baseline data. Surveys consisting of a 5 point rating scale and comment section were linked to a QR code. The primary outcome was the percent of residents in attendance providing feedback via the QR code. Results Over six months, we were unable to meet the goal of a 75% response rate. However, monthly median response rates increased from the baseline 27.9% to 34.2% at the end of cycle 6 indicating a 22.5% change from baseline in participation. The run chart indicates several runs of data, possibly indicating multiple data sets such as different response rates by residency class Conclusions and Next Steps Though we have not reached our goal, we have been able to get meaningful feedback from the residents for faculty. Using this feedback, we can guide topic selection for resident lectures and provide feedback on lecture styles to create a more engaging learning environment. Additional cycles are planned working toward the 75% goal, evaluating response rates by class and day of the week.

98. IMPROVING BRONCHIOLITIS MANAGEMENT WITH A CARE PATH
Ripal Patel, MD, Melissa Schafer, MD, Heidi Ochs, DO, John Andrade, MD, John Pires Ervoes, MD, Eric Gershon, SUNY Upstate Medical University, Syracuse, NY
Background Bronchiolitis is the number one cause of hospitalization in children under 2 years of age. AAP guidelines emphasize that only supportive care is needed for bronchiolitis. Data obtained from our institution showed poor adherence to AAP guidelines. This project was undertaken with the goal of improving compliance with these guidelines. Aim Statement Our aim was to reduce length of stay (LOS) for admitted low risk patients with bronchiolitis, age 1-24 months, from 67 hours to < 48 hours by December 31, 2018 Interventions A care path and respiratory score were adapted for our institution. Every patient admitted for bronchiolitis were assessed and given a score using respiratory rate, auscultation, and use of accessory muscles. All patients were ordered nasal suction, saline and reassessed. Persistently high scores resulted in escalation of care. The respiratory score and order set were built into the EMR. The care path was made hospital policy. Physicians, respiratory and nursing received education. Measures Data from patients age 1-24 months hospitalized with bronchiolitis from Nov - Dec 2017 was obtained. Excluded were those born <34 weeks gestation, prior asthma diagnosis, clinically significant cardiac defects, chronic lung disease, airway anomalies, bacterial pneumonia, and prior intubation. 83 charts were included. The average LOS was 67 hours, average age was 6 months, 50% required oxygen, 12% went to PICU, 27% received steroids, 69% received albuterol, 42% received antibiotics, and 72% had a chest x ray. Results Charts of patients with bronchiolitis from Jan to Dec 2018 were reviewed. Data were collected regarding LOS, PICU use, and use of chest x ray, albuterol, steroids, epinephrine and antibiotics. We saw an increase in cases in Sept-Dec 2018 with no increase in PICU use. Nov and Dec 2018 average LOS was < 36 hrs. After implementation of the care path, guideline adherence improved from 20% in Oct to 86% in Dec 2018. Conclusions and Next Steps With additional education and reinforcement, we hope to make the trend toward improved care for bronchiolitis the standard in our institution. Early observations after implementation of the care path indicate a reduced length of stay, but further data points are needed to know if this change will be sustained.

99. SIMULATED FIRST NIGHT-ONCALL (FNOC): ESTABLISHING COMMUNITY AND A CULTURE OF
Hannah S. Famiglietti, MD, Donna Phillips, MD, Heather Howell, MD, Michael Goonan, MD, Chanele Coble, MD, Sondra Zabar, MD, New York University School of Medicine, New York, NY
Background: The transition from medical student to intern presents a major patient safety concern. Our institution implemented an immersive First Night OnCall (FNOC) simulation to support transitioning trainees and cultivate a culture of safety. Objective: Engage pediatric interns in a pediatric focused FNOC simulation to ensure readiness to recognize and address common safety issues in practice. Methods: Interns were asked to recognize patient safety hazards in a simulated patient room and participate in case based safety discussions. Interns then participated in GOSCEs (Group Observed Standardized Clinical Encounters). GOSCEs tasked trainees to obtain informed consent, evaluate a decompensating patient, recognize a mislabeled culture bottle, and give an effective patient handoff. Faculty debriefed all activities. Learners completed pre and post program assessments and a program evaluation. Results: Twenty incoming interns completed FNOC.
ASSESSMENT AND CARE OF PATIENTS WITH EARLY CHILDHOOD CARIES
Melanie Degliuomini, MD, Angela Chan, MD, Snezana Osorio, MD, MS, Erika Abramson, MD, MS, Robyn Rosenblum, MD, New York Presbyterian Hospital (Cornell Campus), New York, NY

Background Early childhood caries (ECC), defined as one or more decayed, missing, or filled teeth in children under 6 years, is the most common, chronic, preventable condition in childhood. ECC affects 28% of US children 2-5 years of age, particularly children of lower socioeconomic status. The American Academy of Pediatric Dentistry (AAPD) and the AAP recommend that children establish a dental home by 12 months, but lack of standardized ECC assessments and dental referral processes are often barriers to optimal care. Aim Statement In this 12-month long resident-led QI project we aimed to improve the ECC risk assessment rate for children 6 months to 6 years to 70%, and to improve the dental referral rate to 90%. Interventions The Model of Improvement was used for this QI project from December 2017 to December 2018 at a community clinic affiliated with an academic center. An electronic Oral Risk Assessment Tool was created based on AAP guidelines. Residents performed 6 plan-do-study-act (PDSA) cycles utilizing 7 interventions derived from tertiary key drivers (Figure 1a). Measures Process, outcome and balancing measures were collected via electronic medical record review (resident documentation of EEC Model of Improvement was used for this QI project from December 2017 to December 2018 at a community clinic affiliated with an academic center. An electronic Oral Risk Assessment Tool was created based on AAP guidelines. Residents performed 6 plan-do-study-act (PDSA) cycles utilizing 7 interventions derived from tertiary key drivers (Figure 1a). Measures Process, outcome and balancing measures were collected via electronic medical record review (resident documentation of EEC Model of Improvement was used for this QI project from December 2017 to December 2018 at a community clinic affiliated with an academic center. An electronic Oral Risk Assessment Tool was created based on AAP guidelines. Residents performed 6 plan-do-study-act (PDSA) cycles utilizing 7 interventions derived from tertiary key drivers (Figure 1a). Measures Process, outcome and balancing measures were collected via electronic medical record review (resident documentation of EEC Model of Improvement was used for this QI project from December 2017 to December 2018 at a community clinic affiliated with an academic center. An electronic Oral Risk Assessment Tool was created based on AAP guidelines. Residents performed 6 plan-do-study-act (PDSA) cycles utilizing 7 interventions derived from tertiary key drivers (Figure 1a). Measures Process, outcome and balancing measures were collected via electronic medical record review (resident documentation of EEC
risk assessment improved from 37.84% to 77.74% (Figure 1b). Initially, 72.22% of screened patients were at high risk for caries (with >1 risk factor for ECC on risk assessment tool). Over time, this rate significantly decreased to 52.46% largely due to family education (Figure 1c). On average, 47.66% of screened patients had a dental home. Residents reached outcome goal of 90% referral rate for those patients without a dental home. (Figure 1d) Developmental screening rate, as a balancing measure, remained at 100% compliance. Conclusions and Next Steps Implementation of this QI project showed our patient population was at high-risk for ECC, which had previously been unknown, and decreased with our interventions. Creation of an electronic screening tool facilitated screening. Family education and providing a referral list of community dentists were the most successful interventions. Next steps include creating an electronic dental referral system and partnering with community dentists to enhance ECC-related family and patient education.

102. CARPE DIEM MEDIUM: MAKING THE MOST IMPACT IN AN ACADEMIC HALF DAY.
Taylor Couch, MD, Michelle Escala, MD, Amy Hendrix, MA, Michelle Condren, PharmD, Keith Mather, MD, University of Oklahoma School of Community Medicine (Tulsa), Tulsa, OK

Background There are a variety of challenges to providing meaningful and relevant education to pediatric residents, including adapting to different adult learning styles, availability of lecturers, and balancing protection of educational times and coverage of patient care. In 2015, our program noticed a decline in our board pass rate to 25% for this graduating class, which lowered our three year pass rate for first time takers to 65% for 2013-15. Aim Statement Our educational goal is planned to improve in training exam (ITE) standard scores to national average and improve first-time-taker board pass rates to meet 3 year pass rate of at least 80% by 2019 and 100% by 2021. Interventions We used serial PDSA cycles with change processes during the academic afternoons from 2015 through 2019. In 2015-16, we initiated a standardized 18-month curriculum. In 2016-17, we revised curriculum focusing on American Board of Pediatrics (ABP) content specifications and providing residents with standardized pre-reading materials. In 2017-18, we adjusted the curriculum to 12-months and started to follow residents’ progress and assess knowledge gaps using an online pediatric question bank. This also helped us track residents considered “at risk” for board failure. Measures We trended ITE scores and first-time-taker ABP board pass rates to measure effectiveness in changes to half day processes. Results When tracking ITE scores, our intern class in 2015 had a score 9 points below national average, and in their third year closed gap to 3 points below. As for our intern class from 2016, they averaged a 16 point deficit, improved to a 4 point deficit in 2017, and surpassed national average by 2 points in 2018. In regards to first-time-taker board pass rates, we had rates of 40% (2/5 residents) for 2015, 83% (5/6) for 2016, 83% (5/6) for 2017, and 100% (7/7) for 2018. Our 3 year first-time board pass rate increased to 85% for 2016-18. Conclusions and Next Steps Academic half days do pose some challenges in regards to scheduling coverage and faculty lecturers; however, our utilization has been successful and well received by our residents. We have shown significant improvement in ITE scores and board pass rate with minor changes each year. Our next PDSA cycle now incorporates weekly board review for the third year residents and a longitudinal developmental/behavioral/psychiatric curriculum for first and second year residents.

*Winner* APPD Trainee Research Award

103. IMPROVING SCREENING LAB COMPLIANCE IN AN URBAN PEDIATRIC PRACTICE

Table 1- Flow Study Interventions

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Inter-professional Engagement/Education</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Create macro in EMR</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Create and print local pediatric dentistry referral list for consistent distribution</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Group email reminders to Queens pediatric residents</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Review macro in EMR to condense data collection</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Review 1-year results with residents and discuss goals for the year</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Create follow-up database to monitor progress</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Attempt to educate attending/NPs to see if they can utilize macros in order to increase follow-up catch pool</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Family Engagement</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Reviewing oral health self-management goals with families</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

_Oklahoma School of Community Medicine (Tulsa), Tulsa, OK_

Background There are a variety of challenges to providing meaningful and relevant education to pediatric residents, including adapting to different adult learning styles, availability of lecturers, and balancing protection of educational times and coverage of patient care. In 2015, our program noticed a decline in our board pass rate to 25% for this graduating class, which lowered our three year pass rate for first time takers to 65% for 2013-15. Aim Statement Our educational goal is planned to improve in training exam (ITE) standard scores to national average and improve first-time-taker board pass rates to meet 3 year pass rate of at least 80% by 2019 and 100% by 2021. Interventions We used serial PDSA cycles with change processes during the academic afternoons from 2015 through 2019. In 2015-16, we initiated a standardized 18-month curriculum. In 2016-17, we revised curriculum focusing on American Board of Pediatrics (ABP) content specifications and providing residents with standardized pre-reading materials. In 2017-18, we adjusted the curriculum to 12-months and started to follow residents’ progress and assess knowledge gaps using an online pediatric question bank. This also helped us track residents considered “at risk” for board failure. Measures We trended ITE scores and first-time-taker ABP board pass rates to measure effectiveness in changes to half day processes. Results When tracking ITE scores, our intern class in 2015 had a score 9 points below national average, and in their third year closed gap to 3 points below. As for our intern class from 2016, they averaged a 16 point deficit, improved to a 4 point deficit in 2017, and surpassed national average by 2 points in 2018. In regards to first-time-taker board pass rates, we had rates of 40% (2/5 residents) for 2015, 83% (5/6) for 2016, 83% (5/6) for 2017, and 100% (7/7) for 2018. Our 3 year first-time board pass rate increased to 85% for 2016-18. Conclusions and Next Steps Academic half days do pose some challenges in regards to scheduling coverage and faculty lecturers; however, our utilization has been successful and well received by our residents. We have shown significant improvement in ITE scores and board pass rate with minor changes each year. Our next PDSA cycle now incorporates weekly board review for the third year residents and a longitudinal developmental/behavioral/psychiatric curriculum for first and second year residents.

*Winner* APPD Trainee Research Award

103. IMPROVING SCREENING LAB COMPLIANCE IN AN URBAN PEDIATRIC PRACTICE
Background Adverse Childhood Experiences (ACEs) are traumatic events that occur prior to age 18. Exposure to ACEs has been associated with adverse health outcomes. Courtney W. Brantley, MD, Brian Lurie, MD, Sydney Primis, MD, Sara Horstmann, MD, Carolinas Medical Center, Charlotte, NC.

**104. IDENTIFYING PATIENTS AT RISK OF CLINICAL DETERIORATION PRIOR TO PICU TRANSFER**

Hamza Nasir, MD, Sara Ghannam, MD, Sumeet Gill, DO, Scott Studeny, MD, Denrik Abrahant, MD, Archana Ramgopal, DO, Amanda Spicer, ANM, Jamie Fast, CNP, Arnaldo Zayas-Santiago, MD, Katie Pestak, DO, Nicholas Davalla, Amrit Gill, MD, Cleveland Clinic Foundation, Cleveland, OH

Background Cleveland Clinic Children’s incorporated the Situational Awareness (SA) model in 2013 to prevent and reduce patient unrecognized clinical deterioration (UCD). The model equips healthcare providers to identify patients at risk of deterioration via use of various criteria and intervene in a timely manner. From April 2018 through August 2018, only 14% of patients transferred to the PICU from the RNF were identified as SA. Our goal was to increase utilization of the SA model to identify patients at risk of clinical deterioration to at least 50% prior to PICU transfer. This project was sponsored by an ACGME initiative aimed at supporting innovation to transform the clinical learning environment where residents pursue their training. Aim Statement Increase the percentage of patients identified as Situational Awareness prior to transfer to PICU from 14% to 50% by November 2018. Interventions Interventions were implemented over a period of 4 months: 1) incorporating assessment of patients SA status during morning rounds with the multidisciplinary team including Nursing, 2) SA discussion during resident afternoon sign-out, and 3) adding SA status identification box into the resident electronic sign-out form. The processes were audited randomly to ensure interventions were being carried out. Measures Data was collected through a retrospective chart review surveying SA documentation of patients prior to PICU transfer. The data showed a mean rate of 42% with an initial intervention in action period. Lab completion increased to 90% with special cause improvement after on-site phlebotomy training. Cost analysis data pending.

Conclusions and Next Steps Significant increase was noted in lab completion upon the addition of on-site lab phlebotomy at site 2. Initial interventions did not lead to increased compliance rates further highlighting the importance of accessibility in an urban population. Urban underserved clinics may consider addition of on-site phlebotomy to continue to close the gaps in health disparity.

105. ADVERSE CHILDHOOD EXPERIENCES SCREENING IN RESIDENT CONTINUITY CLINIC

Courtney W. Brantley, MD, Brian Lurie, MD, Sydney Primis, MD, Sara Horstmann, MD, Carolinas Medical Center, Charlotte, NC

Background Adverse Childhood Experiences (ACEs) are traumatic events that occur prior to age 18. Exposure to ACEs has been associated with adverse health outcomes. Courtney W. Brantley, MD, Brian Lurie, MD, Sydney Primis, MD, Sara Horstmann, MD, Carolinas Medical Center, Charlotte, NC.

Background Adverse Childhood Experiences (ACEs) are traumatic events that occur prior to age 18. Exposure to ACEs has been associated with adverse health outcomes. Courtney W. Brantley, MD, Brian Lurie, MD, Sydney Primis, MD, Sara Horstmann, MD, Carolinas Medical Center, Charlotte, NC.

**105. ADVERSE CHILDHOOD EXPERIENCES SCREENING IN RESIDENT CONTINUITY CLINIC**

Courtney W. Brantley, MD, Brian Lurie, MD, Sydney Primis, MD, Sara Horstmann, MD, Carolinas Medical Center, Charlotte, NC.

Background Adverse Childhood Experiences (ACEs) are traumatic events that occur prior to age 18. Exposure to ACEs has been associated with adverse health outcomes. Courtney W. Brantley, MD, Brian Lurie, MD, Sydney Primis, MD, Sara Horstmann, MD, Carolinas Medical Center, Charlotte, NC.

Background Adverse Childhood Experiences (ACEs) are traumatic events that occur prior to age 18. Exposure to ACEs has been associated with adverse health outcomes. Courtney W. Brantley, MD, Brian Lurie, MD, Sydney Primis, MD, Sara Horstmann, MD, Carolinas Medical Center, Charlotte, NC.

Background Adverse Childhood Experiences (ACEs) are traumatic events that occur prior to age 18. Exposure to ACEs has been associated with adverse health outcomes. Courtney W. Brantley, MD, Brian Lurie, MD, Sydney Primis, MD, Sara Horstmann, MD, Carolinas Medical Center, Charlotte, NC.

Background Adverse Childhood Experiences (ACEs) are traumatic events that occur prior to age 18. Exposure to ACEs has been associated with adverse health outcomes. Courtney W. Brantley, MD, Brian Lurie, MD, Sydney Primis, MD, Sara Horstmann, MD, Carolinas Medical Center, Charlotte, NC.

Background Adverse Childhood Experiences (ACEs) are traumatic events that occur prior to age 18. Exposure to ACEs has been associated with adverse health outcomes. Courtney W. Brantley, MD, Brian Lurie, MD, Sydney Primis, MD, Sara Horstmann, MD, Carolinas Medical Center, Charlotte, NC.

Background Adverse Childhood Experiences (ACEs) are traumatic events that occur prior to age 18. Exposure to ACEs has been associated with adverse health outcomes. Courtney W. Brantley, MD, Brian Lurie, MD, Sydney Primis, MD, Sara Horstmann, MD, Carolinas Medical Center, Charlotte, NC.

Background Adverse Childhood Experiences (ACEs) are traumatic events that occur prior to age 18. Exposure to ACEs has been associated with adverse health outcomes. Courtney W. Brantley, MD, Brian Lurie, MD, Sydney Primis, MD, Sara Horstmann, MD, Carolinas Medical Center, Charlotte, NC.

Background Adverse Childhood Experiences (ACEs) are traumatic events that occur prior to age 18. Exposure to ACEs has been associated with adverse health outcomes. Courtney W. Brantley, MD, Brian Lurie, MD, Sydney Primis, MD, Sara Horstmann, MD, Carolinas Medical Center, Charlotte, NC.

Background Adverse Childhood Experiences (ACEs) are traumatic events that occur prior to age 18. Exposure to ACEs has been associated with adverse health outcomes. Courtney W. Brantley, MD, Brian Lurie, MD, Sydney Primis, MD, Sara Horstmann, MD, Carolinas Medical Center, Charlotte, NC.

Background Adverse Childhood Experiences (ACEs) are traumatic events that occur prior to age 18. Exposure to ACEs has been associated with adverse health outcomes. Courtney W. Brantley, MD, Brian Lurie, MD, Sydney Primis, MD, Sara Horstmann, MD, Carolinas Medical Center, Charlotte, NC.

Background Adverse Childhood Experiences (ACEs) are traumatic events that occur prior to age 18. Exposure to ACEs has been associated with adverse health outcomes. Courtney W. Brantley, MD, Brian Lurie, MD, Sydney Primis, MD, Sara Horstmann, MD, Carolinas Medical Center, Charlotte, NC.

Background Adverse Childhood Experiences (ACEs) are traumatic events that occur prior to age 18. Exposure to ACEs has been associated with adverse health outcomes. Courtney W. Brantley, MD, Brian Lurie, MD, Sydney Primis, MD, Sara Horstmann, MD, Carolinas Medical Center, Charlotte, NC.

Background Adverse Childhood Experiences (ACEs) are traumatic events that occur prior to age 18. Exposure to ACEs has been associated with adverse health outcomes. Courtney W. Brantley, MD, Brian Lurie, MD, Sydney Primis, MD, Sara Horstmann, MD, Carolinas Medical Center, Charlotte, NC.

Background Adverse Childhood Experiences (ACEs) are traumatic events that occur prior to age 18. Exposure to ACEs has been associated with adverse health outcomes. Courtney W. Brantley, MD, Brian Lurie, MD, Sydney Primis, MD, Sara Horstmann, MD, Carolinas Medical Center, Charlotte, NC.

Background Adverse Childhood Experiences (ACEs) are traumatic events that occur prior to age 18. Exposure to ACEs has been associated with adverse health outcomes. Courtney W. Brantley, MD, Brian Lurie, MD, Sydney Primis, MD, Sara Horstmann, MD, Carolinas Medical Center, Charlotte, NC.

Background Adverse Childhood Experiences (ACEs) are traumatic events that occur prior to age 18. Exposure to ACEs has been associated with adverse health outcomes. Courtney W. Brantley, MD, Brian Lurie, MD, Sydney Primis, MD, Sara Horstmann, MD, Carolinas Medical Center, Charlotte, NC.

Background Adverse Childhood Experiences (ACEs) are traumatic events that occur prior to age 18. Exposure to ACEs has been associated with adverse health outcomes. Courtney W. Brantley, MD, Brian Lurie, MD, Sydney Primis, MD, Sara Horstmann, MD, Carolinas Medical Center, Charlotte, NC.

Background Adverse Childhood Experiences (ACEs) are traumatic events that occur prior to age 18. Exposure to ACEs has been associated with adverse health outcomes. Courtney W. Brantley, MD, Brian Lurie, MD, Sydney Primis, MD, Sara Horstmann, MD, Carolinas Medical Center, Charlotte, NC.

Background Adverse Childhood Experiences (ACEs) are traumatic events that occur prior to age 18. Exposure to ACEs has been associated with adverse health outcomes. Courtney W. Brantley, MD, Brian Lurie, MD, Sydney Primis, MD, Sara Horstmann, MD, Carolinas Medical Center, Charlotte, NC.
been associated with negative health outcomes including developmental delay and mental health conditions. ACEs are common and there are ~17,000 children in our county with exposure to 2+ ACEs. Studies show early resource utilization and promoting resilience can combat the effects of ACEs, however many individuals are not using resources.

**Aim Statement**
This project is aimed at improving screening and recognition of ACEs to allow for referrals to resources in order to decrease effects from ACEs. Our goal is to screen 75% of children ages 0-5 for ACEs during well visits. For those who screen positive (score of 4+), our goal is to refer to resources 75% of the time. The project also focuses on improving provider knowledge of ACEs with a goal of 75% of residents reporting feeling at least “somewhat comfortable” with ACEs screening. This project takes place at Myers Park Pediatrics in the Resident Continuity Clinic and involves children ages 0-5 years. The project was initiated in March 2018 and is ongoing.

**Interventions**
Visual prompts were placed on workstations to help registration staff and providers remember which visits the screening was scheduled to take place. Scoring instructions were placed on the form. After initial data showed many screens were left incomplete, scoring instructions were taken off the form to encourage more families to complete the form without fear of a SW consult which was originally listed on the form. Provider education including Resilience screening and lectures were provided to increase knowledge about ACEs and allow providers to understand the importance of screening. A cover sheet was also placed on the screening form and was edited to provide families more information on why screening was being performed. Measures

- **Outcome measures** included % of children ages 0-5 that are screened for ACEs and % of children ages 0-5 with positive screens that are referred with the goal for both being 75%.
- **Process measures** included % of residents trained in ACEs screening, % of front desk staff trained in distributing ACEs forms, % of forms distributed to families, and % of forms completed by families. Balancing measures included 75% of front desk staff will report no change in work flow due to handing out screening and 75% of residents will report that ACEs screening is helping them learn about ACEs and how to manage them. Results The average % of screening for all patients in the targeted population was 57%. At times the percentage of screens was above the goal, however was not sustained. Results demonstrated random variation despite multiple interventions. Only 4 patients had ACEs scores of 4+, however all were referred to resources which was above our goal of 75%.
- **Only 10% of residents initially reported feeling at least “somewhat comfortable” with ACEs screening, however after initiation of the project and further education, 85% of residents reported feeling at least “somewhat comfortable”, with a goal of 75%.** Eighty-six percent of residents reported that they learned from ACEs screening. When assessing balancing measure, 88% of registration staff reported no change in overall work flow. Conclusions and Next Steps ACEs are common and can have many negative health outcomes. Early intervention with resources can promote resilience and prevent negative outcomes. We have been successful in implementing

**Run Charts –ACEs Screening at Myers Park Pediatrics**

| Chart 1: % of children ages 0-5 screened for ACEs at their WCC |

- **ACEs Screen Given at WCC**
  - **Ages 0-5**
  - **4/11-4/12 Myers Park**
  - **Resilience Screening**
  - **Scoring instructions taken off of form**
  - **ACEs Grand Rounds**
  - **Daily check-in with providers (checking in person)**
  - **Changed signs on computers for providers and registration**

**Values**
**Median**
**Goal**
screening in a local clinic, but have not met sustainability. We have been able to educate providers and ensure that there is no negative impact on clinic workflow. We continue to make changes to improve screening and identification of those affected by ACEs to refer them to resources. We have also been chosen to participate in a Pediatric Integrated Care Collaborative which will provide improved education for our providers and more resources to our patients related to ACEs.

106. IMPROVING THE FREQUENCY AND QUALITY OF FEEDBACK RECEIVED BY RESIDENTS THROUGH EDUCATION, REMINDERS, AND INCENTIVES

Anne Kimball, MD, MPH, Jasmine Weiss, MD, Omar Elsayed-Ali, MD, Gargi Mukherjee, MD, Rachel Gillman, DO, Susie Buchter, MD, Rebecca Sanders, MD, PhD, Melissa Adams, MD, David Wolf, MD, PhD, Emory University, Atlanta, GA

Background Feedback is an essential and effective tool for resident learning and improvement. Our residency-wide quality improvement project is focused on feedback, after identifying this as an area for improvement on our annual ACGME survey. The Milestones Guidebook lists the five features of high quality feedback as timeliness, specificity, balance, reflection, and action plans. Our baseline data revealed that, on average, 85% of residents received weekly feedback, and the feedback was rated as 2.9 out of 5 on a Likert scale, with a 3 being moderately helpful. On assessment of quality measures, residents perceived their feedback as 89% timely, 75% specific, 42% balanced, 40% reflective, and 39% actionable. Aim Statement: Our goal is to improve the verbal feedback for residents on all rotations by increasing the percentage of residents receiving weekly feedback by 30%, improving the average Likert score by 1, and improving each quality measure by 30%. Interventions: We used the model for improvement, with resident-designed monthly PDSA cycles, led by the chief residents. PDSA cycle 1 focused on reminders. Biweekly emails were sent to all residents on setting expectations and asking for feedback, and one email was sent to faculty and fellows about the importance of weekly feedback. PDSA cycle 2 focused on education and incentives. Cards were provided to each resident with tips for receiving high quality feedback and a link to log the feedback, for which points were awarded towards the resident’s “House Staff Cup” team. Measures: Data are collected via weekly online surveys, which are disseminated through a QR code at grand rounds to provide protected time for survey response. Results: We have shown improvement in every outcome measure, though not yet to our goal. The frequency of weekly feedback has improved from 55% to 65% after two PDSA cycles. The average Likert score has improved from 2.9 to 3.23. The five quality measures have improved by an average of 28% from baseline. Conclusions: Improvements and Next Steps: Our largest gains after two PDSA cycles have been in the quality measures, which were likely impacted by improved awareness of what constitutes high quality feedback. The frequency of feedback has improved, but not to our 30% goal. Additional cycles will be designed with input from residents with a goal of overcoming barriers such as time constraints and faculty culture. We hope to see improvements in the evaluation and feedback components on our ACGME survey this year.

107. PATHWAYS INITIATIVE TO IMPROVE TRANSITION CARE IN A MED-PEDS RESIDENCY PROGRAM

Robert Sanchez, MD, Erin Hickey, MD, University of Chicago, Chicago, IL, Jessica Gold, MD, Children’s Hospital of Philadelphia, Philadelphia, PA, George Weyr, MD, Nabil Abou Baker, MD, Rita Rossi-Foulkes, MD, University of Chicago, Chicago, IL

Background: Approximately 750,000 adolescents with special health care needs graduate to adulthood annually, often with their health suffering. Less than half receive the services needed for a successful transition. In Illinois, the Division of Specialized Care for Children Family Survey revealed that only 18.2% of youth ages 14-21 received transition services. A recent review demonstrated that almost two thirds of HCT evaluation studies had statistically significant positive outcomes. Another study demonstrated that providing HCT services resulted in a 28% reduction in per member per month total cost driven by reductions in hospitalization and ED visits. Aim Statement: 1. Increase HCT services for youth and young adults with special health care needs (YASHCN) in a Med-Peds residency practice (10% per year). 2. Increase HCT consultations for YASHCN (10% per year). 3. Improve HCT knowledge, attitudes and practices among Med-Peds residents. (improve annually). 4. Provide Med-Peds residents with a longitudinal QI project aligned with ACGME requirements. Interventions: PATHways is a residency-based HCT consultative service founded to improve health for YASHCN and provide HCT education to residents. PATHways’ QI initiatives are modeled after Gottransition’s Six Core Elements. A HCT policy was disseminated. EMR tools were developed to assess HCT skills and create portable health summaries. A registry of over 200 YASHCN aged 14-26 in the practice was created. Formal HCT education was provided to residents through HCT consultations. Measures: 1. Baseline and annual follow up HCT knowledge,
attitude, and practices survey of residents. 2. Baseline and annual follow up audits of patients in the HCT registry addressing key elements (readiness assessment, HCT planning, creation of portable health summaries). 3. Tracking of consultations: Requesting services, diagnoses, HCT services provided. Results: 33 consultations were provided over 18 months and were received from 9 different services with Pediatrics comprising 70%. Autonomy planning and completion of portable health summaries comprised the majority of consultations (80%). Consultations also aided in guardianship (43%), insurance and income support planning (67%), and identifying adult providers (20%). Residents surveys demonstrated increased HCT knowledge. Residents correctly identified the ages to introduce HCT, begin HCT planning, and prepare for transfer (scores increased by 8%, 21%, and 8%, respectively). They were able to identify specific tools for HCT including the clinic's policy and registry. After one year, 42% of residents stated that they addressed HCT readiness often in their practice, increased from 18%, and no residents reported not ever addressing HCT, improved from 38%. Residents reported providing more frequent guidance on education, insurance planning, registering for adult services, guardianship assessment, and identifying adult providers. Residents reported feeling more empowered and engaged in caring for YASCHN. Baseline and follow up chart audits demonstrated that readiness assessment improved from 10 to 50%, transition planning improved from 20 to 60% and creation of portable health summaries improved from 5 to 45%. Conclusions and Next Steps: The PATHways initiative is a feasible way to improve HCT for YASCHN and resident HCT knowledge, attitudes and practices. Next Steps: 1. Utilize the EMR's new feature, Slicer Dicer for transition registry management and chart audits. 2. Mailers and EMR messages will be sent to all patients in the transition registry directing them to schedule a HCT appointment. 3. Continue to raise awareness about the PATHways consultation services.

108. HEPATITIS B VACCINATION IN DUKE UNIVERSITY AND DUKE REGIONAL HOSPITAL NEWBORN NURSERIES
Govind Krishnan, MD, Matthew R. McCulloch, MD, Sarah Germana, MD, Sophie Shaikh, MD, Jane Trinh, MD, Eve Hammett, CNM, Carleen McKenna, RN, Jazmine Staton, MS, Duke University Hospital, Durham, NC

Background: Vertical transmission continues to be a mode of Hepatitis B virus (HBV) infection despite implementation of prenatal maternal screening. HBV vaccination induces seroprotection in 98% of term infants. The CDC recommends that all infants should receive the first dose of hepatitis B vaccine at birth or within the first 12-24 hours of life before they leave the hospital. Nevertheless, HBV vaccination rates prior to discharge were sub-optimal in the Duke newborn nurseries, which consist of the main Duke University Hospital (DUH) nursery and the community-based Duke Regional Hospital (DRH) nursery. Aim Statement: We aimed to increase all HBV vaccination rates from a baseline of 94% to 96% at the DUH and from 88% to 90% at the DRH nurseries within 1 year. Interventions: Baseline HBV vaccination rates were obtained from the electronic medical record (EMR) by using the 12 months preceding first intervention. The first intervention educated clinicians and nurses on the updated CDC guidelines by displaying posters in work areas. The second intervention aimed to increase project awareness among nursing staff in the nursing newsletter. The third intervention was an interdisciplinary effort among the nursing, physician, and pharmacy teams to coordinate administration of the HBV vaccine with the routine administration of vitamin K injection and erythromycin eye ointment at delivery. Measures: After each intervention, a PDSA cycle was completed, assessing vaccination rates over the next three months on average. We assessed the effect on nursing workflow through a survey as a balancing measure. Results: At both DUH and DRH nurseries respectively, we saw the rates of HBV vaccination increase slightly from baseline rates of 88% and 94% to 92% and 95% after the first two cycles. The third intervention at DUH resulted in a robust response in vaccination rates (up-trending to 95.8% in the month of November). Rates have been above the means for 7 and 10 consecutive months for DUH and DRH since the project began. Conclusions and Next Steps: We have demonstrated a trend in improvements in HBV vaccination rates in the DUH and DRH newborn nurseries over several PDSA cycles. Most notably, the multi-disciplinary intervention of administering HBV with the vitamin K injection and erythromycin eye ointment at DUH had a marked impact. Continued multi-disciplinary efforts to improve HBV vaccination in the newborn nursery at both hospitals will optimize the care of newborn infants in prevention of HBV.

109. IF YOU CALL IT, WILL THEY COME?: USING QUALITY IMPROVEMENT METHODOLOGY TO IMPROVE RESIDENT CODE TEAM LEADERSHIP SKILLS
Amanda J. Rogers, MD, Medical College of Wisconsin Affiliated Hospitals, Milwaukee, WI

Background: Management of an acutely ill or decompensating child is pivotal to a pediatric resident's training. Pediatric physicians should be prepared to recognize and respond to pediatric emergencies. Starting in 2014, senior residents in our program were designated as the code team leader on even days. Subsequent data demonstrate that residents rarely led codes...

---

*Poster Abstracts*
on even days. We therefore developed a quality improvement initiative to improve resident code team leadership skills. Aim Statement Our primary aim was to increase the percent of even day codes led by a resident to 50% by May 2018. Interventions A needs assessment survey was conducted to identify barriers to resident code team leadership. A fishbone diagram developed to categorize barriers to target. Plan Do Study Act cycles were conducted to implement and test various interventions including a simulation-based workshop on code team leadership, data sharing about code events, and just-in-time resources addressing common questions. Measures Outcome measures included the percentage of even day codes led by resident. Process measures included resident self-confidence in their code team leaders. Balancing Measures included the percent of even day codes with subsequent negative events. Results Baseline data demonstrated no even day codes led by residents. Special cause variation was seen following interventions of simulation-based education and just-in-time training with 40% of codes led by senior residents. Improvements were sustained throughout the academic year. Conclusions and Next Steps Using quality improvement methodology we were able to successfully increase the number of codes led by senior residents without increased negative outcomes. Future interventions will aim at sustaining improvement into a new academic year.

MPPDA POSTERS 110-126
110 MPPDA Accreditation Committee
111 MPPDA Curriculum Committee
112 MPPDA Recruitment Committee
113 MPPDA Research Committee
114 MPPDA Transitions Committee
115-126 MPPDA Transitions Learning Collaborative

- Teaching Residents about Health Care Transition
- Supporting Programs to Implement HCT Curricular Activities
- Developing an EPA-Based Evaluation Tool for HCT
- Med-Peds Residents: Knowledge and Attitudes on Health Care Transition
- Transition Care Models
- Teaching Transition as Tidbits at the University of Louisville
- Advancing Transition Assessment
- Key Stakeholder Interviews to Inform a Transition Curriculum for Housestaff
- First Steps in Developing a Transition Care Curriculum for Med-Peds Residents at the University of Colorado
- Loyola Transition Curriculum
- Health Care Transition Challenges When Teaching Med-Peds Residents
- Health Care Transitions (HCT) Residency Curriculum Collaborative Improvement Network (CoIN) Medical College of Wisconsin (MCW) Med-Peds Projects
- Introduction of a Peer-Led Didactic Series on the Transition from Pediatric to Adult Care in a Combined Med-Peds Residency Program

Transitions Learning Collaborative participants:
Alice Kuo, MD; Priyanka Fernandes, MD; Eric Ayers, MD; Laura Bishop, MD; Laura Chady, MD; Ishita Datta, MD; Tom Davis, MD; Nathan Derhammer, MD; Peter Dunbar, MD; Colby Feeney, MD; Sara Gardner, MD; Suzanne McLaughlin, MD; Leisa Lowery, MD; Sarah Mennito, MD; Teresa Nam, MD; Ellen Parker, MD; Pavan Srivastava, MD; Niraj Sharma, MD; Jonathan Tolentino, MD; Julie Venci, MD; Jennifer Walsh, MD; Lori Wan, MD; Ron Williams, MD; Laura Workman, MD
APPD Mobile APP Available
All you need to know about the Annual Meeting is now available on the APPD Mobile APP. For downloading information, please see the insert provided at registration.

Photo Release
By registering for the APPD Annual Meeting, attendees consent to be photographed during the course of the meeting, with the understanding that these images will be used in APPD documents and publications only. If anyone prefers to not have their photo used by APPD, please contact info@appd.org. We also request that you notify the photographer at the time a photo is being taken in which you may be included.

Live-Streaming / Recording Prohibited
The use of live-streaming devices and other recording devices during the APPD Meeting is prohibited.

Mother’s Room
In order to provide privacy and convenience to breastfeeding mothers, the Iberville Room (4th floor) has been reserved each day from 8am-6pm.

Luggage Storage
As you check out of your hotel rooms on Friday morning, you may store your luggage in Studio 1-2 on the 2nd floor. Please note that luggage will be left at your own risk, with neither APPD nor the New Orleans Marriott Hotel assuming any responsibility for your belongings.

CME
CME credit for physicians for the APPD program is included in your registration fee. Please see the insert provided at registration for details on how to receive credit.

Management Team
Laura Degnon, CAE, Executive Director       Kathy Haynes Johnson, Associate Director
laura@appd.org                              kathy@appd.org
Rosemary Haynes, Association Manager       Jen Billingslea, Association Manager
rosemary@appd.org                           jenb@appd.org
Daglyn Carr, Association Administrator     Beth King, LEARN Program Manager
daglyn@appd.org                             beth@appd.org

APPD is managed by Degnon Associates, Inc.
APPD Members: Please consider applying for this fantastic leadership opportunity.

Competencies:
- Experience in planning educational and scientific meetings
- Active participation and presentation at APPD Meetings and other national conferences
- Organizational skills to adhere to deadlines
- Leadership to make decisions quickly and appropriately
- Ability to lead conference calls to guide group discussion in an organized fashion
- Delegation skills to share responsibilities and provide opportunities for leadership in others
- Prior experience reviewing APPD and/or PAS abstracts
- Familiarity with CME requirements and process
- Willingness to commit 1-2 hours weekly during fall and winter, increasing to 5-6 hours per week for a week during two busy review and notification periods, and perhaps up to 8-10 hours per week for a week or two total during review process for individual Enhanced Learning Sessions (formerly workshops) and Educational Scholarship and QI abstracts, including abstract review and group rank discussions
- Enjoy the process - it’s so much fun to see what everybody is doing!!

Interested candidates should submit a brief application to info@appd.org to include
  1. list of relevant experience
  2. paragraph describing interest
  3. priorities for the APPD Annual Spring Meeting

For additional information on duties and responsibilities, please go to www.appd.org/pdf/AppDSpringMtgProgPlanningExecCtte_RolesResp_Rev2018.pdf

The 2019 Program Chair, Adam Rosenberg, would also welcome your questions about his experiences with this process. Please contact him at Adam.Rosenberg@childrenscolorado.org or talk to him during the meeting.

The APPD Board of Directors will review all of the applications and invite the best applicant to serve.

Deadline to apply is May 10.
APPD Global Pediatric Educator Scholarship Recipients

For the third year, the APPD Global Health Learning Community is delighted to welcome two recipients of the APPD Global Pediatric Educator Scholarship. Many pediatric educators from around the globe seek to improve child health by advancing pediatric education in their countries, but often lack access to the educational resources we enjoy through professional associations and conference attendance. Our goal is to recognize pediatric educators who demonstrate early leadership in improving pediatric education in low and middle income countries, and to provide them with additional career development and/or networking opportunities by inviting them to attend the APPD spring conference. We hope that by sharing educational resources and fostering collaboration with these colleagues that we will further the goal of ensuring the health and well being of all children everywhere.

Bigirimana Zepherin, MD
Unilurio University
Nampulo, Mozambique

Dr. Bigirimana Zepherin graduated from Kubansky State Medical Academy in Krasnodar City, Russia in 1996. He worked as a general practitioner in Mozambique from 1996 to 2001. He then enrolled in the pediatric residency program in Maputo-Mozambique, graduating as a general pediatrician in 2005. He worked clinically in the Pediatric Department of Hospital Central de Nampula, laying groundwork to start a pediatric residency training program. In 2010, the Department was nationally accredited to start residency training in General Pediatrics, initially training for two years with training completed with an additional two years in Maputo. Since then, they have trained and graduated 6 pediatricians, with 3 of them are now hired by the Pediatrics Department. They have since expanded to a 4 year residency program, no longer reliant on training in Maputo. They currently have 15 pediatric residents.

Dr. Zepherin is Director of the Pediatric Residency Program and Chair of Pediatrics at Unilurio University in Nampula. He is a Member of the National Examination Board in Pediatrics. He is also Coordinator of Pediatric Research in Hospital Central de Nampula for three main areas of research: Pediatric Infectious Diseases, Neonatal Health and Pediatric Nutrition. His clinical research interest is in Nutrition.

Msandeni Esther Chiume, MBBS, FCPaeds(SA), MScTropPaeds(UK)
Lilongwe, Malawi

Dr. Msandeni “Sandy” Chiume is a 36-year-old Pediatrician, currently serving as Head of Pediatrics and Child Health Department at Kamuzu Central Hospital (KCH) in the Ministry of Health, a major referral center in Lilongwe, the capital city of Malawi.

In the year 2006, she graduated as a medical doctor from the University of Malawi –College of Medicine. Thereafter, she went through internship for 18 months before joining the Ministry of Health up to date. In the Ministry of Health, she has served as a Senior Medical Officer and District Health Officer, overseeing delivery of health services in the districts of Dowa, Lilongwe and Chiradzulu, for a period of 3 years. Later, she was granted a National Aids Commission of Malawi grant to pursue specialist training in Pediatrics. During the period, she received yet another scholarship, a Thomas Mark award to study at the University of Liverpool for a Master of Science degree in Tropical Pediatrics. After successfully finishing her studies in Liverpool, she proceeded to the University of Pretoria to complete the pediatric training. She is one of the exceptional pediatricians who returned back to Malawi to serve her community after graduating in 2015.

Apart from her clinical and management duties at KCH, she perform other duties in the following roles:

- Part-Time clinical lecturer at College of Medicine
- Lead consultant in the PACHIMAKE (Pediatric Alliance for Child Health Improvements at Kamuzu central hospital and its Environ) group
- Board member of Parent and Child Initiative (PACHI)
- Member of the National Polio Executive committee
- Member the National Newborn steering committee
- Member of National Malaria control programme technical working group
Are you involved in medical education and want to advance your educational development to improve yourself and your residency or fellowship program?

APPD LEAD can help you meet those goals.

APPD LEAD is an approximately nine-month educational program that provides outstanding training for educators aspiring to develop the knowledge and skills needed to become leaders in medical education.

The program features:

- Three educational conferences: the first is a stand-alone 3-day meeting followed by a 2-day meeting associated with the Fall and Spring APPD meetings
- Curriculum focusing on organizational leadership, competency-based curriculum development, faculty development, residency and fellowship program administration and scholarship and career development
- Nationally recognized faculty with significant experience in program leadership and medical education
- Peer group activities and support
- Mentored educational project
- A certificate given upon completion of all required program elements

Apply now at www.APPD.org!
APPD Forum for Fellowship Directors at PAS

Baltimore Convention Center
Baltimore, Maryland

Friday, April 26, 2019
8:00am-5:00pm

Registration Now Open!
www.appd.org/meetings/
FellowshipMeeting2019Prelim.pdf

APPD 2019 Annual Fall Meeting

September 26-27, 2019
Renaissance Arlington Capital View
Arlington, Virginia

APPD 2020 Annual Spring Meeting

March 30-April 2, 2020
Sheraton San Diego Hotel & Marina
San Diego, California

Watch for more information coming soon to www.appd.org!