Boston Children's Hospital
Until every child is well™

GME ON-CALL

Volume 7 ,Issue 2 Winter 2016

Message From the Co-Chairs

Alan Woolf, MD, MPH, Debra Boyer, MD

In the GME Office, we are focused on a number of very promising developments in medical education at BCH. The faculty and trainees involved with the Task Force on Strategic Planning in Medical Education, which issued its final report in May of 2015, gathered for its final meeting on December 1st to hear from our Chief Operating Officer, Dr. Kevin Churchwell. Dr. Churchwell celebrated the work of the Task Force over the past two years and outlined the BCH administration's plans for the new Department of Medical Education going forward. Read details about this exciting new approach to medical education at the hospital elsewhere in this newsletter. tion at the hospital elsewhere in this newsletter. Three educational retreats have been held so far this Fall-Winter at BCH: a two-day retreat for the Boston Combined Residency Program on November 20 and 21st, a GME retreat for training program directors on December 2nd, and a BCH Academy retreat on January 8th. Details can be found elsewhere in this issue.

Comings & Goings:

We would also like to congratulate **Jonathan Hron, MD** on the accreditation of the Clinical Informatics Fellowship. The program will have its first fellow on July 1, 2016. We want to take this opportunity to welcome **Michael Hernandez, MD**, Program Director for Pediatric Anesthesiology. He takes over for **Robert Holzman, MD**, who remains in the program as faculty;. We would also like to thank Dr. Holzman for all of his efforts as program director.

We want to take this opportunity to welcome **Michael Hernandez, MD**, Program Director for Pediatric Anesthesiology. He takes over for **Robert Holzman, MD,** who remains in the program as faculty. We would also like to thank Dr. Holzman for all of his efforts as program director. We would also like to welcome **Sandra Korpalska**, fellowship coordinator for Pediatric Nephrology, who replaces **Page Metcalf**, and **Magan Oliveira**, fellowship coordinator for Pediatric Dermatology, who replaces **Diane Lysak**. Thank you to Page and Diane for all their hard work and welcome to Sandra and Magan. We would like to congratulate **Joyce Patterson**, coordinator for the Pediatrics residency, on her retirement and welcome **Rebecca Gold** into the position.

The Boston Combined Residency Program (BCRP), ably led by Drs. Ted Sectish at BCH and Bob Vinci at Boston Medical Center, the GME Office's educator Dr. Ariel Winn, and by the BCRP's Chief Residents has continued to put forward new ideas to promote the scholarly interests and careers of BCH residents. One such new idea – that of sorting the program's 135 residents into affinity groups called 'Resident Academies', has been rolled out over the past two academic years.
The GME Office again is sponsoring the core curriculum "Strategies for Academic Success (SAS)" during the 2015-16 academic year intended for residents and fellows. This outstanding and innovative hospital-wide trainee development program includes five sessions each academic year

Inside this issue:

and covers curricular content in the areas of leadership and teaching skills, career planning, the pursuit of a 'professional development plan', and quality improvement research. Our new GME educators, Drs. Diane Stafford, Ariel Winn, and Debra Boyer, the GME Committee Co-Chair, have been working together to develop the curricular offerings planned for the 5 sessions that are anticipated over the academic year. The first two sessions of SAS were held on October 28th and December 3rd. Two more sessions are planned early in 2016. The dates are March 14th and May 9th.

Discover some of the details of the purposes and functioning of these new academies elsewhere in this edition of GME On-Call.

Don't forget to put some important GME dates in your smartphone. Upcoming meetings of the hospital-wide GME Committee will be held on **Monday February 22nd from 5-6pm**, in the G**arden Conference Room, Wednesday March 9th from 4:00-5:00pm** in the **Enders Building, Byers Room B**, and on **Wednesday April 6th at 4:00-5:00pm** again in the **Byers Room B of the Enders Building**. All training program directors, associate directors, coordinators, and resident/fellow representatives are invited to attend.

The **Teaching Academy at HMS** will hold its regular medical education grand rounds on Wednesday March 2nd on April 6th, both to be convened in the Medical Education Center (TMEC) on Longwood Ave (room TMEC250) from 4:30-5:30pm. The Academy will also sponsor a symposium by the mentoring special interest group to be held on Thursday March 10, 2016 from 3:00-6:00pm. Finally the Academy's Spring membership meeting is planned for Wednesday March 9th from 4:00-5:30pm. Mark your calendars for the Academy's Spring Symposium on the Science of Learning "Bouncing Back: The Science of Resiliency" to be held at the TMEC in the 2nd Floor Atrium on Thursday April 28th from 9:30am-12:00 Noon.

The ACGME will hold its annual meeting in the Gaylord Hotel at National Harbor, Maryland, from February 25th to 28th. And mark your calendars for GME Day at BCH which will be held on Wednesday May 11th this year. There are a lot of exciting events this Winter and Spring to keep you moving forward towards your goals in GME!

Coordinators Corner

Kaytlyn Darling -Adolescent/Young Adult Medicine

Most programs are tasked to complete multiple required evaluation methods including milestones, feedback sessions and annual reviews. Adolescent Medicine also utilizes the annual subspecialty in-training examination (SITE) scores to revise the curriculum and to inform trainees' individual learning plans (ILPs) in anticipation of their taking the Adolescent Medicine Board Examinations following graduation.

SITE scores are confidentially reviewed at the bi-annual meeting of the program evaluation committee (PEC). Scores are reviewed anonymously since a senior-level trainee is on the PEC each year. Areas of curricular weakness are identified and curricular changes/augmentation are considered.

If it is determined that a low score is unique to a specific fellow then feedback and an improvement plan is incorporated into that fellow's ILP. This ILP is developed six months into fellowship training by the trainee and program director (PD) and is reviewed bi-annually at mid-year and end-of-year evaluation meetings between the trainee and the PD. Although SITE scores are only a fraction of the ILP, incorporating test scores helps to prepare the fellow for the Adolescent Medicine Board Examination. Test questions can be enigmatic and at times esoteric. Focusing on board scores as part of the ILP helps the fellow to identify weaknesses in both knowledge and study techniques that are specific to the actual examination.

To date Adolescent Medicine has not analyzed how closely BCH SITE scores predict Board scores; however, this is considered an area for development. Future quality improvement plans include tracking and analysis of both SITE scores and Adolescent Medicine Board examination scores to identify topical areas where testers struggle. These areas could then be highlighted in the learners' ILP, and the Curriculum Committee could consider adding sessions or cases into the curriculum to further cover these topics.

By the Numbers

AAMC Data for 2015-2016

52,550

applicants to medical schools for 2015 -2016

20,631

matriculants to medical schools for 2015-2016

7,015

applicants to Harvard Medical School for 2015-2016

700

Sponsoring Institutions

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By the Numbers

More AAMC Data for 2015-2016:

165
matriculates to Harvard Medical School for 2015-2016

850
students at Harvard Medical School for 2015-2016

7,480
applicants to Pediatrics residencies

Teaching Medical Students –Some Practical Pointers

Each year more than 130 Harvard medical students (HMS) participate in their introduction to clinical pediatrics teaching sessions at BCH. Another 130 4th year HMS take elective rotations at BCH, with cardiology, infectious diseases, emergency medicine, endocrinology, genetics, and ambulatory pediatrics being the most sought after electives. In addition, many more students from other medical schools also come to BCH for elective rotations to take part in athe variety of outstanding learning opportunities in pediatrics it offers. Faculty, residents, and fellows are reminded of their teaching responsibilities in helping students make the most of their time with us. Some practical pointers are listed below:(Table modified from: Pediatrics 2015; 136 #1 July)

Positive Learning Environment	Practical Ways to Make This Happen
Preceptor aware of resources available at course/ clerkship and institution level	Have a list of contact names and numbers for student affairs, mental health support, clerkship director, etc.
Students feel expected	Contact students before rotation. Explain where to park, when and where to arrive, how to dress, what to bring.
Students feel welcome	Orient students upon arrival. Give them a place to put their coat, backpack, lunch, etc. Introduce student to nurses, receptionist, and other people in learning environment.
Students have a space to learn	Allow students to use your internet, textbooks. Ideally, desk or some sort of space for students
Students have autonomy	Ideally, have students start patients on their own while the preceptor continues to see other patients.
Students are part of learning process	Make sure students are aware of, and contribute to, objectives and learning schedule.
Communication is open	Model open communication with students and all members of the health care team.
Preceptor aware of resources available at course/ clerkship and institution level	Have a list of contact names and numbers for student affairs, mental health support, clerkship director, etc.
Students feel expected	Contact students before rotation. Explain where to park, when and where to arrive, how to dress, what to bring.
Students feel welcome	Orient students upon arrival. Give them a place to put their coat, backpack, lunch, etc. Introduce student to nurses, receptionist, and other people in learning environment.
Students have a space to learn	Allow students to use your internet, textbooks. Ideally, desk or some sort of space for students
Students have autonomy	Ideally, have students start patients on their own while the preceptor continues to see other patients.
Students are part of learning process	Make sure students are aware of, and contribute to, objectives and learning schedule.
Communication is open	Model open communication with students and all members of the health care team.
Observation occurs	Observe students in a focused, direct way.
Feedback occurs regularly	Provide concrete feedback
Students have opportunities to show their progress	Provide opportunities to practice after feedback, then observe the targeted skill again, so that students can demonstrate progress.

Questions are asked in a respectful way	Pay attention to how questions are asked. Construct questions based on students' ability.
The environment is respectful	Model respectful communication with students, patients, families, and all members of the health care team.
Students have ample time to learn and participate in other activities (concept of wellness)	Schedule time for students to study on their own as well as time for students to pursue outside interests.
Students feel supported	Inquire as to how students are doing. Direct students to student affairs office, faculty advisor (if applicable), and other resources at medical school if needed.
Students receive assistance in realizing the meaning of learning	Articulate how learning will positively influence students' roles as future physicians.
Students are excited to learn	Create an environment in which students are eager to participate and learn
Student roles are clear	Make expectations clear. Make sure students understand their roles and the roles of all members of health care team.

Housestaff Invited To Enroll in State's Prescription Monitoring Program

Alan Woolf, MD, MPH
Associate Chief Medical Education Officer & DIO

Massachusetts is in the grip of a narcotics epidemic of addiction, overdose, and death. More than 1000 people in Massachusetts died from heroin or other opiates in 2014, a 3.3% increase from 2013. And pharmaceuticals containing controlled substances have played a large role in this abuse epidemic. As one strategy in curbing opiate prescription duplication and diversion and to insure safe prescribing, the state has developed a online Prescription Monitoring Program (PMP).

The PMP is a repository for a patient's history of receipt of Schedule II-V prescriptions for the previous 12 months. Data is reported into the PMP within one business day by all Massachusetts pharmacies and out-of-state pharmacies delivering to people in Massachusetts. To guarantee patient confidentiality and ensure absolute privacy of patient health information, the PMP operates exclusively on a secure web portal and requires nothing more than the entry of basic patient demographic information (name, date of birth, gender, and address). Additional information such as prescriber name, name of the medication, directions for use, and quantity to be dispensed are also required. PMP conforms to all state and federal regulations and policies regarding patient privacy and confidentiality of over 50 million patient prescriptions. The data available on-line in PMP informs clinical decision-making. Using on-line PMP resources, physicians, dentists, podiatrists, advanced practice nurses and physician's assistants, and pharmacists (and state and federal investigative agencies) can review a patient's history of receipt of prescriptions for controlled substances for the past year, in order to discover whether there has been over-prescribing, duplicate prescriptions, or drug-seeking behaviors or diversion.

However physicians-in-training have not previously been participants in PMP, even though they are writing opiate prescriptions in the emergency department, in the outpatient clinics, and in their discharge planning for patients leaving the hospital ward. Thus a whole group of physicians who write prescriptions have been left out of PMP. Now that's about to change in 2016, with the encouragement of Governor Baker's Opioid Working Group, the Executive Office of Health & Human Services of Massachusetts, and the the Office of Prescription Monitoring and Drug Control in the Bureau of Health Care Safety and Quality in the Massachusetts Department of Public Health (Tel: 617 753 7310 or 617 983 6700).

This initiative aims to enroll interns, residents, and clinical fellows voluntarily in PMP, namely those trainees

By the Numbers

More AAMC Data for 2015-2016:

33
applications submitted by candidates for Pediatrics residencies

986
applicants to Child Neurology residencies

10
applications submitted by candidates for Child Neurology residencies

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Alphabet Soup

ABMS
American Board of Medical Specialties

ACCME
Accreditation Council for Continuing Medical Education

CMSS
Council of Medical Specialty Societies

POSNA
Pediatric Orthopaedic Society of North America

who are currently practicing only on a limited, hospital-based medical license by virtue of their training status. All of the Massachusetts teaching hospitals, through their Offices of GME, are collaborating in this initial effort to enroll as many physician trainees as possible. Housestaff who, for moonlighting or whatever reason, hold a full Massachusetts medical license are not included in this initiative; they are mandated to enroll on their own as active Massachusetts practitioners.

Through its Medical Staff Registry and Office of GME, BCH is an active participant in the PMP. We encourage all of our trainees to become familiar with PMP and to sign up as soon as possible. We all need to work together to stem the devastating effects of narcotics abuse on families in Massachusetts. For more information, go to:

http://www.mass.gov/cohhs/gov/departments/dph/programs/hcq/drug-control/ma-online-prescription-monitoring-program/

New Medical Education Plans Announced

The Chief Operating Officer (COO) of Boston Children's Hospital, Dr. Kevin Churchwell, announced at a meeting of the Task Force on the Strategic Plan for Medical Education, on December 1st the key elements of a new 3-year strategic plan for medical education. As a cornerstone of the strategic plan, the Hospital has authorized the creation of a new Department of Medical Education (DME). Dr. Churchwell also announced the appointments of Dr. Alan Leichtner as Chief Medical Education Officer and Dr. Alan Woolf as Associate Chief Medical Education Officer to lead the new Department. The DME will consist of four components: the Office of Continuing Medical Education, the BCH Academy for Innovation in Education, the Office of Graduate Medical Education, and the Liaison Office for Medical Student Education. Two new committees, comprised of representatives from key programs at BCH, will provide operations advice and guidance to the DME. The DME's new Chief will report directly to the COO and the Hospital's Medical Staff Executive Committee.

Dr. Leichtner, outlined plans to hire an educational specialist, an administrative assistant, and several other new staff members to create a core group. The DME's central office will likely be housed in new space at the Landmark Center. Dr. Leichtner noted that the DME will embark on new initiatives to improve the clinical learning environment, provide new approaches to clinical learning, encourage interprofessional education and educational research, solicit new ideas on faculty development, and encourage innovation.

Dr. Churchwell observed: "This is an promising new direction for our shared vision of medical education at BCH." The new DME will leverage the considerable training and education-related resources at BCH in a more coordinated, efficient plan of operations. We look forward to forging new alliances and taking advantage of opportunities to work together collaboratively.

BCRP Strategic Planning Retreat

By Ariel Winn, Ted Sectish, Kate Michelson and Bob Vinci

The Boston Combined Residency Program hosted a strategic planning retreat in the fall of 2015 with the goals of redefining the program's mission, vision and values and developing a list of prioritized goals that the residency should aim to achieve over the next seven years. Planning for the retreat began in July with invitations to participate to key stakeholders, continued through August as surveys were administered to current and past residents, program leadership and division chiefs, and culminated with a 2 day in person session from November 20th through November 21st of 2015. Many members of the residency community were involved in the in person retreat including resident representatives, chief residents, program leadership, invited faculty from Boston Children's Hospital and Boston Medical Center and several outside consultants. The retreat focused on three domains- clinical excellence, leadership development and resident experience.

The residency program's mission, vision and values were redefined through the process with the new version as follows:

Mission	Vision	Values
The BCRP is dedicated to providing outstanding (world-class) clinical training that: • Prioritizes clinical excellence • Aligns to the interests and goals of each resident • Fosters the acquisition and strengthening of leadership and advocacy skills • Creates an environment conducive and supportive of scholarship and innovation • Optimizes the opportunity to advance the science of pediatrics through research	It is the vision of BCRP that each resident completing our program: • Is an effective leader for child health within any chosen career • Is providing clinical care of the highest quality, optimizing the health and well-being of each child under their care	The BCRP believes that superb training promotes care that is: • Patient and family centered • Longitudinal in perspective • Collaborative • Compassionate and humanistic • Culturally competent • Evidence-based • High-value • Inter-professional • Innovative The BCRP believes that a superb training experience requires commitment to: • Development of the individual as a professional • Life-long learning • Development of leaders capable of driving change • Teamwork • Balance in personal and professional life

Through the process, we have developed some key initiatives. In the next 6 months, the BCRP will launch a **BCRP Wellness Committee** that will be charged with developing and overseeing activities and programs to enhance the personal and professional development of residents. To the same end, we have **designated February as "Funuary"** and will support a series of activities to bring residents and program leadership together to participate in leisure activities. The program is also sponsoring **monthly Town Hall meetings** to discuss key initiatives in strategic planning and to create more opportunities for program-wide discussion and communication.

Starting next academic year, we have **increased the number of supervisory rotations in the junior year. The Stem Cell Transplant rotation has also moved from the senior year to the junior year** when many residents make fellowship decisions. We are also excited to be designing a call-free **resident-as-teacher rotation** that all residents will participate in during their junior year. This rotation will focus on residents gaining practical skills in teaching and supervising. Finally, we are working to implement a **new and enhanced approach to Patient and Family Centered Rounds** that activates, empowers, and engages the patient and family as active participants in rounds based on structured communication principles using the I-PASS mnemonic as an organizing framework.

Over the course of the next 1-2 years, program leadership will work with the Office of Medical Education at Boston Children's Hospital and the Department of Pediatrics at Boston Medical Center to develop a robust **Faculty Development Program** with the goals of enhancing

Alphabet Soup

FSMB
Federation of State Medical Boards

NBME
National Board of Medical Examiners

BORM
Board of Registration in Medicine

ABP
American Board of Pediatrics

APSA
American Pediatric Surgical Association
GI

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Upcoming Events

Strategies for Academic Success

4th Session:
Monday March 14th, 2016

5th Session:
Monday May 9th, 2016

GME Day–
WednesdayMay 11th, 2016

House Staff Orientation:
Friday July 1st, 2016

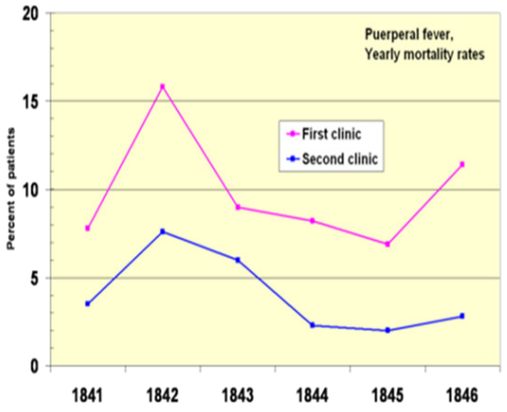
observation, assessment, and feedback; facilitating resident autonomy and empowerment; supporting team leadership; and nurturing resident teaching skills. We plan to introduce a **Leadership Curriculum** that will span the three years and focus on team leadership within the program and ways to be positioned for leadership roles in one's future career. Finally, discussions are already underway about how to innovate our primary care experience across the three years, including plans to design a **longitudinal micro-practice model** and also build a **primary care immersion block** into the junior or senior year.

Housestaff Council for Patient Safety and Quality (HCPSQI) Improvement Newsletter

The History of Quality Improvement

We often think of advancements in medicine as the result of new technology development or cutting edge laboratory research, but some of our most important advancements have come from simple observation and quality improvement. There is perhaps no better example than the work of Dr. Ignaz Semmelweiss. In 1847, Dr. Semmelweiss was a newly appointed house officer at the General Hospital of Vienna in Austria, when he made an interesting observation: women who were delivered by his training physicians were twice as likely to die after childbirth compared to women who were delivered by midwives. As a result, expectant mothers were opting for delivery with a midwife.

In his quest for a solution to this problem, Dr. Semmelweiss decided to observe the activities of the physicians and midwives. That is when he came upon the oldest -and yet still hard to master- problem in clinical medicine: hand washing. Every morning, medical students and physicians rotating in obstetrics and gynecology would spend time dissecting the bodies of women who had died around the time of childbirth, often from sepsis. In the afternoon they would attend the delivery ward. Interestingly, no hand washing was performed in-between. On the other hand, the nurse-midwives did not participate in dissection as part of their practice.



While this is considered "common sense" or standard procedure nowadays, it was revolutionary at the time. Dr. Semmelweiss had realized that disease could be spread by direct contact, at a time when the medical community had little understanding of viruses or bacteria. Dr. Semmelweiss instituted a new program of hand-washing for medical students prior to delivering infants and after dissections in the morning. As a result, the rate of maternal mortality dropped significantly from 17 to <3 percent. Despite numerous publications of his findings, recognition of his contribution to medicine ensued only after his death, when work by Louis Pasteur proved the existence of microbes. To this day, we still strive to improve patient outcomes through infection prevention and daily undertake small cycles of improvement toward that goal. The example of Dr. Semmelweiss should serve as a reminder that there are always opportunities for improvement if we keep our eyes open for them!

Spotlight: The "Autism Friendly Hospital" Initiative

Division of Developmental-Behavioral Pediatrics

Children with Autism Spectrum Disorder (ASD) often require frequent health care services but many have difficulty accessing appropriate care. At Boston Children's Hospital, anecdotes of delayed or missed care are common for our patients with ASD, due in part to parental concerns about their child's ability to tolerate

hospital visits.
Providers from the Autism Spectrum Center have developed a project led by Jennifer Lucarelli MD, a 2nd year DBP fellow at Boston Children's Hospital, along with Laura Weissman MD, a DBP faculty member, and two Staff Psychologists, Leah Wildenger Welchons PhD BCBA and Nancy Sullivan PhD. Through a grant from the BCH Program for Patient Safety and Quality, the initiative aims are to deliver training to non-clinical personnel and evaluate the effect on staff knowledge, comfort and competency in working with patients with ASD. Non-clinical personnel such as front desk staff are often the first contact for patients and their families, The project leaders identified 8 outpatient hospital departments frequented by patients with ASD including: Neurology, Developmental Medicine, Psychiatry, Audiology EEG, phlebotomy and some of the BCH satellite location multispecialty clinics. Participants are expected to complete an online module with basic ASD knowledge followed by an in-person training session tailored to their specific department, including video, case discussion, and reflection. Parents are asked to complete the Autism Barrier to Care Survey, which records their experiences in obtaining recommended care, as well as their overall hospital experience.

To date, 11 training sessions have been conducted for 145 staff members across six of eight target departments. Preliminary data shows a significant change in scores ($p < 0.05$) on 6 questions related to self-reported ASD knowledge and use of strategies to help children with ASD adjust to the hospital environment. On a Program Evaluation, 87% of staff reported they would be able to apply training material "immediately" to their role.

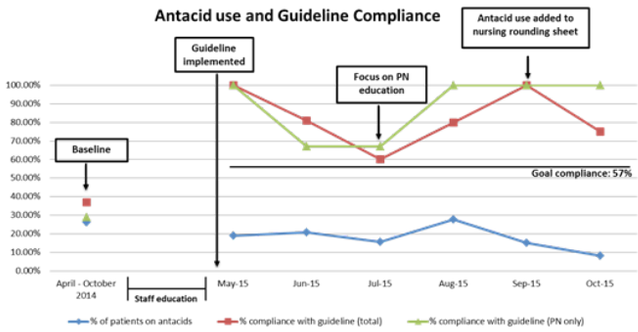
The project leaders are hoping to demonstrate feasibility of this educational model and disseminate the curriculum more broadly throughout our institution (including inpatient units) and potentially to other institutions. Ultimately, this project will increase the capacity of hospital personnel to deliver quality care to ASD patients, and improve the patient and family care experience at BCH and beyond!

For more information on this initiative or if you would like to get involved, you may contact Jennifer Lucarelli (Jennifer.lucarelli@childrens.harvard.edu), Laura Weissman (Laura.Weissman@childrens.harvard.edu) or Nancy Sullivan (Nancy.Sullivan@childrens.harvard.edu).

QI Spotlight: Decreasing non-indicated antacid use in the NICU

Division of Neonatal-Perinatal Medicine

Antacids are used extensively in term and preterm newborns despite limited efficacy and safety data in this vulnerable population. In fact, antacids such as proton pump inhibitors and H2-receptor antagonists have an accruing risk profile related to alterations in the microbiome, leukocyte function and calcium absorption. There is a need to identify appropriate uses for antacid therapy in newborns, supported by best current evidence.



Asimenia Angelidou MD PhD and Katherine Bell MD, 2nd year Neonatology Fellows at Boston Children's Hospital, under the guidance of the BCH NICU Director Anne Hansen MD MPH, have developed this project, seeking to decrease non-indicated antacid use among infants <1 month corrected age through an educational intervention and guideline implementation.

The team performed a retrospective chart review during a 6-month period pre-intervention to assess the baseline rate of antacid administration in the BCH NICU. A guideline was jointly developed by a multidisciplinary team consisting of an attending neonatologist, pediatric intensivist, surgeon, gastroenterologist, and pharmacist collaborating on the project. The guideline was implemented after a 2-month education period of all NICU staff members during monthly staff meetings as well as via e-mail. Trends in antacid administration were recorded monthly and reviewed every 2 months for planning of PDSA cycles. The group also tracked the incidence of side effects that could be attributed to antacid use such as clinical sepsis, necrotizing enterocolitis, and fracture.

Questions? Contact the GME Office
Tery Noseworthy - *Manager*
617-355-3396
Katelynn Axtman - *Senior Administrative Associate*
617-355-4372

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By the Numbers

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Upcoming Events