Title
Organize and Improve Your Clinical Competency Committee With Google Sheets

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34	Biases and Mitigation Strategies	Identify and teach about common cognitive biases and strategies to mitigate them.
35	Time Out!	Use and teach diagnostic time outs while engaging in patient care.
36	Navigating a Minefield	Model behaviors that limit the effect of biases on clinical decision making.
37	Learners Everywhere!	Effectively engage and manage learners of multiple levels.
38	Teaching to Teach	Teach teaching and supervision strategies to senior learners.
39	Milestones	Explain the intended role of the milestones in EM training.
40	Entrustable Professional Activties (EPAs)	Explain the concept of entrustability as it relates to the EPAs.
41	Gimme a Break	Role model breaks in clinical shifts. Help learners take them, too.
42	Your Feedback Sandwich Gives Me Indigestion	Utilize evidence-based feedback frame-works.
43	You Have Needs, Too!	Solicit and incorporate feedback on clinical teaching from learners.
44	Hooray for Science!	Incorporate evidence-based medicine into clinical teaching.
45	What does efficiency even mean?	Help learners reframe their goals to be "efficient."
46	Efficiency is an outcome, not a goal	Teach residents developmentally appropri-ate strategies for improving efficiency.
47	Sign-Outs as Teaching Tools	Use team sign-outs as opportunities to as-sess communication.
48	Optimizing Communica-tion with Consultants	Teach principles that improve communica-tion with other members of the care team.
49	Assessing Communica-tion with Patients and Families	Observe and provide feedback on commu-nication with patients and families.
50	Addressing Practice Variation With Evidence	Assist trainees in putting faculty practice variation into context.
51	Winter Blahs	Share strategies to overcome seasonally-related job frustrations.
52	Happy New Year!	Review mid-year expectations with learners.

29 Organize and Improve Your Clinical Competency Committee With Google Sheets

Fallon T/ Maine Medical Center

Objective: We identified the process of preparation for the Clinical Competency Committee (CCC) meeting as time consuming and prone to individual variability. We aimed to create a data tool that would allow us to easily aggregate, compare, and evaluated data and present this information to our CCC.

Abstract: The clinical competency committee (CCC) must review a broad array of data in an efficient and standardized way. Creation of a structured tool will improve the work of the clinical competency committee and resident assessment.

CCC leaders set out to design a tool that would organize the available data ahead of the CCC meeting, facilitate review of this information by the faculty, and allow for a structured presentation to the committee. We also hoped to reduce the amount of repetitive data entry required by our program coordinator and simplify the process of semiannual review meetings.

A CCC Data Tool was created using Google Sheets. Fields are color coded to identify those that are completed by the program coordinator during a data entry phase as well as those to be completed by the faculty reviewer. A presentation slide is projected during the CCC discussion and used to identify key data. Additional pages present a graph of the 23 milestone scores and aggregate data for export. Color codes are used to highlight milestones where the resident has failed to progress or is more than a standard deviation from the mean for their class. Data is exported using a mail merge to create a semimanual review letter for each resident that can be used by the program director to facilitate the feedback meeting. This ensures that the work product of the CCC is effectively communicated to the resident.

CCC members reported that they would recommend this system to another EM program. Faculty noted decreased time required to prepare for the CCC and a more uniform format to the meeting. Moving forward, we will compare inter-rater reliability amongst faculty and provide ongoing professional development for our CCC members. Our program coordinator estimated that this has reduced her preparation time by over 50% for each meeting and she no longer needs to import hand written data into an electronic format. This system has been adopted by a second EM training program.

Table 1.

Table 2.

30 PEM for EM: A Novel Pediatric Emergency Medicine Curriculum

Schwartz K, Krautwald M, Oyama L, McDaniel M/ University of California, San Diego; Rady Children's Hospital - San Diego

Introduction/Background: Children comprise approximately 20% of the emergency medicine (EM) patient population and graduates of EM residencies report a desire for more training in pediatric emergency care. Expertise from Pediatric EM (PEM) trained physicians may not be available at every institution.

Learning Objective: Design a comprehensive, interactive pediatric emergency medicine curriculum that is translatable to any EM residency.

Curricular Design: A novel PEM curriculum was devised by PEM fellowship trained physicians/educators. Each session comprised a one-hour module on an essential PEM topic. They involved team-based learning, flipped classroom, simulation, procedural workshops, and educational games. Examples included, "The Crumping Newborn," "Pediatric Respiratory Distress Toolbox," "Oregon Trail: Pediatric ID in the ED," and "Magic Bubbles: The Art of the Pediatric Exam, Pain Control, and Distraction." A facilitators' guide, educational resources, and any necessary stimuli were provided to PEM faculty, who led the module and contributed feedback. Learners were EM residents at all levels and some sessions also included rotating EM-bound medical students. Anonymous pre and post-session evaluations were collected.

Impact/Effectiveness: PEM for EM implemented gamification, team-based learning, and simulation to teach essential pediatric EM care. Pre and post-session Likert 1-4 evaluations appraised learner self-assessment of preparation and/or comfort level with common pediatric ED management. The 10 modules, each of which were evaluated individually, showed an increase in confidence level (see Figure 1) and qualitative feedback was overwhelmingly positive. Suggested areas for improvement included requests for follow-up materials, which were incorporated in later sessions, and use of this curricular style in other aspects of didactics. The curriculum is currently in preparation for use at other institutions, including an additional site implemented this year.
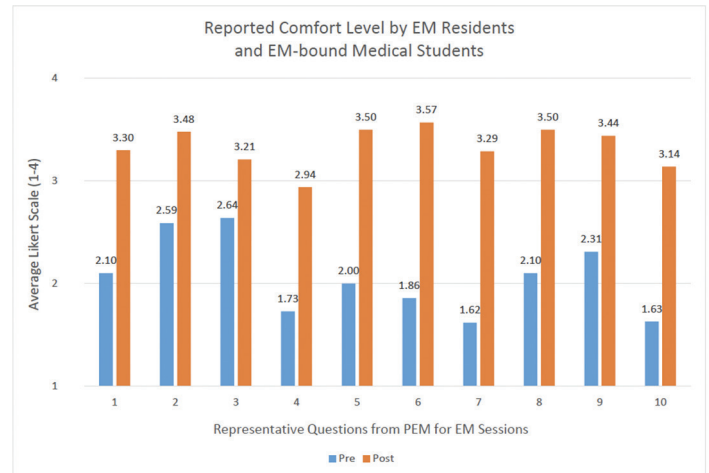
Key: Representative Questions from PEM for EM Sessions
1) Appropriate BRUE Management
2) Abdominal Emergency DDx by Age
3) Common Peds ID Diagnosis
4) Respiratory Support Use
5) U/S for Intussusception
6) Restraint for Procedures
7) Palatable Abx Choice
8) Salter-Harris Fracture Identification/Management
9) High Risk Non-Accidental Trauma Identification
10) Perform Peds GU Exam

Figure 1. Reported Comfort Level by EM Residents an EM-bound Medical Students.

31 Pork Belly Procedural Trainers: Creating Realistic, Cost-effective and Reusable Simulation Tools for Resident Education

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Introduction: The field of emergency medicine (EM) requires physicians to master a variety of different procedural skills. However, many commercially available task trainers and simulation mannequins lack fidelity and are extremely expensive. Often made of plastic or rubber, they make the overall experience unrealistic and unsatisfying. Pork belly with tissue and skin can be used to create several realistic and cost effective procedural trainers.

Educational Objectives: Pork belly simulation trainers (PBSTs) were created with the following educational objectives in mind: 1) provide learners with an authentic procedural experience, replicating human flesh and 2) allow learners to refine and perfect their procedural skills without harming patients in the process. Pork belly simulation trainers were