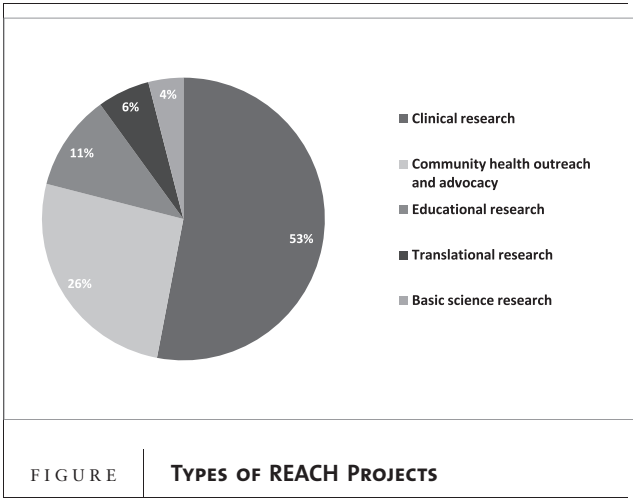




Abbreviation: REACH, Research, Education, and Advocacy in Child Healthcare.

times at 20 national and international conferences. Additionally, 35% of REACH projects resulted in a peer-reviewed publication. The types of projects are depicted in the **FIGURE**.

Conclusions

Our outcomes demonstrate that the REACH program—with longitudinal protected time over 2 years for resident research projects under the mentorship of a faculty member—could serve as a model for adoption by other residency programs as an effective means to enhance their residents’ scholarly output.

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New Ideas

The University of Washington Pediatric Alaska Track: A Novel Approach to Training Primary Care Pediatricians

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Setting and Problem

The University of Washington School of Medicine (UW-SOM) has been a leading medical school in training primary care physicians. Yet due to the small number of residency positions in the Pacific Northwest, the 5-state region of Washington, Wyoming, Alaska, Montana, and Idaho (WWAMI) has some of the lowest physician-to-population, graduate medical education (GME) positions-to-population ratios in the nation, and has the lowest pediatrician-to-child ratio in the country. The UW Pediatric Alaska Track was designed to increase the number of primary care

pediatricians serving rural and underserved populations. The goals are to increase quality and access to health care for children and families throughout the WWAMI region, and to improve the learning environment for residents with a career interest in primary care pediatric practice.

Intervention

The Alaska Track is a primary care track within the UWSOM categorical pediatrics residency. The Alaska Track enrolls 4 residents each year for a total of 12 residents in the program. Each year, Alaska Track residents complete 2 four-week block rotations in a community practice in Anchorage, Alaska, and 2 four-week block rotations in a community practice in either Bethel or Fairbanks, Alaska. To maintain continuity, residents return to the same Alaska sites each year. Over the course of

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TABLE RESIDENT CHARACTERISTICS: ALASKA TRACK VS CATEGORICAL PROGRAM (2012–2014)

Medical School Performance	Alaska Track (n = 8)	Categorical (n = 64)
Step 1 Average	234	231
Step 2 Average	255	246
American Osteopathic Association, %	50	28
Additional Graduate Degree, %	63	28
Residency Performance		
Faculty Evaluation (5-point scale) ^a	4.1	4.2

^a Weighted average of global assessment scores all rotations.

3 years, each resident completes 12 four-week block rotations devoted exclusively to ambulatory, primary care training, and newborn nursery experiences with both Alaska Native and non-native populations. In Seattle, each Alaska Track resident completes 9 four-week block rotations each year for a total of 27 rotations that include the inpatient, intensive care unit, subspecialty, emergency department, and supervisory rotations specified by the Accreditation Council for Graduate Medical Education requirements.

The Alaska Track rotations extended, community-based ambulatory experiences allow residents to see well-child, acute illness, follow-up, and posthospital discharge visits in a manner identical to that of the pediatricians in their assigned practices. Each site also allocates time for residents to develop ongoing quality improvement projects and health advocacy projects in the local community.

Didactic education occurs weekly by video conference between the 4 Alaska Track residents, the program director, and selected faculty. Alaska Track faculty have clinical appointments in the UWSOM, and GME oversight is provided by the UWSOM GME office. Resident salaries are assessed monthly according to site of rotation. Cost of travel, housing, and transportation during the Alaska rotation is provided by the Alaska sites. To maximize the time for shared experiences and class cohesion with their categorical track colleagues, R1s do not begin their Alaska block rotations until March of the R1 year. Alaska Track residents have some interaction with residents from the Alaska Family Medicine Residency.

Outcomes to Date

The first group of first-year residents began training in the Alaska Track in July 2012. We have recruited exceptional trainees whose medical school credentials equal their colleagues in the categorical program. Based on the first 18 months

of faculty evaluations, the performance of Alaska Track is indistinguishable from that of categorical residents (TABLE).

We anticipate that long-term outcomes for the Alaska Track residents will include increased likelihood of practice in rural or underserved areas and increased readiness for primary care practice. Preliminary results for these outcomes will be available with the first graduating class in July 2016.

Conclusion

A widely accepted method for meeting the nation's goal of increased numbers of primary care providers is to develop more primary care training sites in community settings. Many elements of the UW Pediatric Alaska Track are generalizable to other primary care residency programs, although specific structural components likely will vary by location.

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New Ideas

PREDICT: Instituting an Educational Time Out in the Operating Room

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Setting and Problem

Systematic time outs have been widely adopted in and outside the operating room (OR) to verify team preparedness, and review the details of planned procedures. These have been geared toward safety, which is paramount in every clinical encounter. In academic settings there is an added critical focus on education. As duty hour limits have reduced the time spent in the OR, and the complexity of surgical care has increased, maximizing the educational opportunities presented is imperative. A time out is an efficient platform for testing residents’ knowledge and facilitating faculty teaching. We developed the “Educational Time Out” (ETO), modeled after the World Health Organization’s (WHO) “surgical time out,” as a simple intervention before the start of a surgical case to review and assess trainees’ understanding of indications for surgery, the surgical plan, and technical considerations. This framework focuses learners’ attention and promotes the teaching experience at the outset of the case so that each moment forward has a high learning yield.

Intervention

The ETO has been implemented by 2 attending surgeons at our institution, 1 on the breast surgery service and 1 on the minimally invasive surgery service. The senior resident on the case performs the ETO, which is done routinely

after the WHO surgical time out, but before incision. The goal of the ETO is not to repeat any of the points covered by the surgical time out, rather it focuses on preoperative and operative-related teaching points for trainees. Our ETO covers the following: clinical presentation, disease risk factors, physical examination findings, preoperative diagnosis, operative incision and intraoperative course, and treatment (including postoperative orders and long-term therapy). Consequently, the components of the ETO have a simple mnemonic, PREDICT, and can be covered in 30 to 60 seconds (TABLE).

TABLE	COMPONENTS OF THE PREDICT MODEL
	P = Presentation. Presenting complaint leading to the initial surgical evaluation. This may include symptoms, signs, and/or radiographic findings.
	R = Risks. Risk factors for the current disease.
	E = Examination. Physical examination findings at presentation.
	D = Diagnosis. Clinical or pathological diagnosis.
	I = Incision. Trainee states what incision she or he proposes to use.
	C = Concerns. Intraoperative or postoperative concerns and their contingency plans.
	T = Treatment. Current and postoperative treatment plan.

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