CURRICULUM VITAE

PAUL J. SHAREK, M.D., M.P.H.

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CURRENT POSITIONS

Assistant Professor, Department of Pediatrics
Stanford University School of Medicine,
Medical Director of Quality Management, Lucile Packard Children's Hospital,
Chief Clinical Patient Safety Officer, Lucile Packard Children's Hospital
Vice President of Quality, Safety, and Outcomes Management

EDUCATION

1981-1985	Pomona College, Claremont, California	B.A.	Mathematics
1984-1985	University College, Oxford University		Biology
1985-1989	College of Physicians and Surgeons, Columbia University	M.D.	Medicine
1989-1990	University of California, San Francisco	Intern	Pediatrics
1990-1992	University of California, San Francisco	Resident	Pediatrics
1992-1993	University of California, San Francisco	Chief Resident	Pediatrics
1995-1996	University of California, Berkeley	M.P.H.	Epidemiology
1996-1998	Stanford University	Postdoctoral Fellow	Health Care Outcomes & Quality Improvement

ACADEMIC POSITIONS

1992-1993	University of California, San Francisco San Francisco General Hospital	Chief Resident, Pediatrics
1993-1994	University of California, San Francisco	Assistant Clinical Professor, Pediatrics
1996-1998	Stanford University	Postdoctoral Fellow, Pediatrics
1996-2001	University of California, San Francisco	Assistant Clinical Professor, Pediatrics
1998-2005	Stanford University	Assistant Clinical Professor, Pediatrics
2005-present	Stanford University	Assistant Professor, Pediatrics (MCL)
2007-present	Institute for Healthcare Improvement (IHI)	Faculty Member
2008-present	Stanford University Center for Health Policy (CHP) and Center for Primary Care and Outcomes Research (P-COR)	Associate Faculty Member

HONORS AND AWARDS

1984-85	Exchange student, Oxford University, Oxford, England
1985	Bachelors of Arts in Mathematics, Pomona College, Cum Laude
1991-1992	Housestaff Teacher of the Year Award, University of California, San Francisco
1992, 1996, 2000, 2004	Physician's Recognition Award, American Medical Association
2000	Certificate of Recognition from California State Senate, for "efforts to promote public health and awareness concerning asthma"
2002	Golden Coffee Cup Award (inaugural winner), for teaching excellence of the Stanford University Pediatrics Residents
2002	Finalist, California Association of Nonprofit Organizations, "Person of the Year" Award
2003	California AAP Chapter 1 nominee, AAP Steering Committee on Quality Improvement and Management *Quality of Care Award*
2004	Faculty Honor Roll for Teaching Service, given to 35 Stanford University School of Medicine faculty members for role as "an exceptional teacher, based on student's ratings and comments on your individual teaching evaluations, your input to student performance evaluations, and your overall contribution to the running of the clerkship"
2005	First place award, Patient Safety Category, for patient safety research design, for study "Comparing the Utility of a Standard Pediatric Resuscitation Cart with a Pediatric Resuscitation Cart Based on the Broselow Tape: a Randomized, Controlled, Cross-Over Trial involving Simulated Resuscitation Scenarios". 5th International Meeting for Medical Simulation conference, February 2005 Miami, FL.
2005	*Race for Results Award*, awarded by Child Health Corporation of America (CHCA) to 2 hospitals and leaders (Paul Sharek, MD, MPH at LPCH) that produced the "most significant clinical, financial, and safety related improvements" among the 41 CHCA hospitals
2005	Amy J Blue Award, Finalist, Stanford University (Main Campus). Award for the Stanford University staff member who is "exceptionally dedicated, supportive of colleagues and passionate about their work"
2006, 07	R.O.S.E. (Recognition of Service Excellence) Award, Lucile Packard Children's Hospital (x2)
2006	Faculty Honor Roll for Teaching Service, with *Letter of Teaching Distinction*, Stanford University School of Medicine. Given to 8 Stanford University School of Medicine faculty members for role as "an exceptional teacher, based on student's ratings and comments on your individual teaching evaluations, your input to student performance evaluations, and your overall contribution to the running of the clerkship"
2007	*Race for Results Award*, awarded by Child Health Corporation of America (CHCA) to the hospital and leaders (Paul Sharek, MD, MPH at LPCH) that demonstrated the most "significant and sustained improvements in the delivery of safety, effective and efficient care" among the 41 CHCA hospitals
2007	*Champion of Family Centered Care Award*. Annual award from the Lucile Packard Children's Hospital Family Advisory Council, "in recognition for outstanding commitment to promoting family-centered care"
2007	Finalist, *Stanford University School of Medicine Faculty Fellows Leadership Program*. A 1-year long program that "promotes learning from experienced leaders and

receiving mentoring and guidance about leadership. The program represents an important component of our leadership enhancement efforts throughout the School and Medical Center"

2008 Faculty Honor Roll for Teaching Service, with *Letter of Teaching Distinction*, Stanford University School of Medicine. Given to 10 Stanford University School of Medicine faculty members for "standing out as an exceptional teacher, based on student's ratings and comments on your individual teaching evaluations, your input to student performance evaluations, and your overall contribution to the running of the clerkship"

2008 Dr JM Bowman Distinguished Lecture in Neonatal Research (3rd annual) selection, University of Mannitoba, Winnipeg, Manitoba, Canada. Delivered September 25, 2008.

2009 Sydney Snyder, Endowed Patient Safety Lectureship, Children's National Medical Center ("DC Children's Hospital"), Washington, DC. Delivered February 4, 2009

PROFESSIONAL ACTIVITY

Institute for Healthcare Improvement (IHI). Boston, MA

2007-present Co-Principal Investigator, Rx Foundation Harm Study: How Safe is a Hospital. Grant awardee is Institute for Healthcare Improvement.

2007-present Member, Scientific Advisory Committee, charged with developing and implementing the measurement strategy for the IHI "5 million lives campaign"

California Perinatal Quality of Care Collaborative (CPQCC). Palo Alto, CA

2007-present Director of Quality for CPQCC and Chair of the Perinatal Quality Improvement Panel (PQIP). Provide thought leadership and oversight for quality of care initiatives created by CPQCC targeting large scale collaborative quality improvement for the 129 Neonatal Intensive Care Units in CPQCC. Establish strategic plan, redesign the organizational structure, create and implement a charter, and oversee 20-30 site IHI style collaborative quality improvement programs (such as infection reduction-2008 and breast milk feeding improvements-2009) across the state

National Institute for Children's Healthcare Quality (NICHQ)

2007 Co-author, High Alert Medications "How to Guide", a pediatric-based supplement to the IHI 5 million lives campaign literature

2007 Member, Pediatric Affinity Group. Group dedicated to translating the adult patient-based recommendations of the *IHI's 5 million lives campaign* into pediatric-relevant recommendations

Hospital for Sick Kids, Toronto, Ontario, Canada

June 2007 Visiting Scholar, Pediatric Quality and Patient Safety

St Louis Children's Hospital, St Louis, MS

March 2008 Visiting Scholar, Pediatric Quality and Patient Safety

Children's National Medical Center ("DC Children's Hospital"), Washington, DC

Feb 2009 Visiting Scholar, Pediatric Quality and Patient Safety

American Academy of Pediatrics (AAP)

2006-present Project Advisory Committee member, "Safer Healthcare for Kids" project. Oversight committee establishing a formal and practical strategy for describing relevant pediatric patient safety issues and providing solutions for pediatricians. This strategy includes establishing a section of the AAP website dedicated to pediatric patient safety education, and a series of approximately 20 webcasts over a 3 year period.

Department of Quality Management, Lucile Packard Children's Hospital
Department of Pediatrics, Stanford University School of Medicine

1997-2006 Co-developer, and selection committee member: Innovations in Patient Care Program. This program awards yearly Packard Foundation-funded grants for innovative strategies to improve patient care to applicants from Lucile Packard Children's Hospital

1998-2006 Site Director for LPCH. Neonatal Intensive Care Unit 2000 & 2002 (NIC/Q2000 & NIC/Q2002) National Collaborative Quality Improvement Project. This 49-site evidence-based quality improvement collaborative from the Vermont Oxford Neonatal Network aims to achieve measurable improvements in the quality and efficiency of NICU care, develop new tools and knowledge for the quality improvement process, and disseminate the improvement knowledge to the neonatology community.

2000-2002 Member: Pain Management Committee at LPCH, Committees to improve pain management in liver and renal transplant patients, LPCH Clinical Practice Management Committee

2000-2002 Creator and Co-Chair: Discharge Planning Committee

2000-2003: LPCH Site Director, Child Health Accountability Initiative (CHAI), a national 14-site children's hospital collaborative dedicated to improving the quality of health care for children using collaborative research and performance improvement techniques

2000-2003 Medical Director of Case Management. LPCH

2001-2002 LPCH representative: Medical Center Quality Assurance Review Committee, a committee charged with overhauling the peer review process at Stanford University Medical Center and LPCH

2001-2005 Co-Medical Director: Child Health Accountability Initiative (CHAI), a national 14-site children's hospital collaborative dedicated to improving the quality of health care for children using collaborative research and performance improvement techniques

2002 Conference Planning Committee: California Perinatal Quality Care Collaborative Workshop: Successful Strategies for Implementing Neonatal Practice Improvements

2002-2006 Member: Patient Progression Steering Committee, an LPCH committee focusing on streamlining patient throughput, improving the discharge planning process, and enhancing inpatient access to LPCH by minimizing the number of patients denied or delayed admission due to bed shortages

2004-2006 Clinical Transformation Project: Rapid Design committee ("care provision"). This LPCH committee focuses on providing MD input to design a prototype of the results review and order entry components of the Cerner Millenium electronic medical record.

2004-2006	Clinical Transformation Project: Biomedical and Medical Informatics committee. This LPCH committee is a physician oriented committee that is responsible for advising leadership on IT decisions, during the Cerner Millenium electronic medical record implementation, to ensure alignment with the mission and vision of LPCH.
2004-2007	Chair: Who is in Charge of the Ship (WICOTS) Committee. Committee defining accountability for all patients at LPCH, establishing physician and nursing roles related to patient care, defining a formal chain of command strategy, and formalizing standardized communication strategies all to ensure higher patient safety and quality of care
2000-present	Creator and Chairman: LPCH Quality Improvement Steering Committee ("QIC")
2000-present	Creator and Chairman: LPCH Patient Safety Committee
2000-present	Member: LPCH Medical Board
2001-present	Creator and Chairman: LPCH Peer Review Process (Care Improvement Committee and Department of Pediatrics Peer Review Committee)
2002-present	Member, LPCH Pharmacy and Therapuetics Committee
2002-present	Creator and Co-Chair: Quality Service, and Safety Committee, the LPCH Board of Directors committee focusing on oversight of quality, service and safety at LPCH. The committee established, reviews, and presents every 3 months 27 indicators that parsimoniously reflect the quality of care at LPCH to the LPCH Board of Directors
2006-present	Clinical Transformation Steering Committee: This LPCH committee has the charge of overseeing the entire clinical transformation process at LPCH including integration of CPOE and the Electronic Medical Record. Tasks include, but are not limited to: Establish strategic direction for Clinical Transformation; Review and approve proposed Clinical Transformation initiatives; Review and approve Measures and Metrics; Provide organizational leadership, thought leadership, and strategic direction to the project; Overall Program monitoring and risk management
2005-present	Chair: Medication Management Steering Committee. Provides oversight and coordination to all medication related processes at LPCH, with particular focus on enhancing patient safety by system engineering and process redesign
02.01.2008	Panelist, Deans Retreat: "Fostering the Highest Quality Patient Care". Santa Cruz, CA

<u>Department of Pediatrics, University of California, San Francisco</u>

1991-1994	UCSF Pediatric Intern Selection Committee
1992-1993	Delivery of Pediatric Emergency Care Committee, SFGH
1992-1993	Pediatric Transport Policy Committee, San Francisco General Hospital
1993-1994	Head of Primary Care, Department of Pediatrics, San Francisco General Hospital
1994	Preceptor, Introduction to Clinical Medicine for second year medical students
1998-1999	Mentor, University of Connecticut Medical School student, in clinical research
1998-1999	Director of Pediatric Acute Care, Ambulatory Care Center San Francisco General Hospital Department of Pediatrics

<u>San Francisco Health Plan (MediCaid managed care plan for San Francisco)</u>

2001-2003	Member, Quality Improvement Steering Committee

<u>Public Service</u>

1994-1996 Founder and Medical Director, Pediatric Clinic, Family Addiction Center for Education and Treatment. Pediatric clinic providing primary care to children of adults attending methadone maintenance clinic in inner-city San Francisco

1997-1998 Bay View/Hunter's Point Asthma Task Force. Representatives from local government agencies and the community aiming to impact the high prevalence of asthma in children in this low socioeconomic status community of San Francisco.

1998-2007 Board of Directors, Asthma Resource Center. A not for profit organization dedicated to improving the quality of life for children with asthma in a low socioeconomic section of San Francisco

2008-present San Carlos Little League, Board of Directors.

RESEARCH

Research Experience

Summer 1982 Research Assistant, Brain Research Institute, University of California, Los Angeles

Summer 1983 Research Assistant, Neuropsychiatric Institute, University of California, Los Angeles

Summer 1984 Research Assistant, Dept Behavioral Psychiatry, Univ. of California, Los Angeles.

Summer 1984 Research Assistant, Dept Behavioral Psychiatry, Univ. of California, Los Angeles

1996-1998 Postdoctoral Fellow, Outcomes Research, Department of Pediatrics, Stanford Univ.
Work involving: Co-PI on 5-year randomized controlled clinical trial entitled "An Asthma Intervention using a SuperNintendo Video Game", creation and validation of an asthma quality of life questionnaire with the American Academy of Pediatrics, multiple quality improvement projects, application of Meta-Analysis techniques

1998-1999 Physician Research Associate, Department of Pediatrics, Stanford University
Work included: Continuation of 5-year RCT for asthma, Meta-analysis, outcomes research consultant, development of a UCSF-Stanford community-based asthma initiative to study effects of telemedicine on outcomes of inner city children

1999-2005 Assistant Clinical Professor, Department of Pediatrics, Stanford University.

- ✍ Analysis, presentation, and publications of data from 5-year asthma RCT,
- ✍ Prevalence study of asthma in the San Francisco Unified School District,
- ✍ Evaluation of a telemedicine intervention on the outcomes of inner city children with asthma (see grants section)

2005-present Assistant Professor (MCL), Department of Pediatrics, Stanford University

- ✍ Quality Improvement
  1. Research efforts related to outcomes analysis and academic performance improvement in the following areas: infection rates and chronic lung disease rates in the NICU (see publications)
  2. Improved pain management strategies in post transplant pediatric patients (see publications)
- ✍ Patient Safety
  1. Simulation
     a. Evaluation of safety and quality outcomes after implementation of the NeoSim delivery room simulation intervention (see grants section)

b. Evaluation of safety outcomes using a Braselow code cart vs standardized code cart. An Randomized Controlled trial using simulation techniques (see publications)
c. Utilizing simulation techniques to improve the disclosure of adverse events to patients and patients families (see publications)

2. Measurement
   a. Creation of a pediatric focused patient safety indicator dashboard, then tracking these indicators after implementation of patient safety best practices (in conjunction with 4 other California based Children's Hospitals). (see grants section)
   b. Pediatric Trigger Tools: Development and testing of pediatric trigger tools for establishing baseline rates of adverse events in: adverse drug events hospital wide; adverse events in NICUs (see publications); adverse events in PICUs (see grants section); adverse events in Pediatric Emergency departments
3. Human Factors Analysis: Evaluation, with Boston Children's Hospital and DC Children's Hospital, of the effects of legislated reduced resident work hours on patient safety and resident safety (see publications)
4. Systems redesign:
   a. Implementation and analysis of outcomes of a rapid response team intervention (see publications)
   b. Implementation and analysis of a goal sheet to improve communication and outcomes in the Pediatric ICU setting (see publications)
5. Collaborative quality improvement techniques: guiding and analyzing large scale collaborative implementation of "best practice bundles" using the Institute for Healthcare Improvement (IHI) collaborative practice model
   a. Adverse Drug Events
6. Informatics: use of the electronic medical record to improve medication safety by increased fidelity related allergy identification

<u>Original Articles (n-=25)</u>

1986 Colbern D, **Sharek PJ**, Zimmerman E. The Effect of Home or Novel Environment on the Passive Avoidance by Post-training Ethanol. Behavior and Neural Biology. 1986;46:1-12

1999 **Sharek PJ**, Bergman BA. Beclomethasone for asthma in children: effects on linear growth. In: Sharek PJ, Bergman BA, Airways Module of The Cochrane Database of Systematic Reviews, [updated August 1999]. Available in The Cochrane Library [database on disk and CDROM]. The Cochrane Collaboration; Issue 4. Oxford: Updated Software; 1999. Updated quarterly.

2000 **Sharek PJ**, Bergman DA. Inhaled steroids and growth in children with asthma: A meta-analysis. *Pediatrics.* 2000;106:e8.

2001 **Sharek PJ**, Bergman DA. Effect of inhaled corticosteroids on growth. Reply: Letter to the editor. *Pediatrics*.2001;108:1234.

2002 **Sharek PJ**, Benitz WE, Abel NJ, Freeburn MJ, Mayer ML, Bergman, DA. Effect of an Evidence-Based Hand Washing Policy on Hand Washing Rates and False-Positive

Coagulase Negative Staphylococcus Blood and Cerebrospinal Fluid Culture Rates in a Level III NICU. *Journal of Perinatology*.2002;22:137-143

2002 **Sharek PJ**, Mayer ML, Loewy L, et al. Agreement between measures of asthma status: a prospective study to low income children with moderate to severe asthma *Pediatrics*. 2002;110:797-804

2003 **Sharek PJ**, Baker R, Litman F, et al. Evaluation and Development of Potentially Better Practices to Prevent Chronic Lung Disease and Reduce Lung Injury in Neonates. Pediatrics 2003 111: e426-e431.

2003 Kelly B, Rhine W, Baker R, Litman F, Kaempf JW, Schwarz E, Sun S**,** Payne NR, **Sharek PJ**. Implementing Potentially Better Practices to Reduce Lung Injury in Neonates. Pediatrics 2003 111: e432-e436.

2004 Shames RS, **Sharek PJ**, Mayer M, et al.. Effectiveness of A Multi-Component Self Management Program In At-Risk School Age Children With Asthma. Annals of Allergy, Asthma, & Immunology. 2004;92:611-618

2005 Agarwal S, Swanson S, Murphy A, **Sharek PJ**, Halamek LP. Comparing the Utility of a Standard Pediatric Resuscitation Cart with a Pediatric Resuscitation Cart Based on the Broselow Tape: a Randomized, Controlled, Cross-Over Trial involving Simulated Resuscitation Scenarios. *Pediatrics*. 2005;116:e326-e333

2006 **Sharek PJ**, Wayman K, Lin, E, Strichartz D, Sentivany-Collins S, Good J, Esquivel C, Brown M, Cox K. Improved Pain Management in Pediatric Postoperative Liver Transplant Patients Using Parental Education and Nonpharmacologic Interventions. *Pediatric Transplantation*.2006;10:172-177

2006 **Sharek PJ**, Horbar JG, Mason W, et al. Adverse Events in the Neonatal Intensive Care Unit: Development, Testing, and Findings of a NICU-focused Trigger Tool to Identify Harm in North American NICUs. *Pediatrics* 2006;118:1332-1340.

2006 Dunbar AE, **Sharek PJ,** Mickas NA, et al. Implementation and Case Study Results of Potentially Better Practices to Improve Pain Management of the Neonate. *Pediatrics*. 2006; 118:87-94

2006 **Sharek PJ**, Powers R, Koehn A, Anand KJS. Evaluation and Development of Potentially Better Practices to Improve Pain Management of the Neonate. *Pediatrics*. 2006; 118:78-86

2007 Wayman K, Trotter S, **Sharek PJ**, Halamak L. Simulation-Based Medical Error Disclosure Training for Pediatric Healthcare Professionals. *Journal of Healthcare Quality.* 2007;29:12-19

2007 Bergman DA, **Sharek PJ**, Ekegren K, Thyne S, Mayer M, Saunders M. The Use of Telemedicine Access to Schools to Facilitate Expert Assessment of Children With Asthma. *International Journal of Telemedicine and Applications*. 2007;2008:1-7

2007 **Sharek PJ**, Parast LM, Leong K, Coombs J, Earnest K, Sullivan J, Frankel LR, Roth SJ. Sustained Reduction in Hospital-Wide Mortality Associated with Implementation of a Rapid Response Team in an Academic Children's Hospital, *JAMA*. 2007;298(19):2267-2274

2007 **Sharek PJ**, Mullican C, Lavanderos A, Palmer C, Snow V, Kmetik K, Antman M, Knutson D, Dembry, LM. Best Practice Implementation: Lessons Learned from 20

Partnerships. *Joint Commission Journal on Quality and Patient Safety.*2007;33(1):16-26

2008 Agarwal S, Frankel L, Tourner S, McMillan A, **Sharek PJ**. Improving Communication in the Pediatric Intensive Care Unit Using Daily Goal Sheets. *J Crit Care.* 2008 Jun;23:227-35

2008 Takata G, Mason W, Takatoma C, Logsdon T**, Sharek PJ.** Development, Testing, and Findings of a Pediatric-Focused Trigger Tool to Identify Medication Related Harm in US Children's Hospitals. *Pediatrics*. 2008;121:e927-935

2008 Fahrenkopf AM, Sectish TC, Barger L, **Sharek PJ**, Lewin D, Chiang VW, Wiedermann BL, Landrigan CP. Housestaff Burnout and Depression: Consequences for Personal Health, Job Satisfaction, and Patient Safety. *British Medical Journal.* 2008; 336(7642):488-91

2008 Arimura J, Poole RL, Jeng M, Rhine W, **Sharek PJ**. Neonatal Heparin Overdose- A Multidisciplinary Team Approach to Medication Error Prevention. *J Pediatr Pharmacol Ther.* 2008;13:96-98.

2008 Landrigan CP, Fahrenkopf AM, Lewin D, **Sharek PJ**, Barger LK, Eisner M, Edwards S, Chiang VW, Wiedermann BL, Sectish TC. Effects of the ACGME Duty Hour Standards on Sleep, Work Hours, and Safety. *Pediatrics*. 2008;122:250-258

2008 **Sharek PJ**, McClead RE, Taketomo C, Luria JW, Takata GS, Walti B, Tanski M, Carla N, Logsdon TR, Thurm C, Federico F. An Intervention to Decrease Narcotic Related Adverse Drug Events in Children's Hospitals. *Pediatrics*. 2008; 122:e861-866

2009 Goodnough LT, Viele M, Fontaine MJ, Jurado C, Stone N, Quach P, Chua L, Chin M, Scott R, Tokareva I, Tabb K, **Sharek PJ.** Implementation of a Two Specimen Requirement for Verification of ABO/Rh for Blood Transfusion. *Transfusion*. *In press*

Letters to the Editor

2006 Longhurst C, **Sharek PJ**, Hahn J, Sullivan J, Classen D. Perceived increase in mortality after process and policy changes implemented with CPOE. *Pediatrics*. 2006;117:1450-51

2008 **Sharek PJ**, Roth SJ. Cardiorespiratory Arrests and Rapid Response Teams in Pediatrics—Reply. *JAMA*. 2008;299(12):1424

2008 Landrigan CP, Fahrenkopf AM, Lewin D, **Sharek PJ**, Barger LK, Eisner M, Edwards S, Chiang VW, Wiedermann BL, Sectish TC. Effects of the Accreditation Council for Graduate Medical Education Duty-Hour Limits on Sleep, Work Hours, and Safety: In Reply *Pediatrics*. 2008;122:1414-1415.

Invited Reviews

2006 **Sharek PJ**, Classen D. The Incidence of Adverse Events and Medical Error in Pediatrics. *Pediatric Clinics of North America*. 2006;53:1067-1077.

Chapters

1998 **Sharek PJ**, Bergman DA. Improving the Quality of Care in the Office Setting. Ambulatory Pediatric Care, third edition, 1998. Dershewitz, RA editor. Lippincott-Raven publishers, Philadelphia, PA

Abstracts

April 1999 **Sharek PJ**. Using Quality Improvement Methods to Improve Nosocomial Infection Rates in a Neonatal Intensive Care Unit. Presented at the Neonatal Intensive Care Unit 2000 National Collaborative Quality Improvement Project semi annual meeting, Washington DC.

May 1999 **Sharek PJ**, Bergman DA. The Effect of Inhaled Steroids on the Linear Growth of Children with Asthma; A Meta-Analysis. Presented at the Pediatric Academic Societies national meeting, San Francisco, CA

Sept 1999 **Sharek PJ**. Evidence of Improved Nosocomial Infection Rates After Implementation of a Handwashing Policy. Presented at the Neonatal Intensive Care Unit 2000 National Collaborative Quality Improvement Project semi annual meeting, Chicago, IL

May 2000 **Sharek PJ**, Benitz WE, Abel NJ, Freeburn MJ, Bergman, DA. Improved Nosocomial Infection Rates in a Neonatal Intensive Care Unit After Initiation of an Evidence-Based Hand Washing Program. Presented at the Pediatric Academic Societies national meeting, Boston, MA

Sept 2000 **Sharek PJ**. Vitamin A Administration to Improve Chronic Lung Disease at LPCH. Presented at the Neonatal Intensive Care Unit 2000 National Collaborative Quality Improvement Project semi annual meeting, Seattle, WA

Sept 2000 **Sharek PJ**. Gentle Ventilation: Use of Low Tidal Volume Ventilation on Premature Infants at LPCH. Presented at the Neonatal Intensive Care Unit 2000 National Collaborative Quality Improvement Project semi annual meeting, Seattle, WA

April 2001 **Sharek PJ**. Decreasing Adverse Drug Events from TPN Administration at LPCH. Presented at the Neonatal Intensive Care Unit 2000 National Collaborative Quality Improvement Project semi annual meeting, Atlanta, GA

April 2001 **Sharek PJ**. Use of Maximal Barrier Precautions with Central Line Insertion at LPCH. Presented at the Neonatal Intensive Care Unit 2000 National Collaborative Quality Improvement Project semi annual meeting, Atlanta, GA

May 2001 **Sharek PJ**, Mayer ML, Bergman DA, Umetsu D, Shames RA. Correlations Between Measures of Asthma Status: A Longitudinal Study of Low Income Inner City Children. Presented at the Pediatric Academic Societies national meeting, Baltimore, MD

May 2001 **Sharek PJ**, Mayer ML, Bergman DA, Umetsu D, Shames RA. Comparison of Color Zones and Control Charts in Predicting Asthma Exacerbations in Children. Presented at the Pediatric Academic Societies national meeting, Baltimore, MD

May 2001 Bergman DA, Mayer ML, **Sharek PJ**, et al. An Asthma Disease Management Program: Results form a Randomized Clinical Trial. Presented at the Pediatric Academic Societies national meeting, Baltimore, MD

October 2001 **Sharek PJ**. Decreasing Adverse Drug Events from TPN Administration at LPCH: an Update. Presented at the Neonatal Intensive Care Unit 2001 National Collaborative Quality Improvement Project semi annual meeting, Burlington, VT

October 2001 **Sharek PJ**. Securing "Strategic Priority" Status for Patient Safety from LPCH Governance and Leadership Presented at the Neonatal Intensive Care Unit 2001 National Collaborative Quality Improvement Project semi annual meeting, Burlington, VT

March 2002 Loring K, **Sharek PJ**, Bergman DA, Shames R, Mayer M, Umetsu D. Environmental Exposure and Sensitization to Cockroach, Dust Mite, and Cat Allergen: Correlation with

Asthma Symptoms in a Population of Disadvantaged, Inner-City Children in the San Francisco Bay Area. American Academy of Allergy, Asthma and Immunology Annual Meeting, NY, NY

April 2002 **Sharek PJ**. Improving Patient Safety. Decreasing Adverse Drug Events from TPN Administration at LPCH. Presented at the Neonatal Intensive Care Unit 2002 National Collaborative Quality Improvement Project semi annual meeting, New Orleans, LA

Sept 2002 Forte, J, Rhine W, **Sharek PJ,** et al. The Use of Sucrose Analgesia to Relieve Procedural Pain in Neontaes. Presented at the Neonatal Intensive Care Unit 2002 semi-annual meeting, Chicago, IL

Sept 2002 **Sharek PJ,** Forte, J, Rhine W**,** et al. Involving Families in Establishing the Safety Agenda at LPCH. Presented at the Neonatal Intensive Care Unit 2002 semi-annual meeting, Chicago, IL

April 2003 Forte, J, Rhine W, **Sharek PJ,** et al**,** et al. Implementation of Sucrose Analgesia in the LPCH nurseries. Presented at the Neonatal Intensive Care Unit 2002 semi-annual meeting, San Diego, CA

April 2003 **Sharek, PJ**. Dizon R, Ikuta L, et al. Implementation of AHRQ and CDC Barrier Precaution Best Practices to Prevent Central Line Infections

Sept 2003 Forte, J, Almgren C, **Sharek, PJ**, et al. Implementation of Sucrose Analgesia in the Lucile Packard Children's Hospital Nurseries. Presented at the Neonatal Intensive Care Unit 2002 National Collaborative Quality Improvement Project semi annual meeting, Montreal, Quebec, Canada

Sept 2003 Rhine, W, **Sharek, PJ**, Gilley, D, et al. Use of a Human Factors Checklist to improve the safety around clinical alarms at Lucile Packard Children's Hospital. Presented at the Neonatal Intensive Care Unit 2002 National Collaborative Quality Improvement Project semi annual meeting, Montreal, Quebec, Canada

Oct 2003 **Sharek, PJ**, Frankel L, Parker, J, et al. Using AHRQ Patient Safety Best Practices: InTRAhospital transport at Lucile Packard Children's Hospital. Presented at the semi-annual Child Health Accountability Initiative National meeting, San Diego, CA

Oct 2003 **Sharek, PJ**, Poole R, Trotter S. Using AHRQ Patient Safety Best Practices: Corollary Orders at Lucile Packard Children's Hospital. Presented at the semi-annual Child Health Accountability Initiative National meeting, San Diego, CA

Oct 2003 **Sharek, PJ**, Dizon, R, Ikuta L, et al. Using AHRQ Patient Safety Best Practices to Reduce Central Venous Catherter Associated Infections at Lucile Packard Children's Hospital. Presented at the semi-annual Child Health Accountability Initiative National meeting, San Diego, CA

May 2004 Bergman DA, **Sharek PJ**, Ekegren K, Saunders M. The Use of Telemedicine Access to Schools to Facilitate Expert assessment of Children With Asthma. Presented at the Pediatric Academic Societies national meeting, San Francisco, CA

April 2005 Fitzgerald S, DeBattista A, **Sharek P**, Wayman K, Cerini L, Rhine W, Family Involvement in the NICU At LPCH: Increasing Staff Awareness. Presented at the Your Ideal Nicu National Collaborative Quality Improvement Project semi annual meeting, Portland, OR

January 2006 Yaeger KA, Halamek LP, Wayman K, Trotter S, Wise L, Keller H, Ashland, **Sharek PJ**. Simulation-based parent-guided project to improve disclosure of unanticipated outcomes.

Poster Presentation: Sixth Annual International Meeting on Medical Simulation; January 14-17; San Diego, CA

June 2006 Fahrenkopf AM, Sectish T, Barger L, **Sharek PJ**, Lewin D, Chiang VW, Weiderman B, Landrigan CP. Impact of the Accreditation Council for Graduate Medical Education Duty Hour Standards on Resident Sleep, Education, and Safety: A Multicenter Study. Oral Presentation: SLEEP 2006 20th Anniversary Meeting of the Associated Professional Sleep Societies, LLC. Salt Lake City, UT.

Dec 2006 Rhine W, **Sharek PJ,** Armstrong L, Galazo D, Freeman H. Using Microsystems Theory to Improve Quality and Safety in the Lucile Packard Children's Hospital Neonatal Intensive Care Unit. Institute for Healthcare Improvement (IHI) National Forum 2006, Orlando, FL

June 2007 Staveski S, Childrey J, Leong K, **Sharek PJ**, Murphy D, Roth S. Optimizing Patient Safety Through Standardized Provider Handoffs. Fifth World Congress on Pediatric Critical Care, Geneva, Switzerland.

April 2008 Childrey J, Leong K, Murphy D, Roth S, **Sharek PJ**, Staveski S "Improving Pediatric Nurse Practitioners' Work Efficiency and Job Satisfaction while Optimizing Patient Outcomes during Provider Handoffs" National Association of Pediatric Nurse Practitioner's Annual Conference, 2008, Nashville, TN

October 2008 Staveski S, Bond J, Leong K, **Sharek PJ**, Murphy D, Roth S. Optimizing Patient Safety Through Standardized Provider Handoffs. Bay Area Research Day, 2008, San Francisco, CA.

PRESENTATIONS

Named Lectureships

09/25/08 Dr. JM Bowman Lecture in Neonatal Research, University of Manitoba, Winnipeg, Mannitoba, Canada. *Moving Closer to High Reliability, Understanding and Improvement Patient Safety in the Neonatal Intensive Care Unit*

02/04/09 Sydney Snyder, Endowed Patient Safety Lectureship, Children's National Medical Center ("DC Children's Hospital"), Washington, DC. *The Next Generation of Pediatric Patient Safety*

Grand Rounds

6/7/95 San Francisco General Hospital, San Francisco, CA. *Medical Experiences in a Refugee Camp in Southeast Asia*

7/10/97 John Muir Medical Center, Walnut Creek, CA. *Improving the Quality of Care of Children in the Office Setting*

11/25/97 San Francisco General Hospital, San Francisco, CA. *Improving the Quality of Care for Children with Asthma*

7/6/99 San Francisco General Hospital, San Francisco, CA. *Bridging the Gap between Theory and Practice in Caring for Children with Asthma*

8/22/00 San Francisco General Hospital, San Francisco, CA. *You gave how much morphine? Medication Errors: Problems and Solutions*

11/16/00 University of California at San Francisco, San Francisco, CA. *Medication Errors*

1/5/01	Lucile Packard Children's Hospital, Palo Alto, CA. *Medication Errors: What's All the Fuss About?*
2/22/01	Kaiser Permanente, San Francisco, CA. *Medication Errors*
2/11/02	San Francisco General Hospital, San Francisco, CA. *How the *&@#!*% Do I Begin to Improve Patient Safety?: A Practical Approach Used at LPCH*
3/5/07	Stanford University School of Medicine and Medical Center, Stanford CA. Department of Anesthesia. *Moving Closer to High Reliability: Improving Patient Safety in the Operating Room Using Reliability Science and Concepts of Organizational Psychology*
05/29/07	University of California, San Francisco (UCSF), San Francisco General Hospital, San Francisco, CA. *Improving Pediatric Patient Safety Using High Reliability Science*
06/06/07	Hospital for Sick Kids, Toronto, Ontario, Canada. *Using High Reliability Concepts to Improve Pediatric Patient Safety*
09/23/08	Oakland Children's Hospital, Oakland, CA. *Moving Closer to High Reliability: Understanding and Improving Patient Safety in Pediatrics*

Invited Speaker

4/9/1999	Stanford University School of Business, Stanford, CA. Seminar, Quality Management in Health Care. *Tools for Continuous Quality Improvement: the Providers Point of View*
3/31/2000	University of California San Francisco School of Medicine. Continuing Medical Education in Family and Community Medicine. Annual Review in Family Medicine. Controversies and Challenges in Primary Care, San Francisco, CA. *Pediatric Asthma*
10/24/2000	UCSF-Stanford Center for Research and Innovation in Patient Care Research Day 2000, San Francisco, CA. *Improved Coagulase Negative Staph Rates in a Large NICU after Implementation of an Evidence-Based Hand Washing Policy*
12/5/2000	National Association of Children's Hospitals and Related Institutions (NACHRI) Quality Improvement Workshop, San Francisco CA. *Improving Outcomes for Low-Birthweight Premature Infants*
10/5/2001	California Association for Healthcare Quality Symposium "Keys to Patient Safety", Palo Alto, CA. *How the *&@#!*% Do I Begin to Improve Patient Safety? A Practical Approach Used at Lucile Packard Children's Hospital*
12/9/01	Vermont Oxford Neonatal Network 2nd Annual Quality Congress for Neonatology, Washington, D.C. *Improving the Safety of TPN Administration: A Practical Example from Lucile Packard Children's Hospital*
1/25/02	Washington Township Hospital, Fremont CA. *Medication Errors: What's All the Fuss About?*
3/1/02	California Perinatal Quality Care Collaborative Workshop, Los Angeles, CA: Successful Strategies for Implementing Neonatal Practice Improvements. *Use of Quality Improvement Techniques to Prevent Nosocomial Infection in Nurseries*
4/28/02	Keynote speaker, National Association of Neonatal Nurses, Marco Island, FL: *Holy #@$%^&*! You Gave How Much Morphine? Medication Errors: Problems and Solutions*

4/29/02	Keynote speaker, Child Health Corporation of America, Neonatal Intensive Care Management Meeting, Marco Island, FL. *Holy #@$%^&*! You Gave How Much Morphine? Medication Errors: Problems and Solutions*
9/19/02	Child Health Accountability Initiative, semi-annual meeting. Kansas City, MO. *Integration projects developed at the Child Health Accountability Initiatives into the general hospital workflow*
2/25/03	Keynote speaker, Perinatal Hot Topics Statewide Nurse Conference, Sacramento, CA. *Medication Errors*
2/22/03	Beyond Primary Colors: The Spectrum of Perinatal and Pediatric Nursing, Palo Alto, CA: *Patient Safety and Nursing Practice: Background to the Patient Safety Crisis in America*.
3/27/03	Child Health Accountability Initiative, semi-annual meeting. St. Louis, MO. *Multi-site Collaboration as a Strategy to Improve Medication Safety*
3/28/04	Child Health Accountability Initiative, semi-annual meeting. St. Louis, MO. *Integration of the CHAI Pediatric-Focused Trigger Tool into the Workflow*
10/1/03	Child Health Accountability Initiative, semi-annual meeting. San Diego, CA. *Implementing Pediatric Patient Safety Practices: An update on the CHAI awarded Agency for Healthcare Research and Quality's Partnerships for Quality grant*
1/12/04	Child Health Accountability Initiative: 5 year reunion conference, San Diego, CA. *Patient Safety and CHAI: Building the Foundation for the AHRQ Partnerships in Quality Grant Award*
2/9/04	Center for Patient Safety in Neonatal Intensive Care meeting, Burlington, VT. *The Child Health Accountability Initiative (CHAI) and Pediatric Patient Safety: The IHI Trigger System*
10/12/04	American Academy of Pediatrics (AAP) National Conference and Exhibition, San Francisco, CA. Seminar: *Making Health Care Safer for Children: Practical Strategies that Improve Quality and Reduce Malpractice*
03/01/05	National Initiative for Children's Healthcare Quality (NICHQ), Fourth annual forum for improving children's health care, San Diego, CA. *Improvement by Collaboration*
04/06/05	Child Health Corporation of America, Quality and Safety Conference 2005. Phoenix, AZ. "Progress in Patient Safety Panel". *The Role of Physician Leaders in Patient Safety*
04/07/05	Child Health Corporation of America, Quality and Safety Conference 2005. Phoenix, AZ. Race for Results Award presentation. *Adverse Drug Events: What Lucile Packard Children's Hospital did to Decrease them by 70%*
06/07/05	Agency for Healthcare Research and Quality (AHRQ). Conference: Patient Safety and Health Information Technology: Making the Health Care System Safer through Implementation and Innovation. Washington DC. *"Patient Safety across Settings and Populations: Children's Care"* Panel
08/29/05	California Patient Safety Consortium: Fourth Annual California Patient Safety Consortium Meeting. Stanford, CA. *Engaging Physicians in Quality and Patient Safety*
09/12/05	Vermont Oxford Neonatal Network's Neonatal Intensive Care Quality Improvement Collaborative 2005 (NIC/Q2005) semi-annual meeting. Nashville, TN. *Development of a Neonatal Trigger Tool to Identify Adverse Events: Preliminary Results*

09/13/05	Child Health Corporation of America, semi annual national meeting. Chicago, IL. The Culture of Patient Safety at Children's Hospitals: *How We Stack Up Against the Big Boys and Girls (i.e. adults)*.
06/04/07	California Health Information Association (CHIA) annual meeting. Palm Springs, CA. Keynote speaker: *The Role of Health Information Management in Enhancing Patient Safety*
06/16/06	Ohio Children's Hospital Association's (OCHA) "Quality Summit", Columbus, Ohio. *Launching an Ohio-Based Children's Hospital Quality Collaborative.* I was the lone facilitator of the 6 Children's hospital members of OCHA's efforts to embark on a collaborative quality and patient safety improvement initiative. This 6 hour facilitation meeting was attended by the CEOs, Chief Medical Officers, and the Chief Nursing Officers of these 6 children's hospitals.
07/19/06	Child Health Corporation of America (CHCA). *"Improve today" Informational webcast series: Preventing Adverse Drug Events related to Opiates and Narcotics*. Lead speaker, national webcast
07/26/06	National Initiative for Child Health Quality (NICHQ), Child Health Corporation of America (CHCA), American Academy of Pediatrics (AAP) and National Association of Children's Hospitals and Related Institutions (NACHRI): *Getting to Zero: The Kids' Campaign. "Office Hours"*. Lead speaker, national webcast, for part 1: Adverse Drug Events.
09/27/06	Agency for Healthcare Quality and Research (AHRQ).Partnerships for Quality meeting. Rockville, MD. *Improving Pediatric Patient Safety.*
10/08/06	National Association of Children's Hospitals and Related Institutions (NACHRI). National meeting, Boston MA. *Improving Communication in the Pediatric Intensive Care Unit Using Daily Goal Sheets*
03/03/07	California Association of Neonatologists (CAN). Thirteenth Annual Conference. Current Topics and Controversies in Perinatal and Neonatal Medicine, Coronado Island, CA. *Moving Closer to High Reliability: Understanding and Improving Patient Safety in the NICU*.
03/21/07	National Initiative for Children's Healthcare Quality (NICHQ). Sixth Annual National Forum for Improving Children's Healthcare. San Francisco, CA. *Measuring Harm in Pediatrics-A Practical Primer on Trigger Tools. Pediatric Trigger Tools.*
04/25/07	Child Health Corporation of American. Annual meeting. Los Angeles, CA. Plenary session. *Sustained Reduction in Hospital-Wide Mortality Associated with Implementation of a Rapid Response Team in an Academic Children's Hospital*
06/07/07	Hospital for Sick Kids, Toronto, Ontario, Canada. Third annual partners in pediatric patient safety symposium": Spreading the word. *Measuring and Improving Patient Safety*
06/07/07	University of Toronto, Department of Neonatology. *Using quality improvement techniques to improve neonatal outcomes*
06/08/07	University of Toronto Faculty of Medicine. First annual patient safety and quality academic day. *Patient Safety Culture: Obstacles and Enablers. Panel with James Conway, MS, ex-COO Dana-Farber Cancer Institute*

06/08/07 University of Toronto Faculty of Medicine. First annual patient safety and quality academic day. *Advancing an academic approach to patient safety and quality improvement for clinicians. Panelist.*

10/23/07 Child Health Corporation of American. Quality and Safety Leaders Forum. Dallas, TX. *Integrating patients and families to improve pediatric patient safety*

01/15/08 International Meeting on Simulation in Healthcare, 8th annual meeting, San Diego, CA. *Achieving sustainability: Aligning the mission of your simulation program with that of your hospital. The role of patient safety*

03/18/08 National Initiative for Children's Healthcare Quality (NICHQ). Seventh Annual National Forum for Improving Children's Healthcare. Miami, FL. *The Science of Measuring (and Preventing) Harm in Pediatrics: Pediatric Trigger Tools and Beyond.*

03/18/08 National Initiative for Children's Healthcare Quality (NICHQ). Seventh Annual National Forum for Improving Children's Healthcare. Miami, FL. *Transitioning to High Reliability: Operationalizing Simulation*

05/13/08 St Louis Children's Hospital. St Louis, Missouri. *The Science of Measuring (and Preventing) Harm in Pediatrics: Pediatric Trigger Tools and Beyond*

05/13/08 St Louis Children's Hospital. St Louis, Missouri. *Transitioning to High Reliability: Operationalizing Simulation*

05/13/08 St Louis Children's Hospital. St Louis, Missouri. *"Run, Don't Walk". The Rapid Response Team Intervention at LPCH*

05/13/08 St Louis Children's Hospital. St Louis, Missouri. *An Evidence-based Clinical Transformation: The Lucile Packard Children's Hospital Story*

06/05/08 American Academy of Pediatrics Safer Healthcare for Kids Webnar Series. *Run, Don't Walk: Implementing a Rapid Response Team at an Academic Children's Hospital.* Presenter and Moderator.

12/10/08 Institute for Healthcare Improvement, Twentieth Annual National Forum, Nashville, TN. *The North Carolina Patient Safety Study, 2002-2007. Is Hospital Care Getting Safer?*

12/17/2008 Maryland Patient Safety Center, Expert Panel Meeting, Baltimore, MD. *Preventing Healthcare Associated Infections*

12/17/2008 Maryland Patient Safety Center, Expert Panel Meeting, Baltimore, MD. *Measuring and tracking the burden of harm in the Neonatal Intensive Care Unit- the NICU Trigger Tool*

03/03/2009 Health and Life Sciences Symposium, Hewlett Packard 2009, Phoenix, AZ. Keynote speaker. *The future of quality and safety in healthcare. Transitioning to high reliability.*

MEETING PLANNING

3/18/07 National Initiative for Children's Healthcare Quality (NICHQ) and National Association of Children's Hospitals and Related Institutions (NACHRI) "Cross over meeting" San Francisco, CA. *Don't Automate Junk: Overcoming the Pitfalls of Health Information Technology to Achieve the Quality and Safety Promise*. Role: organizer, chair, and facilitator

3/19/07 National Initiative for Children's Healthcare Quality (NICHQ). Sixth Annual National Forum for Improving Children's Healthcare. San Francisco, CA. One-day Exploratorium: *Pediatric Patient Safety Knows no Boundaries: Lessons Learned from Around the Globe*. Role: organizer, chair, facilitator

3/20-3/21/07 National Initiative for Children's Healthcare Quality (NICHQ). Sixth Annual National Forum for Improving Children's Healthcare. San Francisco, CA. Roles: forum steering committee/co-chair; chair of patient safety tract

GRANTS

1996-2000 Co Principal Investigator (Principal Investigator David Bergman, MD, MPH, Stanford University School of Medicine), Asthma Initiative Grant, Packard Foundation. *An Asthma Intervention Using a Super-Nintendo Video Game.* This grant funded a randomized controlled clinical trial of the effectiveness of a disease management model on the outcomes of low socio-economic, inner-city children with asthma

2001-2002 Principal Investigator, Pediatric Health Research Fund Grant, Stanford University. *Decreasing Adverse Drug Events Using a Novel Identification Tool: A Multi-centered Pilot Study*. Grant to integrate a validated computer-based tool that identifies children at risk for and/or who are a victim of an adverse drug event

2001-2004 Co-Investigator (Principal Investigator, Louis Halamek, MD, Stanford University School of Medicine) , AHRQ grant RFA-HS-01-008. Patient Safety Research Dissemination and Education. *Assessment of a Novel Pediatric Simulation Program.* Grant to study the clinical and safety outcomes resulting from a high-risk delivery simulation program in an academic children's hospital (FTE 0.05)

2002-2004 Co-Investigator (Principal Investigator David Bergman, MD, MPH, Stanford University School of Medicine). The California Endowment grant. *An Asthma Telemedicine Project for Underserved Children in Bayview Hunter's Point (a disadvantaged minority population in San Francisco, CA).* Grant to integrate and evaluate a research-proven asthma intervention into an inner-city school system using telemedicine (FTE 0.1)

2002-2004 Co-Investigator (Glenn Takata, MD, MPH, University of Southern California School of Medicine) California Healthcare Foundation grant. *A Statewide Pediatric Initiative to Improve Patient Safety.* Grant to establish a collaborative of California Children's Hospitals to standardize nomenclature around pediatric patient safety and develop/integrate strategies to improve pediatric focused patient safety (FTE 0.1)

2002-2006 Principal Investigator, "AHRQ Partnerships for Quality" grant 1 U18 HS13698-01. *Implementing Pediatric Patient Safety Practices*. Grant to establish a formal partnership between the Child Health Accountability Initiative (CHAI) and the AHRQ to improve patient safety and pain management in children as well as effectively disseminate these advances (FTE 0.16)

2003-2004 Co-Principal Investigator (Principal Investigator Christopher Landrigan, MD, MPH, Harvard University School of Medicine), Pediatric Health Research Fund Grant, Stanford University. Effects of Duty Hour Standards on Patient Safety, Resident Sleep, Resident Safety, and Resident Self-Directed Learning

2006-2007	Co-Investigator (Principal Investigator Swati Agarwal, MD Stanford University School of Medicine, Innovations in Patient Care grant program, Lucile Packard Children's Hospital. "Testing of a Trigger Tool to detect adverse events (AEs) and adverse drug events (ADEs) in the PICU: A multi-site trial."
2007-present	Co-Principal Investigator (Principal Investigator, Christopher Landrigan, MD, MPH, Harvard University School of Medicine), Rx Foundation Harm Study: "How Safe is a Hospital". Grant housed at the Institute for Healthcare Improvement (IHI)

LICENSES AND CERTIFICATIONS

1990	Medical License, California (#G070895)
1992, 99, 2006	Certified, American Board of Pediatrics
1999	Fellow, American Academy of Pediatrics

PERSONAL

Marital Status: Married
Children: Ryan (12 yo), Liam (9 yo)