Regions Emergency Medicine Residency

May 8, 2009

Felix Ankel, MD

History

- Accreditation 1995, 1999, 2003, 2009
- 81 graduates 1999-present
- 108 residents 1996-present

Mission: PAPEEMCE

Provide and promote excellence in emergency medicine care and education

- Patient centered
- Resident focused
- Team oriented
- Transparency
- Professionalism
- Knowledge
- Skills
- Attitudes
- Core competencies
- Contribution to specialty

81 graduates 1999-present

- 50 Minnesota: 11 Regions, 7 Fairview-U, 6 North, 5 EPPA, 5 Abbott, 4 Duluth, 4 United, 3 HealthEast, 2 Waconia, Shakopee, Brainerd, Mayo
- 26 out of state (15): SD 4, NE 3, IA 3, CO 2, IN 2, WI 2 ND 2, MS, OR, NH, MT, WA, UT, VA, NY
- 12 Academic: 10 Regions, Wishard, Mayo
- 15 Hybrid: 7 Fairview-U, 7 North, Mercy-Iowa City
- 50 Community
- 7 Fellows (2 toxicology, faculty development, critical care, simulation, informatics, ultrasound)

108 residents (1996 - present) 25 medical schools

- 37 U of M,
- 8 UND
- 6 USD, Mayo, MCW, Iowa
- 4 Creighton, UW
- 2 Nebraska, Loyola, Indiana, Kansas, Chicago Med School, Colorado
- SUNY-Buffalo, SLU, Des Moines, Nevada, Vermont, Penn, Hawaii, East Carolina, Arizona, Utah, Michigan State, Albany, VA-COM, UCSF, Dartmouth, Yale, Tufts, Cincinnati

26 Faculty (13 Different EM Residencies)

- Regions x 10
- Henry Ford x 2
- Harvard Affiliated x 2
- Illinois x 2
- HCMC
- Brooke Army
- St Vincent's
- UCSF/Fresno
- Christ
- New Mexico
- Indiana
- Boston Medical Center
- Grand Rapids
- Michigan

Rotations (4 weeks blocks)

- Year 1: ED 3.7, SICU 1.3, Ortho 1, MICU 1, Cards 1, OB 1, Mpls Kids 1, Anesthesia 1, Plastics 1, EMS 1
- Year 2: ED 7.3, SICU 1.3, Community ED 1, MICU 1, St Paul Kids 1.3, Tox/Adm 1
- Year 3: ED/ St Paul kids 9.7, SICU 1.3, Elective 1, Community ED 1

Residency Strategic Plan 2005-2010

4/28/05

- SWOT analysis
- Conferences
- Simulation
- Mentorship
- Administrative curriculum
- Scholarly activity
- Individualization of educational experience
- Integration with U of M
- Integration with twin city hospitals
- National presence

2007-2008

- Conference changes
  - Move to Thursdays
  - Increase critical case to 90 minutes
  - Increase simulation time during conf
  - Pre-conference sim sessions
- Structured ultrasound workshops
- Schedule change from teams to sides, 10-hr shifts
- Doctors Dahms, Morgan and Taft assume roles as Asst. PDs
- Incorporation of Peds-EM faculty (Ortega & Reid) into Residency
- Hosting of Ecuadorian EM residents
- EM/FM combined residency discussions
- E-portfolio application submission to ACGME
- Specialized interview days
- Resident self-eval on shift cards
- Nurse mentorship program

2008-2009

- Community ED rotations EM-2 & EM-3
- Clarification of back-up & pull residents
- Ultrasound afternoons during anesthesia rotation
- Melding of cardiology & hospitalist rotation

Program review 2009

- Residency coordination
- Toxicology rotation
- Resident support
- Residency leadership
- Independence
- Progressive responsibility
- Cardiology rotation
- Admin rotation
- ED Conference rooms
- ED Exam rooms
- HCMC rotation
- Plastics rotation

2009-2010

- ED-Integrated rotation for EM-1
- Peds Anesthesia week during EM-3 Selective
- New ED
- Fellowship development (Peds-EM, EMS, International)

Future Directions

- Less resources for GME
- More resources for quality movement
- Quality movement based on sustained change in behavior
- Education = sustained change in behavior
- Change residency from knowledge-based residency to quality residency
- More resources for residency
- Quality matrix (Bingham, Quinn)

The Matrix

Patient Healthcare Matrix: Care of Patient with pneumonia

Competencies \ AIMS	SAFE[1] (Overuse, underuse, misuse)	TIMELY[2] (Delay in hrs, days weeks)	EFFECTIVE[3] (Outcomes, Evidence-based care)	EFFICIENT[4] (Waste of resources)	EQUITABLE[5] (Gender, ethnicity, race, SES)	PATIENT-CENTERED[6] (Preferences, needs, values)
Assessment of Care						
PATIENT CARE[7] (Overall Assessment) Yes/No	No	No	Yes	No	Yes	No
MEDICAL KNOWLEDGE and SKILLS[8] (What must we know?)	Pt could have become septic because of the delay in starting antibiotics. He went home before films were read. Did not get proper care at OSH and came to us.		Once proper diagnosis was made, treatment was appropriate. Outcomes were good.			
INTERPERSONAL AND COMMUNICATION SKILLS[9] (What must we say?)	Spent a lot of time with pt getting history, care, etc. Pt had many other care problems.	Needed to get x-rays first and discuss healthcare issues later.		Should have waited until results of X-ray to make plan of care. We wasted a lot of time going down wrong path.		Team was very good at talking to him but we did not get to his chief complaint fast enough.
PROFESSIONALISM[10] (How must we behave?)	Team was very eager to help and no one acted unprofessional.	What is our role in letting an OHS know that radiology was not available?				
SYSTEM-BASED PRACTICE[11] (What is the process? On whom do we depend? Who depends on us?)	Multiple doctors in multiple systems caused dangerous delay. There were many players: MD, radiology, admissions, insurance, and social worker. This actually caused the problem of getting a fast diagnosis.			Patient needed to go outside of his usual system because he could not get x-rays read at night.		Patient had to navigate the complex system of care at OSH and finally get to Vanderbilt for help.
Improvement						
PRACTICE-BASED LEARNING AND IMPROVEMENT[11]	Getting records from other hospitals is critical when pt	We need a faster system to identify "pneumonia" so they can get ABX		Because we could not get films, they had to be repeated. This patient also needed to		We need to be sure pts with pneumonia are informed of what is happening and

SAEM Annual Meeting
May 22, 2005
New York City, NY

LUNCH SESSION: Closing the Quality Chasm: Research and Educational Initiatives for Academic EM (12:00-1:30 pm), *Sutton North*

Arthur L. Kellermann, MD, MPH, Emory University
Felix K. Ankel, MD, Regions Hospital

The speakers will highlight the implications of the IOM report for education and research in EM. Using examples from their department, the speakers will provide specific ideas for incorporating the IOM's recommendations in EM training programs. Particular attention will be paid to the relationship between the IOM's goals and the ACGME's core competencies. The speakers also will discuss the specific steps academic EM must take to develop a translational research agenda for achieving the IOM's Quality Chasm goals. Extramural funding opportunities, research training programs, and opportunities for collaboration will be identified. At the end of the session, participants will: 1. Identify how the recommendations from the IOM's Quality Chasm Report apply to EM; 2. Acquire specific ideas for incorporating the IOM's Quality Chasm recommendations in their educational programs, including an explanation of how the IOM goals can be used to address the ACGME core competencies; 3. Identify specific steps for developing a translational research agenda in EM to achieve the IOM's Quality Chasm goals, including recommendations for research training, opportunities for collaboration, and funding sources.

Thoughts

- Caring for patients vs. treating patients
- Complex vs. complicated system
- Wisdom of Crowds, James Surowiecki
- The Culture Code, Clotaire Rapaille
- The Foucault Reader, Paul Rabinow (Ed.)
  - Enlightenment vs. obedience
  - Knowledge, power, ethics

Our residency efforts are guided by the Baldridge core values for educational criteria for performance excellence which include:

- Visionary leadership
- Learning centered education
- Organizational and personal learning
- Valuing faculty staff and partners
- Agility
- Focus on the future
- Managing for innovation
- Managing by fact
- Social responsibility
- Focus on results and creating value
- Systems perspective

Additionally, we strive to incorporate the Institute of Medicine's *Report on Health Professions Education: A Bridge to Quality* which suggests five core areas where students and working professionals should develop and maintain proficiency. They include:

- Delivering patient-centered care
- Working as part of interdisciplinary teams
- Practicing evidence-based medicine
- Focusing on quality improvement
- Using information technology