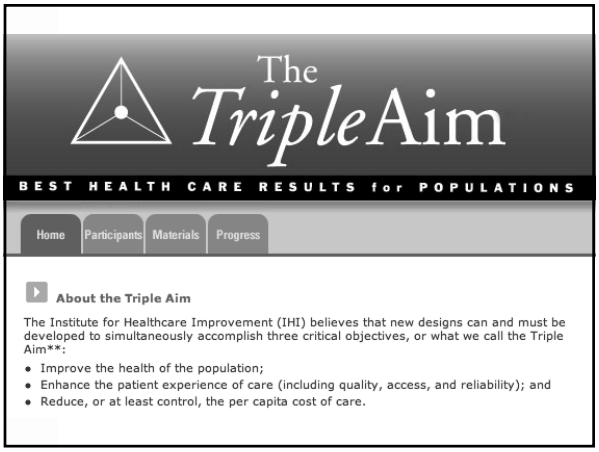
Regions Emergency Medicine Residency

Felix Ankel, MD



History

- Accreditation 1995, 1999, 2003, 2009
- 99 graduates 1999-present
- 128 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

99 graduates 1999-present

- 67 Minnesota: 15 Regions, 11 EPPA, 7 Fairview-U, 6 North, 5 Abbott, 5 HealthEast, 5 United, 4 Duluth, 2 Waconia, Shakopee, Brainerd, Rochester, New Ulm, Princeton
- 31 out of state: SD 5, NE 3, IA 4, ND 3, CO 2, IN 2, WI 2, MT 2, WA 2, CA, NH, NY, OR, UT, VA
- 17 Academic: 15 Regions, Wishard, Mayo
- 14 Hybrid: 7 Fairview-U, 6 North, Mercy-Iowa City
- 67 Community
- 9 Fellows (3 toxicology, faculty development, critical care, simulation, informatics, ultrasound, EMS)

128 residents (1996 - present)
38 medical schools

- 45 U of M
- 8 UND
- 7 MCW, Iowa, USD, Mayo
- 5 Creighton
- 4 UW
- 2 Nebraska, Loyola, Indiana, Kansas, Chicago Med School, Colorado, Loma Linda, SLU
- SUNY-Buffalo, Des Moines, Nevada, Vermont, Penn, Hawaii, East Carolina, Arizona, Utah, Michigan State, SUNY-Syracuse, VA-COM, UCSF, Dartmouth, Yale, Tufts, Cincinnati, Morehouse, Florida, Nova-COM, Temple, LSU

30 Faculty (13 Different EM Residencies)

- Regions x 15
- Henry Ford x 2
- Harvard Affiliated x 2
- Illinois x 2
- HCMC
- Brooke Army
- St Vincent's
- Christ
- Indiana
- Boston Medical Center
- Grand Rapids
- Michigan
- Resurrection

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

2009-2010

- ED-I rotation (EM, Anes, EMS)
- 3 new ultrasound machines
- EM-3 Peds anesthesia
- New ED
- Cards/Hospitalist rotation
- Fellowship development (EM-Peds, EMS, International)

Residency Strategic Plan 2010-2015

4/21/010

- SWOT analysis
- Review of strategic plans of department, hospital, IME, and healthplan
- Outcomes (*quality)*
- Knowledge translation (*web 2.0* and work with librarians)
- Procedural competency
- Non-clinical training (*longitudinal admin*)
- Benchmarks and scorecards
- Resources (*wellness and resilience*)

Program review 2010

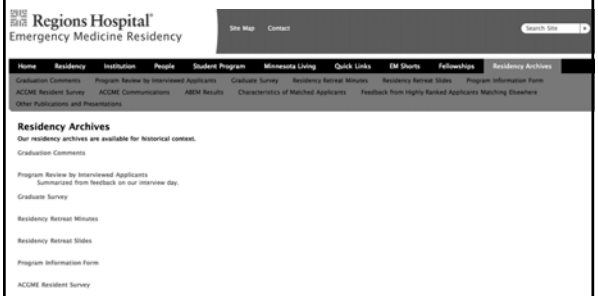
- Residency coordination
- Resident support
- Social work staff
- Faculty supervision
- Progressive responsibility
- Residency leadership
- EMS
- Cardiology rotation
- Ortho rotation
- Admin rotation
- Anesthesia rotation
- Education vs service
- Research
- Plastics rotation

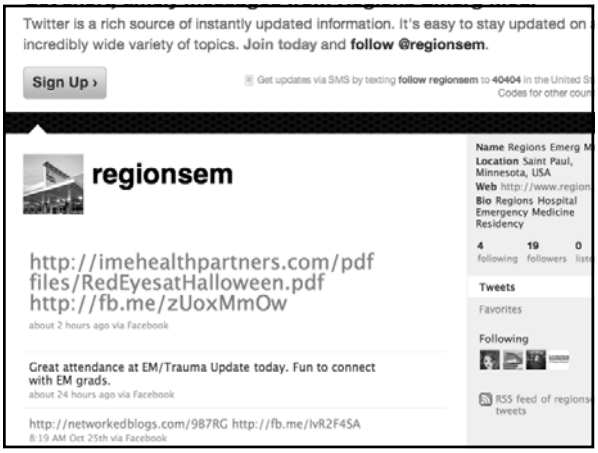
2010-2011

- 10 interns
- New procedural skills lab
- EMS fellow, EM-peds sponsorship
- Quality, international fellowship approval
- ROD, MSOD – longitudinal admin experience
- Night float block
- Hudson selective pilot
- Quality teams
- Recruitment boom

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.)
- Drive, Dan Pink





Questions to consider

- Web 2.0
  - Consolidate and optimize current on line interactive resources
- Longitudinal admin experience
  - Determine strengths and areas to tweak
- QI program design
  - Review, discuss progress and recommend improvement
- Wellness and resilience
  - Develop plan to maintain and improve current wellness and resilience

Questions to consider

Emergency Medicine Resident/Faculty Retreat

Minnesota Transportation Museum - Jackson Street Roundhouse

October 29, 2009

Residents				Support/Guests			
✓	Aaron Burnett, MD	✓	Kara Kim, MD	✓	Pat Anderson	✓	Beth Heinz
	Nate Curl, MD	✓	Kolja Paech, MD	✓	Lori Barrett	✓	Mary Healy, RN
✓	Aaron Feist, MD	✓	Jillian Smith, MD	✓	Ryan Aga	✓	Louis Ling, MD
✓	Leah Gapinski, MD	✓	Timmy Sullivan, MD	✓	Eugenia Canaan	✓	Gary Mayeux
✓	Shani Go, MD	✓	Peter Baggenstos	✓	Nicole Cox	✓	Jennifer Neville
✓	Nicci Stoik, MD	✓	Eric Dahl	✓	Debra Curran	✓	Carl Patow, MD
✓	Heather Sutherland, MD		Tyler Ferrell	✓	Marcella de la Torre	✓	Eric Peterson
✓	Greg Vigesaa, DO	✓	Kate Graham	✓	Jennifer Feeken	✓	Debi Ryan
✓	Brent Walters, MD	✓	Clint Hawthorne	✓	Richelle Jader, RN	✓	Jennifer Schiffler
✓	Catie Carlson, MD	✓	Bjorn Peterson	✓	Linda Hart		
✓	Katie Davidson, MD	✓	JR Walker				
✓	Autumn Erwin, MD	✓	Ben Watters				
✓	Alex Gerbig, MD	✓	Casey Woster				
Faculty							
✓	Felix Ankel, MD		Paul Haller, MD		Kevin Kilgore, MD	✓	Karen Quaday, MD
✓	Emily Binstadt		Carson Harris, MD		Peter Kumasaka, MD	✓	Marty Richards, MD
	Mary Carr, MD	✓	Cullen Hegarty, MD		Levon Ohaodha, MD		Sam Stellpflug, MD
	Won Chung, MD	✓	Keith Henry, MD	✓	Richard Lamon, MD	✓	Stephanie Taft, MD
✓	Rachel Dahms, MD	✓	Brad Hernandez, MD	✓	Robert LeFevere, MD	✓	Michael Zwank, MD
	Kristen Engebretsen, PharmD	✓	Joel Holger, MD		Barb LeTourneau, MD		Drew Zinkel, MD
✓	RJ Frascone, MD	✓	Kurt Isenberger, MD		Matt Morgan, MD		
✓	Brad Gordon, MD		Kory Kaye, MD		Jessie Nelson, MD		

Person	Agenda Item	Action Plan/Key Points
Ankel	Welcome and Historical Perspective	Dr. Ankel welcomed and acknowledged invited guests. Presented historical perspective.
	Updates	Department Review: Kurt Isenberger and Richelle Jader Nursing Update: Mary Healy IME/GME Update: Carl Patow Quality Committee, Hospital Board of Directors: Karen Quaday Best Care/Best Experience: Beth Heinz: Quality Measures: Marcella de la Torre and Kara Kim UMN Emergency Department: Louis Ling: Residency Schedules, G2 updates: Rachel Dahms Residency Conference and G1 updates: Stephanie Taft Student and Residency Recruitment: Cullen Hegarty: Chief Residents: Aaron Burnett, Leah Gapinski, Brent Walters
	Small Groups	Attendees were divided into small groups. Group were led by N Anderson, A Burnett, L Gapinski, P Tanghe, B Walters. Participants were asked to identify residency strengths, areas of focus, and quality issues.

	Large Group	Each facilitator presented their groups findings. Attendees were then asked to identify their top 3 strengths, top 3 areas for focus and ways to integrate quality into EM residency. **Strengths**: Listed below in order identified as participants top 3 choices • **Responsiveness of residency (14)** • **ICU's (12)** • **Procedures early in residency (8)** • **Camaraderie/cohesiveness (5)** • **Wellness – families and residents (4)** • Peds trauma (4) • Strong residency leadership (4) • Simulation (3) • International and national initiatives (3) • MD/RN collaboration (2) • New physical improvements (2) • Ultrasound and equipment(2) • Research funding (2) • Social workers (2) • Interim Department Head (2) • Quality of residents (2) • Evidence based medicine (2) • Inhouse radiology (2) • Access to pharmacy (2) • Protective time (1) • Patient Population (1) • Peds experience (1) • Graduates response (1) • Quality of MN healthcare (1) • Didactics (1) • Procedure Lab(1) • Own Vocera • Informal staff interactions • Access to consultants • Resident benefits (insurance, etc) • Teamwork • Triage rotation • Resuscitation/critical care • HCMC resident exchange • EMS – Continuity of care experience • Flexibility • Peds anesthesia • Resident individuality • Dynamic program • Appreciation of residency • Recruitment • EMR Dot phrases • Variety of community rotations • Community respect of residency • Openness to learning • Opportunity to teach • Subspecialty representation • Quality of ancillary staff • HP mission • Increase faculty teaching • Resident leaders • Residency support • Inhouse ancillary • Increase provider flow Quality of providers

		Focus Areas: Listed below in order identified as participants top 3 choices • **ED Scheduling – night/day transition (19)** • **Ortho procedures in ED (15)** • **Residents in Pod C (12)** • **Education space (Sim/Conference) (10)** • **Photos of RN's (9)** • More computers for resident room (8) • "Fixing" E and A (7) • G2 ownership of side (7) • Rural opportunity (6) • Face-to-face communications (6) • Research support – start up (8) • Unequal A & E shifts – G2 scheduling (5) • Resident coffee maker (5) • Faculty at conference (5) • Ultrasound – faculty comfort/probes (5) • Quality – long term (4) • Admin experience (4) • Documentation education (3) • Epic/Documentation (3) • ED break room (3) • Add critical decision to conference (3) • ERIC/Internet (2) • Vacation scheduling (2) • Food service hours (2) • Basic skills – IV's EKG (2) • Rapid journal club (2) • Consultants at critical case (2) • Geographic isolation (2) • Res shift/staff and times (2) • Hospitalist hand offs (2) • Peds Resuscitation (1) • Decrease Pod F (1) • Morning rounds (1) • Integration of Children's experience (1) • EBM (1) • Patient feedback to residents • Ortho rotation • Understanding of roles in department • Balance of initiative - clarity • Integrate Admin with evidence based medicine • Decreased patients/residents • Managing expectations • Patient education regarding ED • AM Simulation • Hospital library computers for non-library tasks • Accessibility of info on web sites • Perception of "regional" residency • SICU schedule • Peds EM – Split 3 weeks/3weeks • Research support • Fellowship opportunities • Increase formal RN/MD interactions • Morning sign-outs • Peds experience in Pods A & E • Palliative Care experience in EM-1 • Billing/Coding Education • ED1 Orientation

		Integrate Quality into EM Residency • Class collaborative quality project (3) • Simulation projects (2) • Order sets (1) • Brief Journal Reviews • Communicate quality initiatives • Team quality initiatives • Individual quality
	Focus Areas	**ED Scheduling**: Desire for more circadian rhythm, especially the transition from night to day shifts. This will be a focus for next year as the majority of the schedule is completed through June 2009. **Pod C and Pod A:** Discussed how and when to change Pod C to Pod A . C Carlson, K Kim and K Davidson volunteered to work on this with Rachel Dahms. **Comprehensive Education Space with simulation:** Being worked on the hospital level. Contact Carl Patow or Karen Quaday with questions. **Ortho Procedures within the ED**: S Witt, K Graham, B Peterson, and T Sullivan will meet to discuss ortho reduction opportunities in the ED.

Residency Strategy Planning Meeting

Thursday, April 21, 2010 8:00-1:30
St Croix Room, 8170 Bldg
Recorded by: Pat Anderson

Present

Pat Anderson	Cullen Hegarty, MD	Pete Tanghe, MD	Jeff Fritz
Gary Gosewisch, MD	Eric Roth, MD	Katie Davidson, MD	Tim Lindquist
Jessie Nelson, MD	Eugenia Canaan	Richelle Jader	Drew Zinkel, MD
Felix Ankel, MD	Jon Henkel, RN	Susan Walls, RN	Elie Gertner, MD
Kate Graham, MD	Jennifer Schiffler, RN	Marcella de la Torre	Manu Madhok, MD
Carl Patow, MD, MPH	Maddy Cohen, MSW	Kara Kim, MD	Mike Zwank, MD
Lori Barrett	Keith Henry, MD	Steve Wandersee, PA-C	Brad Gordon, MD
Mary Healy, RN	Stephanie Taft, MD	Scott Donner, MD	Marc Martel, MD
Karen Quaday, MD	Rachel Dahms, MD	Gretchen Leiterman	
Aaron Burnett, MD	Brad Hernandez, MD	Mary Wittenbreer	

Item	Action Plan/Key Points
SWOT	As a group a SWOT table was made identifying our residency's strength, weakness, opportunities, and treats. Table is attached.
Review or Other Strategic Plans	How can we strategically integrate the residency into the plans of the department hospital, IME, and healthplans?
Outcomes:	What characteristics of knowledge, skills and attitudes in a graduating resident are sought after by employees? Employers are looking not only for smart ED physicians, but for physicians with the following qualities: - team players - good communication skills - humanstic characteristics - empathy - patient advocate - documentation competency - leadership ability - good follow through - effective teachers - adaptable to new culture - creative - good management/organization skill - What are the things Regions is doing to graduate residents with these qualities and what can we do to influence our grads for the future. Regions has done the following: - Robert Knopp Humanism Award - Shift card evaluations which include patient care compassion to promote culture of kindness. - IME sponsors a Core Competency Conference each year. This year the theme is "Communication as a Driver of Quality" with workshops on Interpreters' Observation on Medical Communication. Afternoon session with be a trip to MN Institute of Art for an exercise in visual thinking strategies.

Knowledge Translation	How do we translate best knowledge into best practice? Discussion and thoughts: - In the future there will be more expectation of obtaining information on the go through smart phones, Twitter, etc. - More interactive websites - CME courses to keep staff skills up - Core lectures to teach core competency with most up to date literature. Need to have ongoing renewing library for education. - Resident QI projects for best practices. - Develop a depository of up to date educational data. Integration of quality into the didactics - Disseminating knowledge through QI initiatives - Introduction of critical appraisal of conference lectures - Incorporate EBM into practice and look at outcomes - EKG curriculum. Look at teach class specific level of training, experiential training, smaller group sessions. - Resident one on one sessions with faculty
Procedural Competency	How do we ensure procedural competency? Discussion and thoughts: - New grads have it. - Sim labs for maintaining skills - CME courses - Teaching each other - Hospital are moving toward requiring staff to show that they are competent in procedures by documenting a required numbers of procedures - Education day with a combination of teaching and stations. - Resident procedural competency verification by staff - Feedback to resident - Regional resource for rarely performed procedures – have residents teach community physicians. - Class-specific ultrasound training
Non-Clinical Training	How do we train future leaders of the healthcare delivery system? Discussion and thoughts: - Encourage more community involvement - Patient satisfaction data included in 6 month evals. - Conferences focused on communication and scripting - Teach by role modeling - Constructive feedback - Resident comparison with RVU per hour. - 360 evaluation
Benchmarks & Scorecards	How do we measure our outcomes to our goals? Discussion and thoughts: - Push on trying to get Picker to adopt a point of service mechanism. - Smart, kind, fast – report card - Report card with patient complaints, speed, tract utilization, peer evals, team player
Resources	What resources will we need to ensure success?

SWOT

Strengths	Weaknesses	Opportunities	Threats
Leadership/Faculty	Few other Regions' residents	Educational synergy	Increasing number of residencies, recruitment challenges
Resident Applicants – interests, geographic, Intelligence	Lack of integrated admin experience	Integration of quality	Decreased funding for educational offerings
Collaboration	Diversity	Collaboration with local programs	Academic suprastructure funding
Organization	Research execution	Fellowship development	UMN funding challenges
Vitality	Documentation time	Integrating IHI triple aims (performance, experience, stewardship)	Lack of team connection in ED pods
Educational Quality	Communication across Pods	Simulation vision – develop faculty	Becoming in-bred, lack of diversity
Support	Educational space	Community selective sites - collaboration	Decreasing leaders/admin support "depth of bench"
Prominence and National Recognition	Coding and billing education	Improve documentation model	GAMC funding impact
Hospital Integration	Simulation infrastructure	Use library resources for customized information push through web 2.0 means	Academic time
Community Resource	Underutilization of knowledge based resources	Leadership development – Systems – Bedside	Lack of outcomes data to support value of education
Quality of Residents	Integration of inpatient peds	Develop research	Research support
Teaching	Ortho reduction skills	RN mentorship	Balancing service vs resident needs
Systems-based	Patient satisfaction	Mutidisciplinary sim	Autonomy vs integration
Reputation	Psychiatric curriculum	Regional UME-GME-CME collaboration	Bedside teaching experience & support
Quality of graduates	Minimal educational offerings to other ED providers	Collaboration with other disciplines Integrated education	Running a pod – clinical leadership
Innovative	Geographic location	Clinical learning center	Competing priorities - complexity

Stable	Minimal dissemination of education to regional community hospitals. Lack of educational marketing.	Healthcare advocacy	Maintaining clinical/educational quality
Responsive	Clinical research infrastructure	Unique rural experience (WI)	Maintining quality simulation
Flexible	Sub-optimal use of Epic	Relationship with UMN	New chair (unknown)
Resilient	Admin load	Expanded role of patient education	Community support (selective)
Critical Care Exposure	Increasing reporting demands without admin support	Publishing our work	Lack of consistent ownership of dept.
Quality of fellowships		Faculty development	Faculty retention – faculty development
Humanistic		Highlight critical care experience	Caregiver well-being
		EMIG involvement	Disruptive forces in healthcare delivery systems, e.g., freestanding EDs.
		UMN resources	Stability of academic EM department at UMN
		Medico-legal and media training	
		Real-time resident feedback: patient satisfaction, quality markers, performance, stewardship	
		Evolving technology	
		Defininition of procedural competency standards	
		Regional center for procedural competency training	