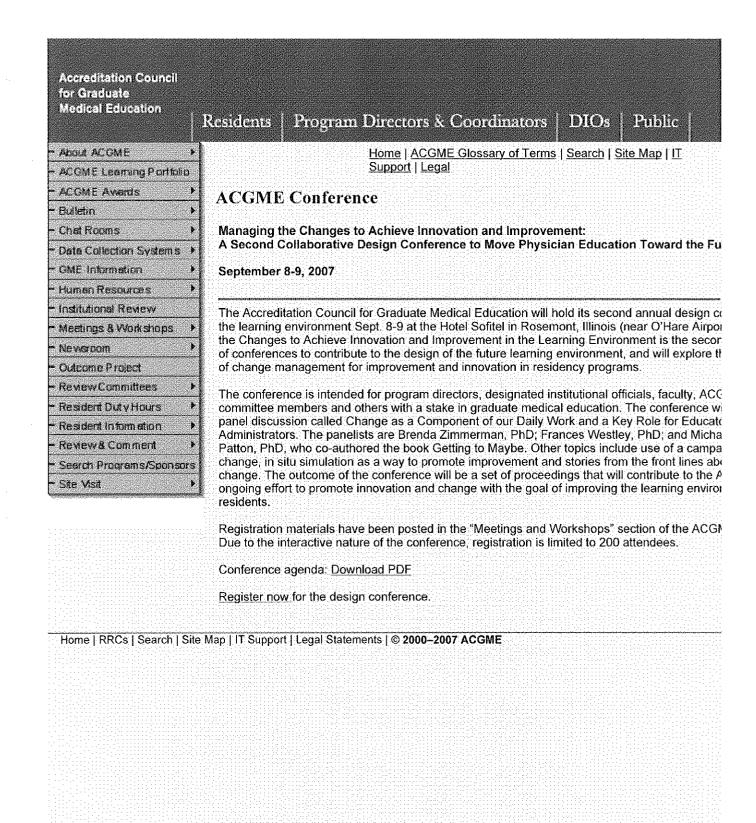
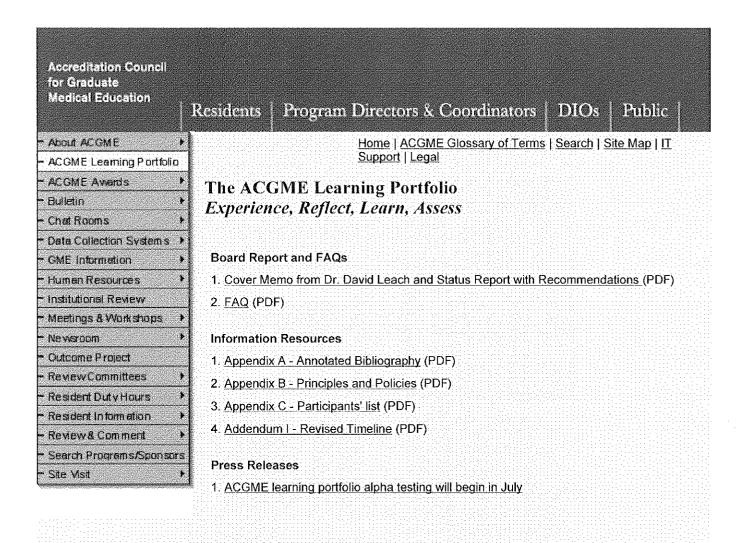
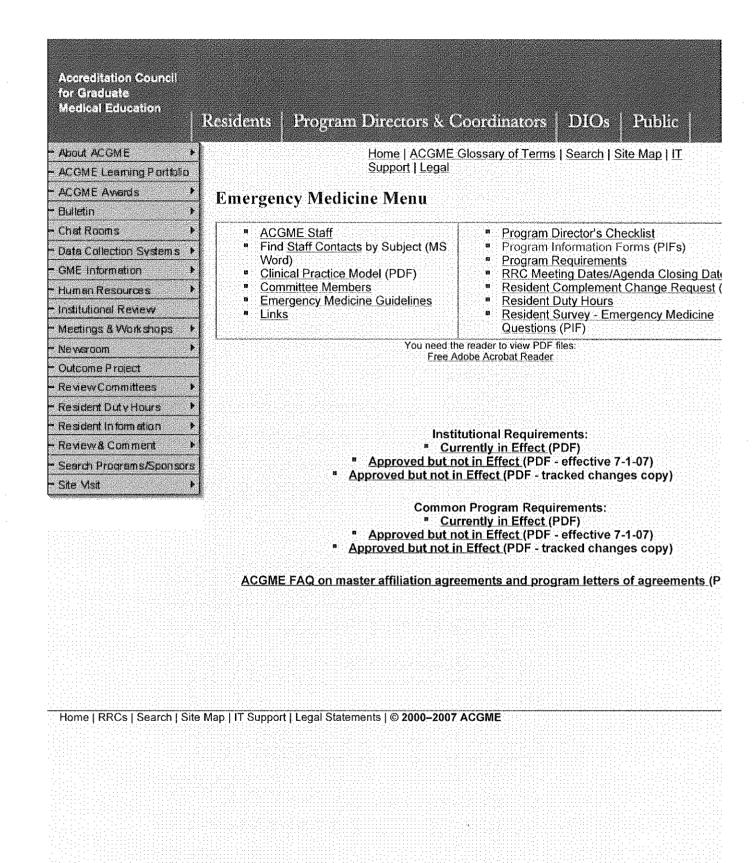


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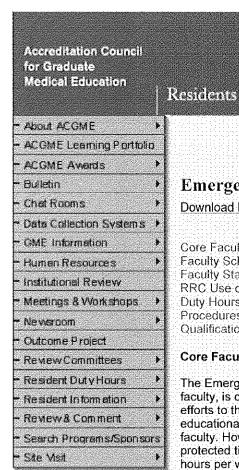




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Emergency Medicine Guidelines

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Core Faculty Maximum Clinical Time Guideline Faculty Scholarly Activity Faculty Staffing Levels RRC Use of ABEM Data Duty Hours on Emergency Medicine Rotations Procedures and Resuscitations Qualifications for Emergency Medicine Faculty

Core Faculty Maximum Clinical Time Guideline

The Emergency Medicine program requirements state "A core faculty member, a member of the faculty, is one who provides clinical service and teaching, devotes the majority of his or her prof efforts to the program, and has sufficient time protected from direct service responsibilities to m educational requirements of the program." The RRC realizes there is a great deal of variability is faculty. However, the RRC feels it is useful for Program Directors to understand how the RRC a protected time for core faculty. The RRC feels that core faculty should not be working more than hours per week. This maximum would allow for some protected time as specified in the Program Requirements.

Faculty Scholarly Activity

The RRC-EM maintains that scholarly activities are an essential component of graduate medica The Program Requirements state "Graduate medical education must take place in an environm and scholarship in which residents participate in the development of new knowledge, learn to every research findings, and develop habits of inquiry as a continuing professional responsibility. The whole must demonstrate broad involvement in scholarly activity." The Program Requirements s range of scholarly activities for both individual core faculty as well as the program as a whole. T uses the following guidelines in assessing this Program Requirement.

Individual Core Faculty Productivity: Each designated core faculty member must demonstrate a piece of scholarship per year as noted in the Program Requirements.

Collective Program Scholarly Productivity: The program as a whole must demonstrate significan to the specialty of Emergency Medicine. On average, these collective contributions should equa the total achieved if 20% of the core faculty were to publish one original, scientific peer-reviewed each year.

Faculty Staffing Levels

It is important that each program maintain sufficient levels of faculty staff coverage in the emerg departments in order to ensure adequate clinical instruction and supervision, as well as efficient clinical operations. The RRC-EM uses a minimum faculty staffing ratio of 4.5 patients per facult guideline in this determination.

The RRC-EM acknowledges that many program factors (such as patient acuity, ancillary staffing ED and hospital facilities, ED crowding, use of mid-level providers, among others), may have ar this determination. Thus, the RRC-EM will consider exceptions to this minimum guideline, and r or down in individual circumstances, as necessary.

RRC Use of ABEM Data

"Successful attainment of board certification by program graduates is an objective measure use EM to evaluate program quality. Program graduates are expected to take the ABEM Written and certifying examinations. Over the 5-year period immediate preceding program review at least 70 graduates taking the Written Examination and at least 80% of graduates taking the Oral Examination become certified on their first attempt. The RRC-EM will take into account improvement or decliperiod considered and will consistently monitor programs according to these criteria."

Duty Hours on Emergency Medicine Rotations

"There must at least an equivalent period of continuous time off between scheduled work period may attend educational activities between work periods, but at some point in the 24 hour period equivalent period of continuous time off between the end of one activity (work or educational) are another activity (work or educational)."

GUIDELINES FOR PROCEDURES AND RESUSCITATIONS

Numbers include both patient care and laboratory simulations

Adult medical resuscitation	45
Adult trauma resuscitation	35
ED Bedside ultrasound	*
Cardiac pacing	06
Central venous access	20
Chest tubes	10
Procedural sedation	15
Cricothyrotomy	03
Disclocation reduction	10
Intubations	35
Lumbar Puncture	15
Pediatric medical resuscitation	15
Pediatric trauma resuscitation	10
Pericardiocentesis	03
Vaginal delivery	10
* See Procedural Competency Guideline	

Qualifications for Emergency Medicine Faculty

All emergency medicine faculty supervising emergency medicine residents on emergency medi must be board certified by the American Board of Emergency Medicine, or have appropriate edqualifications in emergency medicine. Examples of educational qualifications acceptable to the

- Certification by the American Osteopathic Board of Emergency Medicine
- Certification by a subspecialty board sponsored or cosponsored by the American Board Medicine
- Recent residency or fellowship graduates actively working toward certification by the ab-

Additionally, faculty providing supervision to emergency medicine residents on emergency med must have appropriate qualifications relative to the patient population for which they provide EV supervision. For example, a faculty member board certified in pediatrics and pediatric emergence would be qualified to supervise EM residents on pediatric cases, but not adult cases.

Core Competencies Guideline

Annual Competency Assessment – The programs must define competencies that are expect year of training taking into account the defined ACGME core competencies. Multiple tools may I evaluate these competencies. Competency evaluation of chief complaints, procedures, resuscit service rotations may be used as part of the annual competency evaluation. The RRC will revie

What competencies are expected for each year of training? What are the measurable competer for each year of training? How are these objectives measured? How are deficiencies remediate

Deficiencies in specific areas does not necessarily mean that the resident is held back in progre next year; however, plans must be in place to achieve the required competencies.

Chief Complaint Competency - The RRC expects that programs will assess the competency chandle key chief complaints in emergency medicine. At the time of program review, the program demonstrate how it assesses resident competency for 3 chief complaints over the course of the program. The program can use a variety of tools including direct observation, check-lists, simula

Procedural Competency – The primary responsibility for the determination of procedural composite with the program director and the faculty. The RRC accredits programs, and does not certify or individuals.

The RRC expects programs to assess the competency of residents to perform key index proced time of program review, the program will need to demonstrate how it assesses competency of a procedures.

Selected index procedures should consequentially impact patient care, and ideally facilitate con assessment initiatives across disciplines.

One of the selected procedures must be ED bedside ultrasound (PR V.B.2.b; appendix 1)

Resuscitation Competency – The RRC expects programs to assess resident competency in the resuscitation of critical patients. These include adult and pediatric medical and trauma resuscitation of program review, the program will demonstrate how it assesses competency in one type resuscitation. The program may use a variety of techniques including simulations and direct observed.

Off-Service Rotations – The program should define measurable competency objectives for off rotations, how the objectives are assessed and remediated when necessary. At the time of prog is expected that measurable objectives and the tools used for evaluation will be available for ha service rotations.

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