Resident / Fellow Survey Data Summary
Program: **[1102621144] HealthPartners Institute for Medical Education Program**
Emergency medicine
Residents / fellows responded to this Survey: **March 2010 - April 2010**

Total Residents / Fellows on Duty: **27**
Total Responses to Survey: **27**
Response Rate: **100.0%**

#	Question	Yes	No	Not applicable
1.	Do the faculty spend sufficient time TEACHING residents/fellows in your program?	100.0	0.0	
2.	Do the faculty spend sufficient time SUPERVISING the residents/fellows in your program?	100.0	0.0	
3.	Do your faculty members regularly participate in organized clinical discussions?	96.3	3.7	0.0
4.	Do your faculty members regularly participate in rounds?	40.7	7.4	51.9
5.	Do your faculty members regularly participate in journal clubs?	88.9	11.1	0.0
6.	Do your faculty members regularly participate in conferences?	96.3	3.7	0.0
7.	Do you have the opportunity to confidentially evaluate your FACULTY, in writing or electronically, at least once a year?	100.0	0.0	
8.	Do you have the opportunity to confidentially evaluate your overall PROGRAM, in writing or electronically, at least once a year?	100.0	0.0	
9.	Has your program provided you access to, either by hard copy or electronically, written goals and objectives for the program overall?	100.0	0.0	
10.	Has your program provided you access to, either by hard copy or electronically, written goals and objectives for each rotation and major assignment?	100.0	0.0	
11.	Do you receive written or electronic feedback on your performance for each rotation and major assignment?	85.2	14.8	
12.	Are you able to review your current and previous performance evaluations upon request?	100.0	0.0	
13.	Have you had sufficient education (from your program, your hospital(s), your institution, or your faculty) to recognize and counteract the signs of fatigue and sleep deprivation?	96.3	3.7	
14.	Does your program offer you the opportunity to participate in research or scholarly activities?	100.0	0.0	
15.	Have residents / fellows had the opportunity to assess the program for the purposes of program improvement?	96.3	3.7	
16.	Has your ability to learn been compromised by the presence of trainees who are not part of your program, such as residents from other specialties, subspecialty fellows, PhD students, or nurse practitioners?	11.1	88.9	
17a.	Does your program provide an environment where residents/fellows can raise problems or concerns without fear of intimidation or fear of retaliation?	92.6	7.4	

#	Question	Extremely satisfied	Very satisfied	Somewhat satisfied	Slightly satisfied	Not at all satisfied
17b.	How satisfied are you with your program's process to deal confidentially with problems or concerns you might have?	51.9	25.9	7.4	3.7	11.1

#	Question	At all times	Some of the time	None of the time
18.	How often are you able to access, either in print or electronic format, the specialty specific and other reference materials that you need?	92.6	7.4	0.0

#	Question	Extremely often	Very often	Sometimes	Rarely	Never
19a.	How often do your rotations and other major assignments provide an appropriate balance between clinical education and other demands, such as service obligations?	37.0	44.4	14.8	0.0	3.7

#	Question	Never	Rarely	Sometimes	Very often	Extremely often
19b.	How often has your clinical education been compromised by excessive service obligations?	25.9	51.9	22.2	0.0	0.0

#	Question	Extremely often	Very often	Sometimes	Rarely	Never	Not applicable
20a.	Duty hours must be limited to 80 hours per week, averaged over a four-week period, inclusive of all in-house call activities.	92.6	7.4	0.0	0.0	0.0	0.0
20b.	Residents / fellows must be provided with 1 day in 7 free from all educational and clinical responsibilities, averaged over a 4-week period, inclusive of call.	85.2	14.8	0.0	0.0	0.0	0.0
20c.	There should be a 10-hour time period provided between all daily duty periods and after in-house call.	55.6	40.7	3.7	0.0	0.0	0.0
20d.	In-house call must occur no more frequently than every third night, averaged over a four-week period.	88.9	7.4	0.0	0.0	0.0	3.7
20e.	Continuous on-site duty, including in-house call, must not exceed 24 consecutive hours. Residents and fellows may remain on duty for up to 6 additional hours to participate in didactic activities, transfer care of patients, conduct outpatient clinics and maintain continuity of medical and surgical care.	81.5	14.8	0.0	0.0	3.7	0.0
20f.	No new patients may be accepted after 24 hours of continuous duty.	92.6	3.7	0.0	0.0	0.0	3.7
20g.	At-home call must not be so frequent as to preclude rest and reasonable personal time for each resident / fellow.	88.9	3.7	0.0	0.0	0.0	7.4
20h.	Residents / fellows taking at-home call must be provided with 1 day in 7 completely free from all educational and clinical responsibilities, averaged over a 4-week period.	85.2	7.4	0.0	0.0	0.0	7.4
20i.	When residents and fellows are called into the hospital from home, the hours they spend in-house are counted toward the 80-hour limit.	88.9	3.7	0.0	0.0	0.0	7.4

#	Question	Other services	Within my specialty	Both	Not applicable
21.	If you noted any duty hours issues in the section above, would you say that those issues occurred mostly on rotations to other services outside your specialty?	7.4	7.4	7.4	77.8

= shaded areas contain non-compliant responses.

Percentages may not add to 100% due to rounding.

The Residency Review Committee for Emergency Medicine
Resident Questionnaire
Program: **[1102621144] HealthPartners Institute for Medical Education Program**
Residents responded to this Survey: **March 2010 - December 2009**

Total Residents on Duty: **27**
Total Responses to Survey: **27**
Response Rate: **100%**

	None	Few	Some	Most	All
How many faculty attend and meaningfully participate in scheduled weekly conferences?	0	4	20	3	0

	No, not this year	Once this year	2-3 times this year	4 or more times this year
Has your program director (or designee) met with you and conducted a formal review of your overall progress and performance in this program?	0	11	16	0

Does your program provide you the opportunity to:	No	Yes
perform an appropriate number of procedures to be competent?	0	27
direct an appropriate number of major resuscitations to be competent?	0	27
become a competent Emergency Medicine physician?	0	27

2010 Program Survey by Residents

	Category/Question	Average
22	Accessibility and responsiveness of program manager and program coordinator (Lori & Pat)	**8.3**
	22) Two of the definite perks of this program.	
	22) Wonderful!!!	
	22) Hope they never retire (or wait until I graduate at least).	
	22) Have always been helpful and friendly, assisting in navigating residency has been terrific.	
56	Your support of the residency. Are you content here? Would you recommend this program to others?	**7.9**
	56) Absolutely.	
	56) Absolutely happy here, glad I chose here, would recommend to anyone interested in this program.	
20	Quality and responsiveness of social work staff in the ED.	**7.8**
	20) Great assets to appropriate management of BH patients.	
	20) A great group!	
	20) Some social workers are very slow....	
59	Your impression of the EM-3 support of the residency a group.	**7.8**
10	Faculty supervision of EM residents	**7.7**
	10) good balance of autonomy and supervision	
	10) Working with our faculty is one of the most rewarding aspects of this program.	
	10) I would appreciate staff to come into the room with me and discuss physical findings when they find them... more bedside teaching.	
	10) A variety of teaching.	
	10) Generally great, but there are exceptions	
12	Opportunities for progressive resident responsibility in patient care	**7.7**
25	Overall direction/assistance/support provided by IME.	**7.7**
	25) Would Like a Workout facility in Hospital	
	25) The "comminucation" conference was excellent!	
	25) It is unclear (to me) how the IME is actually involved/related to the operation of our residency but I assume that because the residency holds great reputation within Regions/HP, well-staffed, well-funded and we have exciting experiences like trips to SAEM and involvement in off-campus conferences like ethics, trauma and core competence that IME must also be doing a good job.	
33	Overall rating of the Regions Emergency Department rotation	**7.7**
	33) I have been very happy with my ED experience thus far.	
23	Overall direction and leadership of residency provided by director, associate and assistant directors (Ankel, Dahms, Hegarty & Taft).	**7.7**
	23) A great team.	
	23) Feel very fortunate to be here.	
31	Opportunities for involvement in the EMS system.	**7.7**
	31) Ample opportunity for involvement if so desired.	
60	Overall program rating.	**7.7**
	60) This is what I was hoping for in residency, and I have no regrets for selecting EM and Regions. The diversity in off-service training, EM exposure, EMS training and relationships with attendings/residents has been great. There are attendings and residents here that push you, and make you want to push yourself to be a better physician.	
15	Overall quality of EM faculty - academic competence, clinical competence, teaching ability.	**7.6**
	15) I think all the staff are very book smart but I question clinical competence as they "talk the talk but consult the walk"	
57	Your impression of the EM-1 support of the residency as a group.	**7.6**

2010 Program Survey by Residents

18	Competence and responsiveness of Clerk staff in the ED	**7.6**
41	Overall rating of the Emergency Medical Services rotation (within last 12 months)	**7.5**
	41) Great EMS experience. Learned a lot about pre-hospital and a great time interacting with the staff.	
17	Competence and responsiveness of ERT staff in the ED	**7.4**
	17) The ERT staff are terrific. However, there need to be more females available to chaperone pelvic examinations in PODs where gynecological complaints are seen.	
	17) Can be difficult if only men are working in Pod A for pelvic exams.	
	17) Generally very good, but on occasion it's difficult to get what you need.	
43	Overall rating of the SICU rotation	**7.4**
	43) Great Experience. Improvement of the note template would be extremely helpful.	
	43) Something must be done about the documentation system in the SICU. Residents spend the majority of their day (and night) in the SICU working on documentation. This is time that could be spent learning about their patients' conditions, searching the literature for treatment strategies, and meeting with patients' family members to update them on the treatment plan. Dictation, scribes, and shortened note template are options.	
	43) Fun to work with other ER residents.	
	43) Learned a lot about ICU care: pressors, hemodynamics, sepsis, etc.	
	43) One of the jewles of the residency. It should be protected at all costs. Maintaining the EM presence in the SICU should be a priority.	
	43) Excellent teaching and procedural experience. Great critical care opportunities. Admittedly rough schedule but definitely worth having daily presence in SICU - would consider breaking G1, G2 rotations into 3+3 or 4+2 wk blocks.	
7	Patient volume and quality of medical, surgical, pediatric, gynecological and behavioral emergency cases seen in the ED	**7.4**
	7) Pediatric experience is not as strong as I believe it may be in other programs.	
	7) At times we are understaffed for the patient population	
	7) Maybe a little light on general pediatric complaints compared to other topics.	
47	Quality and quantity of community rotations	**7.4**
	47) Abbott N W was a great experience.	
48	Quality and quantity of electives	**7.3**
16	Quality and responsiveness of ED Nursing staff	**7.3**
49	Does the progam and/or institution have a systemÂ through which you are able to raise and resolve issues without fear of intimidation or retaliation?	**7.3**
28	Availability and quality of resident involvement in Simulation activities.	**7.3**
	28) More sim would be useful	
	28) Too much reliance on simulation. Nothing trumps a live organism.	
30	Quality of resident involvement in teaching of EM residents, rotators and medical students	**7.3**
44	Overall rating of the Toxicology rotation (within last 12 months)	**7.3**
54	Availability and accessibility to resources for academic development (memberships to specialty societies, attendance at national conferences,inservice and oral board preparation, mentorship opportunities).	**7.2**
24	Departmental direction and leadership by department head and administrative director (Isenberger & Jader).	**7.2**
	24) Very good at addressing topics quickly and making changes promptly as needed.	

2010 Program Survey by Residents

29	Quality of US program in the ED quality of ultrasound education and teaching. Opportunities to perform ultrasound examinations in the ED.	**7.2**
	29) Majroity of the staff have no idea how to turn the machines on and the majorty are VERY RELUCTANT to order a formal ultrasound...	
	29) Would consider a few dedicated US shifts as 3rd year to provide opportunities to brush-up skills (get all questions answered) prior to graduation. I am not sure an entire month dedicated to US is needed now with dedicated G1 rotation.	
40	Overall rating of the MICU rotation (within last 12 months)	**7.1**
	40) Good teaching most of the time, definitely good critical care and procedural experience.	
11	Opportunities to run resuscitations.	**7.1**
	11) Have not run many but see that I will with time.	
	11) great with good backup so I don't feel alone with the adrenaline.	
19	Quality and team attitude of Physician Assistant staff in the ED.	**7.1**
	19) I believe that this took a hit this year with all of the new changes.	
	19) Great PAs. Morale is somewhat low at this time which is unfortunate; the working relationship with the PAs used to be a strength.	
21	Competence and responsiveness of ancillary care providers, x-ray, lab, respiratory, blood bank, transportation.	**7.1**
	21) Lab can sometimes be delayed.	
55	Opportunities for involvement in recruitment and selection of future residents.	**7.1**
	55) I felt that this year the residents comments were not taken to heart.	
	55) Definite positive presence in recruitment. Regarding match this year -- Specific applicant who matched at Regions had what I observed to be overwhelmingly negative response during 'closed door ranking' of applicants.	
8	Number of procedures	**7.0**
	8) Volume of procedures is a clear strength.	
	8) Procedure labs are fantastic	
	8) No shortage of procedures in this ED.	
	8) Luck of the draw- not as many chest tubes/lumbar punctures at this point. I'm sure they will come.	
36	Overall rating of the OB rotation (within last 12 months)	**7.0**
	36) More opportunities for deliveries as a male would have been nice.	
	36) In right now.	
53	A availability and accessibility of activities promoting general resident well being (scheduling and leave policies, access to advisors, access to resident support services).	**7.0**
	53) Known leaves (paternity, maternity, etc.) might be incorporated into scheduling to distribute the absence among many residents.	
	53) In my opinion, vacation scheduling has become unnecessarily arduous. I would recommend returning to resident-requested vacation weeks. If there is a conflict, the more senior resident (G3,G2,G1) would be given preference for scheduling. If the conflict exists between two residents of the same class, a coin toss could be used.	
9	Quality/responsiveness of specialty back-up to the ED	**6.9**
	9) Is in general excellent.	
	9) Most services are eager to support the ED and teach. It makes for a great learning environment.	
	9) Staff always defers and sends patietns up or home without doing much... even a joint tap or a simple splint... "call a consultant" is the vibe i get from the majority of staff....	
13	Accessibility and maintenance of equipment in ED exam rooms.	**6.9**

	13) My only concern is the limited availability of pelvic exam carts. I believe that performing a pelvic exam with an inverted bedpan is rather uncomfortable for the patient. Triage decisions should be made based on the possibility of a pelvic exam being performed. If the exam is at all likely, the patient should be taken to a room where a pelvic exam cart is available.	
	13) Techs need to fill the LAC carts more frequently.	
58	Your impression of the EM-2 support of the residency as a group.	**6.9**
27	Availability and quality of resident involvement in CQI (chart audits, QI conference involvement)	**6.8**
	27) Dr. Lefevere does an excellent job of maintaining this conference as an educational experience rather than a punitive one.	
42	Overall rating of the St. Paul Children's ED rotation	**6.8**
	42) This is a solid childrens hospital rotation. It just makes me remeber why I went into adult EM.	
	42) Good volume of peds pts to independently evaluate.	
	42) not a lot of sick kids, and when there are, staff are reluctant to let us see them primarily	
37	Overall rating of the Minneapolis Children's ED rotation (within last 12 months)	**6.8**
	37) Enjoyed the bread and butter, no trauma activity while I was on service.	
14	Accessibility and condition of ED conference rooms	**6.7**
	14) Difficult for residents to attend off site conferences.	
	14) Great upgrade in Lyndell. Nice work!	
	14) Lindell is awesome.	
26	Overall quality of format and content of ED conferences - critical case, core content, journal club, QI, small groups.	**6.7**
	26) Focus needs to be directed on core curriculum.	
	26) I like the format of critical case, but I'm afraid that this conference sometimes sends the wrong message to residents (i.e. you need to CT, lab, etc. everyone with a presentation similar to the patient discussed today or you might miss this devastating illness). The focus should be on the distinguishing features of the critical illness that warrant aggressive workup and treatment.	
	26) I want the people who see the patients up on the stage, not somebody to read the physical exam. Lame case. 1st on differential list is usually PE... and boring powerpoint after. To make these conferences better I would like to see video clips of the ressusitation and definetly pictures of interesting clinical findgins (not x-rays) actual jpeg's... but the whole taking-a-picture with the camera in the safe thing is way too cumbersome and not worth the time.	
	26) Regarding critical case: would greatly appreciate significantly more faculty input as this would facilitate learning after resident guessing/problem solving on some occasions. Could mix in "bread and butter" (core content) type EM cases with critical case. Zebras are fun but sometimes common ED practices are overlooked in regards to conference possibly based on assumption of knowledge?	
	26) critical case is great, trauma conference is generally low yield, QI great and small groups/sim are usually very helpful	
46	Overall rating of the HCMC ED rotation (within last 12 months)	**6.7**
35	Overall rating of the Plastics/Hand rotation (within last 12 months)	**6.6**
	35) great ED consults, responsive attendings and teaching chiefs.	
32	Opportunities for involvement in ED research. Faculty encouragement, departmental support and sufficient time during residency to participate in research.	**6.6**
	32) There is a lack of department support for resident projects ie helping get through the IRB process, selecting and submitting to journals etc	

50	Do your rotations and other major assignments emphasize clinical education over any other concerns, such as fulfillling service obligations?	**6.6**
	50) When understaffed in the ER, the movement of patients is much higher stressed than clinicle education	
38	Overall rating of the Anesthesia rotation (within last 12 months).	**6.5**
	38) Sometimes I feel like a "stranger" going room to room intubating then leaving. Maybe it would be good to incorporate a few days when we shadow a CRNA. That way we get to know the staff better, the get to know us, and we see the whole anesthesia process. I feel like that way the anesthesia crew wouldn't feel like we were "tube-and-dash"-ing.	
	38) Great to get the numbers/comfortable. Enjoyed the extension throughout the year to tweak my approach after experiences in the ED. The break up in exposure makes relationships with attendings difficult (and gaining their trust for "difficult intubations").	
45	Overall rating of the Adminstration experience (within last 12 months)	**6.4**
34	Overall rating of the Orthopedics rotation (last 12 months)	**6.3**
	34) hard to gauge the hours: there was down time during the day and then consults coming in finally once our shift was about to end- creating the problem stay later to learn or go home after being in the hospital for several hours.	
	34) If goal of rotation is reductions then the rotation needs improvement as this does not occur predictably. Consider "procedure" month in ED - present in ED for any/all procedures including ortho, sedations, cardioversions, tubes, lines, etc. This could also be opportunity to observe/learn resuscitations.	
39	Overall rating of the Cardiology rotation (within last 12 months).	**6.0**
	39) Maybe having an EKG file of "bread & butter" and "need to know" dangerous EKG to review while on this rotation?	
1	List the three most important aspects of this program for you.	
	1) Autonomy, teaching, education	
	1) My relationship with other residents. Dedications to EBM.	
	1) Great training Great teachers Good variety	
	1) People, procedures, exposure to sick patients	
	1) 1) Support of Residency 2) Emphasis on Procedural Competency 2) Critical Care Experience	
	1) 1. Optimal diversity of patients: socioeconomic, cultural, and overall health status of patients are well-balanced at Regions. 2. Support from the program directors, program coordinators, and HP IME. 3. Great interactions with consulting services.	
	1) 1) "The people!" Working with pleasant people maked all the difference. 2) Adaptability. 3) Wellness-aware.	
	1) Quality of teaching Ability to improve the program based on feedback ICU experience	
	1) The people (other residents, staff, nurses and ERTs), the location (Midwest near my family) and the program philosophy.	
	1) The people Procedures The overall training experience	
	1) Balance of appropriate clinical rotations, supportive program leadership, quality of health care system.	
	1) Hospital Location Opportunities to experience more of a private style of medicine.	
	1) 1. Diversity in patients (demographics, presentations, acuity) 2. Strength of off-service training 3. Personality (btwn residents, staff/attendings, ancillary)	
	1) 1. Matt Morgan 2. Independence 3. Critical care experience.	
	1) 1. people 2. procedures 3. critical care	
	1) autonomy procedures critical care	
	1) Faculty/resident culture - appropriate balance of formality and diversity. Diverse medical/procedural oppurtunities and experience. Stated and observed focus on resident wellness.	
	1) exposure to all things common comfort with procedures exposure to sick patients and feeling comfortable with management issues	
2	List the strengths of the residency program.	

	2) ICU care, autonomy	
	2) The critical care time. The excellent relationship between staff and residents. The emphasis on wellness.	
	2) As above. Also, good patient load, lots of procedures, good exposure to bread and butter emergency medicine.	
	2) Flexibility to needs of residents, teaching staff, critical care time	
	2) As Listed in Previous Response	
	2) Faculty with diverse backgrounds and interests, involvement in aspects of healthcare outside of ED shifts, focus on procedural and critical care competency.	
	2) See above.	
	2) Openness to change and new ideas Overall great people in the program (Everything listed above)	
	2) See one, do one, teach one place. Graduated responsibility Patient population Felix as PD	
	2) The people The cirriculum The opportunities	
	2) HealthPartners, Felix Ankel, equipment resources within department, hospital's commitment to constantly improving processes, patient mix, relationships with other departments within the hospital.	
	2) People Administrators Foward Thinking.	
	2) Progressive responsibility- graduated responsibility in patient care with back-up on difficult cases as needed.	
	2) procedures, critical care, working in a public/private system	
	2) procedures critical care number of patient encounters	
	2) Diversity in faculty training, practice style and practice experience. Diverse medical/procedural oppurtunities and experience. Critical Care experience - esp relationship with Trauma service. Stated and observed focus on resident wellness.	
	2) critical case staff busy ed	
3	What should the residency CONTINUE DOING to improve?	
	3) Continue the EM/IM conferences and building relationship with IM through conferences, and triage hospitalist rotation.	
	3) Continue conferences, good teaching time. continue Pod C exposure for 3rd year residents.	
	3) Continue to push ultrasound, and adjusting staff in pods	
	3) Focus on QI and continue to emphasize educational aspects that promote the development of good EM physicians.	
	3) Continue to develop the ultrasound and research programs, utilize resources available in the medical library, and collaborate with HCMC, U of M, and Mayo.	
	3) I like how "self aware" the program is, constantly seeking to improve itself.	
	3) Continue listening to the residents and staff and incoporating that feedback for improvement (we do a great job of this!)	
	3) Being responsive to resident feedback. Recruiting quality people that are easy to get along with.	
	3) Continue with real time changes and tweaks Continue with recruitment	
	3) WOrk to include residents in quality and process review committees, continue to be flexible and review educational objectives of all rotations.	
	3) Process evaluation Continue to listen to the residents, their gripes, and what they would like changed which I feel is already being done adequately.	
	3) Listen to the residents.	
	3) stressing critical care from day 1, ie with interns doing code blue airways	
	3) critical care US	
	3) Continue to focus on things above/beyond mere medical proficiency as this makes Regions Program stand out.	
4	What should the residency STOP DOING to improve the residency?	
	4) none	
	4) The palliative care experience is good, but it is somewhat duplicated as we do a lot of palliative care in the ICU.	
	4) EM-Integrated does not prepare first years as well for the ED as the conventional approach.	

	4) I would recommend that the leadership take a close look at the leave policy for maternity, paternity, etc. While it is important that residents who choose to have children during residency are given time off to adapt to their new life circumstances, it often seems that those residents who have chosen not to have children during residency are expected to cover for those who have chosen to do so.	
	4) In a perfect world, I would like to stop consistently staying 1.5-2 hours after my shift ends.	
	4) -	
	4) Some decisions should just be made by leadership, not put to a consensus vote.	
	4) focusing to heavily on the buisness aspects of medicine	
	4) less "busy work"	
	4) med student c spine talk needs fixing	
5	What should the residency START DOING to improve theÂ residency?	
	5) none	
	5) Look into a neurology rotation.	
	5) Unsure	
	5) NA	
	5) I find it very unsanitary that residents are expected to launder their own scrubs and lab coats. Frequently these garments are exposed to blood and bodily fluids while on duty, yet we're expected to take the soiled garments home and place them in the same laundry machines used by our families. I would recommend looking into a way for scrubs and lab coats to be laundered at the hospital.	
	5) Work on getting residents home within an hour of the shift's end (changing how sign-outs work, overlapping shifts, etc.)	
	5) -	
	5) More options at places such as Hudson for selective rotations.	
	5) Take more responsibility in the ER- as in patient procedures and patient care vs triage.	
	5) Utilizing Web 2.0 Small group journal club discussion.	
	5) i feel weak in ortho. not sure how to fix this, but would be nice to feel more comfortable with reductions.	
6	Where should the residency focus its energy in the next year?	
	6) more focus on teaching	
	6) on continuing to improve first year design. Also continue to work on scheduling.	
	6) Appropriate staffing, integrating and educating residents on use of c arm for reductions	
	6) Establishing a cohesive supportive work environment in the ED.	
	6) I would recommend revising the conference attendance policy. First, missed conference for vacation weeks should not count against the resident (i.e. count it as 0/0 hrs. rather than 0/5 hrs.). Second, consider revising the 75% attendance requirement, which was initiated when video review of conferences was still available. Third, closely examine how scheduling patterns affect conference attendance (i.e. if a resident is on night shift every Wed. and Thurs. 75% attendance would lead to massive sleep deprivation).	
	6) Keep up the great work!	
	6) -	
	6) Keep adjusting the staffing as needed to account for changes in census numbers.	
	6) Recruitment	
	6) Staffing models, quality cirriculum	
	6) Better website... yes.. even though it was just re-done. Hire a professional, that is what they are fore. HTML is so 2000's we need some JAVA, integrate google calendars, get online lectures cooking!	
	6) Simulation training- simulating tta/codes with "teachable moments".	
	6) on integrating the 10th resident into the program	
	6) Continuing to advance US training. Bring a somewhat difficult to understand aim of "quality" into daily practice in the ED. C-arm training/use. Nitrous oxide use in procedural sedation for both peds/adults.	
	6) i like the talk of integrating quality improvement into the curriculum.	
51	How many times in the previous three months were you scheduled fewer than 10 hours off between duty shifts (including conferences)?	
	51) 2	

	51) 3-4	
	51) 0	
	51) ~2 times; I attended conference after a night shift.	
	51) Once.	
	51) A few times, but I just skipped conference (and am still over 75% attendance).	
	51) 4	
	51) 4	
	51) None	
	51) Several times (more than 5) for ED shifts and conferences	
	51) 2 times, and this just happened to be a rare occurence.	
	51) 2	
	51) none	
	51) Every G2 evening shift. Every Wed shift at St Paul Childrens.	
	51) 3 times?	
52	How many times in the previous three months were you scheduled fewer than 10 hours off between duty shifts (excluding conferences)?	
	52) 0	
	52) none	
	52) 2	
	52) 0	
	52))	
	52) Never.	
	52) None.	
	52) 0	
	52) 0	
	52) None	
	52) Never	
	52) 1 time, and I was able to re-organize my schedule to get the time off.	
	52) 0	
	52) none	
	52) None	
	0	
61	Please give feedback on annual program survey (e.g., questions to add or delete for future surveys).	
	61) Doing great	
	61) How do you rate the appropriateness of the method of selecting rotation/vacation blocks for G1, G2, G3 years.	
	General Comments	
	Great training, feel very well prepared.	
	Great Experience so far, on the whole great teaching staff and other residents	
	Glad to be here!	
	Regions ER Residency Program is an excellent program and I am very happy that I chose this program as my top choice for Emergency Medicine	
	Very happy with my choice	
	I think this program is very well-rounded. Good hospital support, good patient mix, busy and interesting ER.	
	Great Residency and great residents. Some of the older staff (not naming any particular names here) should be asked to leave. Too many consultations (specifically simple orthopedic splinting (distal radial fractures)) and not enough interventions. I find that I do less and admit more which I believe is secondary to staff not being comfortable with procedures. Some residents seemingly have time to do international work experiences whereas others don't. Not sure what specific criteria must be met or how one can leave clinical duties to do such a thing as it sounds interesting.	
	Very happy I have been here for residency.	
	Great residency	
	I enjoy this residency and consider myself fortunate to be training here. This is the right field for me and a great place to learn my vocation.	

2010 Program Evaluation by Faculty

23	Accessibility and responsiveness of program manager and programÂ coordinator (Lori & Pat)	**8.3**
	23) Amzaing as always.	
	23) The BEST!!!	
21	Quality and responsiveness of social work staff in the ED.	**7.9**
	21) Can't say enough great things.	
	21) overloaded at times	
1	Rate the overall quality of the residency program.	**7.8**
	1) Less contact with consultants in ED than other programs = a weakness and a strength.	
12	Overall clinical competence of EM-3 residents.	**7.8**
13	Opportunities for progressive resident responsibility in patient care	**7.7**
	13) seems to be resident specific	
24	Overall direction and leadership of residency provided by director, associate and assistant directors (Ankel, Dahms, Hegarty & Taft).	**7.6**
	24) Great job at providing a diverse and multifaceted leadership team.	
	24) Sharp, dedicated, greeat role models	
34	A availability and accessibility of activities promoting general resident well being (scheduling and leave policies, access to advisors, access to resident support services).	**7.5**
40	Your impression of faculty support of the residency. Do the faculty promote the residency to others and work to improve the residency?	**7.5**
7	Patient volume and quality of medical, surgical, pediatric, gynecological and behavioral emergency cases seen in the ED	**7.4**
22	Competence and responsiveness of ancillary care providers, x-ray, lab, respiratory, blood bank, transportation.	**7.4**
	22) x ray is excellent, though lab has improved, it is still the department I feel we struggle with most	
39	Your impression of the EM-3 support of the residency a group. Do the residents promote the residency to others and work to improve the residency?	**7.3**
33	Your impression of the Toxicology rotation and overall performance by EM residents on Tox.	**7.3**
	33) Hit or miss on the number of cases to be evaluated. Some months heavier than others.	
30	Quality of resident involvement in teaching of EM residents, rotators and medical students	**7.2**
37	Your impression of the EM-1 support of the residency as a group. Do the residents promote the residency to others and work to improve the residency?	**7.2**
17	Quality and responsiveness of ED Nursing staff	**7.1**
	17) Excellent	
	17) some (Andrew H) are always "in know" on how pts are doing and even let you know when labs are back and will let you know if there is a change in pt status. (the last is one of the MOST important traits that provides improved SAFETY in pt care.	
	17) We have many new RN's so the "safety net" of experienced ED nurses has changed. Many of the new RN's are experienced, but there are also many younger ones. Critical that they understand their critical role in identifying the ill patient who the student/intern/resident may not.	
28	Overall quality of format and content of ED conferences - critical case, core content, journal club, QI, small groups.	**7.1**
	28) difficult struggle to keep up to date with educational technology/needs of younger learners/antiquated RRC requirements	
25	Departmental direction and leadership by department head and administrative director (Isenberger & Jader).	**7.1**
	25) He is doing a great job in a very difficult position.	
	25) I think Kurt has done a great job but am somewhat concerned that other staff (eg PA's) are so unhappy	
	25) Kurt is doing a great job in his interm role	

	25) Remains focused and are tuned into the pulse of the department. Very supportive to department staff regardless of staff's level.	
20	Quality and team attitude of Physician Assistant staff in the ED.	**7.1**
	20) Again, much turnover in this group. I like the can do attitude that they have but strongly feel that new grads or PA's that have not worked in an ED should do 6 months of critical case to improve their knowledge of critical illness.	
	20) could use more so that we can adequate staff the ED so that those working are less frustrated.	
	20) Mixed group over the past year: some are 100% committed to Regions ED and hard working--others have been focused on their job/pay/hours and have let that affect their performance.	
10	Overall clinical competence of EM-1 residents	**7.0**
	10) Strong group.	
	10) We complain sometimes about the consultants but I think that they are very responsive here. Interaction with radiology is fantastic.	
19	Competence and responsiveness of Clerk staff in the ED	**7.0**
	19) couldn't live with out them	
	19) Great attitude. not easily frustrated under stress.	
26	Faculty support for residency activities.	**7.0**
38	Your impression of the EM-2 support of the residency as a group. Do the residents promote the residency to others and work to improve the residency?	**6.9**
36	Opportunities for involvement in recruitment and selection of future residents.	**6.9**
18	Competence and responsiveness of ERT staff in the ED	**6.9**
	18) We understaff this role. Would double the number of ERT's. I am more often looking for an ERT than an RN.	
	18) When available, they are great.	
32	Overall performance of HCMC residents and success of Regions-HCMC "swap"	**6.9**
	32) Solid residents	
	32) Their residents come with a different skill set, so I just have to remember that though they are very bright folks, they often do not appear to have the critical care and airway experience of our G2's and must be supervised more as a G1 in this respect. All have been very pleasant and eager to learn and very nice to work with.	
35	Availability and accessibility to resources for academic development (memberships to specialty societies, attendance at national conferences,inservice and oral board preparation, mentorship opportunities).	**6.8**
9	Quality/responsiveness of specialty back-up to the ED	**6.8**
	9) I think we are almost spoiled.	
	9) Ortho is overworked. Why not have EM ortho rotator stationed in Ed in evenings when coverage is light?	
	9) Some great, some not so (e.g. Surgery and OB staff come to ED for consult, Ortho, plastics, and ENT do not)	
	9) this is so variable service to service, it is difficult to specifically comment on but is generally quite good.	
	9) Would be nice to see staff from some specialty groups some times...	
11	Overall clinical competence of EM-2 residents	**6.7**
	11) Slower starters, most comming along nicely now.	
15	Resident performance in handling transfer calls.	**6.6**
	15) wish we could do a better job coaching system somehow	
27	Overall direction/assistance/support provided by IME.	**6.6**
	27) feel too removed to judge this.	
14	Resident performance in handling EMS radio calls.	**6.5**
	14) resident specific	

29	Quality of US program in the ED quality of ultrasound education and teaching. Opportunities for residents to perform ultrasound examinations in the ED.	**6.5**
	29) PT volume makes it difficult to do enough US (particularly staff)	
16	Accessibility and condition of ED conference rooms	**6.4**
	16) need dedicated and up to date conference space	
8	Resident coverage for patient volume	**5.8**
	8) Would be great to eventually have residents in Pod C/D area when that area is open as well.	
31	Opportunities for involvement in ED research. Faculty encouragement, departmental support and sufficient time during residency to participate in research.	**5.2**
2	List the strengths of the residency program.	
	2) develops personal responsibility and confidence	
	2) Leadership, ED and SICU rotation, conference days including small group and simulations days, EMS opportunities, TOXICOLOGY rotation/opportunities, Lori and Pat, the residents	
	2) Most everything. I appreciate the leadership of the residency.	
	2) People (Residents, Faculty), Vision, Innovation	
	2) Strong clinical experience with great didactics. Opportunites of graduated responsibility are key.	
3	What should the residency CONTINUE DOING to improve?	
	3) CQI, continue to enagage stakeholders outside of EM	
	3) diverse faculty. Interested residents. Great support at admin, clerical, (ED and office) hospital that makes changes, pts.	
	3) Great patient acuity and variety	
	3) Improve the clinical research infrastructure. Continue to encourage healthparters to improve inpatient peds.	
	3) Large and diverse patient population> Good outside experience with rotations at Children's, North Memorial, HCMC, and elective. SICU rotation results in fair number of procedures. There are a large number of young staff MD's who are interested in teaching.	
	3) Leadership, people	
	3) Research on basic clinical questions.	
4	What should the residency STOP DOING to improve the residency?	
	4) Decrease the resident exposure to psych patients as it is excessive.	
	4) JFac shifts should never have G3 supervising G3. ?Apod?	
	4) the frequent shifting of resident responsibilities.	
5	What should the residency START DOING to improve theÂ residency?	
	5) Consider tweaking ORTHOPEDICS to continue to give the residents the ortho training they need when they graduate.	
	5) Have all resident shifts align with the staff physician to facilitate evaluating, teaching and team structure.	
	5) I remain to be not a big fan of the critical case format. It forces residents in the audience into close-ended questions and is very unlike any real patient encounter or presentation. Start the case off with a short narrative, then open it up to discussion, and while it is called critical case, I feel that the focus becomes too much on just a sick patient who dwindles and dies and everybody leaves the room wondering what should I take home from that, what did I LEARN? We need to focus more on this aspect - FORCE those who present to really come into conference with the teaching points - 2 or 3 bullets. I would also suggest changing the name of the conference to something else and allow it to be open to interesting cases rather than just critical cases or once a month have a quick clinical case conference with 3-5 cases - (for example, last week I had a good case of gout - podagra and the residents hand't seen it before and weren't quite sure what to do with it - NSAIDS? steroids? This would be great and high yield. Another example was a traveler from Cambodia with fever - how do we approach this? Neither case was critical, but both would be good for the conference. Just some thoughts.	
	5) Implement QI projects for each resident	
	5) More followup of discharges. Mandate some followup.	
6	Where should the residency focus its energy next year?	
	6) Buffing up the ORTHO rotation, continue to allow freedom with electives, focus on making the HUDSON rotation the best it can be as a rural ED rotation will be a great addition to the program.	

	6) Clinical research and ED staffing. We need to maximize the resident exposure to all of the medical patients (including D) and decrease the psych exposure. This would be in line with off service rotations that we eliminate or change if the teaching/experience is subpar.	
	6) faculty engagement in clinical research. Further integration of quality, operations and education. Develop more expectations for those labeled, "core faculty" and develop incentives for being "core faculty."	
	6) I think that our residents would benefit from the managing of behavioral health patients with supervision by behavioral health staff MD's.	
	6) Intergration of CQI and education	
	6) lack of dental coverage. lack of pediatric coverage	
	6) reconsider size of residency. Midlevel coverage can be slim sometimes.	
41	Please provide any additional comments about the program that you feel would be helpful.	
42	Please provide feedback on the annual program survey (e.g., questions to add or delete for future surveys).	
	42) Too long!!! Seriously.	