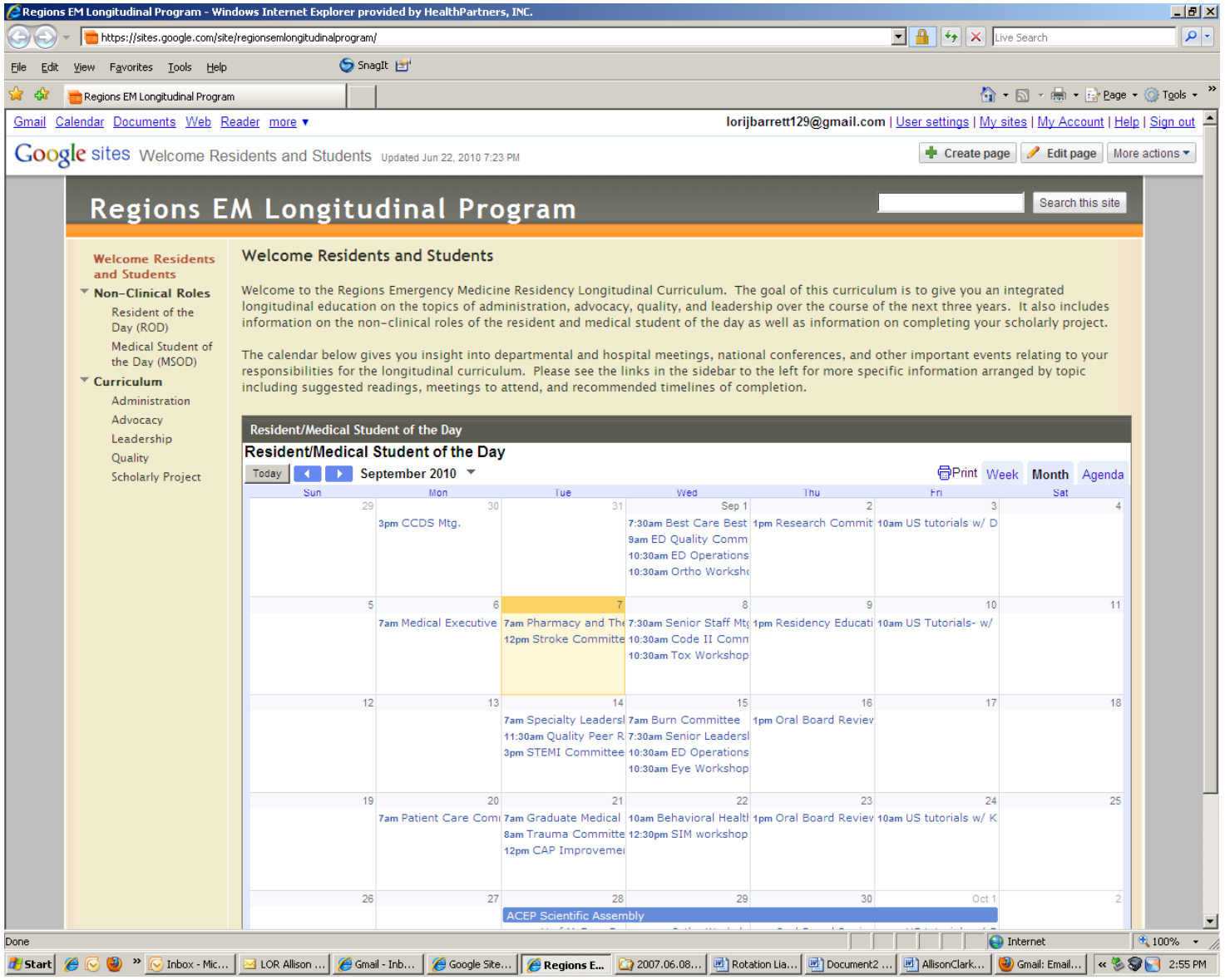

Regions EM Longitudinal Program - Windows Internet Explorer provided by HealthPartners, INC.
https://sites.google.com/site/regionsemlongitudinalprogram/
Live Search
File Edit View Favorites Tools Help
SnagIt
Regions EM Longitudinal Program
Page Tools
Gmail Calendar Documents Web Reader more
lorijbarrett129@gmail.com | User settings | My sites | My Account | Help | Sign out
Google sites Welcome Residents and Students Updated Jun 22, 2010 7:23 PM
Create page Edit page More actions
Regions EM Longitudinal Program
Search this site
Welcome Residents and Students
Non-Clinical Roles
Resident of the Day (ROD)
Medical Student of the Day (MSOD)
Curriculum
Administration
Advocacy
Leadership
Quality
Scholarly Project
Welcome Residents and Students
Welcome to the Regions Emergency Medicine Residency Longitudinal Curriculum. The goal of this curriculum is to give you an integrated longitudinal education on the topics of administration, advocacy, quality, and leadership over the course of the next three years. It also includes information on the non-clinical roles of the resident and medical student of the day as well as information on completing your scholarly project.
The calendar below gives you insight into departmental and hospital meetings, national conferences, and other important events relating to your responsibilities for the longitudinal curriculum. Please see the links in the sidebar to the left for more specific information arranged by topic including suggested readings, meetings to attend, and recommended timelines of completion.
Resident/Medical Student of the Day
Resident/Medical Student of the Day
Today
September 2010
Print Week Month Agenda
Sun Mon Tue Wed Thu Fri Sat
29 30 3pm CCDS Mtg. 31 Sep 1 7:30am Best Care Best 9am ED Quality Comm 10:30am ED Operations 10:30am Ortho Worksh 2 1pm Research Commit 3 10am US tutorials w/ D 4
5 6 7am Medical Executive 7 7am Pharmacy and The 12pm Stroke Committe 8 7:30am Senior Staff Mtg 10:30am Code II Comn 10:30am Tox Workshop 9 1pm Residency Educati 10 10am US Tutorials- w/ 11
12 13 14 7am Specialty Leadersl 11:30am Quality Peer R 3pm STEMI Committee 15 7am Burn Committee 7:30am Senior Leadersl 10:30am ED Operations 10:30am Eye Workshop 16 1pm Oral Board Reviev 17 18
19 20 7am Patient Care Comi 21 7am Graduate Medical 8am Trauma Committe 12pm CAP Improvemei 22 10am Behavioral Healtl 12:30pm SIM workshop 23 1pm Oral Board Reviev 24 10am US tutorials w/ K 25
26 27 28 ACEP Scientific Assembly 29 30 Oct 1 2
Done
Internet
100%
Start
Inbox - Mic... LOR Allison ... Gmail - Inb... Google Site... Regions E... 2007.06.08... Rotation Lia... Document2 ... AllisonClark... Gmail: Email...
2:55 PM

Barrett, Lori J

From: Roth, Eric B
Sent: Friday, August 20, 2010 9:06 AM
To: EMD Residents 2012; EMD Residents 2011
Subject: ROD "priorites"

Team Awesome,

There has been a little confusion regarding what to do on ROD days that was brought up during the G1 meeting. I think some of you might have similar questions so Im forwarding this on to you all. If you feel comfortable with what you are supposed to do on ROD feel free to stop reading now. If you have some confusion, read on.

ROD is designed to give you a little bit of autonomy regarding how to spend ROD time so that you can personally maximize your admin/quality/teaching experience during residency according to your interests, but there is at least one priority rule. So in order of priority…

Absolutely

1. If you are scheduled for ROD on a day when you are also scheduled for another clinical rotation activity, ie Ultrasthesia, Toxicology, EMS, ect the clinical activity should ALWAYS take priority. Sorry if this was not clear before. If you are ultrasthesia, you should be in the OR for every intubation opportunity and should NOT miss an intubation for some ROD activity (7a presentation, meeting, anything), same for tox; tox consults, case reviews, lectures, presentations, etc, all of these things should take priority over ROD activites. We are trying to eliminate and certainly minimize ROD days scheduled when you are also scheduled for something else.

Suggeseted

2. ROD pager activities. ROD pager goes off for code CVA and code STEMI. You should report to the ED and observe the management of these cases. There are also STEMI and CVA case review documents on the ROD website that you should complete after the case. MSOD and Drew Zinkel, when around, will also respond to these and review the case.

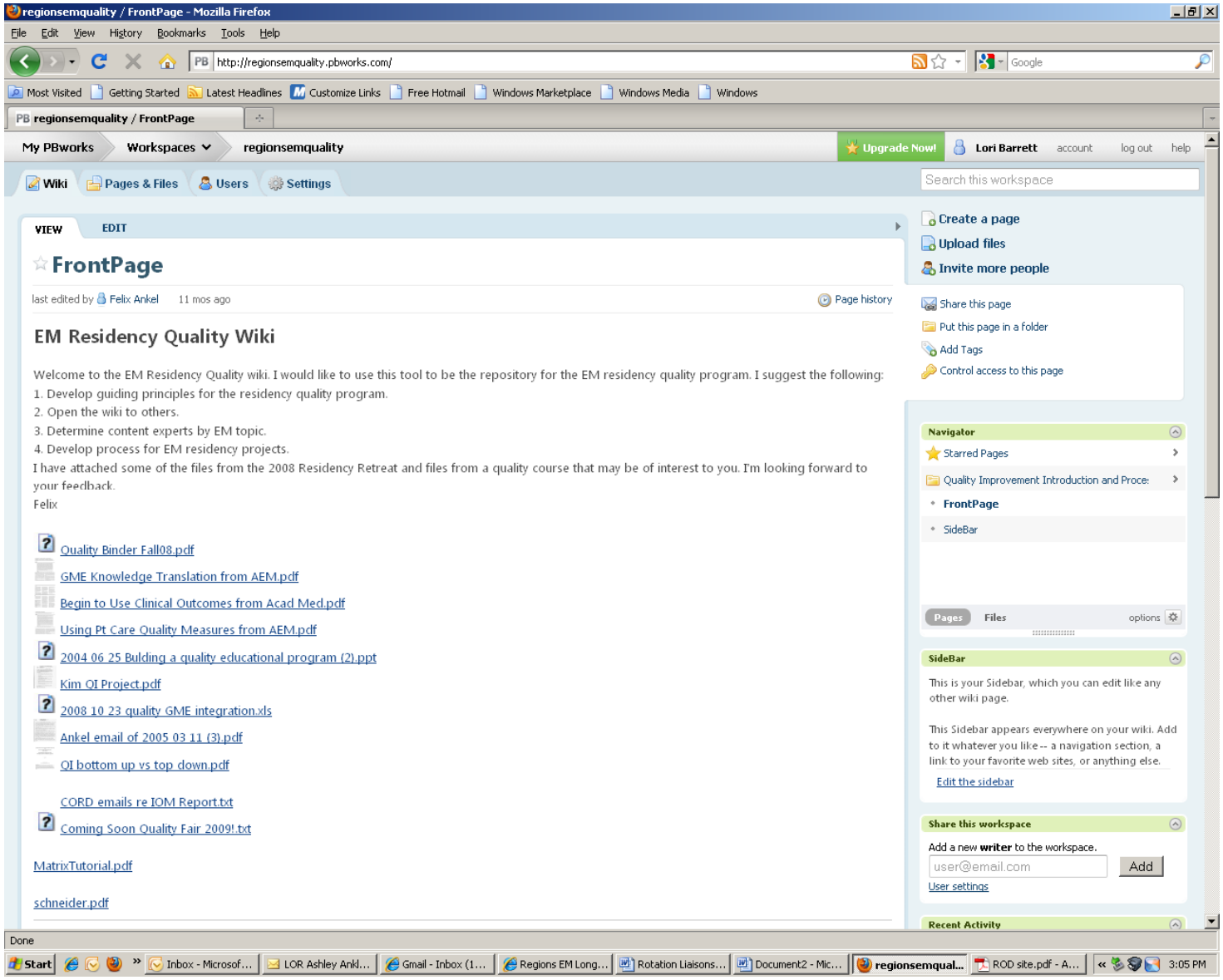
3. ROD meetings. The meeting schedule is on the ROD website and ROD calendar. There are occasions where meetings overlap or there are two different meetings at once. Use your discretion, no one meeting is deemed more important than another, you can personalize your Longitudinal Program experience. If at any point we decide that one meeting is absolutely more important than another scheduled at the same time, we will remove the less important one from the schedule. If you are going to a ROD meeting, you should be there a couple minutes eary.

So you might have question: If I am in a meeting and the ROD pager goes off, what do I do? I would suggest that you politely excuse yourself from the meeting and report to the ED to observe the case, that is probably higher yield and a less frequent occurence. However, if you are in a meeting that are very interested in, use your discretion. Conversly, if I am in the middle of observing a code CVA and a meeting is about to start, what do I do? Use your discretion, it is probably more useful to continue onserving the case but not always, especially if the bulk of the management is completed and you have been discussing it with Drew as it goes on. You should probably not walk into a meeting halfway through because you were finishing up a case.

4. Other ROD activities. Critical case presentations, CORD tests, etc… Again, use your discretion, if you have been to two meetings and you need to do your critical case presentation still, it is reasonable to miss a third meeting in favor of preparing your talk.

I hope that helps with clarity.

ER


regionsemquality / FrontPage - Mozilla Firefox
File Edit View History Bookmarks Tools Help
http://regionsemquality.pbworks.com/
Most Visited Getting Started Latest Headlines Customize Links Free Hotmail Windows Marketplace Windows Media Windows
regionsemquality / FrontPage
My PBworks Workspaces regionsemquality
Upgrade Now! Lori Barrett account log out help
Wiki Pages & Files Users Settings
Search this workspace
VIEW EDIT
FrontPage
last edited by Felix Ankel 11 mos ago
Page history
EM Residency Quality Wiki
Welcome to the EM Residency Quality wiki. I would like to use this tool to be the repository for the EM residency quality program. I suggest the following:
1. Develop guiding principles for the residency quality program.
2. Open the wiki to others.
3. Determine content experts by EM topic.
4. Develop process for EM residency projects.
I have attached some of the files from the 2008 Residency Retreat and files from a quality course that may be of interest to you. I'm looking forward to your feedback.
Felix
Quality Binder Fall08.pdf
GME Knowledge Translation from AEM.pdf
Begin to Use Clinical Outcomes from Acad Med.pdf
Using Pt Care Quality Measures from AEM.pdf
2004 06 25 Bulding a quality educational program (2).ppt
Kim QI Project.pdf
2008 10 23 quality GME integration.xls
Ankel email of 2005 03 11 (3).pdf
QI bottom up vs top down.pdf
CORD emails re IOM Report.txt
Coming Soon Quality Fair 2009!.txt
MatrixTutorial.pdf
schneider.pdf
Create a page
Upload files
Invite more people
Share this page
Put this page in a folder
Add Tags
Control access to this page
Navigator
Starred Pages
Quality Improvement Introduction and Proce:
FrontPage
SideBar
Pages Files options
SideBar
This is your Sidebar, which you can edit like any other wiki page.
This Sidebar appears everywhere on your wiki. Add to it whatever you like -- a navigation section, a link to your favorite web sites, or anything else.
Edit the sidebar
Share this workspace
Add a new writer to the workspace.
user@email.com
Add
User settings
Recent Activity
Done
Start
Inbox - Microsof...
LOR Ashley Ankl...
Gmail - Inbox (1...
Regions EM Long...
Rotation Liaisons...
Document2 - Mic...
regionsemqual...
ROD site.pdf - A...
3:05 PM

Felix Ankel

From: Felix Ankel [ankel001@tc.umn.edu]
ent: Friday, March 11, 2005 11:00 AM
o: 'robert knopp'; 'Brent.R.Asplin@HealthPartners.com'
Cc: 'Won.G.Chung@HealthPartners.com'
Subject: RE: clinical variation among staff

This is an area close to my heart and one that Brad G and I have been discussing from time to time. Brad calls this nodes of expertise. To get on my soapbox

"My vision is to increase the amount of medical knowledge that is effectively translated from what is known and what is practiced. My goal is to develop curricula and lead educational systems that are learner centered, multi-disciplinary, web based, "open source", continuously available and accessible, experientially focused, and outcomes based. I believe creating innovative curricula, continuously mentoring students, residents, and faculty, and systematically capturing the wisdom of learners and teachers for dissemination best achieve this."

I think this translation piece is the rate limiting factor for quality care and have been setting the groundwork for a Regions EM defined best practice in care (rather than relying on interpretation of former clinician of external proprietary guidelines)

This is what is set so far.
1. EMREL library to archive and search residency wisdom (e.g. can search Knopp + UTI) 2. Emres listserve that facilitates dialogue between practitioners inside and outside the department 3. 18 month curriculum that addresses breadth of EM content 4. 20+ faculty with defined core content "expert" designation

This is what we have but haven't tapped into for this
Education volunteer willing to focus speakers to ensure didactics are of appropriate eadth AND depth and facilitate wisdom posted on emrel in organized manner 2. EMR implementation with ability to link potential diagnosis to Regions defined best practices

These are thoughts I've considered
1. Each resident (27) is a core content expert when they start the residency and is paired with the core content expert faculty. One of their administrative projects is to develop one best practice guideline/per year with their faculty expert. They also review the other guidelines with their faculty on a yearly basis. This will allow each graduating resident to have the breadth of EM knowledge with and area of specified depth plus the experience of writing clinical guidelines 2. The clinical guidelines are living documents where proposed updates are presented on the emres list. Residents and faculty can be instructed to use JADE for this (journal articles delivered electronically) in a push me method. 3. The regions clinical guidelines are cross referenced and linked to our EMR 4. All 27 areas are reviewed in conference as a state of the art panel with the resident and faculty. E.g. we would have a state of the art panel every two weeks (state of the art panels would be 10-15% of all conference time, this will still allow for "core" board type material)

I think great discussion piece for strategic plan. This is one way of reducing MD variation and falls in nicely within the IOM,IHI, Leapfrog, ?Partners for health indicatives (the GE leapfrog equivalent). I think it would be more robust than milliman or Interqual, it addresses acgme issues such as systems based practice and practice based learning, it ultimately will help patient acre and health care education, and can serve as the foundation of our academic research, educational, and operational initiatives for our department.

Thoughts??

- lix

-----Original Message-----
From: robert knopp [mailto:knopp003@umn.edu]
Sent: Tuesday, March 08, 2005 11:43 AM

To: Brent.R.Asplin@HealthPartners.com
Cc: Felix Ankel; Won.G.Chung@HealthPartners.com
Subject: clinical variation among staff

Over the past six months, a recurring question has been posed to me: a resident or staff indicates that they recently reviewed a state of the art paper or attended a conference that reviewed best practices in a certain area and that there is substantial variation in how we do things in our ED regarding clinical condition X such that we are not achieving what we should be doing. Most recently the issue raised was management of CHF. But examples of other issues include aspects of trauma care, mesenteric ischemia, appropriate use of heparin for PE, airway management, antibiotic use.

I know that there are other issues consuming a lot of time. However, I do think for the more common clinical problems we need a strategy to narrow the variability and increase the frequency with which patients are treated with the latest information.

Bob