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	