Strategic Planning Meeting April 21, 2010

NOTES/Comments from Attendees:

Outcomes:

GG (EPPA) - 133 physicians - 280,000 pt/year. Changes, balance between patient care and speed. Continue learning in first position (2nd residency – 10,000 hr). Look for physicians who are: team players, ability to get along, follow through with documentation, dependable.

PT (HealthEast): Agree with GS. Looking for physicians who can articulate their goals for their "2nd residency", team player, leadership ability, effective teaching, adaptable to new culture.

SD (Fairview) – Group perspective – people who can manage complicated system – supervise residents from off service rotation – patient advocate – communication skills with off services and consultants – able to run department

RJ: Always asks team players, how ware they are of themselves – insight what they put out and how they impact others.

MH: Present and paying attentions, questions that they ask during interviews.

KQ: Future – empathy and creativity needed for success. Interpersonal skills.

What are thing we are doing that good for the end goal or residency and what can we do to influence our grads for the future. Is there a Regions grad style?

We have done – Humanism award, shift card/eval – pt care comparison to promote culture of kindness. Is there more that we can do to increase kindness of residents? Resident wellness is important.

Balance – should we have more centralized control over schedule. Giving resident control that fits for them. More education about shift work.

Kind, "present" physician who can jump into leadership roles. Residency strength is ED 24/7 presence.

CP: HP core competency conference for residents – open to others CME offered. Four workshops dealing with Observation, interpreter of medial encounters, Afternoon session with be a trip to MN Institute of Art A how to observe, using paintings, what kind of bias bring to situations.

Idea for 2011 – connecting the residents to the communities- historyof tc – theater production

Knowledge Translation:

MB: People will not be tied to desk computer – more use of data phones, E-book readers – will expect information quicker. Information acquired on the go. Twitter.

Information pushed vs when you need it. Information overload. Push and pull – open when you want. In future, more interactive website.

GG: Mandate procedure lab, mandated CME courses. Board range of CME dollars. Physician Review O – 15 member panel. Cases from nurse, administrator, surgeons, etc. Review about 15 blinded cases per month. Address trends that are noted. Also push information out.

TL: dir of Quality performance Improvement. 5 project managers. Each have 2 service lines.

EG: core competency – core lectures to teach core competency with most up to date literature. Need to have ongoing renewing lib for ed. QI issues – when res on AAHC rotation must do a QI project id, focus group, research, small pilot project, report. 20 have been done in the last two years – difficulty getting them implement in hospital and residency.

MH: SW work with group of nurses on strengtheng perceptor role to strengthen role – more definition, more understanding. Better connection with preceptor eval, during orientation, developing cheat sheets.

Theme: push info not the best way of doing things. Have a repository of up to date educational data. Integration of quality into the didactics.

Introduction of critical appraisal of conference lectures.

Disseminating knowledge through QI initiatives.

ER: Protocol for procedure sedation – at nursing, PA, staff, etc.

MM: Revamping ekg curr. Level of training appropriate, experiential training, smaller group sessions. Class specific ultrasound teaching. Intern school on Fri pm – ed with chief residents and faculty.

Incorporate EBM into practice and look at outcomes.

MZ: focused ultrasound teaching for the G1s, but don't have specific teachings after that.

One-to-one sessions with faculty

Procedural Competency

SD: critical care, procedural skills are pretty good with new grads. Maintain – little difficult as some procedures are sparce. Going to OR, conferences to maintain skills you have.

PT: New grads have it. Sim labs may lead to maintaining skills in common procedures.

GG: Lots of procedues in the community. Consultant don't go to EPPA EDs. They start and do everything. Teach each other skills and different ways to do same thing. Use of CME course to keep skills. Moving toward showing procedure number to show competence. (procedure log like). EPPA will do CME courses as needed. Hospital has mandates. Procedures– need to pull numbers and submit for hospital reaccreditation.

RD: Gold standard, but also able to use other ways. How do you define procedural compentency?

MW: RN education days combination of teaching and stations.

EG: IM need to do certain amount and be supervised. Does procedures every few months to maintain his skills.

RD: If you fails look at and why. Mechanism for evaluation of what happens.

MM: Procedural competency card – staff complete. Procedures numbers varies.

How do you know when you are competent – when you feel ready to teach it to others. Who determines readiness – staff physicians? Ask for tips from staff or senior resident about what went wrong.

Non-Clinical Training

PT: Same thing as mentioned previously – team player, but can turn on superstar when needed.

GG: Regions does a good job on humastic side. Encouraging more community involvement. New hires – reviewed at 3,6,9 1 year. Fast, kind, and smart.

Regions– Patient sat data by res included in 6 month evals. Conf incorp communication and scripting. Teach by role modeling and constructive feedback.

EPPA uses real time surveys with feedback next day.

MM (HCMC) – no pt satisfaction or peer review.

GL: Push on trying to get Picker to adopt a point of service mechanism. Point of service more positive.

Go from being fast kind smart to fast kind smart and cost effective

PT: Used to profiling.

GG: Report card with pt complaints, speed, tract utilization, peer evals, team member

KQ: multi task, organization skills

Smart kind fast – report card? Divided by appropriate level of training. 360 eva- peer eval is the most important to residents.