Regions Hospital℠

EMERGENCY MEDICINE RESIDENCY RETREAT 2007

Quality Care, Quality Education

Thursday, October 25, 2007

The Bakken Library and Museum Great Hall– Minneapolis, MN
www.thebakken.org

Agenda

7:00 Continental Breakfast

7:15 Welcome, Historical Perspective
Felix Ankel, MD

7:30 The Year in Review and Updates (Panel)
Brent Asplin MD, Won Chung MD, Richelle Jader RN, Jon Henkel RN, Jeff Fritz, Karen Poor RN, Carl Patow MD, Tara O'Connell MD, Louis Ling MD, Joseph Clinton, MD, Michelle Biros, MD, Michael Zwank, MD, Kelly Barringer MD, Ben Peake MD, Sam Stellpflug MD, Cullen Hegarty MD

8:30 Residency Training: Quo Vadis
Patrick Holland, MD '02

9:30 Small Group Session
Facilitators: Holland, Barringer, Peake, Stellpflug

10:30 Break

11:00 Large Group Session

12:30 Wrap-up
Felix Ankel, MD

Emergency Medicine
2007 Resident/Faculty Retreat

Wednesday, October 25, 2007 - 7:30 am - 12:30 pm
The Bakken Museum & Library
Recorded by: Pat Anderson

✓ if present

	Residents	✓	Duncan McBean, MD		Support/Guests		
✓	Luke Albrecht, MD	✓	Adina Miller, MD	✓	Pat Anderson	✓	Pat Holland, MD
✓	Kelly Barringer, MD	✓	Tara O'Connell, MD	✓	Lori Barrett	✓	Richelle Jader, RN
✓	Joey Charles, MD	✓	Charis Thatcher, MD	✓	Michelle Biros, MD	✓	Louis Ling, MD
	Mark Connelly, MD	✓	Aaron Burnett, MD	✓	Laura Borchert	✓	Mary Ann McNeil
✓	Ben Peake, MD	✓	Nate Curl, MD	✓	Eugenia Canaan	✓	Lesley Moore
✓	Jon Shultz, MD	✓	Aaron Feist, MD	✓	Joseph Clinton, MD	✓	Patti Murakami
	Natasha Srb, MD	✓	Leah Gapinski, MD	✓	Scott Donner, MD	✓	Shannon O'Keefe
✓	Sam Stellpflug, MD	✓	Shani Go, MD	✓	Jeff Fritz	✓	Henry Ortega, MD
✓	Paul Travnicek, MD	✓	Nicci Stoik, MD	✓	Mary Healy, RN	✓	Carl Patow, MD
✓	Owen Anderson, MD	✓	Heather Sutherland, MD	✓	John Henkel, RN	✓	Karen Poor, RN
	Chris Dillon, MD	✓	Greg Vigesaa, DO				
✓	Joe Dolan, MD	✓	Brent Walters, MD				
✓	Danielle Jackson, MD						
	Faculty						
✓	Felix Ankel, MD		RJ Frascone, MD	✓	Kurt Isenberger, MD		Barb LeTourneau, MD
✓	Brent Asplin, MD	✓	Brad Gordon, MD		Kory Kaye, MD	✓	Alda Moettus, MD
	Mary Carr, MD		Paul Haller, MD		Kevin Kilgore, MD	✓	Matt Morgan, MD
	Won Chung, MD		Carson Harris, MD	✓	Robert Knopp, MD		Jessie Nelson, MD
✓	Rachel Dahms, MD	✓	Cullen Hegarty, MD	✓	Peter Kumasaka, MD		Karen Quaday, MD
	Kristen Engebretsen, PharmD		Brad Hernandez, MD		Richard Lamon, MD	✓	Stephanie Taft, MD
		✓	Joel Holger, MD		Robert LeFevere, MD	✓	Michael Zwank, MD

Time		Item	Key Points
7:15 am	Ankel	Welcome	Historical review (handout)
7:30	Fritz	Construction Update	Expansion project Construction is on schedule. There is a board in 2nd floor reception area of future look. In Feb 08 work will begin in admin area. Lindell will be turned into cubicles for the affected displace office space. Phase 1 scheduled to be open in June 09. Equipment & supplies - Let Jeff know if you see something at other places.
	Henkel	Nursing Update	Explained role as Nurse Manager – oversees approx. 200 staff: nurses, ERTs, paramedics, clerks. Nursing staff have a great relationship with residents. Expectation of quality & pt satisfaction. Residents and nursing staff work together - most importantly looking after patients. Jon asked residents to provide direct feedback.
	Healy	Nursing Update	Communication in a big department can be difficult. Mary suggested ways to aid in communicating expectations..

	Jader	Operations Update	We are all connected in some way as a group, and need to stay connected. If our goals are to provide better experience for staff and patients, everything else will fall in place. This is more easily accomplished when all are working together.
	O'Connell	Quality Update	AIAMC – national group of non-university teaching hospitals. Along with HP has sponsored a national initiative to improve quality care and how to focus graduated medical education. IHI is focusing on the 5 million life campaign. Residents will be surveyed.
	Peake	Chief's Update	We've applied to be part of the ACGME's e-portfolio, which is designed as a place to put everything that is accomplished during residency. First EM/IM conference is scheduled for November 1. Handout on other residency updates was included in packet.
	Ling	UM-GME Update	We are doing what we should be and looking to the future. Finances –importance of RMS to be accountable and maximize reimbursement. Portfolio - a reflective tool to identify where residents have been. Residents should continuously add to it for future use.
	Patow	IME Update	The IME is responsible for residencies, medical students , CME (recently re-accredited for 6 years,) Medical Library. A program director's retreat will be conducted next week addressing our patient experience, Expansion 2009 and what that will mean to residents. Dr. Patow currently serves on the ACGME Board of Directors and the Committee on Innovation in the Learning Environment, which looks at trends in medical education and innovation. Congratulated Cullen Hegarty on winning the 2007 Excellence in Education Award.
	Ankel	Peds Update	Henry Ortega and Sam Reid have been appointed Peds/EM faculty for the residency. They will have a presence at critical case, conferences, and interviewing. They have a strong academic interest, and welcome working with residents on projects.

	Clinton	UM-DEM Update	It is a good time to be practicing medicine. Dr. Clinton advised residents to be reflective, bring up issues, and make the most of the day. UM-DEM has been an active department for 5 years, working on academic development for Regions, HCMC and UM faculty. There are a record number of UM students now going into EM.
	Biros	UM Research Update	Increasing the amount of research that is based at UM. Focus: • Unique perspective as editor of AEM to see trends. • Special expertise in EM – sim as educational technique. • Knowledge translation in terms of patient-centered care. • Overcrowding and science of surge – impact on future practice.
	Hegarty	Student Update Simulation Update Recruitment Update	Med Student rotation is a required rotation and is going well. Advanced rotation is going well. At UM – medical students and nursing students are doing a combined resuscitation workshop, focusing on teamwork and communication. Simulation – biggest change is the addition of Emily Binstadt, who joins Jessie Nelson in our sim efforts. In the past year, there have been 7am conference day sim cases, e.g., mock TTA, in addition to small group simulations as part of the conference day. New focus areas, Peds/EM, EMS, Tox, have been assigned to specific interview days. Applicants with an interest in these areas will be offered the opportunity to meet with individuals from SPC, EMS & Tox following their interviews at Regions.
	Gordon	EMR Update	Dr. Gordon has taken on new responsibilities as director of medical informatics for the hospital. His clinical time in the ED will remain the same, but he will spend more time tweaking the EMR, focusing on documentation improvements.
	Asplin	Faculty Update	There is much interest in the ED positions being offered. Joining new staff, Emily Binstadt and Stephanie Taft, are Jason Gengerke (Oct), Keith Henry (Dec) and Luke Albrecht (Aug 08).

	Zwank	Ultrasound Update	Ultrasound training is improving, but still ranked lower. Would like to have residents more involved in Wed tutorials. P.Kumasaka will be focusing on faculty training, while M.Zwank will focus on resident training Areas of focus: • Ultrasound elective in 3rd year. • Incorporate US into new resident orientation • Incorporate US into anesthesia rotation. • Research projects • MZ happy to talk to people.
8:30 9:30	Holland Small Group	Residency Training: Quo Vadis	P.Holland presented his views on life after residency with tips from former residents as well as tips for junior faculty. Groups were facilitated by Holland, Peake, Barringer and Stellpflug. Participants were asked to identify residency strengths and areas of focus.

10:30	Ankel	Large Group	Strengths: areas in bold are those identified by participants as one of their top three choices. - **Staff, faculty, coordinators (4)** - Conferences – interactive progressive - **Res leadership (6)** - **Pt pop – div – cty/community (7)** - Staff diversity - Peds experience (1) - Look to future – beyond residency - Reputation on off-services (2) - HP support of residency - **Camaraderie (15)** - Resident development - Flexibility and willingness to change (1) - **Critical care training (15)** - Team approach (1) - Consistent off service rotations - Transparency (1) - **Simulation (4)** - **Procedures (11)** - Evaluation process (1) - Cooperative learning (1) - Rotation CQI (1) - Staff with street credibility (2) - Event medicine - National presence - Navy scrubs - Early airway experience (1) - **Willingness to change (4)** - Access to interpreters - Good sub-specialty experience - Consultants - Toxicology (1)

			Areas of Focus: areas in bold are those identified by participants as one of their top three choices. - **Ultrasound (19)** - **EPIC (14)** - Behavior Health patients - **Hallway patients (5)** - **Scribes (12)** - **Discharge Process (9)** - Psychiatry residents - Intra department communication - Inter-department communication (1) - **Hospital based child care (7)** - Cafeteria - Phones (2) - Recycling (2) - Dental coverage (1) - Auto follow-up on patients (1) - **Formal faculty to resident feedback (4)** - Communication with primary care MDs - Joint EM/FM program
		Large Group (cont.)	Areas of Focus (cont.) - **Streamline residency admin requirements (10)** - **Fluoro (6)** - Procedural variability – staff open mindedness - **Peds airway (5)** - **Non MD-initiated items in ED (7)** - EMS - Cardiology - Ortho - **Peds experience – critical care (10)** - Documentation/best practices (4) - Faculty evaluations (2) - Ethics/professionalism (1) - Chart review (1) - **Increase # of work stations (10)** - Resident diversity (2) - **RN pictures in ED (7)** - MD name on whiteboard

			Top Focus Areas Ultrasound 1) Increase staff proficiency 2) Front load training in residency Staff – Mike Zwank Resident liasons: - G1 – Aaron Burnnet - G2 – Owen Anderson - G3 – Kelly Barringer Epic documentation, workstations - Staff – Brad Gordon Streamline admin requirements, procedure log, cord test, duty hours - Staff – Rachel Dahms ED working environment, hallway patients, scribes, discharge process, non-MD initiated items in ED, RN pictures. Peds critical care/airway (small animal lab) - Joey Charles

Regions Emergency Medicine Residency

July 16, 2008

Felix Ankel, MD

History

- Accreditation 1995, 1999, 2003
- 80 graduates 1999-present
- 108 residents 1996-present

Mission: PAPEEMCE

Provide and promote excellence in emergency medicine care and education

- Patient centered
- Resident focused
- Team oriented
- Transparency
- Professionalism
- Knowledge
- Skills
- Attitudes
- Core competencies
- Contribution to specialty

80 graduates 1999-present

- 49 Minnesota: 10 Regions, 7 Fairview-U, 6 North, 6 EPPA, 5 Abbott, 4 Duluth, 4 United, 2 Waconia, 2 HealthEast, Shakopee, Brainerd, Mayo
- 26 out of state (15): SD 4, NE 3, IA 3, CO 2, IN 2, WI 2 ND 2, MS, OR, NH, MT, WA, UT, VA, NY
- 12 Academic: 10 Regions, Wishard, Mayo
- 15 Hybrid: 7 Fairview-U, 7 North, Mercy-Iowa City
- 50 Community
- 7 Fellows (2 toxicology, faculty development, critical care, simulation, informatics, ultrasound)

108 residents (1996 - present) 25 medical schools

- 37 U of M,
- 8 UND
- 6 USD, Mayo, MCW, Iowa
- 4 Creighton, UW
- 2 Nebraska, Loyola, Indiana, Kansas, Chicago Med School, Colorado
- SUNY-Buffalo, SLU, Des Moines, Nevada, Vermont, Penn, Hawaii, East Carolina, Arizona, Utah, Michigan State, Albany, VA-COM, UCSF, Dartmouth, Yale, Tufts, Cincinnati

31 Faculty (14 Different EM Residencies)

- Regions x 10
- Henry Ford x 2
- Harvard Affiliated x 2
- Illinois x 2
- Pittsburgh
- HCMC
- Brooke Army
- St Vincent's
- UCSF/Fresno
- Christ
- New Mexico
- Indiana
- Boston Medical Center
- Grand Rapids
- Michigan

Rotations (4 weeks blocks)

- Year 1: ED 3.7, SICU 1.3, Ortho 1, MICU 1, Cards 1, OB 1, Mpls Kids 1, Anesthesia 1, Plastics 1, EMS 1
- Year 2: ED 7.3, SICU 1.3, Community ED 1, MICU 1, St Paul Kids 1.3, Tox/Adm 1
- Year 3: ED/ St Paul kids 9.7, SICU 1.3, Elective 1, Community ED 1

Residency Strategic Plan 2005-2010

4/28/05

- SWOT analysis
- Conferences
- Simulation
- Mentorship
- Administrative curriculum
- Scholarly activity
- Individualization of educational experience
- Integration with U of M
- Integration with twin city hospitals
- National presence

2006-2007

- Ultrasound workshops, EPIC, Relationship with hospitalists, Admin education, Pt based scheduling
- Micro to macro: Integration with U of M, twin cites hospitals
- EM education to EM delivery education: EMR, flow, quality, pt satisfaction
- Rotation CQI throughout year
- Leadership experiences: residents on national committees, society and editorial boards
- Mentorship
- Anatomy lab, procedure lab
- 3 chief residents, off-service residents
- Combined conferences, guest speakers, alumni engagement
- Increased selective site, formalized Ecuador elective
- Focus on ED teaching and feedback

2007-2008

- Conference changes
  - Move to Thursdays
  - Increase critical case to 90 minutes
  - Increase simulation time during conf
  - Pre-conference sim sessions
- Structured ultrasound workshops
- Schedule change from teams to sides, 10-hr shifts
- Doctors Dahms, Morgan and Taft assume roles as Asst. PDs
- Incorporation of Peds-EM faculty (Ortega & Reid) into Residency
- Hosting of Ecuadorian EM residents
- EM/FM combined residency discussions
- E-portfolio application submission to ACGME
- Specialized interview days
- Resident self-eval on shift cards
- Nurse mentorship program

Program review 2008

- Residency coordination
- HealthEast rotation (1)
- MICU rotation
- Resident responsibility and independence
- EMS rotation
- Residency leadership
- Cardiology rotation
- Orthopedics Rotation
- ED Call Room
- Admin rotation
- Ultrasound
- Research

2008-2009

- Community ED rotations EM-2 & EM-3
- Clarification of back-up & pull residents
- Ultrasound afternoons during anesthesia rotation
- Improvement of cardiology rotation

Themes

- Bedside teaching/microskills faculty assessment cards
- Merging residency & quality movement
- Merging residency & patient satisfaction movement

Our residency efforts are guided by the Baldridge core values for educational criteria for performance excellence which include:

- Visionary leadership
- Learning centered education
- Organizational and personal learning
- Valuing faculty staff and partners
- Agility
- Focus on the future
- Managing for innovation
- Managing by fact
- Social responsibility
- Focus on results and creating value
- Systems perspective

Additionally, we strive to incorporate the Institute of Medicine's *Report on Health Professions Education: A Bridge to Quality* which suggests five core areas where students and working professionals should develop and maintain proficiency. They include:

- Delivering patient-centered care
- Working as part of interdisciplinary teams
- Practicing evidence-based medicine
- Focusing on quality improvement
- Using information technology

Questions to consider

2008 Program Review- Faculty

Category/Question
List the strengths of the residency program.
2) The program encourages residents to be progressive in the management of patient and encourages patients in the new modalities coming into Emergency Medicine.
2) Great residents
2) The residency program has many strengths but by far the leading reason is the staff/faculty. Dr. Ankel's dedication and commitment to the program is the number one reason our residency program is rated so high. Secondly the support by Dr. Asplin and the continual support by our esteemed staff (Such as Drs. Knopp, Holger, Harris, Quaday,Dahms, Hegarty) make this program outstanding.
2) The PD, the support staff, the residents
2) Clinical training, resident involvement in decisions/committees, conference and clinical education, quality of the residents, quality of the staff, quality of the residency administration staff (Lori/Pat), support of department/chair.
2) Education, approachable faculty, great residents
2) Leadership, patient, faculty, residents, nurses, support services, transparency, educational focus, ethical
2) Progressive, innovative, vigilent of educational opportunities
2) Broad staff base. Frequent assessments of the program itself to make sure it is meeting our goals and vision. Cutting edge.
2) Patient volume and variety, Acuity of patients. Toxicology
2) Heterogenious faculty and resident groups
2) faculty involvement faculty diversity strong leadership despite recent turnover Lori and Pat!
2) Elasticity, rigor, experience.
2) residency support-Lori and Pat, Felix and assistants are interested and available.
2) Excellent exposure to critical care/critical patients. Excellent airway exposure. Excellent Ultrasound teaching.
2) Solid leadership, Felix very committed to great reident education.
2) Great leadership from Felix, Lori and Pat. Motivated residents who take pride in their program.
2) the faculty, the facility, mix of patient population, ability to do procedures
2) Graduated responsibility. Residents staff directly with attendings. Sense of camaraderie. Emphasis on well-being. Extensive critical care experience. Relatively diverse group of faculty. Good relationship with most consult services, trauma surgery in particular. Adequate numbers of procedures. High acuity of patients.
List the weaknesses of the residency program.
3) I think sometimes there is more emphasis put on seeing patients and not enough time allowed for academic pursuits.
3) Time to allow outside pursuits (ie ATR). Pediatric exposure and Regions support of peds.
3) Lack of pediatrics is an issue, however residents are getting pediatric training at other hospitals.
3) Need more focus on research and other more traditional academic pursuits.
3) Ultrasound MACHINES (not teaching/interest)--need a west end machine and need all machines to have batteries to avoid long boot-up issues.
3) The Admin piece. I wish we had more didactics around basics like chest pain eval, abd pain eval and less textbook oriented topics. I would be willing to work with this (KQ). I also wish we had mandatory followup of discharged patients.
3) Research. Pediatric resuscitations. Too much psych. Poor relationship with Hospitalists happens too much
3) too many evaluations

3) On the whole, we struggle to find the right balance between patient care, education and other faculty requirements (research, documentation, etc.).	
3) I think that some staff have limited interest in teaching and onsite feedback. We need more conferences with certain specialties- colorectal to talk about hemorrhoids, etc; GU to talk about kidneys stones, torsion, epididymitis, etc. More objective ratings on feedback cards-too many excellent avid having to give feedback	
3) Dichotomous vectors of HP/throughput/outreach and academics. Outreach is less of a distraction than it has been in the past which is good. The lack of clinical research is disappointing and needs to be re-visited.	
3) peds trauma	
3) admin exposure	
3) diversity	
3) we are chronically understaffed with midlevel providers, so that the residents have extremely stressful shifts each time they work. so many of them feel overwhelmed with the number of patients they are carrying and the onerous documentation burden. too many psychiatric patients too much expectation to move patients	
3) Ultrasound program. Under-staffing which decreases time for clinical teaching. Pediatric visits to primary site relatively low but compensated by peds EM experience at Children's hospitals.	
Lists ways to improve or address areas of weakness in the program.	
4) It's difficult; I think maybe longer shifts and less shifts may be one way of increasing time off of the floor.	
4) Change the resident scholarly project into a true research project.	
4) Buy a new US for the west end of the ED and get a battery for the other US machines.	
4) work to get peds back at Regions	
4) more time, more admin assistance from the department. More defined but less onerous research/project process for residents (and their advisors).	
4) see above	
4) We have a more motivated, younger RN staff who may be more supportive of clinical research than the staff of 5 years ago.	
4) leadership of admin exposure, engagement of Drs Asplin, Chun, Quaday	
4) continue to assess and re-assess program, resident and staff satisfaction.	
4) add more midlevel providers, especially at night, so residents can think about their patients First year residents should pick up the pace after January, so they aren't so overwhelmed with the transition to 2d year	**Rating Scale** 1-3 Poor 4-6 Adequate 7-9 Outstanding
4) Increased support/time for ultrasound training of faculty. Increase staffing.	
	Average
Accessibility and responsiveness of program coordinator and program assistant (Lori & Pat)	**8.2**
22) They seem to have a finger on what is going on with the residents personally and academically.	
22) 2nd and 3rd mothers since I was a resident here. You thought the upheaval of assistant/associate residency directors was tough. When decide to retire - watch out!	
22) They run the day-to-day program--they are organized, helpful, and are utterly indespensible.	
22) Lori and Pat are the best!	
22) indespensible!	
Opportunities for resident responsibility for patient care	**7.9**
11) Good level of autonomy.	
Overall clinical competence of EM-3 residents.	**7.8**

10) All ready to go out there and practice alone. 10) they are all great	
Quality and responsiveness of social work staff in the ED.	**7.8**
20) we are spoiled rotten! 20) I'm not sure what we would do without the SWs helping out. 20) They are unbelievable. They never complain, even when volume is overwhelming. Deserve more credit for the work that they do.	
Overall direction and leadership of residency provided by director and assistant directors (Ankel, Dahms, Hegarty, Morgan, Taft)	**7.6**
23) The addition of some of the new staff has improved the overall leadership of the resident group. 23) Hard working group. Only thought is to be more open/receptive to feedback at times--sometimes feedback is given and there is an immediate negative response by the PD. I think if feedback is requested we should at least listen and then reply later with a response to the feedback. Also, I'd limit some of the new feedback we're giving to residents via email and do more verbal communication--email communication can be hard to interpret emotion/feelings at times and I think for resident well being a face to face talk will 9/10 times be more beneficial. 23) For the number of people we have in the residency leadership, it seems more should be accomplished- publications, chapters, presentations, etc. The residency has always been excellent with fewer people at the helm. I would think the additional people would enable more production. 23) Excellent leadership by Ankel, great engagement of asst Pds 23) Solid. 23) Ankle works tremendously hard on the residency program and keeps it together, although he can be hard to talk to with concerns about specific residents or scheduling shifts. He seems very set in his ideas and resistant to change.	
Patient volume and quality of medical, surgical, pediatric, gynecological and behavioral emergency cases seen in the ED	**7.6**
5) Pediatrics at Regions is weak. 5) Have more of the psych pts be taken care of by PA's 5) could use more peds, but I don't really want them here until the hospital's more prepared for them. I don't think more comments about the BH situation are all that helpful. We know it's a problem - just need to manage it. 5) Too much psyche. Too little peds. 5) This is a very mixed question. I feel see a good mix of med, surg, and probably too many of some Gyn cases (1st trimester bleeds). Too many behavioral health patients, although the PAs protect the residents from the extended stay patient cares. If you're looking only at Regions, not enough sick kids. 5) too many psychiatric patients--they do not contribute to learning at all too many drug seekers	
Opportunities for progressive resident responsibility in patient care	**7.6**
12) Transition to 2nd year is a quantum leap, pretty stressful but a god developmental step. . 12) first year residents need to be pushed to see more patients after Jan 1. (snip) Great opportunities for early intubations and procedures and running codes.	
Quality and team attitude of Physician Assistant staff in the ED. 19) They work together well and not infrequently the residents will ask PA's for information and also the PA's look to the residents as a source of information.	**7.5**
19) lots of variability now. Some I trust implicitly, some I watch like a hawk. I appreciate their willingness to take care of our BH pts - they do a very good job with this difficult and not-very-satisfying pt population. I know that's not what they went into this job for.	

19) LOVE the PAs! There is some variability among them (some see more patients, some have more positive attitudes. 19) They do not get enough credit for the things that they do. 19) PAs are great--we need to do a better job of keeping/retaining the best PAs as our department does rely on them in our current staffing model. 19) most are great	
Your impression of the SICU rotation and overall performance by EM residents on SICU.	**7.4**
36) improved with more responsibility and b/u	
Rate the overall quality of the residency program.	**7.4**
1) Strong training, good leaders. An ideal training site with a diverse population. Staff overall are committed to education. 1) outstanding	
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?	**7.4**
43) Outstanding end of training attitude, much better then last year's third year class	
A availability and accessibility of activities promoting general resident well being (scheduling and leave policies, access to advisors, access to resident support services).	**7.2**
38) good support and except for SICU hours are ok 38) A resident and family-friendly residency.	
Your impression of the MICU rotation and overall performance by EM resident on MICU.	**7.2**
Competence and responsiveness of Clerk staff in the ED	**7.2**
18) individual dependent 18) almost all are great	
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**
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?	**7.1**
41) A phenomenal group. Wish we could have interns like this every year! 41) A little much of the "system is doing this to us" from a few. Most actively search out opportunities to maximize their education	
Overall clinical competence of EM-1 residents	**7.1**
8) very good class on the whole 8) Our intern class is awesome! Year-to-year we recruit a strong intern class. 8) some are better than others (snip)-- some may not be ready for July, when the expectations sky-rocket.	
Quality of resident involvement in teaching of EM residents, rotators and medical students	**7.1**
29) they get lots of opportunities to teach. Do we as faculty give them enough support and teaching as to how to teach? 29) Ample opportunities.	
Overall clinical competence of EM-2 residents	**7.1**
9) Solid. 9) most are great--with a few exceptions	
Departmental direction and leadership by department head and associate department head (Asplin & Chung)	**7.1**
24) Great job--only thought is to have a clear sense of where education fits into our ED overall and use that in decision-making. I think education is valued but sometimes feel that the HP/Regions suggestions/decisions clearly trump education. 24) difficult job mediating between lots of conflicting interests and personalities	

24) Asplin is doing a great job in a difficult position, but is intimidating to talk to with concerns. He should be more approachable to the general Senior staff doctors. I am less clear as to Chung's role, but he needs to support the ED staff doctors more (snip), e.g., relationships with hospitalists. (snip)	
Overall performance of HCMC residents and success of Regions-HCMC "swap"	**7.0**
31) The perception is that it is beneficial to both groups although I am not personally aware of the resident feedback from both groups. 31) HCMC residents have been a joy to work with not sure how the residents feel overall on the other end but I have heard good things. 31) A great experience. 31) I think that this is a great relationship and eye opening about differences in the programs (I think favorably in terms of our residents). 31) some are quite good, others seem procedurally behind our residents	
Opportunities for involvement in recruitment and selection of future residents.	**6.9**
Your impression of the Toxicology rotation and overall performance by EM residents on Tox.	**6.9**
Quality/responsiveness of specialty back-up to the ED	**6.9**
7) Has deteriorated some since the mvt of the specialty clinics off campus. 7) I would like to see more Staff presence in ED of specialty back-up when their residents are the first (and usually only) evaluator. 7) Consultant response is based on thier commitment to their inpatient population. Consulting residents tend to over-order studies (by phone) without evaluating patient first. 7) in the grand scheme of things (across the US), we're doing fine. 7) surgery is slow sometimes 7) Ortho and TACS consults sometimes take hours. Otherwise OK. 7) Most excellent, decrease of unprofessional behavior by hospitalists appreciated 7) podiatry is great, as is hand. neurosurgery is not. too much push-back from certain hospitalists on admissions (this is not the case with United hospitalists at all---it's a pleasure to send a patient there)	
Overall quality of format and content of ED conferences - critical case, core content, journal club, QI, small groups.	**6.8**
27) I'd vote for more small group/simulation conference days to get away from the old powerpoint lecture sessions. I love the new 90min critical case. 27) small groups are nice addition - it would be nice to see more faculty involved in this. Also, I've noticed my few core content lectures are coming around more frequently - are we having more scheduling issues than usual? 27) need better faculty attendance at journal club, QI. Need more specialist participation. Need all residents to read the journal articles and oarticipate journal club 27) Good variety with the changes Matt has made. 27) Excellent leadership by Morgan	
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?	**6.8**
42) A solid group. 42) Most really contribute to the residency	
Faculty support for residency activities.	**6.7**
25) Variable. 25) Not enough research support. The money available for this is very adequate. 25) lots of folks didn't come to graduation dinner 25) Could use more faculty attendence at conference, especially by operations people	
Competence and responsiveness of ancillary care providers, x-ray, lab, respiratory, blood bank, transportation.	**6.7**

21) Lab compared to Hudson seems slow and to have more hemolysis issues. 21) Respiratory is excellent 21) occasional annoyances with hemolyzed samples, otherwise no issues. 21) Lab is often slow. 21) inconsistent responsiveness of lab 21) labs can be slow to come back	
Quality of US program in the ED quality of ultrasound education and teaching. Opportunities for residents to perform ultrasound examinations in the ED.	**6.7**
28) Need more input, support and dedication of US by staff other than core US staff. 28) See above re: need for new machine for WEST and a battery for machine #2 (check our number of machines vs HCMC and you'll see why they do more US). 28) getting better. Faculty getting more comfortable. I'm not convinced we need to harp on US so much. In how many jobs will we be expected to do transvag, RUQ US, etc. I'm not out to replace the ultrasonographer. 28) Need more US for critical case-then residents will understand its importance/relevance 28) Decent, and improving. 28) Excellent leadership by Zwank 28) Residents often so busy, it's difficult to use the ultrasound for non-emergent things to get more experience and practice. Largely due to resident responsibility for large patient volume but also because ultrasounds are very cumbersome and one has to be booted up every time it is moved.	
Quality and responsiveness of ED Nursing staff	**6.7**
16) Excellent floor nurses, less hostility by nurse management towards residency recently. This is appreciated 16) most are great and helpful	
Competence and responsiveness of ERT staff in the ED	**6.6**
17) Some work very hard while others do not, perfering to chit-chat. 17) This is where we are most understaffed. They are the least expensive piece to staff and the hardest to find. I don't know why we don't add more. It is frequently quicker to get something yourself as a staff or resident MD than it is to find a ERT. 17) ERTs are good, numbers at times seem low. 17) variable	
Overall performance of EM resident on Plastics/Hand rotation.	**6.6**
33) EM staff often end up supervising consults in the ED since Hand staff aren't present. 33) appears adequate	
Accessibility and maintenance of equipment in ED exam rooms.	**6.5**
14) Not always stocked since we have been in construction 14) Frequently diagnostid equipment does not work and on weekends not restocked. 14) occasionally run into bad bulbs for otoscopes, but ERT's responsive to my asking for help. 14) otoscopes not working or available enough 14) Overall OK. 14) Ultrasound machines--need one new one for WEST and need a battery for machine #2. Ideal world getting a video fiberoptic intubating scope (ala Karl Storz) would be great for patient care and education of the residents.	
Overall performance of EM resident on Orthopedics rotation.	**6.3**
32) Continues to appear to be a thorn in our side. Low quality teaching and some abuse by Ortho staff and residents. 32) could be more involvement on the part of the orthpedic staff.	
Overall direction/assistance/support provided by IME.	**6.2**
26) Not very visible.	

Resident performance in handling EMS radio calls.	**6.1**
13) resident appearance at radio seems a little more variable lately (but we're at year change so I'd bet there's some confusion). 13) Some residents respond well, others not. 13) Adequate but could be improved with more training in triage 13) Residents do ok--I'm not sure what percent they do vs. staff, but it would be nice to have them respond to more of the radio calls.	
Your impression of the OB rotation and overall performance by EM resident on OB.	**5.8**
34) need more deliveries 34) I'm told by the residents that there are very few deliveries because of the number of the people involved and vying for deliveries. 34) Need to do OB elsewhere or guarentee they'll get their deliveries here.	
Resident coverage for patient volume	**5.7**
6) could use more residents, or more paramedical personnel such as PA-C's 6) One resident on the B/west side at night is not enough for some nights--especially when there is one staff/one resident then for the early hours of the night and all rooms are full. ?need to expand residency given new ED expansion. 6) we don't need more residents. We need to move patient upstairs quicker. Probably need more PAs 6) Seems OK, thanks to the PAs for extra midlevel staffing. 6) Overnights can be very thin. At times seem dangerous. 6) residents are often overwhelmed and EPIC documentation is onerous for them they need scribes (or a less cumbersome system) some of the more conscientious residents are here long after their shifts end documenting (somewhat better after the 10 hour shifts were implemented) 6) Needs to be increased mid-level staffing (whether resident or PA) in order to increase time for teaching.	
Accessibility and condition of ED conference rooms	**5.5**
15) Too small. Auditorium is large enough, but outdated. 15) Tough with construction but working ok. It was nice to have our own conference space in the past. *A dedicated sim/education room should be included in our new office/ED space when we move for staff, resident and RN/tech/other ED education via simulation. 15) can't wait until the construction is over! Tell me they'll be some cool educational space coming, please. Amphitheater is getting run down. 15) There needs to be dedicated conference space with a wider availability. 15) The amphitheater is fine...but all the alternative arrangemets we're making during construction are confusing. The AV setups are different, and sometimes the rooms are too small. 15) It would be nice to have state of the art conference room, does not seem to be a priority for hospital 15) Good when able to use amphitheatre for conferences but poor when not able.	
Opportunities for involvement in ED research. Faculty encouragement, departmental support and sufficient time during residency to participate in research.	**4.9**
30) opportunities are there. However, there isn't a lot of HP support unless it falls into what HP is into (health systems stuff). EMD support is there. But the process beyond that is rather painful (IRB). Sufficient time - no way - for faculty or research. 30) Serios work needs to be done here. Start with the IRB which is notorious for being obstructive and then get some faculty who know how to navigate the process (there are a few but not enough with enough time). 30) Not a focus at Regions, although there are opportunities.	

30) Fair. We need a dedicated section of our department to assist with research to really get things rolling. Currently there are a lot of people listed as the 'research people' for our deparment that are overloaded/overwhelmed with their current duties/projects and can't mentor staff/resident projects.	
Please provide any additional comments about the program that you feel would be helpful.	
44) outstanding residency, a privilege to work at Regions 44) We have a great program which is strong. Need to continue to finds ways to improve and to tweak rotations. Need to have a greater national presence with lectures and national conferences. More clinical research. 44) EPIC is a huge burden to the residents (and the faculty)--documentation requirements are ridiculous, and added to that is CPOE, discharge instructions, etc. They need scribes, or some other help with documentation so they can do their real job, which is seeing and taking care of patients.	

2008 Program Review- Residents

Question
List the three most important aspects of this program for you.
1) The people (all staff). Diverse pt population (community and county in one). Opportunities to do just about anything and having support to do so. 1) faculty support: staff is always available at sometime for the residents and are willing to change their schedules to assist residents through difficult times, progressive responsibility is the sigle best thing about this program. From day 1 we evolve into increasing levels of responsibility and critical care time in the MICU and SICU. 1) 1) Friendly Staff 2) ICU Experience 3) Opportunity to do procedures 1) 1) Great people to work with 2) Critical care exposure 3) Diversity of patient population/pathology 1) -patient diversity and acuity -diverse faculty -strong ICU experience 1) autonomy, communication with staff, and great conferences 1) teaching staff that are relatable to residents avanced skill learning teaching opportunities directional feedback for the residents and reflective in the program 1) progressive responsibility autonomy great resident and faculty support 1) 1. Patient variety and volume 2. Pediatric and critical care experience 3. Program leadership 1) Critical care experience Excellent faculty and teachers Pediatric experiences 1) I expecially enjoy the critical care months and the ED experience. These are the hilights of this residency (in addition to the excellent collegues that I have the opportunity to learn from)! 1) 1) Patient interactions 2) ICU rotations 3) procedures 1) Patient population/cross section is ideal. Excellent staff/resident chemistry. Forward thinking and flexible. 1) transperancy, good environment, enjoy the graduated responsibility rationing. 1) supportive environment critical care experience good training and preparation for life beyond residency
List the strengths of the residency program.
2) See above. Very resident focused. Change happens in real time as issues arise. 2) Felix's leadership, SICU time, young, involved staff. Staff that spends time doing community shifts and works with us, allowing us a window into what our lives will be like after residency. great position in the hospital, well respected amongst other departments. Our residents feel as though we are a part of the hospital, rather than just a bunch of grunts. 2) Conference Items noted above 2) See above 2) -ICU experience -high patient acuity -very resident friendly -good trauma experience 2) autonomy, communication with staff, and great conferences 2) great residents some very supportive staff good critical care exposure 2) independent learning opporunities ability for leadership and graded responsibility teaching and life-long learning SIM center 2) faculty patient variety resident responsibility 2) Provides a firm foundation in the intern year followed by progressive responsibility in years two and three which transforms medical students into confident and competent emergency physicians. 2) Support from the residency leadership when issues arise in the hospital Excellent leadership team Peds experience Critical care experience Excellent mix of patients from urban/rural/suburban areas with a great sick referral population 2) Residency leadership/support staff. Support for family-oriented residents. Grounding in patient mgmt/flow. 2) excellent staff, plenty of pathology 2) Critical care, procedures, independence of ED, good relationship with TACS, good people in ED, healthy environment to work in 2) ICU rotations Procedural competencies 2) progressive responsibility critical care procedural experience

List the weaknesses of the residency program.

3) Cards (being addressed) US (getting stronger)
3) We are continuing to work on US, we frankly need more WORKING machines. We need a dedicated machine or two for the west side and one for each resusitation room.
3) Ultrasound
3) Some off service rotations need some work. There are a lot of extraneous duties such as logging hours, filling out numerous surveys, etc.
3) -US experience -Cardiology rotation -Orthopedics rotation -excessive amount of nonclinical duties that result in reduced studying time
3) little time for reading/due to RRC junk
3) politics administrative STUFF research projects--no one to staff/supervise. everyone too busy with other things
3) too much paper pushing non-automated procedure logger
3) too much extra paper work/tasks
3) Expectations vary widely between staff physicians. The younger members of the staff are focused on efficiency and flow and sometimes forget to teach critical thinking skills while the older members of the staff seem more dedicated to a thorough approach while forgetting the need to teach efficiency along with clinical knowledge.
3) Lack of automation of the program: swapping badges, entering procedures manually instead of automatically
3) Research seems hard to do initially/resources. More critical care pediatric experience scheduled would be good. Automated schedule/procedure entry?
3) Does not have a huge name nationally
3) 1) Trauma organization and consistent interactions/understanding with TACS on traumas 2) Bedside teaching 3) Ancillary obligations/responsibilites not related to medical education or patient care
3) seems to be alot of regulations and think that residents could be given more autonomy
3) need to focus on more timely evaluations administrative rotation is poorly structured and expectations unclear (they are working on this) somewhat difficult relationship with the hospitalists (at times), although this is not a specific fault of the residency program

Lists ways to improve or address areas of weakness in the program.

4) Incorporate US into other rotations (OB, ortho, etc when down time). Much of this has to be resident driven. When I was on OB and I paired up with the resident on anesthesia and we went and did US a few times/week.
4) purchase more machines
4) Incorporate an US experience into the curriculum; e.g., during anesthesia

4) I believe the off service rotations and the extraneous duties are both being addressed currently
4) -US: we do a lot of them, but the process of logging the procedure is too tedius; having another US machine that's on the B side would help, especially during a busy shift; the images would often not print - i don't have the time to track down the images in the middle of a busy shift. -Cardiology: we should be involved in the STEMI's; we should have dedicated time in the echo reading room (I tried doing this during my month, but the PA kept giving me consults so I never had the chance to spend enough time with the cardiologist reading echo's); not much teaching - EKG readings or management of cardiac disease; we should be informed of when cardioversions take place since we don't see a lot of this in the ED. -Ortho: overall a malignant rotation - no teaching from staff and residents were always too busy to teach; there was no education to be had in clinic. - nonclinical duties: procedure logs (there must be a way to log our procedures from our procedure notes), duty hours (our schedule is on amion!), endless surverys.
4) streamlife paperwork and emails/evals
4) see previous attempts.
4) Advance EPIC capabilities
4) eliminate unnecessary duties

4) This is obviously a touchy subject in that you can't mandate how a physician practices. My hope is that during faculty meetings, this divide can be addressed and each side can learn to adapt more toward a middle ground that, while focused on efficiency, is also focused on quality care and teaching. 4) Move 3 critical cases to 2 critical cases during thursday conference Relationship with gillette to get peds airways Admit pediatrics to our hospital 4) Automate schedule/procedure entry. Expose first years to a research intro early/dscribe resources&options. PICU/Peds anesthesia days? 4) Continue to focus on publications and presentations at national meetings. Recruit residents and med students from across the country 4) come up with a residency board for some decisions vote on some matters 4) have more frequent informal checks of how residents are doing, maybe assistant residency directors could go through the feedback cards on a more frequent basis and address any problems well before the delayed six month evaluation, so that the resident can be aware of and try to correct any problems Ultrasound - focus on getting more studies as an intern and having the interns be more comfortable with the ultrasound Streamline the "extra" things the residents have to do - for instance, EPIC should be able to pull in procedures so that a separate procedure log isn't needed; consider another way to log hours rather than entering hours on an individual day basis (maybe EPIC could help with this - if the resident is logged into EPIC then that obviously means they are working in the ED)	

	Rating Scale 1-3 Poor 4-6 Adequate 7-9 Outstanding
Question	**Average**
Accessibility and responsiveness of program coordinator and program assistant (Lori & Pat)	**8.0**
23) the scale doesn't go high enough 23) The major hangup I have is with the med student workshops being required if you didn't rotate at Regions as a student. I don't find this in any of the program materials and the 4-hour resuscitation lab can be quite difficult to fit into one's schedule.	
Overall rating of the St John's ED rotation (within last 12 months)	**8.0**
Overall rating of the MICU rotation (within last 12 months)	**7.9**
41) Excellent. Much more comfortable with sick pts. Lots of procedures. 41) great opportunity to see sick patients, great staff. 41) No problems here.	
Opportunities for progressive resident responsibility in patient care	**7.8**
12) best thing about the program 12) I feel that the progression in responsibility is appropriate and tailored to each individual resident 12) No problems here.	
Opportunities for resident responsibility for patient care	**7.8**
11) No problems here.	
Independence allowed/encouraged by faculty in the ED.	**7.7**
9) with the exception of one staff the faculty allows us our independence and will provide direction as needed 9) Again this is an area of excellence 9) again, variable, but the majority are very good 9) Staff dependent. Dr. Ankel follow residents into rooms... 9) some staff better than others 9) See above comments. It really varies between staff physicians.	
Overall rating of the Emergency Medical Services rotation (within last 12 months)	**7.7**
Overall direction and leadership of residency provided by director and assistant directors (Ankel, Dahms, Hegarty, Morgan, Taft)	**7.6**

24) excellent support and direction, feel well protected from traditional scut work while off service. Our off service rotations are very open to our suggestions for improvement because of our residency leadership involvement. 24) There's been quite a regime change in the program leadership, but things seem to be going well. I would like to see more "nuts and bolts" (i.e. practical info about how to work in the ED) covered in orientation for future residents. I would also like a more uniform response from the leadership when untoward outcomes occur in the ED or off-service rotations. 24) A lot of positive changes have been made this year. Rachel is probably the assistant director who is most accessible and who easily relates to the residents. She is incredibly helpful.	
Opportunities for involvement in the EMS system.	**7.6**
32) No problems here.	
Overall rating of the Plastics/Hand rotation (within last 12 months)	**7.6**
36) A solid rotation for learning the basics of hand injuries. 36) A very good rotation that I believe is valuable.	
Quality of resident involvement in teaching of EM residents, rotators and medical students	**7.5**
31) No problems here.	
Your impression of the EM-1 support of the residency as a group.	**7.5**
59) No problems here. 59) We are all very happy, support each other and the other residents and speak very highly of this program to people outside of it	
Your impression of the EM-3 support of the residency a group.	**7.5**
61) No problems here.	
Overall program rating	**7.5**
Overall rating of the SICU rotation	**7.4**
44) The BEST off service rotation. I would not decrease the time we spend there at all. it not only teaches critical care skills/procedures but it ensures a strong relationship with the TACS service and helps TTA's run smoothly. 44) Best rotation of residency 44) the best off service rotation, what an opportunity 44) great opportunity to see sick patients, great staff. 44) No formal orientation or manual, occasional procedures, and a lot of time spent typing ridiculously complicated notes.	
Overall quality of EM faculty - academic competence, clinical competence, teaching ability.	**7.4**
16) See above for my comments re: the split between old school and new school. All in all, an outstanding group to train under. 16) Certain EM staff members are consistently fantastic in terms of teaching - Rachel, Brad H., Rob, Keith H, Stephanie	
Quality and responsiveness of social work staff in the ED.	**7.4**
21) Very person specific and most are wonderful. There were a couple of times when I spoke with SW about a pt, and that pt was not evaluated for several hours (in one case it was over 8 hours) despite several visits on my part to try and expedite things. 21) A huge asset in dealing with psych patients 21) Generally good, although services can get quite backlogged when the crisis area is busy.	
Overall rating of the Regions Emergency Department rotation	**7.4**
34) Having a G2 running an entire side of the ED seems a bit daunting and certainly doesn't improve the patient experience in terms of waiting time or quality of care delivered. Documentation is a painful process, especially in that we still haven't received feedback as to whether or not we're doing it properly. There has to be an easier and more efficient way.	
Opportunities for involvement in recruitment and selection of future residents.	**7.4**
57) G1's hosting the applicant dinners is great. 57) No problems here.	
Your support of the residency. Are you content here? Would you recommend this program to others?	**7.4**
58) Love it. I know I made the right choice and am proud to be here.	

58) I am very, very happy things worked out as they did. I honestly feel that there is no better residency program for me in the entire country. 58) very content, I highly recommend the program to potential applicants 58) I am content here and am confident that Regioms will have prepared me well for community or academic practice when I am finished. I do recommend the program to others.	
Your impression of the EM-2 support of the residency as a group.	**7.4**
60) No problems here.	
Overall rating of the United ED rotation (within last 12 months)	**7.4**
52) great teaching and overall experience	
Departmental direction and leadership by department head and associate department head (Asplin & Chung)	**7.4**
25) Efficiency is nice as is quality, but sometimes it seems like quality is sacrificed in order to "move the meat" and make money for the department. 25) Always feel very well represented by Asplin and Chung 25) The residents sometimes get the impression that administration is not as responsive to departmental concerns as they should be. When we let them know about a specific issue or problem, it would be helpful if they could give us feedback of what the resolution of the issue was that would be helpful and would give the residents a feeling that their concerns are being listened to and acted upon.	
Overall rating of the Anesthesia rotation (within last 12 months).	**7.3**
39) Will be better with more US. 39) More pediatric anesthesia would be nice 39) There was one anesthesiologist who did not let ED residents intubate his patients. 39) please one week of pediatric intubations on our anes month. Dr. ortega wants to help make it happen. 39) great chance to intubate without pressure 39) The afternoons are self directed which I think is good. I got many procedures in the ED during the afternoons. 39) Ultrasound should be a major focus of the afternoon time on this rotation rather than TCU visits.	
Competence and responsiveness of Clerk staff in the ED	**7.3**
19) The clerks are always willing to help! 19) All ancillary staff/nursing are top notch in the ED. 19) Excellent group. The only issue I sometimes have is when registration is still taking place when I'm seeing a critically ill patient. Getting the right treatments in place should precede registration.	
Availability and quality of resident involvement in Simulation activities.	**7.3**
29) Very helpful and a great resource. 29) No problems here. 29) An area of increasing importance and exposure in the residency. I really enjoy the 7AM sim cases on Thursday with Cullen. I try to attend as often as possible 29) Increased opportunities this year with pre conference sim cases - this is helpful!	
Patient volume and quality of medical, surgical, pediatric, gynecological and behavioral emergency cases seen in the ED	**7.3**
5) great patient population mix between innercity and HMO patients 5) we would learn more if we saw less psych pts. HCMC has their own eval unit. its not going to change. but the quantity distracts from learning. 5) No problems here.	
Quality and team attitude of Physician Assistant staff in the ED.	**7.3**
20) No problems here. 20) (snip) 20) Most of the PAs are fantastic.(snip) Would appreciate having some PAs see more patients.	
Overall rating of the Minneapolis Children's ED rotation (within last 12 months)	**7.2**
38) Great experience.	

38) wish i would have been scheduled for a variety of shifts, am, pm, etc. I was almost always scheduled 7 p - 3 a. 38) Somewhat of a regression to medical student days. Very close monitoring by staff and lack of pediatric procedures.	
Faculty supervision of EM residents	**7.2**
8) I wish staff would be more willing supervise some procedures that I am still uncomfortable doing on my own (instead of "here's how you do it, call me if you need help"). 8) great staff, very helpful and understanding 8) Clear expectations should be established in terms of when staff want to hear about patients, which procedures are OK to do without supervision, etc.	
Overall quality of format and content of ED conferences - critical case, core content, journal club, QI, small groups.	**7.2**
27) Great job, Matt! I really enjoy the revised format and would encourage more interactive/small group formats rather than standard lectures. We've all sat through countless hours of lectures in medical school. 27) Overall, I think its been outstanding, but the recent switch over the past several months, I feel, has made conference less academic/educational, though maybe more pleasant. 27) two critical cases instead of three. more reviews of the literature like morgan just did; going over top papers in EM that will influence our practice.	
Opportunities to run resuscitations.	**7.1**
10) as an intern haven't had a lot of opportunities yet 10) Both in ED and during our critical care months. Again excellent aspect of our program. 10) No problems here. 10) Obviously this is greatly increased third year - getting the second years involved at the end of second year to learn to run resuscitation with the third years there as backup is a great idea	
Competence and responsiveness of ERT staff in the ED	**7.1**
18) ERT's are for the most part always willing to help, however, at times, I've had to ask multiple times before something gets done. 18) Mainly good, although some have been known to sit around and chat for entire shifts or make themselves unavailable. 18) The more senior ERTs are consistently fantastic. (snip) (Occasionally newer ERTs should be counselled on prioritization on potentially unstable patients.)	
Overall rating of the St. Paul Children's ED rotation	**7.1**
43) An asset to our program. I love rotating there. The staff are great and are excellent doctors.	
Number of procedures	**7.1**
6) we give away procedures to younger residents, rotators and PAs 6) everybody needs more thoractomies, whatever. but defibrillations and cardioversion are suprisingly low. non FAST exam ultrasounds are also low, untrained staff, not easy/available machines, its an effort. 6) I have many, many more procedures than my friends at other EM residencies across the country 6) Often seems like big procedures in traumas go to TACS by default regardless of time of day. 6) like to have more procedural sedation 6) Pediatric procedures continue to be a struggle. I'm not sure how to fix this one.	
Overall direction/assistance/support provided by IME.	**7.0**
26) No problems here.	
Quality and quantity of community selectives	**7.0**
Quality/responsiveness of specialty back-up to the ED	**6.8**
7) Very resident and service dependent. 7) Major problems with Ortho at times, otherwise quite good. Excellent relationship with TACS since our SICU experience. 7) very, very variable...from a 1 to a 9, but overall very good. 7) Orthopedics is a little sluggish in their response at times. Otherwise quite good.	

7) Neurosurgery and GI are the most difficult services to work with in my experience. However, it's not nearly as bad as many other hospitals in the country.	
Quality and responsiveness of ED Nursing staff	**6.8**
17) (snip) (Occasional difficulty in nurse responsiveness in unstable patients.) 17) (snip) There are certainly more good nurses than bad. I have the hardest time dealing with those who look down on residents due to their lack of experience rather than trying to help residents grow. 17) Overall excellent.	
Overall rating of the Toxicology rotation (within last 12 months)	**6.8**
Availability and quality of resident involvement in CQI (chart audits, QI conference involvement)	**6.8**
28) I'm still awaiting the results of my chart audit. QI conference is outstanding.	
Quality and quantity of electives	**6.7**
54) I feel that there is support to develop and design any elective that is not currently available. 54) really, 2 is too many? if we know where some of our holes are, lets us fill them before we graduate.	
Overall rating of the OB rotation (within last 12 months)	**6.7**
37) It would be good to try and plug this in with some US. 37) Dr. Das appears to be very interested in maximizing the learning for ED residents. She took the time to introduce me to the midwives and FP docs so that I could get more deliveries. 37) No problems here.	
Overall rating of the North Memorial ED rotation (within last 12 months)	**6.7**
Competence and responsiveness of ancillary care providers, x-ray, lab, respiratory, blood bank, transportation.	**6.6**
22) The lab on overnights does not consistantly process our ED labs as urgent/STAT. Frequently of late, we have to call to get them to pull the samples out of the rack and run them. Other services listed are outstanding. 22) The EKG technicians turn over so often that occasionally forget to hand EKGs to a physician. 22) Continual problems with the lab losing or not running specimens or not seeing specimens when they are sent. I am tired of calling lab after waiting hours for specimens only to hear them say "we never got it" or "we never got that order" or "oh...it's sitting right here". Patients wait and our waiting time increases because of lab problems. It would be great to have triage start more IV's/draw rainbows of tubes and urine specimens to speed things up. Team triage should be expanded because it is great. We should have more preexisting nursing order sets: i.e.: female plus abdominal pain equals get urine in triage and send to lab to await our orders. Epigastric abd pain and not vomiting equals give GI cocktail so that when we see them we are one step ahead of the game.	
Availability and accessibility to resources for academic development (memberships to specialty societies, attendance at national conferences,inservice and oral board preparation, mentorship opportunities).	**6.6**
56) not enough opportunities to go, be involved. we're too busy covering this ED. 56) No problems here. 56) If this could be discussed right away during intern year and if this could be explained to us more, residents may be more likely to be interested in participating in these opportunities (SAEM, ACEP committees, etc...)	
Availability and accessibility of activities promoting general resident well being (scheduling and leave policies, access to advisors, access to resident support services).	**6.6**
55) The program as a whole is conducive to well-being. The one gripe I have with schedules is that G1s only work evenings and nights. I would also recommend looking at the Tangiers ED scheduling software, as it is based on circadian patterns and has been well-accepted elsewhere. 55) workout room for residents should have been done years ago. poor ED resident call room situation. 55) The chiefs this year did a fantastic job of working around multiple maternity/paternity leaves.	

Overall rating of the HCMC ED rotation (within last 12 months)	**6.3**
47) great opportunity to see another way of doing things, but quite a regression in responsibility. Felt like a third year med student again	
Accessibility and maintenance of equipment in ED exam rooms.	**6.2**
13) more US machines 13) There should really be a portable ultrasound machine for the B side. If we want to step up our ultrasound program, we should make it easy for residents to incorporate exams into patient encounters. Having to run to the A side, power down the machine, bring it to the B side, power it up, etc. is a huge waste of time. Beyond that, if a TTA is called, the exam is interrupted and the machine must be returned to room 1 or 2. 13) Many times otoscopes/opthalmoscopes are missing or broken in the rooms, especially on the B side. 13) Not uncommonly, otoscope lights are burned out or otoscope heads are missing, overhead exam lights are sometimes difficult to maneuver	
Accessibility and condition of ED conference rooms	**6.2**
15) Once again, fine for now while construction is underway. 15) Difficult to hear. We need to institute a microphone system (perhaps the chiefs could walk around conference with the microphones). The microphone on the podium should always be on. It is useless to invite radiology to our critical case if people cannot hear what they are saying. The overhead projector in the conference room is very noisy; any way to decrease the noise when it is on? 15) It is often difficult to hear some speakers in the amphitheater, would advise that speakers (esp radiology or other people who aren't there all the time) be reminded that they need to speak up or speak into the microphone because most of the audience can't hear them if they are not specifically cognizant of speaking loudly and directed toward the audience	
Opportunities for involvement in ED research. Faculty encouragement, departmental support and sufficient time during residency to participate in research.	**6.1**
33) There is just not enough time to do a decent project. There is also minimal support or guidance. 33) Drs. Gordon and Holger do great work. The process of a "big picture" meeting has broken down now that Elshaday has left. This needs to be resumed, even if in a different format. 33) Opportunities and encouragement are outstanding but there is insufficient time during residency to effectively pursue research. 33) More time to do real research would be helpful. The reason that most of the residents do other things for their projects (EMS, writing book chapters, etc...) is because of difficulties with assisting residents through the research process (especially with IRB process, etc...). This is obviously quite variable depending on project advisor level of involvement.	
Quality of US program in the ED quality of ultrasound education and teaching. Opportunities to perform ultrasound examinations in the ED.	**5.9**
30) Moving in the right direction! 30) we are working on this 30) Variable depending on which staff is working 30) you need more machines, just buy them. make them easy to use. make the tracking/logging easier. 30) too many complications in printing the US images. I have done many US that I have not gotten credit for because the US machine, for whatever reason, won't print. I don't have enough time in the department to try to troubleshoot. 30) This is our achilles heel. It's not a matter of having ultrasound faculty, it's a matter of having all faculty who are comfortable with and encourage the use of ultrasound. HCMC even has a RDMS in the department during the day who helps with bedside teaching. 30) consider more ultrasound experience during the years outside of ED; cardiac ultrasound with techs, transvaginal ultrasounds with techs, etc. 30) I would like to have mandatory U/S lectures. One hour every other Thursday would be appropriate.	

30) The opportunites are great for U/S use in the ED, however, due to pt volume and resident load issues, the actual opportunites to perform adequate/complete U/S exams in the ED are limited. 30) it's what you make of it....all the resources are there 30) Mike especially is putting a lot of effort into improving the ultrasound experience. Part of the problem is that there are varying levels of staff comfort with ultrasound, making the experience somewhat inconsistent for the residents. I know they are working on staff ultrasound certification.	
Overall rating of the Adminstration rotation (within last 12 months)	**5.5**
Accessibility and condition of ED call room and resident quarters	**5.4**
14) Call room in the library right now will be tough as it is in a higher flow area, even at night. That being said, I have never used it, but know people that have/do. 14) not a problem 14) It's fine for the time being. I wonder about laundry service...is there an actual way to get white coats laundered when they come in contact with blood or other body fluids? 14) Sharing a call room with the library is unacceptable. We are unable to use the call room during the day. There is a disconnect; conference attendance is required, we work shifts prior to conference and the day of conference, there is no place to sleep to catch up on sleep prior to having to work again. 14) The old call room was very inadequate, the plans for the new one sound great	
Overall rating of the Orthopedics rotation (last 12 months)	**5.2**
35) Not a friendy environment. They seem to have some anamosity for ED residents. Some of their staff (Dr. Buck) have serious problems relating to others (including residents and patients) in a respectful and professional manner. 35) I learned to splint as well as a few things about dislocation reduction. I think the best place to learn ortho is in the ED and not in the OR, clinic, or doing inpatient consults. What about time at a primary care sports medicine clinic?	
Overall rating of the Cardiology rotation (within last 12 months).	**5.1**
40) Working on the flaws. We are all aware of the issues here (teaching, EKG, etc). 40) We have disussed this. 40) Not much teaching; no involvement with STEMI's; no time set aside for reading echo's; the cardiogy PAs did not do much work (it would be nice if they did a consult each day so that we can go to the echo reading room to learn how to read echos, or go to the OR to watch a cardioversion). 40) more teaching would have been helpful 40) Inpatient consults were rather unhelpful in terms of learning cardiology, although a number of staff did sit down with me and discuss management of serious cardiac disorders.	