RGHP-Emergency Medicine

Anonymous EM Program Evaluation by Residents - Revised

7/1/2010 - 6/30/2011

Included Status Types: RL1,RL2,RL3

Show All Comments

Question:	Answers:		%	Total

Q1.
List the three most important aspects of this program for you.

1) good balance between pushing residents out of their comfort zone to help them grow and supporting/encouraging them as they are pushed; 2) collegiality and comraderie amongst the people working in the ED; 3) acknowledging that residents are people outside of work too and providing support to help them grow as doctors and as people outside of work
education procedures learning environment
Visionary leadership Excellent pt population High didactic quality of all rotations
- training - experience (not the same as training) - quality of life
people family friendly attitude progressive thinking
Open to change, and continued improvement Continued focus on teaching Respect among staff & residents
Autonomy Developing excellent, competent physicians Being surrounded by enthusiastic residents and staff
Education Preparation Comradre
1. Faculty teaching 2. Broad exposure (patients/dx/procedures) 3. Collegial atmosphere
Critical care focus, progressive responsibility, autonomy
1. Critical Care Experience 2. Graduated Autonomy 3. Early exposure to intubations.
Progressive REsponsibility Ability to participate in the care of critically ill patients early on. Forward thinking residency leadership
Commitment to high-quality educational experiences, supportive personalities of staff and residency administration, and quality of off-service rotations.
Comradierie, education, staff
1- All around quality of the people here 2- Relatively large amount of critical care rotations 3- Constant self-evaluation to improve the program
People - staff, residents, nurses, techs Patients Location
patient encounters
patient population supportive staff community hospital in urban setting
Time in the ER, time in the MICU/SICU
Superb education good relationships with co-workers location
Ability to learn Emergency Medicine Autonomy Relationship with staff
Excellent teaching Friendly, understanding atmosphere Good mix of clinical rotations
ED experience opportunity to get procedures Off service rotations are great with no scut work (except for plastics)
staff, fellow residents, learning opportunities
faculty engagement balanced education/service quality clinical experiences
ED experience ICU experience Procedures

Q2.
List the strengths of the residency program

critical care, changing environment to grow flexibility, chances to be in leadership roles within the residency/department, large number of patient contacts, diversity of experience amongst faculty, supportive faculty that do excellent teaching, amazing administrative staff, good leadership of the residency, good support of the residency from the hospital
opportunities outside of residency to advance professionally the department's support of the residency the abundance of resources to help patients in the department
Strong visionary leadership with excellent clinic setting for learning wide range of EM curricula and diverse EM practice styles. Forward-thinking ideals of leadership. Incredibly responsive leadership and programming to facilitate improvements and respond to weaknesses/challenges in EM education. Unparalleled ancillary staff of nurses, unit clerks, ERTs, EMTs, and custodians. Excellent off-service rotations emphasizing critical care and minimizing "busy work"(aka scut).
- experience - uniformly excellent colleagues
progressive PD broad experience strong coordinators (LB and PA)
See above
Critical care training Graduated responsibility Teaching
Comraderie Education
1. Critical care 2. Diverse faculty 3. New facility
Critical care focus, progressive responsibility, autonomy, awesome people, focus on education
1. Critical Care 2. Toxicology program in-house. 3. Early exposure to procedures.
Ahead of our time in terms of thinking about preparing residents in all aspects of healthcare, not just medical knowledge. Excellent staff and leadership.
Open to feedback, excellent facilities and ancillary support, for the most part good relationships with other hospital departments, off-service rotations are generally focused towards ED-specific objectives, commitment to wellness.
Quality of residents, Simulation, Commitment of program to reisdents
Family friendly Dedicated staff and residents
People Mission Felix, Cullen, Rachel, Stephanie, Lori and Pat
great staff that teach, great hands on experience, lots of variety
supportive and quality teaching staff other residents are fantastic
great staff - teaching and teaching styles focus on wellness, focus on developing portfolio for future, QI, reputation for producing great doctors
Autonomy Relationship to staff Listening to needs of residents/suggestions from residents Appropriate time working to not working
Excellent teaching Friendly, understanding atmosphere Good mix of clinical rotations Emphasis on wellness Listening and acting on resident feedback
Procedures available to residents
Staff, fellow residents, learning opportunities, ICU experience
constant feedback and working to improve off-service rotations to tailor to needs of EM residents culture that education is high priority good relationships between residency and the department, staff, etc.
Community

Q3.
List areas of focus for the residency program.

scheduling (to make it less of a burden to make the schedule and to make it more "fair" in terms of evening/night shifts before/after conference and to make vacations more flexible, etc); building a sense of cohesiveness despite the pod system
Could somehow improve flexibility in scheduling of block schedule in regards to how vacation time is requested (dont restrict vacation time to block schedule sequence) and how holidays are spread over each class for the 3 years (example - several residents had holidays off for G2 and G3 yr while others worked both years)
- more focus on training. less on experience (i.e. pushing patient throughput less at the expense of experience, but focusing more on training -- i.e. in room supervision, regular simulation, regular management drills)
find balance between being appropriately and overly responsive to feedback preparation for community EM

-
QI was a great addition this year, but needs some tweaking.
Preparation
Resident confidentiality. Respecting feedback from residents.
quality projects/ROD role
1. Ultrasound 2. Getting higher faculty attendance at conference.
Continue adding staff support to quality projects to help residents navigate what can be a complicated system of implementing change. Continue encouraging the use of US in the evaluation of critically ill patients.
Maximize core content and limit amount of extraneous conference presentations.
Improving consistency US education, increasing staff/resident shift times to improved amount bedside teaching, better commitment to shift evals
Better/more core content during conference (and fewer ancillary topics)
ROD Core competency
wellness in medicine and personal life, high quality emergency medicine
beefing up conference - more bread/butter, core content.
QI
Unsure
Conference - ensuring that common things are commonly talked about, and that conference teaching is practical and applicable (this is already improving with more Sim center days and more core content) Surgical subspecialty rotations
1. Feedback on notes from staff. 2. Better involvement of mentors. Although staff are supposed to give feedback on our documentation, the only time I get feedback is from the Coding staff. I'm yet to have a staff give me feedback on how to make my documentation better. I know Dr. LeFevere reviews notes and talks about better documentation during conference but it will be nice to have some sort of feedback from staff especially early in first year when we're still learning how to document correctly. I'm not sure how other residents' mentors are but I felt mine was too busy to meet with me. We only met my first 2 months of residency when I had questions and I requested to meet. it will be nice if the mentors take the initiative too in scheudling meetings.
ICU, wellness, quality
improving feedback loops between staff and residents focusing conferences back to core content
Can't think of any

Q4.
What should the residency CONTINUE DOING to improve?

wellness within the residency (not discussions about it)
Continue responsiveness to resident ideas, this program is excellent because of ongoing discourse between residents and leadership and subsequent evolution of programming/education.
-- continue attention to feedback
expanding academic opportunities being progressive and working to stay ahead of the curve
-
Incorporating sim into conference and teaching
Move away from busy work and focus on core stuff
Great simulation training. New overlapping shifts looking forward to (so end times line up, work with particular faculty).
Being flexible and responsive to residents needs, adjusting rotations as needed
Continue sim conferences, they are a favorite amongst the residents.
Continue to listen to all stakeholders, continue to be in tune with morale and mental health of residents.
being receptive to internal feedback
continue being open to suggestion for change staff; continue great teaching

Continue to be resident-friendly Great staff
continue to strive to be on the leading edge of programs with vision focused on 2 steps ahead, not on what's important now. continue to focus on wellness and community
Listening to resident suggestions
All the things that are strengths!
It is nice to have the rotation evals pushed through to us by email. continue having more small group conference time and simulation and procedure labs.
ICU, wellness,
listening to feedback about rotations, schedules, and conference content to tailor the educational content to resident needs

Q5.
What should the residency STOP DOING to improve the residency?

Stop the abundance of QI projects and residency wellness discussions during conference time
-- more emphasis on quality improvement as a departmental goal rather than an individual goal; QI will likely be difficult to acheive without nurse and ERT buy-in -- less emphasis on "REDS" and more emphasis on slowing down in appropriate situations (i.e. slow down when you have a sick patient, even if there are a number of chronic / subacute / not sick people getting angry while waiting)
-
adding more steps to anything
C pod shifts. Poor experience by graduating class. Does not seem to be working. Less "wellness" and "quality" and focus more on core content.
Cannot think of anything.
Having so many lectures about quality and wellness
1. Less extraneous surveys!
Streamline the amount of surveys and feedback processes.
be careful of push administration and ED operations vs resident needs/education on issues such as scheduling
taking time from conference for group projects/QI. these should be done outside as nothing was ever really accomplished during conference anyway
Nothing
Less emphasis on wellness lectures
Stop having PAs take away sick patients from residents. Several times, code red has been called and if PA gets there before the resident, they refuse to let the resident take on the patient primarily. I've had this experience mainly with one PA. This residency is for residents to learn to take care of sick patients.
quality

Q6.
What should the residency START DOING to improve the residency?

I think it's a great idea for the interns to have the time away at the end of first year at SAEM - provides a good release from the stress of residency, celebrates the end of intern year, provides good bonding,... I think it would be helpful to have something similar at the end of 2nd year. Second year is in some ways more stressful than intern year and it would be good to have another scheduled time away to reconnect with the class, celebrate being done with 2nd year and prepare for 3rd year. I think it needs to be 2-3 days of time away. It could be in June after the interns get back from SAEM so they could start practicing stepping up to the 2nd year roles.
Changing the staffing overnight and evening shifts. However, I believe this is already in transition for next year
keep working on the administrative rotation
Respecting resident input. Allow for feedback from residents which is annonymous.
Team management (during codes)- closed loop communication, important first steps, etc.

More education about contracts, jobs, malpractice (practical things that we will face once done with residency)
More core content in conferences.
Nothing
Conference should focus more on the bread & butter core content of EM.
increase research, maybe out of hospital journal club etc
Nothing
more on wellness activities and resident bonding activities
nothing
go back to more core content in the lecture series

Q7.
List any specific rotation comments.

Hudson was a fantastic experience (already put more on that specific rotation evaluation but I think anyone who wants to do it would benefit from it!). The SICU is fantastic learning - hard work but exhausting but totally worth it. Really valuable to have the elective time 3rd year - nice to get to choose what we want to do with that.
SICU is the best rotation for learning. It taught me how to be confident caring for sick patients. The teaching by Dr. Bennett is invaluable.
-- continue thinking about SICU hours -- these do get in the way of optimal learning and patient care
-
none
Really enjoyed time at St Paul childrens (quality teaching, working with fellows).
We have an excellent tox rotation, with excellent talks given during the tox rotation. It would be great if those talks could be captured in video format and posted somewhere for review at any time by residents.
None
SICU - would like better commitment by SICU staff to informal talks/teahcing ED - more bedside/post pt presentation teaching, more shift feedback
better teaching on cards
None
plastics in 2nd year is not a good idea. If by any chance, the rotation is cancelled, it should be replaced with another month in Children's ED
none

Q8.
Other comments

I will miss Regions more than I can say. I'm incredibly grateful for the training I've recieved here and the friends I've made. I will be back to visit for sure and maybe someday for longer and will be sure to stay in touch wherever I am! If any residents want to do an elective in Anchorage I'd be happy to help with that (at least for the next 3 years!).
Overall -- my 3 yrs at Regions were great. Regions was first on my rank list and I have no regrets about choosing Regions and would do it all again if given the choice.
Overal excellent residents, great reputation nationwide. Excellent teaching staff and opportunities for residents
none
I am very pleased with the residency and would choose it again!
None
it would be nice to have more money for books - esp first year - i'd like to own the hand book and manual for fractures etc

Đº

RGHP-Emergency Medicine

Anonymous Emergency Medicine Program Evaluation by Faculty - Revised

7/1/2010 - 6/30/2011

Included Status Types: Faculty,Program Director

Show All Comments

Question:	Answers:		%	Total

Q1.
List the three most important aspects of this program.

Diversity Caliber of faculty Residents
Willingness to change and advance. Dedication from the residency leadership to make it great. Support from the department.
Supportive Administration Committment to clinical excellence Excellent faculty and consistently stellar residents
Receptiveness to feedback. Remaining current. Strong presence in the hospital.
People Purpose Creativity
Dedication to education, Lori/Pat, solid clinical rotations
Quality of residents Quality of staff Quality of off service experiences
teaching bedside care learning the new world of operating within a highly interconnected system maintaining high wellness of learners
Patient care Medical education
The residents--they are generally great. The staff dedication to teaching. The program support from the Department , HPIME, Lori and Pat.
Patient exposure, teaching, critical care exposure
excellent exposure to a wide variety of specialty/subspecialty experience.
graduated responsibility of Residents Great pt population EM Staff at all levels
Resident involvement in the direction of the program The close interaction between staff and resident in patient evaluation and treatment Depth of experience received.
People, people people
great teaching great commitment to education
adaptiblity, focus on sound patient care,
Leadership, clinical experience, comraderie
Independence, support, humanity
Residents Residency Leadership and support Ownership of the ER

Q2.
List the strengths of the residency program.

Dedicated Faculty Residents' knowledge base Leadership
Intensive care training. Great residents, willing and excited to participate and learn actively. Dedicated residency leadership. Involved teaching faculty.
Smart and energetic residents Excellent patient diversity Ample opportunity for procedural skill development
Residents Leadership Resources
Felix as a leader, Awesome chief residents, great residents overall
All of the above

program staff patient population system environment prepares for the future of healthcare
The selection process has consistently yielded a group of clinically sound residents. Residents have a broad variety of rotations.
Residents, staff, Lori and Pat, small group conferences, ED and most off service rotations (ex: SICU), program leadership, support from Department and HPIME, facilities, focus on wellness, and responsiveness to feedback.
Good residents, Varied teaching staff, Procedures and US.
not inbred -- faculty diversity excellent pt population for experience strong trauma experience
heterogenaity of favulty
Strong support staff Dedicated faculty Strong residents Very good working relationships with other departments
same as above
flexibility, people, resident-focused
Lori and Pat Great leadership Great commitment by everyone to education
fairly diverse faculty, strong recruiting of residents, Lori/Pat
Supportive, humane, realistic
Excellent residents Strong leadership Sense of community and teamwork

Q3.
List the areas of focus for the residency program.

National recognition International involvement Community Ed/ Preventive Healthcare
It would be nice for us as faculty to be more consistent giving positive feedback and, more importantly, constructive criticism. If the residents were used to hearing it and expected it, it would not be a big deal and I think they would more quickly be able to recognize weaknesses.
Core content - this seems to be foremost on the minds of the residents. Alternate methods of this content should be explored - podcast, video, etc
Resilience training Automation of repetitive administrative tasks HBI training for residents
work on scheduling issues, work on weaker rotations (Plastics, Ortho, Cards).
continuing to be agile in the face of rapid changes learning how to lead the hospital/system on handoffs/communication
Bedside teaching. Patient care.
I think we can tweak the way we do 6 month evaluations to have them more timely right after the evals are done. I think we are very receptive to feedback but occasionally the residents will comment that they feel they are not anonymous--we need to stress to them that they are and we value their input (as we do)!
wellness
making the program more health and family friendly
professionalism
would like to see stricter rule, more 'fascism', less 'commune' as Felix will sometimes phrase it.
Refining of quality curriculum Streamlining necessary "paperwork" -- e.g. procedure logs

Q4.
What should the residency CONTINUING DOING to improve the residency?

attract med students from outside area
The willingness of this program and department to change with advances in care and technology is possibly its greatest strength.
Continue to be flexible and willing to change with the changing landscape of health care Continue to foster quality and safety Continue to teach physician resilience
Responding to feedback.

Continue integrating the residency into IHI triple aim
Keep on addressing issues as they come up, or even before. You seem to have a good radar for issues.
collaborative planning and decision-making process wellness activities keeping residents engaged in system activities (meetings, QI, etc)
Residents appear to have good social support for this challenging period of their career.
Continue to stay dynamic--it's one of the best features of the program that we are willing to change to improve.
presenting Thurs conf in multiple ways (some lect, some small group, some case based, etc) continue striving for resident diversity
critical case review
see #1
Emphasize small group learning
Developing Web 2.0 Support extracurricular activity such as outside committees -- regional and national committees Monitoring/evaluating rotations -- looking for ways to improve

Q5.
What should the residency STOP DOING to improve the residency?

Reacting to outside stimuli without primary data or context
Less powerpoint blocks, more interactive discussions.
Nothing major I can think of.
Too much emphasis on excessive documentation. Not enough face time teaching residents on the floor- they spend too much time typing.
encourage "shotgun" lab ordering
Need to find areas to relieve the residents of things to do. We keep adding things on. Most do not seem very difficult, but keep nickel and diming them. They are very resilient and have not whined much (that I am aware of), but feel that we are taxing them some and one day, we may just add the straw that breaks the camel's back. Pull residents from Pod C
Should be less of the physical stress associated with the training programs - here and elsewhere.
evaluate staff on US training.
Lack of clear long-range plan for achieving core content

Q6.
What should the residency START DOING to improve the residency?

Have clear benchmarks and dashboards available designed with resident input available on demand Have integrated web 2.0. educational delivery system available 24/7
More time in the community hospitals
building video based ultrasound tutorials
still looking for a better way to distribute patients in pods -- regarding distribution of work load and criticality on some shifts
summate practice changes from critical case review
More J fac type shifts or movement to allow residents to run dept. More Selective rotations for Real World experience (if they are allowed more autonomous functioning at these sites).
Increase the number of outside (outside the ER) speakers to cover core topics.
Formalize follow-up so that we know residents are following up their patients.
I think the re-arranging of the midlevel shifts will help.
More self-sufficiency and confidence among residents when speaking with consultants

Q7.
Other Comments.

I love working here because of the residents and the residency

ACGME	2010-2011 Resident Survey - page 1	Residents Surveyed: 28
1102621144	HealthPartners Institute for Medical Education Program - Emergency medicine	Residents Responding: 23
		Response Rate: 82%

Duty Hours

	Never	Rarely	Sometimes	Very often	Extremely often	NA
How often did you break the rule that duty hours must be limited to 80 hours per week, averaged over a 4-week period, inclusive of all in-house call activities?	65.2%	21.7%	13.0%	0.0%	0.0%	
How often did you break the rule that residents/fellows must be scheduled for a minimum of 1 day in 7 free from all residency related duties, averaged over a 4-week period?	69.6%	21.7%	8.7%	0.0%	0.0%	
How often did you break the rule that in-house call must occur no more frequently than every 3rd night, averaged over a 4-week period?	73.9%	4.3%	0.0%	0.0%	0.0%	21.7%
How often did you break the rule that there should be a 10-hour time period provided between all daily duty periods and after in-house call?	34.8%	47.8%	17.4%	0.0%	0.0%	
How often did you break the rule that continuous on-site duty, including in-house call, may be scheduled to a maximum of 24 consecutive hours with up to 6 additional hours on duty to allow for continuity or transition of care, scheduled didactic activities, or outpatient clinics?	82.6%	17.4%	0.0%	0.0%	0.0%	
How often did you break the rule that at-home call must not be so frequent as to preclude rest and reasonable personal time for you?	39.1%	8.7%	0.0%	0.0%	0.0%	52.2%
When you take at-home call and are called into the hospital, how often did you count the hours spent in-house towards the 80-hour limit?	8.7%	8.7%	0.0%	13.0%	8.7%	60.9%

Which of the following explain why you reported breaking one or more of the duty hour rules:	Yes
Because your patient(s) needed your expertise, skill, or attention?	0.0%
Because you had to complete paperwork on patients, or other administrative work?	21.7%
Because you wanted to work additional hours for the educational experience?	8.7%
Because you had to cover someone else's work or patient load?	4.3%
Because of a night-float system?	4.3%
Because of a schedule conflict, such as educational conferences scheduled during your free time?	30.4%
Any other reasons?	0.0%

Faculty

	Extremely	Very	Somewhat / Sometimes	Slightly / Rarely	Not at all / Never
How sufficient is the supervision you receive from faculty and staff in your program?	30.4%	60.9%	4.3%	4.3%	0.0%
How often do your faculty and staff provide an appropriate level of supervision for residents when the residents care for patients?	43.5%	34.8%	17.4%	4.3%	0.0%
How sufficient is the instruction you receive from faculty and staff in your program?	34.8%	34.8%	21.7%	8.7%	0.0%
Thinking about the faculty and staff in your program overall, how interested are they in your residency education?	39.1%	34.8%	13.0%	13.0%	0.0%
Thinking about the faculty and staff in your program overall, how effective are they in creating an environment of scholarship and inquiry?	34.8%	39.1%	8.7%	13.0%	4.3%

Evaluation

	No	Yes
If you want to review feedback on your performance, are you able to access your evaluations?	4.3%	95.7%

	Extremely	Very	Somewhat	Slightly	Not at all	Don't evaluate
How satisfied are you that your program treats your evaluations of faculty members confidentially?	47.8%	34.8%	0.0%	0.0%	17.4%	0.0%
How satisfied are you that your program treats your evaluations of the program confidentially?	56.5%	26.1%	0.0%	0.0%	17.4%	0.0%
How satisfied are you with the way your program uses the evaluations that residents/fellows provide to improve the program?	39.1%	30.4%	13.0%	8.7%	8.7%	0.0%
Overall, how satisfied are you with the written or electronic feedback you receive after you complete a rotation or major assignment?	4.3%	60.9%	21.7%	8.7%	4.3%	

= Shaded areas contain non-compliant responses.
Percentages may not add to 100% due to rounding.

Residents Surveyed: 28
Residents Responding: 23
Response Rate: 82%

Educational Content

	No	Yes
Has your program provided you with its general goals and objectives in either a hard copy or electronic form?	0.0%	100.0%
Has your program provided you with goals and objectives for each rotation and major assignment in either a hard copy or electronic form?	0.0%	100.0%
Has your program adequately instructed you on how to manage the negative effects of fatigue and sleep deprivation on patient care?	8.7%	91.3%

	Extremely	Very	Somewhat / Sometimes	Slightly / Rarely	Not at all / Never
How satisfied are you with the opportunities your program provides for you to participate in research or scholarly activities?	30.4%	52.2%	4.3%	4.3%	8.7%
In your opinion, how often do your rotations and other major assignments provide an appropriate balance between your residency education and other clinical demands?	30.4%	30.4%	39.1%	0.0%	0.0%
How often has your clinical education been compromised by excessive service obligations?	0.0%	0.0%	39.1%	34.8%	26.1%

Resources

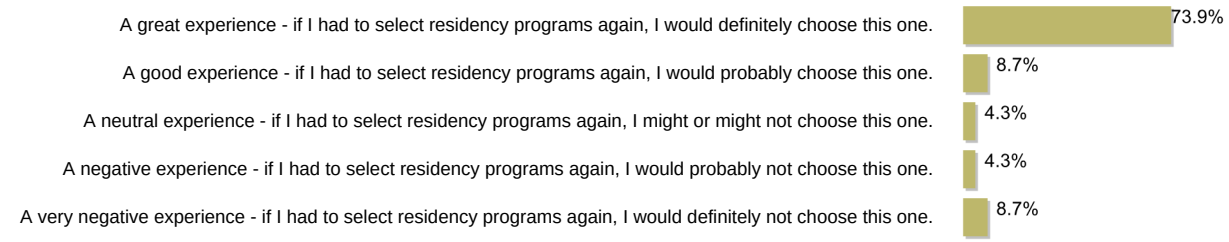
	No	Yes
When you need reference materials for your specialty, do you have ready access to printed or electronic materials?	0.0%	100.0%

	Extremely	Very	Somewhat / Sometimes	Slightly / Rarely	Not at all / Never
How often do you work in interdisciplinary teams to care for patients?	43.5%	34.8%	21.7%	0.0%	0.0%
How satisfied are you with your program's process to deal confidentially with problems or concerns residents/fellows might have?	43.5%	21.7%	17.4%	0.0%	17.4%
How often has your ability to learn been compromised by the presence of trainees who are not part of your program, such as residents from other specialties, subspecialty fellows, PhD students, or nurse practitioners?	0.0%	0.0%	39.1%	52.2%	8.7%

	A great deal	Quite a bit	Somewhat	A little	Not at all
To what extent does your program provide an environment where residents/fellows can raise problems or concerns without fear of intimidation or fear of retaliation?	56.5%	8.7%	17.4%	0.0%	17.4%

Overall Experience

Which of the following best summarizes your opinion of your residency program?



= Shaded areas contain non-compliant responses.
Percentages may not add to 100% due to rounding.

	None	Few	Some	Most	All
How many faculty attend and meaningfully participate in scheduled weekly conferences?	0.0%	30.4%	56.5%	13.0%	0.0%

	No, not this year	Once this year	2-3 times this year	4 or more times this year
Has your program director (or designee) met with you and conducted a formal review of your overall progress and performance in the program?	0.0%	43.5%	56.5%	0.0%

	No	Yes
Does your program provide you the opportunity to perform an appropriate number of procedures to be competent?	8.7%	91.3%
Does your program provide you the opportunity to direct an appropriate number of major resuscitations to be competent?	8.7%	91.3%
Does your program provide you the opportunity to become a competent Emergency Medicine physician?	0.0%	100.0%

Percentages may not add to 100% due to rounding.

Barrett, Lori J

Subject: FW: ACGME survey

From: Woster, Casey M
Sent: Friday, May 27, 2011 6:54 AM
To: Hegarty, Cullen B; Ankel, Felix K; Dahms, Rachel A; Taft, Stephanie A
Cc: Walker, Jerome R; Peterson, Bjorn K; Roth, Eric B; Davidson, Katharine E; Kim, Kara S
Subject: RE: ACGME survey

hey everyone,
I talked about the survey with those who were still around by the time I got to lunch after a Code Blue. Here are the highlights of the discussion, which was good.

1) Duty Hours
- many didn't realize that breaking the 80 hr work week was to be averaged over the entire 4 wks, not just individual wks. They would have answered differently with that in mind. The culprit for an individual wk >80 hrs was usually Plastics, occasionally the MICU. Plastics was also the likely culprit for the reported violation of not receiving 1 day off per 7 averaged out over 4 wks.
- Some didn't realize that only the hours spent in the hospital on a home-call count towards the 80 hr work wk.
- major cause of 10 hr between shifts duty hour violation related to conference attendance

2) Faculty
- residents were comfortable with amount of faculty supervision during procedures
- most would like more bedside teaching during shifts
- a possible idea would be to have staff or even alumni recently graduated talk (maybe at alumni day?) about ways to improve efficiency that they've learned since graduation
- more staff at conference would be a good thing

3) Evaluation
- no one present had concerns about confidentiality during staff and resident evaluations
- those present were satisfied with feedback in evaluations, new system of emailing evals is good

4) Educational content
- as previously stated, more core content
- instead of ROD presentation requiring resident to arrive at 7am, G3 could lead short discussion at morning sign out over teaching point from overnight shift (similar to HCMC signout)
- Plastics is major source of excessive service obligations

5) Resources
- no one present found presence of trainees to compromise learning

Random
- some not excited about C pod shifts, as viewed as similar to A pod
- those spoken with would be ok if we emailed them prior to survey to remind them to fill out this survey (as only 23/28 did), as there is some tachyphylaxis towards surveys in general at this point

sorry if it's too long. sorry to beat a dead horse with reference to Plastics and lack of core content, as we all know these are issues that will be addressed.

Casey

ATTACHMENT B

NEW TRACER METHOD

Traditional definition:

Tracer Methodology – an evaluation method in which surveyors select a patient, resident or client and use that individual's record as a roadmap to move through an organization to assess and evaluate the organization's systems of providing care and services.

ACGME SAYS…they will NOT use this method as JCAHO (patient care tracer) or IPRO (medical record to examine duty hours) do.

They will instead use it to **PROVE POSITIVE OUTCOMES**

They will instead use it to **TRACE AN ONGOING PROGRAM PROCESS**

From ACGME: How are you meeting new standards in…?

– Supervision

– Teamwork

– Transitions of Care

– Delegation of progressive responsibility

– Necessary improvements identified, including:

• How did you fix _____? How did you monitor fix of _____? – Citations

– ACGME Survey non-compliant responses

– Identified Duty Hour non-compliance

– APE Action Plan items

NEW METHODS OF COLLECTING INFORMATION FROM RESIDENTS PRIOR TO PROGRAM SITE VISITS

ACGME: Intention is to have residents look at their entire experience, not just the last interaction, call, rotation.

ACGME: This gives residents substantial input into the site visit, enabling them to feel more engaged, especially helpful in larger programs where only 12 residents are able to meet with site visitor.

ACGME: Believes this shifts focus away from the documents and to the experience Site Visit Interview Sequence.

A very short initial interview with program director and training program administrator (TPA).

- 1.5 to 2 hours with the residents
- 1 hour with faculty
- Wrap up with program director and TPA

Information from residents directs remaining interviews, review of data, and tour of facilities.

NEW ACGME FACULTY SURVEY

1) Number of hours you devote to professional efforts? Which efforts?

2) How often do you participate in group educational activities?

3) When (during rotation) do you give residents documented written feedback?

4) How often do residents participate in QI/patient safety programs (monthly, semiannually, never, etc.)?

5) What impact have duty hour standards had? What effect have they had on residents' ability to learn?

6) How satisfied are you with your program's ability to confidentially deal with resident concerns?

7) How satisfied are you with fatigue management education?

8) How often do you have sufficient time to adequately supervise residents?

9) Do residents recognize their own limits and seek guidance when appropriate?

10) Do residents communicate well?

11) How often does the sponsoring institution and the program provide adequately for safe patient care by residents?

12) How successful is the program in preventing excessive reliance on residents to maximize patients seen?

13) How often is resident workload level and expertise appropriate?

14) How often are residents work directly related to education?

15) How often do personnel participate in teams?

16) Have you personally worked with residents on a scholarly project this year?

CHECK LIST FOR THE ACGME ACCREDITATION SITE VISIT

Please check off the items as you complete them during your preparation for the ACGME program site visit. Forward a copy of the completed check list to your site visitor along with the PIF. This will ensure that all documents needed for the accreditation site visit are complete and available on the day of the site visit. Many thanks in advance.

Site Visit Document Preparation

- Please follow the instructions on your Review Committee's web page to determine the documents you need to complete.
- Once completed, ask your Designated Institutional Official (DIO) to review and sign the PIF.
- After signatures are obtained, make 4 hard copies of the PIF documents. One copy must be single sided; the remaining three copies may be double sided, if preferred.
- Send one (1) single-sided copy of the documents to the site visitor at the above address of the site visitor **14 days** before the date of the site visit.
- Provide the remaining three (3) sets to the ACGME site visitor on the day of the visit.
- Notify residents of the site visit interview. In programs with ten or fewer residents, the site visitor will interview all residents on duty on the day of the visit. In programs with more than 10 residents, the site visitor will interview 10 to 12 **peer-selected** residents, representing all years of training. Extra-year chiefs may not participate.

Include the Following Documents with the PIF Materials You Send to the Site Visitor

- A copy of the site visit schedule with names and titles of all the participants.
- Detailed directions to the institution and the meeting room in which the visit will be conducted.
- The contact number of the program director or another staff member, ideally with a cell phone or pager number for the site visitor to contact the program if an emergency or other urgent need to contact the program arises.

On the Day of the Visit, Please Have these Documents Available for Review by the Site Visitor

Common Program Requirements

__ 1. Policy for supervision of residents/fellows (addressing progressive responsibilities for patient care, and faculty responsibility for supervision)
__ 2. Program policies and procedures for residents' duty hours and work environment
__ 3. Moonlighting policy
__ 4. Overall educational goals for the program
__ 5. Competency-based goals and objectives for each assignment at each educational level
__ 6. Transfer protocols and sample educational materials related to handovers/transfers
__ 7. Sample schedules that inform all members of the health care team of attending physicians and residents/fellows currently responsible for each patient's care

__ 8. Protocols defining common circumstances requiring faculty involvement (care of a complex patient, ICU transfer, DNR or other end of life decision (by year/level of training)
__ 9. Protocol and (completed) sample documents for episodes when residents/fellows remain on duty beyond scheduled hours
__10. Policies to ensure that residents/fellows have adequate rest between daily duty periods and after in-house call (showing differences by year/level of training)
__ 11. Sample documents offering evidence of resident participation in Quality Improvement and Safety Projects
__ 12. Current Program Letters of Agreement (PLAs)
__ 13. Files of current residents/fellows and most recent program graduates:
- If applicable, files of current residents/fellows who have transferred into the program including documentation of previous experiences and competency-based performance evaluations
- If applicable, files of residents/fellows who have transferred out of this program into another program

__ 14. Evaluations of residents/fellows at the completion of each assignment*
__ 15. Evaluations showing use of multiple evaluators (e.g., faculty, peers, patients, self, and other professional staff)
__ 16. Documentation of residents'/fellows' semiannual evaluations of performance with feedback
__ 17. Final (summative) evaluation of residents/fellows, documenting performance during the final period of education and verifying that the resident/fellow has demonstrated sufficient competence to enter practice without direct supervision
__ 18. Completed annual written confidential evaluations of faculty by the residents/fellows
__ 19. Completed annual written confidential evaluations of the program by the residents/fellows
__ 20. Completed annual written confidential evaluations of the program by the faculty
__ 21. Documentation of program evaluation and written improvement plan
__ 22. Documentation of duty hours for resident/fellows in this program

Additional Documents if specified by the RRC:

a. Review of Case/Procedure logs
b. Documentation of conference attendance

* Programs using computerized evaluation system may generate and print summary reports, rather than show individual records.

GRADUATE MEDICAL EDUCATION ADMINISTRATION

RESIDENCY PROGRAM INTERNAL REVIEW REPORT

Program Information

NAME OF RESIDENCY PROGRAM:	Emergency Medicine
ACCREDITATION STATUS:	5 years
DATE OF NEXT RRC SITE VISIT:	02/2014
DATE(S) OF INTERNAL REVIEW:	06/08/2011
DATE PRESENTED TO GMEC:	Proposed Date: July 19, 2011

Names & Titles of Internal Review Committee

INTERNAL REVIEW CHAIR:	Matt Layman, MD Anesthesia Residency Site Director
FACULTY REVIEWERS:	Louis Ling, MD EM Professor of Emergency Medicine, Associate Dean for GME, UMN Medical School
RESIDENT REPRESENTATIVE:	Thomas Leventhal, MD Internal Medicine Chief Resident
GME ADMINISTRATION:	Eugenia Canaan, MALS GME Director, Regions Hospital

Names of Interviewees

PROGRAM DIRECTOR:	Felix Ankel, MD		
DEPARTMENT CHAIR:	Kurt Isenberger, MD		
KEY FACULTY:	Rachel Dahms, MD	Stephanie Taft, MD	Cullen Hegarty, MD
PEER-SELECTED RESIDENTS FROM EACH LEVEL OF TRAINING:	Peter Baggenstos, MD Gary Mayeux, MD	Katie Davidson, MD Kolja Paech, MD	Alex Gerbig, MD; Casey Woster, MD
GME COORDINATOR/MANAGER	Lori Barrett		

Materials sent to Committee prior to the Institutional Internal Review

6/6/2011: Email from Eugenia Canaan to IR Committee containing the following documents:

- Agenda
- Internal Review Sample Questions
- Two Key Program Documents: 1) completed Self Study Form; 2) Requested attachments

Materials provided by the Institution/Interviewees for review by the Internal Review Committee

All pertinent documents received by the EM residency program were placed in a binder and made available the day of the Internal Review. The key program documents were made available in advance, electronically and during the Internal Review.

PAST RRC CITATIONS AND THE METHOD OF RESOLUTION

Taken from RRC Letter dated: 4/30/09

#1	**CITATION:**	Internal Review: Internal reviews must be in process and documented in the GMEC minutes by approximately the midpoint of the accreditation cycle. The accreditation cycle is calculated from the date of the meeting at which the final accreditation action was taken to the time of the next site visit. (Institutional Requirement IV.A.2) The Internal Review was reviewed by the Graduate Medical Education Committee approximately two months prior to the site visit.
	RESPONSE:	10/2/2009 --The GME office has instituted a new process that actively tracks all our internal review dates, so that they are all performed at or before the halfway point through the accreditation cycle (August, 2011).
	UPDATE:	(2011) This citation has been addressed.

#2	**CITATION:**	Program Letters of Agreement: There must be a program letter of agreement (PLA) between the program and each participating site providing a required assignment. The PLA must be renewed at least every five years. The PLA should: identify the faculty who will assume both educational and supervisory responsibilities for residents; specify their responsibilities for teaching, supervision, and formal evaluation of residents, as specified later in this document; specify the duration and content of the educational experience; and, state the policies and procedures that will govern resident education during the assignment. (Program Requirement I.B.1 – I.B.1.d) The PLA's do not include references to the policies and procedures that govern resident education during the rotation.
	RESPONSE:	10/2/2009 – PLAs for the current year are currently being renewed and include policies and procedures that govern resident education while on rotation.
	UPDATE:	(2011) This citation has been addressed.

#3	**CITATION:**	Faculty Qualifications: The physician faculty must have current certification in the specialty by the American Board of Emergency Medicine, or possess qualifications acceptable to the Review committee. (Program Requirement II.B.2) Dr. Paul Haller is not certified by the American Board of Emergency Medicine.
	RESPONSE:	10/2/2009 – Dr. Haller is ABPS, BCEM boarded and Internal Medicine boarded. Dr. Haller does not work single covered shifts in the emergency department where emergency medicine residents are supervised.
	UPDATE:	(2011) This citation has been addressed.

#4	**CITATION:**	Resources: In every hospital in which the emergency department is used as a training site, the following must be provided: … laboratory and diagnostic imaging results returned on a timely basis (especially those required on a STAT basis) (Program Requirement II.D.1.c). Children's Hospital Minneapolis reports O negative or type specific blood availability as 45 minutes versus Children's Hospital of St. Paul as 15 minutes. These must be available on a timely basis.
	RESPONSE:	10/2/2009 – The process of obtaining O neg blood at Children's Hospital-Minneapolis ED has been reviewed. Dr. Patrick Carolan confirms that the time is 15 minutes or less.
	UPDATE:	(2011) This citation has been addressed.

#5	**CITATION:**	Faculty to Resident Ratio: There must be a minimum of one core physician faculty member for every three residents in the program. When the total resident complement exceeds 30, the faculty-resident ratio of one core faculty member for every three residents may be altered with appropriate educational justification. (Program Requirement II.B.2.b). According to the information in the PIF, the program lists nine core faculty members. This number is below the requirement for the current approved resident complement of 30.
	RESPONSE:	10/2/2009 – There are currently 27 residents enrolled in the program and 9 core physician faculty members identified (3:1 ratio). At the time of the site visit, one resident had extended her residency training due to a leave of absence, increasing our enrollment to 28 residents. This is no longer the case.
	UPDATE:	(2011) Additional core faculty have been identified for our current complement of residents.

PAST INTERNAL REVIEW CONCERNS AND METHOD OF RESOLUTION

Excerpted from past Internal Review dated: 4/14/2008

#1	**CONCERN:**	It may be helpful if IME leadership were to assist in the negotiations (physician to physician) with Gillette's Anesthesia Dept and/or Health Specialty Center to increase the Pediatrics experience with intubations. Emphasize Regions Hospital's commitment to the training of ER physicians and appeal to their good senses to assist.
	RESPONSE:	The EM program director supports the IME engagement in this.
	UPDATE:	(2011) Third year EM residents now rotate through pediatric anesthesia at Children's Hospital-St. Paul.

#2	**CONCERN:**	IME to advocate for the preservation of animal labs for the purpose of training procedures that do not lend themselves to simulation.
	RESPONSE:	The EM program director supports the IME engagement in this.
	UPDATE:	(2011) The EM residency has discontinued live animal procedural labs.

#3	**CONCERN:**	Consider setting up a formal Peer Review process with a committee of 2-3 to review unexpected deaths and unanticipated negative outcomes.
	RESPONSE:	The EM residency will work with the EM quality committee to address this.
	UPDATE:	(2011) residents are engaged in peer-review and quality improvement processes of the department.

#4	**CONCERN:**	Consider affiliations with other training sites for Cardiology and Ob/Gyn. Intervene with leadership of Cardiology, Neurosurgery, and Orthopaedics to improve teaching relationship with ER residency.
	RESPONSE:	The EM residency directorship has met with the head of cardiology. It will continue to engage the other departments to maximize the teaching relationship with the EM residency.
	UPDATE:	(2011) residency directorship continues to engage Regions Hospital services to maximize educational relationship.

#5	**CONCERN:**	2nd and 3rd year residents should be able to take referral calls which is an important part of the training program.
	RESPONSE:	The EM residency has a system of mentored transfer call that ensures efficiency.
	UPDATE:	(2011) EM residents continue to take mentored transfer calls.

#6	**CONCERN:**	Encourage a formal educational program related to "delivery of bad news", utilizing palliative care faculty and emphasizing "role-playing" and other teaching tools.
	RESPONSE:	The EM program director will encourage this program and has a faculty member identified that could serve as liaison with the palliative care faculty.
	UPDATE:	(2011) Keith Henry is the residency palliative care liaison and works closely with James Risser to provide palliative care training to EM residents.

PROGRAM DIRECTOR FEEDBACK

1. Clarified the role of the "blue cards".
2. Acknowledged that the ROD is in first year and accountability will be tightened.
3. Faculty attendance at conferences has a base of 10% and averages at 19% and participation is incentivized.
4. Faculty compensation is adequate but the program could use more administrative support.
5. Unaware of issues of Pediatric resuscitation exposure.
6. Peds/EM fellowship: well supported by the program but needs more administrative support.

DEPARTMENT CHAIR FEEDBACK

1. Delineation between community-based faculty, teaching faculty and core faculty … very positive.
2. Annual review of staff is a great way to identify problems and place on performance improvement program.
3. If you're in the bottom 1/3 twice in a row, that is very useful objective criteria that is actionable.
4. Residents would like to see more "engaged" faculty at conferences.
5. Program director and the department chair are very proactive, transparent and afford a lot of communication among core faculty.

FACULTY FEEDBACK

1.	Program in place for Wellness 4 hours in 18 months.
2.	Advisor structure variable.
3.	Staffing increased to meet increased census in order to maximize resident educational experience.
4.	Stress debriefing is inconsistent.
5.	Preference to revert back to use of live tissue procedure lab at least for limited procedures that cannot be modeled/replicated by simulators.
6.	Ultrasound was perceived as weak in the past but it has improved.

RESIDENT FEEDBACK

1.	CRNA students in OR dilutes learning experience.
2.	Ortho experience has improved.
3.	Plastics rotation being worked on.
4.	Use of “blue cards” is variable.
5.	Too many students (medical, PA, other).
6.	Six month evaluation summaries generic and rambling.
7.	No structure for meetings with the advisors but they are always “available”.
8.	Communication with some consultants can be stressful.

GME COORDINATOR/MANAGER FEEDBACK

1.	Overextended and could use more support.
2.	Likes ROD.
3.	
4.	
5.	

PROGRAM STRENGTHS

1.	Faculty support.
2.	Transparency and responsiveness to resident concerns.
3.	Collaboration with outside specialties.
4.	Recognition of the importance of Wellness and Resiliency programming.
5.	Direction and leadership of residency.

PROGRAM CHALLENGES

1.	Debriefing following critical events (e.g. G1 facing first death)
2.	Balancing resident expectations with program feasibility.
3.	Variability in feedback mechanisms.
4.	Inadequate support staff.
5.	Further clarification of role of Resident of the Day (ROD).

PROGRAM COMPLIANCE

	Yes	No
1. In the reviewers' opinion, is the residency program in substantial compliance with the ACGME Common Program and RRC Requirements?	☒	☐

RECOMMENDATION FROM THE INTERNAL REVIEW COMMITTEE

#1	**RECOMMENDATION:**	Food: *Provide access for a variety of healthy food and snacks for overnight team*
	PD RESPONSE:	Dr. Zabrina Evens has met with Food Services to address this.

#2	**RECOMMENDATION:**	Procedure lab: *Find an equal alternative for the animal procedure lab*
	PD RESPONSE:	Drs. Jessie Nelson & Rachel Dahms have developed a non-animal procedure lab to teach EM residents resuscitative skills. Their innovative approach was selected as the Innovations in EM Education (IEME) winner at the 2010 Society of Academic Emergency Medicine annual meeting. They are currently training the trainers in this approach to develop a dynamic cadre of faculty educators.

#3	**RECOMMENDATION:**	Balance peds experience (g2 g3 years): *Provide continuous pediatric experience during 2nd and 3rd year*
	PD RESPONSE:	Discussions with scheduling chief residents will occur for the 2012-2013 scheduling cycle.

#4	**RECOMMENDATION:**	Clarify evaluation methods: *Provide a formal, consistent and timely feedback mechanism*
	PD RESPONSE:	Daily shift cards now go to residents with copies to program directors. Monthly off-service evaluations are sent via New Innovations for resident signature.

#5	**RECOMMENDATION:**	Semi-annual meetings: *Provide more structure.*
	PD RESPONSE:	Six-month evaluations are now scheduled en-bloc. These include 360 evals from faculty, nurses, peers and self.

#6	**RECOMMENDATION:**	Investigate adequacy of coordinator support: *A comparison of other similarly sized EM residency programs might be instructive.*
	PD RESPONSE:	The program is looking into a LEAN process to automate repetitive tasks to be able to successfully manage residency mandates.

#7	**RECOMMENDATION:**	Formalize/publicize debriefing process: *Have access to a formal debriefing process for situations that trouble team members*
	PD RESPONSE:	The emergency department and hospital provide a system of critical incident stress debriefing. Residents are invited to these sessions. The residency will work with current and future chief residents to inform residents that they are able to request a CISD at any time.

ACTION TAKEN BY GMEC

DATE OF GMEC:	July 19, 2011
ACTION TAKEN:	Program found to be in compliance. Formal response due back to GMEC in November, 2011.
FOLLOW-UP DATE:	

Step 6: Duty Hour Information/Board Pass Rates (if applicable)

Duty Hour Information/Board Pass Rates (if applicable)

What percentage of residents will participate in patient safety programs during the current academic year? Leave blank if no residents are on duty for a specific year within the program. *

Year 1 Residents 100 %

Year 2 Residents 100 %

Year 3 Residents 100 %

What percentage of residents participate in interdisciplinary clinical quality improvement programs to improve health outcomes? Leave blank if no residents are on duty for a specific year within the program. *

Year 1 Residents 100 %

Year 2 Residents 100 %

Year 3 Residents 100 %

How often do clinical care needs (in terms of volume and/or complexity of cases) exceed residents' ability to provide appropriate and quality care? Leave blank if no residents are on duty for a specific year within the program. *

Year 1 Residents:

☐ Extremely Often ☐ Very Often ☐ Sometimes ☐ Rarely ☉ Never

Year 2 Residents:

☐ Extremely Often ☐ Very Often ☐ Sometimes ☐ Rarely ☉ Never

Year 3 Residents:

☐ Extremely Often ☐ Very Often ☐ Sometimes ☐ Rarely ☉ Never

Briefly describe your back up system when clinical care needs exceed the residents' ability.*

For each clinical encounter, our residents have a strong safety net of team members, including senior residents, consultants and supervising attending, who are able to provide support and coverage. The ED clinical load is not solely dependent on resident clinical load. EM residents provide care for approximately 40% of total ED volume. Our residents manage between 1.2 to 1.8 patients per hour, depending on PGY level, which is within EM standards. The majority of the rest of the patients are seen by physician assistants and attending physicians. During busy times of the

year, such as the summer, extra staff attending are scheduled in our Pod D area to make sure clinical care needs do not exceed the residents' ability. Our department has a minimum of 2 attending MDs on site 24/7 to help assure that residents' clinical care demands do not exceed the residents' ability. The department head or his designee are on call to the emergency department 24/7 and available to activate a staff MD call-in system when surge volumes exceed departmental capacity. This surge call-in system is not resident-based.

Briefly describe how clinical assignments are designed to minimize the number of transitions in patient care. *

Our residents cover the emergency department 24/7 with defined morning, evening and night transition times. Resident shift length includes a one-hour overlap between shifts to minimize hand-offs and finalize patient care and hand-offs to admitting services.

How do the program and the sponsoring institution ensure that hand-over processes facilitate both continuity of care and patient safety? Please select up to 3 mechanisms: *

- [ ] Electronic hand-over form (a stand alone or part of an electronic medical record system)
- [ ] Paper hand-over form
- [x] Direct (in person) faculty supervision of handovers
- [ ] Indirect (via phone or electronic means) faculty supervision of handovers
- [ ] Senior Resident supervision of junior residents
- [ ] Hand-over education program (lecture-based)
- [x] Hand-over tutorial (web-based or self-directed)
- [x] Scheduled face-to-face handoff meetings
- [ ] Other (specify below)

Only specify if Other is selected

Indicate the ways that your program educates residents to recognize the signs of fatigue and sleep deprivation. Check all that apply. *

- [x] Didactics/Lecture
- [ ] Computer based learning modules
- [ ] Grand rounds
- [ ] Small group seminars or discussion
- [ ] Simulated patient encounters
- [ ] On-the-job training

☐ One-on-one experiences with faculty and attending

☑ Other (specify below)

Only specify if Other is selected

Orientation discussion

Indicate which sites have the following facilities and amenities available to residents when they are on-call.

Enter a response for each column. *

Primary Hospital	**At all Hospital-call Locations**	**At some Hospital-call Locations**
☑ Sleeping Rooms	☐ Sleeping Rooms	☐ Sleeping Rooms
☑ Sleeping Rooms segregated by gender	☐ Sleeping Rooms segregated by gender	☐ Sleeping Rooms segregated by gender
☑ Shower/ bath	☐ Shower/ bath	☐ Shower/ bath
☑ Secure areas (lockers or rooms that can be locked)	☐ Secure areas (lockers or rooms that can be locked)	☐ Secure areas (lockers or rooms that can be locked)
☐ 24-hour food service (cafeteria)	☐ 24-hour food service (cafeteria)	☐ 24-hour food service (cafeteria)
☑ 24-hour food availability (vending machines)	☐ 24-hour food availability (vending machines)	☐ 24-hour food availability (vending machines)
☐ None	☐ None	☐ None
	☑ N/A	☑ N/A

Which of the following transportation options does the program or institution offer residents who may be too fatigued to safely return home? Check the one most frequently used option. *

☐ Money for taxi

☐ Money for public transportation

☐ One-way transportation service (such as a dedicated facility bus service)

☐ Transportation service which includes option to return to the hospital or facility the next day

☐ Reliance on other staff or residents to provide transport

☐ No transport service provided

◉ Other (specify below)

Only specify if Other is selected

A call room is available 24/7 for residents who are unable to drive.

Briefly describe how the program director and faculty evaluate the resident's abilities to determine progressive authority and responsibility, conditional independence and a supervisory role in patient care. Specify the criteria, and how the process differs by year of training. *

Residency Policy on Progressive Responsibility

Purpose
Progressive responsibility is expected for each resident over the three year residency program.
Background
Each year has unique expectations and requirements. These are reflected in the educational requirements in the rotation goals and in the promotion criteria. It is expected that self-directed reading is done on a regular basis and is the responsibility of the individual resident.
Residents are encouraged to utilize their faculty advisor and other residents to assist in gaining progressive responsibility. The EM-3 year of residency will culminate with expectations of a high level of clinical case management, but in addition, will come with expectations of advanced administrative, supervisory, and education skills.

Responsibilities

PGY-3
Third year residents are in charge until June 1st at which time, the second year residents will assume the senior resident role whenever they are on duty.
The resident is responsible for the clinical and administrative direction of the department under the supervision of the attending faculty. The resident is responsible for supervising medical students and residents from other services. The resident provides assistance/direction to the EM-1 resident when able. The resident directs trauma resuscitations as per the TTA guidelines. All medical and pediatric resuscitations brought to Regions ED are also led and directed by the senior resident.
Under the supervision of the attending faculty, the senior resident will be responsible for maintaining patient flow, supervising/directing paramedic calls, taking transfer calls, and handling any administrative problems that may arise during the shift.
The EM-3 assigned to the ED is responsible for obtaining the ultrasound examination and providing back-up for the second year resident in charge of the airway in all trauma activations.
The EM-3 resident is also responsible for teaching assigned medical student workshops.

PGY-2
The resident is responsible for the evaluation and treatment of all stable patients and unstable or arrested medical patients who are placed in the resuscitation area. The resident does not routinely have responsibility for supervising medical students or residents from other services. EM-2 residents will have the opportunity to consult on paramedic cases which require physician involvement. In these situations, the resident will have calls supervised by a senior resident or attending faculty. The E-2 resident handles all transfer calls in conjunction with faculty or senior resident supervision. EM-2 residents participate in pediatric and trauma resuscitations as directed by the EM-3. The EM-2 resident is in charge of airway management for all trauma activations.
The EM-2 resident is also responsible for assisting the EM-3 with the teaching assigned medical student workshops

PGY-1
The resident evaluates stable patients with no life-threatening problem under the supervision of

attending faculty or PGY-3 residents. The senior emergency medicine resident may delegate procedures to the PGY-1 in unstable medical and pediatric patients. During the second half of the year, PGY-1 residents will evaluate patients with potential life-threats who are hemodynamically stable and are placed in the resuscitation area. The PGY-1 resident has no supervisory responsibilities.

Policy Last Updated: June 9, 2011

Excluding call from home, what was the LONGEST averaged number of hours on duty per week, inclusive of all in-house call and all moonlighting worked by ANY resident for the most recent 4-week period: * 72.0

Are residents at the PGY-2-level or above permitted to moonlight? *

◉ Yes ○ No

(if yes) Under what circumstances?

Moonlighting Policy

Purpose
To outline the departmental policy on resident moonlighting.

Background
The Department of Emergency Medicine discourages residents from moonlighting. Although the residency will permit moonlighting, such activities are limited according to the following stipulations.

Responsibilities
Resident moonlighting is only permitted in the EM-2 and EM-3 years. The only exception to this is for EM-1 residents teaching for EMS or assisting with UMN workshops. It is the responsibility of the resident to obtain appropriate licensing, DEA certification, credentialing, and to ensure malpractice coverage.

Policy
Residents must abide by the following

1. Residents must have written pre-approval by the Program Director to moonlight. This must be obtained prior to scheduling any shifts, and ideally would be obtained prior to credentialing.
2. Residents must meet all residency promotion requirements to moonlight.
3. Residents must have received passing evaluations for all rotations.
4. Residents must have obtained an in-training score that would put them at or above the 25% percentile on written boards.
5. Any resident on remediation, probation or suspension is prohibited from moonlighting.
6. Residents may not moonlight more than 24 hours per month (excluding moonlighting during vacation weeks.) The total number of hours worked in any week must be <80 (moonlighting plus regular residency duties).
7. Residents may not moonlight while on leave.
8. Moonlighting may not conflict with resident responsibilities.
9. Residents must complete any moonlighting shifts at least 12 hours before they are required to work in the ED or on another service.
10. Residents must notify the Program Director on a monthly basis of any moonlighting they plan to do.

11. Residents must document moonlighting in duty hours tracking system (RMS).
12. Residents may only work in an unsupervised ED in the EM-3 year. Any exceptions to this policy must be approved by the Program Director.
13. Residents may have their moonlighting privileges revoked by the residency if their circumstances change during the course of an academic year.

Policy Last Updated: June 9, 2011

Are PGY-1 residents permitted to moonlight? *

☐ Yes ☉ No

On average, do residents have 1 full day out of 7 free from educational and clinical responsibilities? *

☉ Yes ☐ No

What was the LONGEST CONTINUOUS duty shift (in hours) worked by any PGY-1 resident during the most recent 4-week period? * 16

Excluding call from home, what was the LONGEST CONTINUOUS duty shift (in hours) worked by ANY resident at the PGY-2 level or above during the most recent 4-week period? * 24

Do residents have an adequate rest period between daily duty periods and after in-house call (appropriate for their level of training as defined by the specialty specific requirements)? *

☉ Yes ☐ No

Enter hours to all that apply: *

	Minimum hours free between duty periods	N/A	Minimum hours free after 24-hours of in-house duty	N/A
Beginners (including PGY1 residents)	9	☐		☑
Intermediate (as defined in the specialty specific requirements)	9	☐	24	☐
Final Years (as defined in the specialty specific requirements)	9	☐	24	☐

Provide an explanation for any instances where the hours free between duty periods are less than 8 hours:

What is the maximum number of consecutive nights of night float assigned to any resident in the program? * 0

Are PGY-1 residents assigned 24 consecutive hours of in-house call? *

☐ Yes ☉ No

On average, how many days per week of in-house call (excluding home call and night float) were residents at the PGY-2 level and above assigned for the most recent 4-week period?* 0.2

Briefly describe any ambulatory and non-hospital settings other than the inpatient experience the program uses in the education of residents and how experiences in those settings help prepare residents for independent practice in the specialty: *

Residents are prepared for independent practice through a variety of experiences.

Regions Hospital offers residents a full spectrum of topics in emergency medicine based on the Model of the Clinical Practice of Emergency Medicine. The core curriculum is designed to repeat itself in its entirety on an 18-month basis. As there are several modalities of learning, the didactic curriculum is set up to cover both the depth and breadth of emergency medicine through traditional as well as innovative and interactive means. Curriculum components include:

Critical Case Conference, a favorite of residents and faculty alike, provides an interactive forum for discussion of a case of educational value. Case discussion is focused not only on the content of the eventual diagnosis, but also on the decision-making process in evaluating critically-ill patients with limited immediate data.

Core Content Lectures reinforce knowledge that is gained on clinical rotations as well as supplement the clinical experience. Lectures are given by faculty members who are experts in a core content area.

Journal Club is held on a regular basis and facilitates discussion of two or three current practice-changing articles in emergency medicine.

Joint Conferences are collaborative conferences held in conjunction with other departments such as radiology, trauma services, critical care, and internal medicine to discuss related areas of interest.

Small Group Sessions encourage interactive learning. Small group simulation days have been incorporated into the curriculum. Residents are divided into three groups and rotate through stations that may include case discussion, simulation or mini-lectures.

Our residency encourages experiences outside the typical EM core content lecture. Residents attend an annual core competencies conference sponsored by HealthPartners IME, procedural competency day in the anatomy lab at the University of Minnesota, and combined simulation experiences with HCMC residents at the University of Minnesota SimPortal. Other conferences include a hand-on splinting workshop with orthopedic surgeons, alumi day conference of case presentations and panel discussions with Regions' graduates, and a combined EM/Trauma Update co-sponsored by HCMC, North Memorial, Mayo and Regions.

The Regions Emergency Medicine Residency also prepares residents for independent practice of emergency medicine through an integrated longitudinal curriculum focused on administration, advocacy, quality, and leadership that spans three years. A foundation of this curriculum is the Resident-of-the-Day (ROD), where residents are relieved of clinical duties to attend and evaluate administrative meetings, present 7am teaching rounds, observe and evaluate in real time high stakes healthcare delivery scenarios that occur in the ED, such as myocardial infarction and stroke.

Briefly describe residents' use of electronic medical records and how this contributes to their education and preparation for independent practice in their specialty: *

Our residents use the electronic medical record for patient care, education, and preparation of independent practice of emergency medicine. Our emergency department uses the Epic system, which is used in many hospitals where our graduates now work.

Summary of Interview Feedback – 2010/11

45 Forms returned.

Informative	Fair	Not Helpful	No Opinion
1	2	3	4

Too Early	Good Time	Too Late	No Opinion
1	2	3	4

	Average
Overview	1.2
Faculty Interview 1	1.1
Faculty Interview 2	1.0
Faculty Interview 3	1.1
Resident Interview/Tour	1.0
Meeting with Coordinator	1.1
Thurs Conference If applicable	1.0

	Average
Start time	2.0

What did you feel were our strengths?

Great, friendly people!
Opportunity to meet all 3 program assistants. Benefits talk was good. TRANSPARENCY
Informal dinner better for conversations. Really liked 1:1 tour.
Packet of information with everything you need to know. Everyone very friendly! Responsiveness of leadership to suggestions. Attendings interested in teaching.
1:1 interview/tour with resident.
Critical care experience as well as EMS opportunities.
Well-organized, everyone was very friendly and helpful.
Friendly, nice facility.
Lunch was awesome!! The best I have had at any interview. Faculty and residents were very helpful.
Your program is open about who you are and what you're all about!
Very comfortable staff/residents. Really enjoyed individual tour!
Critical care, pursuit of individual interest throughout residency, faculty commitment to emergency medicine outside of regular shifts
Community, EMS, friendly.
Transparency, accessibility or information.
Atmosphere, faculty and staff, facilities, location, sense of satisfaction by residents.
The social before really helped give a feel for the residents. Everyone was extremely helpful and kind!
Good people, passionate about program, environment of learning, open to change.
Transparency. The day was organized. I really enjoyed the walking tour.
Info, helpful staff, friendly faculty.
Personality of the program and everyone involved.
Residents and faculty are very open and friendly, making the day a great experience and not stressful. Also very informative about the program.
Resident happiness, simulation, conference. Well organized day and efficient!
1:1 tour, social night before.
Great people, extremely informative.
I liked that the tours were small, this allowed more opportunity to ask questions, meeting about benefits was great (this was actually unique to Regions and I liked it!)
Location, acuity, level 1 trauma, everybody was very nice.
Trauma seems to be impressive.

I appreciated the presentation you provided on the benefits package available to residents. None of the other programs I have interviewed at had anything like this and I found it very helpful and informative.
Personality, wellness-oriented, invested in residents.
Critical care, peds experience, responsiveness to resident input, quality projects.
Support for the residents, openness to change, procedural training including simulation.
Very friendly faculty, great international programs (this is very popular among applicants – maybe advertise more), very transparent.
Good organization, things ran on time. Overall fell, peo0ple I met with, critical care experience, EMS experience, and the transparency, amount of info given.
Very open about strengths/weaknesses, friendly people, 1:1 tour with the resident.
Self-assessment! Your program seems to do an excellent job at gathering feedback from residents and faculty and acting on it! Residents seem very happy.
Unique SICU set up. Resident and faculty were all extremely pleasant and laid-back. Very honest and forthcoming with information.
Well organized! The information given to us including comments from residents in the program.
Engaging faculty, friendly residents.
Very open, willing to shape positives and negatives. Friendly. Accommodating and inviting of resident weaknesses.
The tour and the resident/faculty descriptions and explanations on program were great.
Education centered, dynamic program with great people.
Resident driven off-service rotations. Great resident participation in curriculum.
Friendliness and transparency – very honest about weaknesses.
Very nice people, good facilities.
Friendly, well organized. Applicant focused. Lots of information.
Interview day was a very enjoyable experience.

What were our weaknesses?

Perhaps that most residents seem to already have ties to Minnesota. I do not, so I felt that perhaps that would be looked down upon.
Not as much opportunities for residents to learn reaching skills.
Not many interactions with more residents, mostly saw the same 3 residents throughout interview process.
All nights and evenings during internship might make it difficult to see my spouse – but it's only a year.
Information overload in packet (I know you cut it down, but it is still a bit much…)
From the residents, it sounded like they saw too many psych patients.
Lunch was delicious, but a went a little long.
Having interviews after lunch. It's nice to have them done before hand.
Video looks low quality, no overview of curriculum during intro.
It was very slightly confusing regarding the meeting location for the morning.
It would have been nice to have water/soda and Kleenex available in our waiting room.
Peds.
Limited residents available.
Perhaps adding more specifics about off-service rotations and the PGY1 role when off-service in the intro talk would be useful.
Pre interview dinner only had a few residents.
It would be helpful to see the Children's Hospital.
Loved the program. The only concern is volume but I think your patient population more than makes up for that.
Perhaps a better idea of research being currently conducted (abstract rather than just heading on website)
Sim Center still getting up-to-date it seems.
Fell a bit behind just before interviews … ended up with only about 14 minutes with Dr. Ankel. No real weaknesses though.

What did you like about your interview?

1:1 tour with resident.
Enough time in between to rest.
They were laid back and I felt comfortable asking questions and feel they were answered.
Good chance to ask any questions. Very friendly faculty.
Very informative about program.
Very laid back, non-stressful.
I though the overview video answered a lot of my questions. I also really like the 1:1 interview/tour.
1:1 tour.
Mellow, low threat.
My interviews were very friendly and positive and they gave me a great idea of what Regions has to offer me.
I enjoyed the opportunity to speak with the residents at length about how they feel about the residency program.
Very warm atmosphere.
Very efficient, individual tour was great touch. Faculty interview was relaxed and it was easy to see their excitement about the program.
No tough questions.
Very laid back, good conversation. No pressure.
The video intro was a good synopsis of what the program entails.
The time 8-1 and the organization. The interviewers were very easy to talk with.
Informative, interviewers excited about program, section on benefits.
I liked how informal the day was but how at the same time, the interviewers were interested to get to know me.
Compartmentalized so less repeat questions.
Everyone tried to ask about different aspects of my application.
Informative more conversational then just questions. I like the 1:1 tour.
I was very relaxed and didn't fell interrogated. Everyone was very helpful and very kind.
All the faculty which I spoke with were very friendly, informative, and willing to answer any questions I had.
Relaxed, comprehensive.
Everybody was very friendly during the interview.
I found the day to be very informative. I enjoyed discussing the strengths of Reigons Hosptial's program and all the recreational opportunities the Twin Cities have to offer.
Great people. Easygoing style, conversational. Answered all of my questions well.
Enthusiasm of program directors and residents; openness about weaknesses in program from residents'' perspective.
Friendly and informative.
Comfortable, good info.
Less formal/very informational. Especially liked speaking with Dr. Burnett regarding EMS at Regions.
1:1 time with the resident, interviewers allowed time for me to ask tons of questions.
I felt like the interveners were actually trying to get to know me and see if were a good fit for each others. The coordinators did an excellent job of keeping the day running smoothly.
Painless and laid back. Felt like each interviewer go to know me as a person and not just go through my application. Loved the 10:30 start!!
That I was able to do this during away rotation! This really helped!
Informal conversation style, Great information about the program.
Laid back and interested in addressing applicants questions.
I enjoyed the laid back nature and organization between interviewers so each interview was different.
Everyone was very nice and willing to answer questions. I also liked the shorter tour for rotators.

Very personable and informative.
Perfect number of interviews, everybody helped us find where to go.
Low key. Seemed as though we were just having a conversation.
Laid back attitude.

What did you dislike?

The interviews were a little short/rushed.
The instructions were a bit round about – perhaps including the arrival instructions in the body of the e-mail
Didn't feel like I talked much about myself or application.
Too much down time, not enough residents over lunch.
I had a lot of downtime, waiting for interviews. Although I understand this is a necessary thing to work in all the applicants.
We kept moving back and forth between rooms while waiting for interviews.
The walking tour didn't seem very productive.
Having each interviewer begin by asking if I had questions about the program – would have liked more openings to talk about my strengths as a candidate.
Had to have my mom send suit to me last minute! This hover was well worth it!
Interviewers were eager to answer questions which was great, but having some questions for applicants might have been nice and show more interest.
Watching the video first.
Not a big fan of the video but realize that information has to be disseminated.

Video Comments:

Introduction video vs. live person has both positives and weakness.
I watched this on my own beforehand. This could be suggested and the showing removed from the interview day.
Great video, very informative.
I liked it.
Was informative.
Helpful.
Very informative.
Good overview of the program.
Unique aspect, not a lot of programs show video. I liked it.
I thought the video was excellent and touched on many of the questions I had. I'm glad I had the opportunity to watch it online so I could use it to help decide to apply here months ago.
Nicely down, informative.
A little too long, maybe edit it down a bit.
Informative, I appreciate having access to it on the residency website.
I found the video to be informative and I was glad to follow-up with Dr. Dahms in a more interactive session about the residency program.
It seemed outdated – year old.
Good and informative.
Great video! Very informative, a unique way of presenting information that allowed multiple resident/faculty input, not just the person who would be showing PowerPoint.
Very well done.
Very entertaining.
Perfect length of time and very informative.
Video was great – you are the only program that's done that.
Well done.
Well done, not too long, informative.

Great! Way better way to hear into about the program.
Very unity, had not seen something quite like this at other programs.
Good – maybe a little long.
Keep it!
Informative, short but focused on nuts and bolts of program
It's nice to have commentary on film – consider more data, stats, curriculum info, etc or a supplemental PowerPoint.
Enjoyed it and gave me a good opening idea of what to expect for the day.
It was nice to hear about ultrasound, sim and toxicology.
Very informative and good introduction to program.
I liked it… a pleasant alternative to another PowerPoint presentation.
Video did not fit size of screen.
Lots of info in a short time which was nice.

General Comments:
Thank you!
Website (regionsem.org) is very thorough and helpful. Respect and appreciate the transparency.
The more interaction with may different residents from all 3 classes, the better. Helps show how residents interact rather than have small group for interview day. I think by the end of the tour/interview day/social there was a good variety.
Great Day.
Thank you for scheduling time for me to observe in the ED. I also thought the benefits overview was helpful. Most programs just give you the sheet.
Great interview day.
Regions is a delightful program and it is well featured on interview day.
Excellent interview. I absolutely loved it. Friendly interview, friendly happy residents, beautiful facility.
Would love to be here.
Excellent structure and length of day. Well run.
As comfortable and as good of a time as an interview can be.
Awesome interview day. Thank you! Also, I enjoyed the talk from Lori – informative!
Great overall.
Excellent day!
Thank you!
Only suggestion would be to request early vs. late start when requesting interview dates.
So far this was my favorite interview. Very well-organized and extremely informative!
Thank you very much for the opportunity to come visit Regions! I had a wonderful time!
Excellent overall impression. Ran very smoothly. People were fun to be around.
Enjoyed the whole experience. Fantastic program, great residents who represented the program well.
Enjoyed the get-together at Sonali's place.
Great program.
Great job, well organized.
Great experience, great program.
Great job.
Definitely worth the trip to interview at Regions.
Very impressed, a lot of information given.
Enjoyed the day overall, probably not as stressful as it would otherwise be if we didn't already know some of the faculty. Even so the interviews were doable.
Overall, great, friendly interview experience.
Overall, was a great interview day!
Would love to be there next year.
Loved the program highlights. Thanks for a great interview day. Great program.

Regions Hospital Emergency Medicine Residence
2011 Applicant Survey of Highly Ranked Applicants

What did you feel were our strengths?

Friendliness, transparency

I thought your facility and Emergency Department was beautiful and extremely impressive. I thought the people were very friendly and informative.

Excellent program with great training. Very strong staff, residents. I really liked the close-knit nature of residents/staff relationships. Truly an exceptional program all around.

Fantastically modern, with podcasts/facebook/etc items that your residency feels comfortable using. Very friendly and supportive attendings. Brand new ED!

Welcoming, friendly, strong teaching staff and residency leadership

Faculty, learning environment, friendly atmosphere, SICU.

The residents were happy and friendly. I appreciated the openness with which you presented your program.

The experience of working in a community hospital but treating the "community" and "county" patient. The extensive icu time. The faculty.

The personality of your program, and your willingness to put student/resident education as a priority.

friendly, 3 years, progressive, listen to your residents, combo of county/community/academic settings with wide patient variety

What were our weaknesses?

Almost everybody at the program is already associated with MN in some way- it just seemed to me that I might fit in better in a place with a more diverse mix of folks

I ended up feeling like a four year program better suited me. Otherwise I didn't see any weaknesses.

Honestly, there were no major weaknesses that stand out. A large determining factor for me was location. If my decision was based solely on program, Regions would have been in my top three for sure.

Lack of true county experience and international opportunities. I also wanted to leave MN.

I think you have a very strong program! In the end, my family wanted to be in a different geographical region and I ranked 4 year, more academic programs highly.

Ultrasound is still young but is growing rapidly.

Small?, Volume?, Progressive responsibilities, trauma?

What did you like about the interview process?

Reasonable length and number of interviews, friendly staff, no confusion about where to go

I liked the tour and the time spent talking with current residents. I thought that was very helpful.

Great interviews, friendly, conversational. Plenty of time to talk to residents. Substantial amount of

No questions that "put you on the spot." Very approachable and friendly tone.

Good amount of interviews, good conversation

Laid back, informal. I had a great conversation with Dr. Ankel.

I enjoyed all of my interviews with faculty and staff. Having a personal tour and time with a resident was

Talking with the faculty. The individualized tours of the hospital.

Ahah! I interviewed by Skype, because my flights to Minnesota got cancelled... TWICE. Yet, you were still willing to interview me! It was fantastic. You guys are so kind.

Half-day option was nice.

What did you dislike?

Nothing! I'm happy that I came to interview. I guess the only thing that felt out of place was the person who came to talk at the end of the day - not sure what her purpose was. I think she was a representative from the hospital, but didn't relay anything of importance.

The intro video, rather would of had somebody personally introduce us.

What was one thing that we could have offered that would have increased your likelihood of choosing Regions?

More diverse mix of people, especially residents- I just felt that I would be the only person without ties to MN and the Twin Cities

I would have been more likely to chose Regions if it was a four year program. I also was looking for a stronger pre-hospital/EMS program.

If I had to think of something, maybe a stronger international program. Though again, this was only a small part of my decision making process.

Nothing. Would have ranked you #1 but had to move out of MN for family reasons.

I felt I fit better with a county-style program because it fit more with what I wanted as far as being able to instruct younger residents and the additional responsibilities during my third year

Was more about location than anything else.

Nothing, it was my next choice on my list.

More days of sunshine :)

More teaching of the underclassmen during the residency

Program matched to (optional):

University of Pittsburgh

Alameda County Medical Center

Alameda County Medical Center, Oakland CA

Advocate Christ Medical Center

Washington University in St. Louis

UC-Davis

Additional comments:

This was my first interview and one of the most friendly, warm places I interviewed at. Honestly, one factor in me not ranking it higher was that I'm looking to get away from cold weather after 4 years in Chicago, as most of my interests outside of medicine take place outside in warmer weather.

I really enjoyed my experience at Regions and felt that the faculty and residents helped me to solidify my decision to enter emergency medicine.

I loved the program. Did a visiting rotation here and loved it. Great staff/faculty. Would recommend doing away here for medical students.

I really like your program and ranked it the second highest out of all of the midwest programs I ranked. I just would rather be in California than the Midwest (these Winters kill my soul), and I thought MCW (my highest ranked midwest program) has a bigger role in its community that you guys do.