The Sarasota Model:

Operational Proposal for Longitudinal Residency "Houses" in a Resident-run Wellness Initiative

I. EXECUTIVE SUMMARY

RATIONALE

Wellness = individual mental and physical health + fulfillment.

Fulfillment comes from the combination of **Competence, Autonomy, Belonging, Creativity and Impact.** (Berg et al. 2019)

"We have all the ingredients for wellness. "

- Within the pilot site's Emergency Medicine (EM) Residency Program (Sarasota, FL), we have all the resources (moving stipend, good salary, moonlighting, committees, research, great Emergency Care Center [ECC] & staff) and environmental variables (i.e., no overnights as post-graduate year [PGY]-1s, safe neighborhoods, lots of procedures, great attendings) that would be needed to have "optimal wellness," and the perspectives from peers & speakers at a recent national conference confirmed that we are incredibly lucky. ***We have all the ingredients for wellness.***

- However, research suggests that residents still benefit from structured guidance and mentorship to promote optimal wellness. Without a recipe, the ingredients are useless. (Eskander et al 2021.)

- **Mission:** Promote longitudinal mentorship structure and provide the opportunity for meaningful engagement and leadership opportunities throughout the residents' three years of training in an elective, lighthearted organizational structure designed to supplement and facilitate the goals and priorities of residency program leadership.

- **Solution:** Creating residency houses will accomplish six main goals:

    - **1)** Create a **group structure** that persists throughout the residency training which will **foster community and mentorship connections**.

    - **2)** Allow residents and faculty to be **meaningfully involved in the betterment of the program** in a lasting way.

    - **3)** Facilitate **accountability and engagement** on the part of both residents and EM faculty, using positive reinforcement in the form of a public points system run with full transparency by the houses themselves.

    - **4)** Provide a **self-sustaining organizational structure** within the residency program which can guide, advise, implement, and monitor the individual

contributions of residents and faculty in a lasting framework that promotes long-term progress and betterment of the pilot site's EM residency program.

- **5) Monitor and manage the details of daily operations**, mentoring, career guidance, networking, hospital committees, wellness and other resident affairs that are not directly under the purview of program leadership or the explicit responsibility of a paid core faculty member.

- **6)** Provide the opportunity for residents and faculty to practice and enhance **teamwork and leadership skills** beginning in intern year which will assist their future careers as clinicians, faculty, administrators and more.

- **Expected Returns:** Betterment of the pilot site's EM residency program resident experience by:
  - A) Providing community structure and operational organization
  - B) Facilitating group mentorship
  - C) Creating a positive feedback system (house points) that:
    - **rewards desirable behaviors** (i.e., procedures given by faculty, procedures done by residents, public acknowledgement of kudos, publications, community involvement, winning trivia, being the first group to 100% complete required surveys, etc.)
    - **discourages undesirable behaviors** (i.e., late forms, tardiness, late exams, etc.)
- **Guidelines/limitations:**
  - A) No additional work or effort will be required from residents; all activities are completely voluntary
  - B) Does not interfere with resident education or clinical experiences
  - C) Structure must be self-sustaining through multiple classes of residents
  - D) All residents will be offered the opportunity to participate without discrimination
  - E) No punishment or negative points will be used

2. OVERVIEW

- **Summary:** Create three residency houses which may compete against each other for points, each with (3) permanent core faculty, (3) PGY-3s, (3) PGY-2s, (3) PGY-1s. Each house will be formed with an identity and distinct areas it oversees.
    - The **House Identity** is composed of:
        - House "**Traits**" to allow resident self-selection
        - House "**Committee**" & areas of oversight that the House's Committee will report to the chief resident/program leadership via the elected House Leader on a regular basis
        - A House "**Account**" to keep track of House points.
- **Mission statement:** The longitudinal houses system will provide a mentorship structure, facilitate communication between the residents, attendings and faculty and enable cultural and operational elements of the residency program to be retained despite the relatively short training (3-4 years) of an Emergency Medicine resident.
- **Longitudinal social framework:** to facilitate interpersonal connections, accountability, group inclusivity, mentorship, collaboration, communication, and continuity of individual contributions using positive reinforcement and lighthearted competition in a publicized forum. These goals will be accomplished via well-supported theories of leadership and group dynamics, including:
    - Continuity of program culture and collaborative progress via collective memory
    - Public points system as forum to provide positive recognition, encourage group accountability
    - Competition as a source of engagement and group identity
    - Team spirit, interpersonal connection, mentorship
    - Group responsibility as a unifying element of each team
    - Operational Structure, self-regulation to foster team and individual accountability
    - Functional groups with a size of 5-9 individuals for unity and cohesiveness.

3. POINT VALUES

	Time = < 1 hour	*Time = 1-2 hours*	*Time = 3-5 hours (or rare)*	*Time = 10-20 hours*
	10 points	**25 points**	**50 points**	**100 points**
PROCEDURES	Ultrasound-guided IV	Nerve block	Lumbar puncture	ECC delivery
	Laceration repair (easy) (does not include staples)	Intubation incl. nasal/awake	Thoracentesis	Cricothyrotomy
	PICC line	Central line/dialysis Cath	Transvenous pacer	Pericardiocentesis
	Paracentesis	Chest Tube	Lateral canthotomy	Resuscitative C section
	TVUS	Laceration repair (hard) - <10 y/o; >8 cm; >15 sutures		Trauma thoracotomy
	Arterial line	Joint aspiration/reduction		
KUDOS	Great job with clinical management **	Good catch (prevented bad outcome) **		
	Kudos from ECC staff/peers/attendings **	Per resident participating in recruitment /outreach		
	Great job teaching (faculty or resident) **	Patient writes nice letter about you		
TEAM ACTIVITIES	Points per resident who attended wellness events	Winning trivia in lecture	Winning larger team competition	Kickoff celebration
	Create a social media post	Resident mentorship meeting.	Hosts a group wellness event (for all residents)	
ACADEMICS	Every member passed monthly quiz	Hospital committee involvement	Highest % passed quizzes for entire year	Present at national conference
	Submit case for positive quality improvement	Submit case for case Presentation	Present at a regional conference	High score on inservice exam
		Lecture/evidence based medicine presentation	Published case report in peer reviewed journal	Published peer reviewed research
FORMS	All members documented sim procedures	All forms for month turned in by all members.	First team to reach ultrasound goals for year	
	All sedation forms correct	All hours logged by all team members.	Highest new procedure totals per month	

Overall objectives
document procedures
complete forms
demonstrate clinical proficiency
promote resident involvement/community
create a system to publicly acknowledge people
** = *(Must be approved)*

Figure 1 *– A proposed points structure for the residency houses. Starred items (**) require approval by leadership. The example given is based on the ACGME requirements for an emergency medicine resident. Colors indicate the objective that each item fulfills. The estimated cumulative annual points per house for required items in a three-year program with nine residents per class is greater than 5000 points per year. (ECC – Emergency Care Center. US – Ultrasound. IV – intravenous.)*

Incentivize the things that matter. Identify the things that make the program successful and make them fun. Facilitate engagement through public recognition. Reward any efforts that represent the program well (publications, committee involvement), competency, staff relations, community building.

THINGS TO TRACK FOR PROGRAM AFFAIRS LONG-TERM:

QI / Research/ scholarly	Program business	Other
Current projects Connections/ How to Resident Publications IRB guidance Curriculum improvement Patient follow-up forms Orientation/ intern welcoming	Procedures Forms / Evals Kudos Exams Lectures Rotations Social media / recruitment /Interview scheduling and events	Committees / resident membership Sim GMEC Feedback/concerns Wellness Community Outreach Resources available to residents FAQ / Tips and tricks

4. SCHEDULES

IMPLEMENTATION TIMELINE

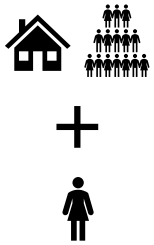
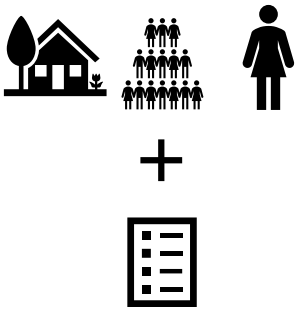
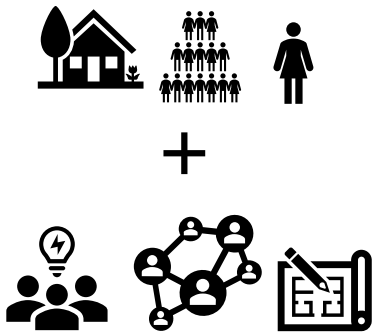
Possible timeframe	0-1 months	1-6 months	1-5 years	5-10+ years
Level of complexity	Houses / Families only	House & House leader	Houses + house leader + recognition of individual resident achievements	Houses + house leader + collaborative efforts to improve individual resident lives/success/careers
		 ↑ Elected House Leader	 (record/recognize individual residents' achievements)	 (Facilitate collaborative group efforts)
Description	Most basic version Just houses/ families that do stuff	Elected house leader serves as the point of contact for chiefs/program leadership	Somewhat involved in program improvement/resident academic & institutional experience. Houses record/recognize individual contributions of their members	Most autonomous – houses have individually defined their own collective purpose that unifies the house as a group, and has the ability to create lasting change in the program Houses have established systems to track past resident efforts and then can build on the improvements made to program by residents before them (rather than needlessly duplicating their efforts)

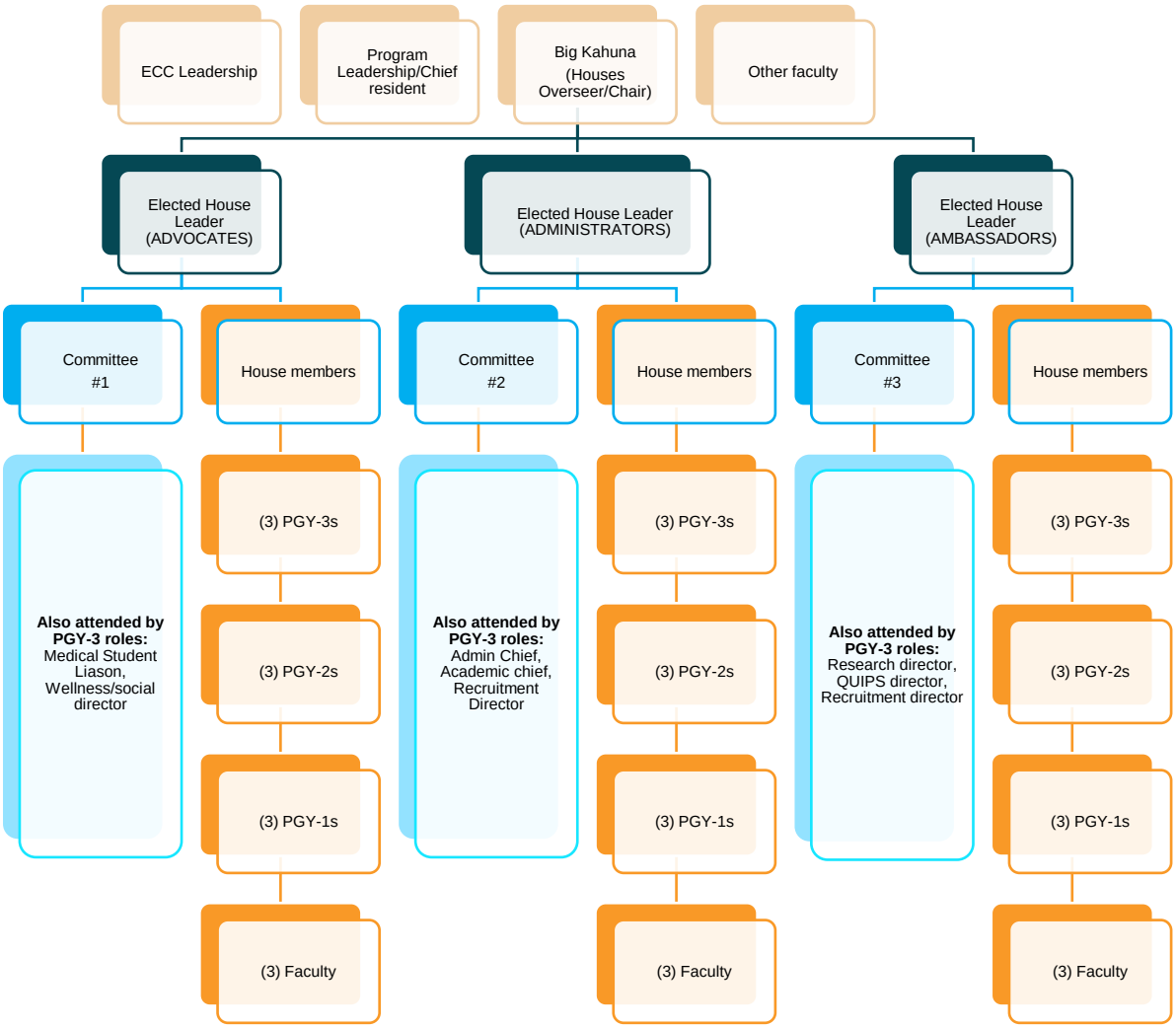
Table 1 – A proposed 10-year timeline for the implementation of the Sarasota Model at a naïve residency program. Actual implementation times may vary.

General Committee Meeting Agenda Template:

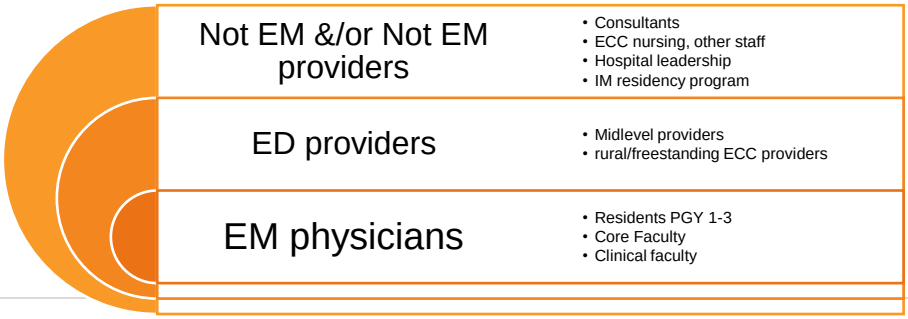
- **General House affairs:**
  - Kudos/top earner for the month
  - Areas of improvement
  - Suggestions for house activities
  - Any other business
- **Committee specific business for areas overseen by the house**
  - **Advocates**: wellness events, procedure counts, cumulative kudos to residents, suggestions for improvement, resident complaints/concerns that have been brought up in the past and follow-up to ensure they were addressed, resources available to residents, faculty strengths and interests, suggestions to improve program.
  - **Administrators**: cumulative point totals, any forms that need to be turned in, late to lecture, upcoming deadlines, highest performing faculty (by points), other business from program to residents, anything that needs to be communicated to ECC or other group leadership?
  - **Ambassadors**: careers and networking, hospital committee participation by residents and ER-related items, hospital connections, medical student recruitment, social media.

5. RESIDENCY HOUSES: STRUCTURE

ORGANIZATIONAL STRUCTURE:



POTENTIALLY INVOLVED PARTIES:



HOUSE RESPONSIBILITIES

Team or house responsibilities will serve two purposes:

1. **Continuity of culture, progress, and program goals**
    a. Career/networking
    b. Connections/resource knowledge within hospital
    c. Connections/resource knowledge outside of hospital
    d. Skills and knowledge
    e. Self-sustaining organization from within houses
2. **House Committees/Responsibilities to facilitate house unity/pride**
    a. Teach residents to work together and lead a group
    b. Enable faculty engagement with a set of house goals
    c. Have defined objectives

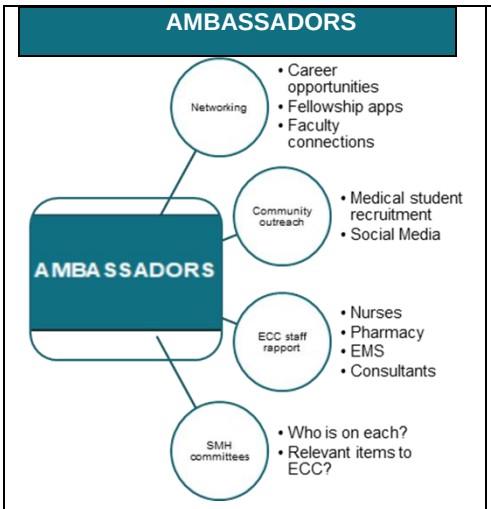
Oversight:

- **House Core Faculty:** mentorship and guidance
- **House Leader:** elected by peers within house, possibly in mid-august
- **House Committee:** monthly or quarterly meetings to address specific agenda, which is then reported to Chief Resident(s) and/or program leadership
- **Responsibilities (a potential framework):**
    - **"Many hands make light work."**
    - **Program ambassadors committee (run by AMBASSADORS house)**: All interactions between the residents, residency program, faculty etc. and external entities (including hospital committees, fellowship opportunities, career opportunities, networking interactions and database, professional societies, external opportunities, community outreach, rapport building with ECC staff, rapport building with consultants and IM residents, etc.) are the purview of the Ambassadors committee.
    - **Program communication and operations committee (run by ADMINISTRATORS house)**: relay information from program leadership and chief residents to faculty and residents in effective, easily accessible media and ensure that there is some permanent, comprehensive, reliable record of communications. This includes things like tracking certifications, electronic forms, procedure counts, and will be responsible for compiling and reporting points from the three houses.

- **<u>Resident advocacy and wellness committee</u> (run by ADVOCATES house)**: all resident requests, complaints, suggestions, wellness, orientation, etc. are directed to this committee. Anonymous submissions can be routed through the wellness director (PGY-3, not necessarily in this house, but must attend committee meetings) in the event a resident is not comfortable discussing the submission publicly. The committee will address all active submissions once a month and will ensure closed loop communication. If a submission has not been fully addressed, i.e., answer to questions, program response for complaints, etc., then it will carry over to next meeting minutes. This will be reflected in monthly meeting minutes. There will also be a review of planned wellness activities, feedback from med students which was told to residents, and interface with Graduate Medical Education Committee. A summary will be sent to the program leadership and to other leadership bodies (if applicable) each month.

OPTIONS FOR HOUSE DIVISIONS/RESPONSIBILITIES:

- **Option A: Logistical / Systems based:** Designed to clearly define structure of where to go for a desired action.



[residency program] → [external/outside of the program]

<u>ADMINISTRATORS</u>: Communicate on **behalf of program** to residents

[*to the residents*]

- Track the points system
- Deadlines and other upcoming dates (maintain the program calendar)
- Forms tracking: evals, surveys,
- Conference/retreat communications & details?

<u>ADVOCATES</u>: Communicate on **behalf of residents** to program

[*to the Program*]

- Wellness activities/Food
- GMEC/Questions issues /complaints from ER
- Financial / salary / reimbursement
- Resident birthdays

Recognition activities (kudos, resident of the month, requirements completion)

- **AMBASSADORS** - career/networking, outreach, community involvement, hospital committees, medical student recruitment, social media
- **ADMINISTRATORS** – forms/program business, residency interviews
- **<u>ADVOCATES –</u>**Resident advocates, wellness activities

- ***Non-housed (Objective) Faculty:*** (suggested to be) Program director, associate program director, Medical Director of department, Research Director, etc. (to maintain objectivity and/or accessibility due to immense contributions to program)
- **Option B:** Based on personalities to enable resident self-selection into houses (to be discussed as a class in orientation week.
    - All program faculty and residents grouped based on personality tests
- **Option C: No house responsibilities, random assignment:** Will be difficult to divide future classes, houses will not aid in the creation and continuity of program culture.

Arbitration/Resolving issues:

- Brought to house leaders, then to chief resident, then to Houses Overseer/Chair
- Residents may switch houses if they find another resident to switch with
- Faculty may switch houses if they find another faculty to switch with

Goals

- Houses will be responsible for long-term, self-sustaining maintenance and oversight of details of critical (but sometimes intangible) program functions that are not under the direct purview of program leadership. This may include things such as: social media, medical student outreach, wellness activities, intern welcoming committee, committee involvement, career and networking, faculty engagement beyond scholarly activities and required mentorship.
- Houses will provide mentorship and a sense of community in an organizational structure which is easy to maintain and sustain with only minimal program oversight.
- There is a regular feedback cycle in which residents and faculty can relay their thoughts and feelings to house committee/elected house leader on a monthly basis. For instance, residents may be surveyed and asked, do you feel you need more, same or less mentorship? If they need more, then the house collectively figures out how to provide more mentorship (I.e., via upper-level residents or faculty).

Rationale for group sizes

- Ideal size for a functional team is 5-9 people, depending on the scenario.
- Division into houses with (9) residents and (3) faculty would provide a spectrum of group sizes depending on the task at hand:
    - **Trivia or group competitions:** (12) people and/or ~1/3 of total present.

- **Mentorship:** Each cohort of (3) interns would have (6) upper-level residents to connect with as well as (3) faculty. It is assumed that smaller groups would form spontaneously within this mentorship family. Faculty would be provided with tools to guide and enhance mentorship including tools from AAMC, AWAEM, and SAEM mentorship resources. They would be asked to teach their residents how to mentor those below them as well.
- **Annual Elected House Leadership:** With an elected House Leader, the leader would be the chosen representative of (8) resident peers and would be responsible for communication with those (8) peers.
- **Houses Leadership (Overseer):** The chosen Overseer would be responsible for communication with the (9) house faculty if needed. This is expected to be infrequent. The chosen Overseer would also passively monitor the points submitted on behalf of core and clinical faculty to ensure equality. This is designed to avoid putting the chief resident in any awkward situations or ever having to confront core/clinical faculty.
- **Houses Leadership (Chief Resident(s)):** The (3) elected House Leaders will be responsible for communicating with the chief resident on a regular basis (likely monthly). The content of this communication will be structured (i.e., given to chief in a templated form) and will include updates for things such as: mentorship activities/progress, Issues, kudos, points, and committee meetings minutes. The chief resident will work closely with Overseer (1) and the program leadership/program coordinator (3) to steer the overall direction of the residency program. This ensures that the chief resident interfaces with approximately (6) key people who will collectively ensure the chief resident knows nearly everything that is going on in the program.
- **Non-Housed Faculty:** These faculty are chosen due to their immense value to all residents. The fact that they are not assigned to a single house, allows them to remain neutral and available to all residents needing advice, mentorship or guidance. The Overseer should be chosen from the non-housed faculty. Ideally, the Overseer will not be the same as the program director. The Residency Houses system is designed to be a playful game that supplements official program business. Choosing the Program director as Overseer, would undermine the lighthearted nature of this endeavor.

6. OPERATIONS

July	Aug	Sept	Oct	Nov	Dec
House **Committee meetings (#1 of 4)** open to unhoused interns. PGY-1s choose houses.	House meetings to elect house leaders.		House committee meeting review #2 of 4	Fellowship applications due	Break
Jan	Feb	Mar	Apr	May	Jun
House committee meeting review #3 of 4	In-service exam		House committee meeting review #4 of 4	Graduation / awards	Break

7. PILOT SITE ANALYSIS

- **Program Overview of pilot site:** Program established with well-proofed structure, monthly quizzes with required reading monthly, 90,000+ visits to the associated ECC per year, no competing residents for procedures, focus on wellness, well-funded, 9 residents per year and three classes total, safe environment, family-friendly, now entering its fourth year, focus on tests as a measure of achievement/progress, moderate number of research/extracurricular activities, many residents/docs came here to be community EM providers.
- **Key participants:** Program Leadership; Core Faculty; Clinical faculty; Residents

PERCEIVED GOALS OF KEY STAKEHOLDERS:

Program	Residents	Collective
• 100% pass rate • High-quality EM clinicians • Good applicants, good incoming interns • Organized documentation and program affairs • Happy Residents	• High quality teaching • Many learning opportunities • Ability to be involved in leadership and make a positive change for future • Become excellent physicians and leaders • Peer mentorship, contribute to group • Find good careers after residency	• Maintain strong relationships between ECC/academic program/hospital • Become the residency program that everyone else wants to be

Pilot Site – Emergency Medicine Residency Program SWOT

STRENGTHS

- Experienced program director, strong leader
- Well-supported by hospital
- Experienced, high-quality attendings
- High-quality consultants
- Residents have many positive connections and opportunities within hospital
- Admin/Business curriculum
- EM docs in key positions in hospital administration
- Great ultrasound program
- Large ECC & freestanding/rural ECC
- Moonlighting allowed
- Exceptional scheduling and financial support
- Faculty that is open and supportive to resident-led initiatives and program improvements

WEAKNESSES

- Desire for improved communication
- Desire to improve sense of community
- Desire for individualized network/career advice/directions
- Desire for more clinical teaching on shift
- Desire for faculty to be engaged in scholarly activities
- Desire for improved positive feedback/recognition
- Desire for a unifying long-term vision/direction
- Potential loss of culture due to 1-year chiefs and annual resident turn over

OPPORTUNITIES

- Increase resident interest and involvement in hospital
- Facilitate ECC staff and resident bonding
- Improve resident cohesiveness between and within classes
- Reduce turnover/lost information due to graduating a class every year
- Improve communication
- Work towards a consistent goal/mission as a unified group
- Increased resident participation would potentially lighten administrative/mentoring duties for faculty
- Provide a structure by which motivated individuals can create lasting change
- Create an electronic forms system to reduce busy work

THREATS

- New program so all residents must succeed
- Uncertainty for all programs in the match process
- Potential for less academic involvement at community hospital