UNIVERSITY OF MINNESOTA
GRADUATE MEDICAL EDUCATION

2015-2016

Program Policy and Procedure Manual

Methodist Hospital
Family Medicine Residency Program

Department of
Family Medicine and Community Health
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INTRODUCTION/EXPLANATION OF MANUAL
Welcome to the Methodist Hospital Family Medicine Residency Program! The Methodist Hospital Family Medicine Residency Program is sponsored by the University of Minnesota Department of Family Medicine and Community Health (DFMCH). This manual provides policies and procedures for the Methodist Hospital Family Medicine Residency Program and the DFMCH. Contact Jeremy Springer, MD, Residency Program Director, or Tammy Pederson, Residency Program Coordinator, with questions regarding the content of this manual. The information contained in this program manual pertains to all residents in the UMN/Methodist Hospital Family Medicine Residency Program except as otherwise identified.

DEPARTMENT MISSION STATEMENT
To connect the University of Minnesota mission of discovery, learning, and public service with our communities—through the teaching, research and practice of family medicine and community health.

PROGRAM MISSION STATEMENT
Park Nicollet Clinic - Creekside has a dual mission of patient care and education:

To provide personalized high-quality care to each patient and to serve the health needs of our community.

To create an outstanding educational experience for family medicine residents and students in an enthusiastic environment where respect, teamwork, responsibility, continuous learning and innovation are valued.

I. STUDENT SERVICES

PAGERS
A Park Nicollet pager will be issued to each resident during orientation. This pager is to be used and worn for the duration of residency training. Information Management is responsible for the maintenance of pagers. Upon graduation from the program and/or termination of employment with Park Nicollet, all residents must return pagers to Information Management as they are property of Park Nicollet. Please see the program coordinator or clinic manager with any questions.

E-MAIL AND INTERNET ACCESS
Each resident will be given unique email accounts at the beginning of residency – one at the University of Minnesota and one at Park Nicollet. For communication purposes, residents are required to check both accounts on a daily basis and will be held accountable for the information communicated to them in e-mails.

The Department and University use the UMN email as the official means of communicating to residents. Residents are responsible for reading and responding to their UMN email. **Residents should not auto-forward their UMN email to any other email account.**

Computers can be found on all floors in the hospital and at every resident desk in the resident’s room in clinic. Each resident is given an account on the PNHS network and have access to email, calendar
function and Internet. Residents experiencing computer problems, contact the helpdesk at 952-993-9000.

As employees of PNHS, all residents are given access to Internet. Employees are expected to use discretion and comply with PNHS policies at all times.

Call 612-301-4357 for computer support for the University of Minnesota e-mail or internet services.

Web Page Resources:
University of Minnesota
www.umn.edu
University of Minnesota Department of Family Medicine and Community Health
http://www.familymedicine.umn.edu/
Methodist Hospital Family Medicine Residency Program
http://www.familymedicine.umn.edu/education-training/residency-programs/methodist
University of Minnesota Medical School
www.med.umn.edu
University of Minnesota Graduate Medical School (GME)
www.med.umn.edu/gme
Email and Library Access for Graduates
http://www.gme.umn.edu/residents/GradEmailLibAccess/index.htm

MAIL
Resident inboxes are located on the shelf above each desk in the resident’s room. Mail will be sorted and delivered to their personal box on a daily basis. It is expected that residents will open, read and respond to mail on a regular and timely basis. Outgoing mail can be deposited in the outgoing box on the wall outside of the resident’s room or in the mail bins at the front desk.

Occasionally, it is necessary to send important information to your home for your immediate attention. It is critical that we have your current home address and phone number at all times. If you move, please contact your residency coordinator at (952) 993-7711 and let her know your new mailing information. You will also need to complete a Change Form to be sent to Human Resources. She will also e-mail Laura Pham, residency programs coordinator, at the DFMCH. To update your address with UMN, please log into www.myu.umn.edu and choose the “My Info” tab to edit your information.

The addresses, main phone and fax numbers for the University of Minnesota Department of Family Medicine & Community Health Graduate Medical Education are as follows:

Phone: 612-624-2622
Fax: 612-626-2694

Mailing:
University of Minnesota
Dept. of Family Medicine and Community Health
420 Delaware Street SE, MMC 381
Minneapolis, MN 55455

Shipping:
University of Minnesota
IMMUNIZATIONS AND VACCINATIONS

The University’s requirement for immunizations and vaccinations for residents is consistent with those of the Centers for Disease Control and Prevention (CDC) [http://www.cdc.gov/vaccines](http://www.cdc.gov/vaccines), Occupational Safety and Health Administration (OSHA), and Minnesota state law for health care workers. Residents cannot be in patient care settings without the required immunization. To help ensure you have the required immunizations, a listing of the required immunizations and vaccinations and related information can be accessed by going to [http://www.bhs.umn.edu/immunization-requirements.htm](http://www.bhs.umn.edu/immunization-requirements.htm) and clicking on “Academic Health Center Student.”

To print out a personalized immunization report and immunization form to update your immunizations, visit [www.bhs.umn.edu/myboynton](http://www.bhs.umn.edu/myboynton)

HIPAA AND SECURITY MANDATORY EDUCATION

All HIPAA training is managed through the Graduate Medical Office at the University of Minnesota and is administered through an onboarding checklist.

NAME CHANGES

Notify your residency coordinator of any expected name change. In order to process your name change for University of Minnesota payroll services, and to update other databases, you must provide Laura Pham, residency programs coordinator, somm0104@umn.edu, (612) 626-0194 in the Department of Family Medicine and Community Health with a copy of a legal document from the state or federal government (e.g. driver’s license, social security card, passport) with your new name.

TUITION AND FEES

All residents (trainees) are registered as students at the University of Minnesota. Currently tuition and student services fees are being waived for trainees enrolled in Graduate Medical Education programs. Your access to student services will vary dependent on the student classification you are appointed to.

II. BENEFITS

SALARY FOR 2015-2016

<table>
<thead>
<tr>
<th>Year</th>
<th>Salary</th>
</tr>
</thead>
<tbody>
<tr>
<td>First</td>
<td>$51,517</td>
</tr>
<tr>
<td>Second</td>
<td>$53,102</td>
</tr>
<tr>
<td>Third</td>
<td>$54,929</td>
</tr>
</tbody>
</table>
HOLIDAYS

2015-2016 Holidays
Saturday, July 4, 2015  Independence Day
Monday, September 7, 2015  Labor Day
Thursday, November 26, 2015  Thanksgiving Holiday
Friday, December 25, 2015  Christmas Day
Friday, January 1, 2016  New Year’s Day
Monday, May 30, 2016  Memorial Day

VACATION
Fifteen (15) paid working days are granted for vacation each G1-G3 years.

Application for all vacations must be made in writing to the program coordinator 60 days in advance of the requested time. (Residents are allowed only ONE late notification per year. Late notifications are requests submitted after publication of the monthly clinic schedule.) Scheduling vacation at the beginning of the resident year is strongly encouraged.

Submit all absence forms to Tammy. Do not make final arrangements/purchase airline tickets, etc., until you receive this completed form back. The following criteria applies to scheduled vacation:
- Annual vacations must be taken in the year of service for which the vacation is granted and may not be accumulated. Any vacation time that is not used at the end of each year will be lost and will not be paid out.
- 1st year resident may take up to 1 week total during the 3 months of Family Medicine Rotations.
- No more than one week (i.e., 5 weekdays) of vacations can be take per rotation.
- Limited vacation will be granted in the last two weeks of the third year.
- No vacation will be allowed during Peds 3, FMI, FM4 and OB shifts.
- Residents will not be permitted to take more than 2 days off from ER & Ped 2 rotation.
- Local program rules will apply for regulations pertaining to rotations where no vacation is allowed.
- Senior resident on service rotations will be required to work the holiday.
- Vacations requested around the observed holidays will be based on seniority. Holiday vacation requests will be determined two months prior to the holiday.
- A resident does not have the option of reducing the total time required for the residency by foregoing vacation time.
- Vacations may not be approved if requesting time off during a scheduled programmatic course.

LEAVE OF ABSENCE
All leaves must be approved by the program director and submitted to Tammy Pederson prior to all resident leaves. If you are on an unpaid leave of absence and you want your benefits to continue, you must contact Tammy immediately. If you fail to notify Tammy about continuing your benefits, they will be discontinued.

Please remember the continuity of care requirement when planning for a leave. The ABFM has a three-month continuity of care requirement. Should a leave exceed that time limit, the following ABFM criteria apply in determining resident status:
1. The resident may not be readmitted to the program at a level beyond that attained at the time of
departure.
2. Prior to reentry, approval of the ABFM is to be obtained (similar to that for any admission at an
advanced level).
3. Requests to the ABFM for authorization for readmission must provide a detailed description of
the evaluation used to determine the level at which the resident is to be readmitted.

SICK LEAVE
Short periods of sick leave that would not compromise the total one-month away from the program can
be handled at the discretion of the program director. However, sick time, when added to vacation time
and any other personal time away (no more than 6 extra days), resulting in more than 21 working days
away (see American Board of Family Medicine requirements) from the program in a PGY year will be
considered a medical leave (see Medical Leave Policy), and the days in excess of 21 working days must
be made up before the resident progresses to the next PGY level. This will extend your residency, and is
a non-negotiable ABFM requirement (see ABFM requirements). A resident leave for any reason must
be discussed with and approved by the program director.

PARENTAL LEAVE
Every effort should be made to schedule the most demanding rotations earlier in pregnancy and the least
strenuous around the time of the resident’s expected date of delivery. The rotation performed around the
time of the expected date of delivery should be one in which the resident is not essential to the service.
The resident call schedule should be arranged to have no call around the expected time of delivery and
while on leave. However, the resident is expected to make up call before or after the time, so as not to
disadvantage the other residents.

A resident birth partner shall be granted, upon request to the program director, up to two weeks paid
parental leave for the birth of a child. The leave must commence no sooner than two weeks prior to the
anticipated delivery date and no later than six weeks after the delivery. The leave must be consecutive
and without interruption. Any leave that when added to vacation time and any other personal time away
results in more than one month away from the program in a PGY year must be made up before the
resident progresses to the next PGY level. This will extend residency, and is a non-negotiable ABFM
requirement (see Leave of Absence).
Also, see “Parental-Newborn Elective.”

MEDICAL LEAVE
Any sick time added to vacation time and other personal time that results in more than one-month away
from the program in a PGY year must be processed as a formal leave of absence. Contact Tammy
Pederson for a leave of absence request form. All leaves must be approved by the program director.
Stipend and benefits may or may not be paid during medical leaves of absence; this determination is
made on an individual basis by the program director.

PERSONAL LEAVE
Days away from the program may be granted at the discretion of the program director, for not more than
three (3) days at a time. If this leave, when added to vacation time and sick leave, results in more than
one month away from the program in a PGY year, the days in excess of one month must be made up before the resident progresses to the next PGY year. Please note that this MAY extend your residency.

**American Board of Family Medicine Requirements:**
**Effect of Leave for Satisfying Completion of Program**

American Board of Family Medicine (ABFM) requirements state that the maximum, cumulative amount of time a resident may be away from the program for personal absences including vacation, sick and miscellaneous leave without making up the time must not exceed one month per PGY year. **One month is equal to 30 calendar days or 21 working days.** Time in excess of one month in each PGY year must be made up before the resident advances to the next PGY level, and the time must be added to the projected date of completion of the required 36 months of training.

**PROFESSIONAL AND ACADEMIC LEAVE**
CME time will be granted at the discretion of and under the direction of the program director.

**American Academy of Family Physicians Annual Scientific Assembly**
http://www.aafp.org/events/fmx.html
September 29 – October 3, 2015. The convention provides a unique opportunity for family physicians to work and socialize with other family physicians, residents, and medical students. The convention also offers you an opportunity to participate in the Academy’s policy making process. When the Congress of Delegates convenes before the convention, your testimony is welcome at the reference hearings. If you are interested in attending the meeting, please contact your Program Director.

**AAFP National Conference for Family Medicine Residents and Students**
http://www.aafp.org/events/national-conference.html
July 30 – August 1, 2015. Family Medicine leaders and educators conduct special lectures, workshops, procedures courses, and clinics. More than 300 Family Medicine Residency Programs are represented in the Exposition Hall. The National Congress of Family Medicine Residents and the National Congress of Student Members hold their annual meetings during the conference.

If a resident attends, part of the resident’s responsibility is to recruit applicants at our residency exhibit booth. If you are interested in attending this conference, contact your Program Director. For travel information and conference information, contact Laura Pham, residency programs coordinator, at (612) 626-0194 or somm0104@umn.edu.

**CME Courses**
A variety of courses are available through the Office of Continuing Medicine Education at the University of Minnesota. There are fees for most courses and pre-registration is required. For more information, refer to their website at http://www.cme.umn.edu/

**Minnesota Academy of Family Physicians Spring Refresher** (Annually in April)
Second year residents are automatically scheduled for some or all of this conference depending on their rotation schedule. Other residents must obtain approval from the Program Director prior to registering for the Spring Refresher. For further information, visit www.mafp.org.

**U of M Department of Family Medicine and Community Health Grand Rounds**
The purpose of the U of M Department of Family Medicine and Community Health Grand Rounds is to allow faculty, residents, fellows, students on rotation, and staff the opportunity to:

- Learn original research findings applied to a clinical scenario
Problem solve clinical vignettes with evidence-based findings
Consider topics of relevance to Family Medicine in an academic context.

The schedule of Grand Rounds presentations will be made by the Directors of Education and Research with input from the Research Advisory Committee and Residency Program Directors.

To view the Grand Rounds calendar or to view web-streaming and past session archives go to the following link:  http://www.fm.umn.edu/education/grandrounds/home.html

UNAUTHORIZED LEAVE
Unauthorized leaves are not permitted and subjected to disciplinary action.
## Benefit Summary - Creekside Residents 2015

<table>
<thead>
<tr>
<th>Benefits</th>
<th>Who's Covered</th>
<th>When Eligible</th>
<th>Benefits Description</th>
<th>Your Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health care program</td>
<td>Park Nicollet First Plan or Personal Choice Plan both administered by Health Partners</td>
<td>Date of hire</td>
<td>Two plan options:&lt;br&gt;• The Park Nicollet First Plan to use Park Nicollet Health System as your provider network&lt;br&gt;• The Personal Choice plan offers a more extensive provider network with coverage that varies based on the provider you see</td>
<td>Premium cost sharing. See premium table. Premium deducted on pre-tax basis.</td>
</tr>
<tr>
<td>Dental care program</td>
<td>Park Nicollet dental plan administered by HealthPartners</td>
<td>Date of hire</td>
<td>Park Nicollet’s dental plan has three benefit levels, with varying benefits in each level. Your benefit level will be dependent on your dentist's participation in the HealthPartners network. There is an out of network option.</td>
<td>Premium cost sharing. See premium table. Premium deducted on pre-tax basis.</td>
</tr>
<tr>
<td>Optical program</td>
<td>Optical &amp; Contact Lens Benefit</td>
<td>Date of hire</td>
<td>A benefit plan for employees to purchase glasses and/or contact lenses at discounted prices from Park Nicollet Optical Stores. There is no out of network option.</td>
<td>See premium table. Premium deducted on pre-tax basis.</td>
</tr>
<tr>
<td>Flexible spending accounts (FSA)</td>
<td>Health Care, Dependent Care and Work Related Transportation Reimbursement Accounts</td>
<td>Date of hire</td>
<td>Elect a pre-tax salary reduction to cover IRS eligible expenses.&lt;br&gt;Health - annual min $1000 max $2550&lt;br&gt;Dependent - annual min $1000 max $5000&lt;br&gt;Parking - annual min $24 max $3000&lt;br&gt;Public transit - annual min $24 max $1560</td>
<td>Health and dependent care pre-tax election divided equally and deducted on each pay check. Parking and public transit FSAs deducted 24 times per year if paid biweekly, and 12 times per year if paid monthly.</td>
</tr>
<tr>
<td>Income protection</td>
<td>Sick Time</td>
<td>Date of Hire</td>
<td>As allowed by the American Board of Family Medicine.</td>
<td>Park Nicollet paid.</td>
</tr>
<tr>
<td></td>
<td>Short-Term Disability</td>
<td>After 6 months of employment</td>
<td>For medically related disability: Full salary, first 12 weeks; 80% salary, next 14 weeks. For disability due to injury, accident or illness: 60% of monthly earnings after 26 weeks of disability.</td>
<td>Park Nicollet paid.</td>
</tr>
<tr>
<td></td>
<td>Long-Term Disability</td>
<td>Upon approval of carrier</td>
<td>For medically related disability: Full salary, first 12 weeks; 80% salary, next 14 weeks. For disability due to injury, accident or illness: 60% of monthly earnings after 26 weeks of disability.</td>
<td>Park Nicollet paid.</td>
</tr>
<tr>
<td>Survivor's protection</td>
<td>Basic Life Insurance Group Term Policy</td>
<td>First of the month coinciding with or following date of hire or transfer to eligible status</td>
<td>Choice of 2 X basic annual earnings or $50,000 coverage to age 70. 50% thereafter</td>
<td>Imputed Life. Income tax on the cost of employer-paid life insurance that exceeds $50,000. Premium based on age and amount of coverage elected. See premium table.</td>
</tr>
<tr>
<td></td>
<td>Supplemental Group Term Life Insurance (optional-paid by team member)</td>
<td>Same as basic life</td>
<td>1 to 4 X basic annual earnings*&lt;br&gt;**Earnings based on previous year’s Pension eligible wages: First year - annualized practice compensation.</td>
<td>Premium based on amount of coverage elected. See premium table.</td>
</tr>
<tr>
<td></td>
<td>Dependent Group Term Life Insurance (optional-paid by team member)</td>
<td>Same as basic life</td>
<td>Same as basic life&lt;br&gt;Spouse - choice of $25,000, $50,000, $75,000, $100,000, $125,000, $150,000, $175,000, $200,000&lt;br&gt;Children - $10,000&lt;br&gt;$1,000 (14 days - 6 months)&lt;br&gt;Optional amounts between $25,000 and $500,000 available. Coverage for family members also available.</td>
<td>Premium based on amount of coverage elected. See premium table.</td>
</tr>
<tr>
<td></td>
<td>Accidental Death &amp; Dismemberment (optional-paid by team member)</td>
<td>Same as basic life</td>
<td>Same as basic life&lt;br&gt;Spouse - choice of $25,000, $50,000, $75,000, $100,000, $125,000, $150,000, $175,000, $200,000&lt;br&gt;Children - $10,000&lt;br&gt;$1,000 (14 days - 6 months)&lt;br&gt;Optional amounts between $25,000 and $500,000 available. Coverage for family members also available.</td>
<td>Premium based on amount of coverage elected. See premium table.</td>
</tr>
<tr>
<td>Retirement plans</td>
<td>BENEFITS</td>
<td>WHO’S COVERED</td>
<td>WHEN ELIGIBLE</td>
<td>BENEFITS DESCRIPTION</td>
</tr>
<tr>
<td>------------------</td>
<td>----------</td>
<td>---------------</td>
<td>---------------</td>
<td>----------------------</td>
</tr>
<tr>
<td>Park Nicotell Health Services 401(k) Retirement Savings Plan</td>
<td>All staff who meet Plan eligibility requirements</td>
<td>First Jan. 1 or July 1 following age 21 and completion of 1 year of employment (at least 1,000 hrs)</td>
<td><strong>PNSH Automatic contribution.</strong> Formula: 4.5% of eligible pay plus 5.2% of eligible pay over 100% of Social Security wage base. Annual contribution. Must be employed 12/31 and have worked 1,000 hours within the calendar year. <strong>Team Member contribution</strong> Voluntary pre-tax or Roth after-tax contributions of up to annual maximum ($18,000 in 2015; $24,000 age 50+).</td>
<td>Park Nicotell paid.</td>
</tr>
<tr>
<td>Sick leave</td>
<td>Sick leave</td>
<td>All regular full-time and part-time staff (40+ hrs/week)</td>
<td>Date of hire</td>
<td><strong>PNSH discretionary 401(k) matching contribution.</strong> (on first 4% of salary contributed) is budgeted for $3-40 per dollar and may increase to $5.50 per dollar based on Park Nicotell’s operating income level. Annual employer contribution. Must be employed 12/31 and have worked 1,000 hours within the calendar year.</td>
</tr>
<tr>
<td>Other</td>
<td>Vacation</td>
<td>Full-time and part-time staff</td>
<td>Date of hire</td>
<td><strong>PNSH Automatic contribution.</strong> Formula: 4.5% of eligible pay plus 5.2% of eligible pay over 100% of Social Security wage base. Annual contribution. Must be employed 12/31 and have worked 1,000 hours within the calendar year.</td>
</tr>
<tr>
<td></td>
<td>Holidays</td>
<td>Full-time and part-time staff</td>
<td>Date of hire</td>
<td>6 scheduled yr (part-time prorated)</td>
</tr>
<tr>
<td></td>
<td>Relocation Reimbursement</td>
<td>All matched applicants</td>
<td>Upon submission of receipts</td>
<td>Up to $3,000 reimbursement for moving expenses (must be submitted by 12/31)</td>
</tr>
<tr>
<td></td>
<td>Professional Liability</td>
<td>Full-time and part-time staff</td>
<td>Date of hire</td>
<td>Coverage for all professional services as a provider.</td>
</tr>
<tr>
<td></td>
<td>Medical &amp; DEA License</td>
<td>Full-time and part-time staff</td>
<td>Date of hire</td>
<td>State &amp; DEA Licenses paid.</td>
</tr>
<tr>
<td></td>
<td>Professional Association Dues</td>
<td>Full-time and part-time staff</td>
<td>Date of hire</td>
<td>State &amp; County Association dues paid. Specialty Association dues paid.</td>
</tr>
<tr>
<td></td>
<td>Hospital Staff Dues</td>
<td>All staff</td>
<td>Date of hire</td>
<td>Hospital Staff dues necessary to your Practice paid.</td>
</tr>
<tr>
<td></td>
<td>Board Dues</td>
<td>All staff</td>
<td>Date of hire</td>
<td>Board exams taken prior to graduation are paid by Park Nicotell. Exams taken after graduation will be paid if Resident has signed a contract to continue working at Park Nicotell.</td>
</tr>
<tr>
<td></td>
<td>Company Discounts</td>
<td>All staff</td>
<td>Date of hire</td>
<td>Special discounts available for staff at PN cafeterias, PN pharmacies, PN optical departments and discounted tickets to theaters and other entertainment.</td>
</tr>
</tbody>
</table>

This “Benefit Summary” is intended to be a Summary of Benefits. If there is any inconsistency between this “Benefit Summary” and the “Health and Welfare Plan for employees of Park Nicotell” and your Contract Agreement, the “Health and Welfare Plan” and your contract will prevail.

*Spouse Eligibility: Spouses who have access to health and/or dental coverage through their own employers are not eligible unless they are required to pay more than 50% of the premium. An Affidavit of Spouse Status For Health and Dental Coverage is required upon enrollment.*
LAUNDRY SERVICE
Each resident will be given two white coats during orientation. If coat needs to be replaced, please contact your residency coordinator.

MEALS
During orientation week, each resident will be given instructions on the procedure for meals at the Methodist Hospital cafeteria. If a resident is unable to obtain food during their call day due to duties that prevent them from utilizing the cafeteria, the nursing supervisor will obtain a boxed meal from the hospital kitchen for the resident. In addition there is a café and vending food service room and other beverage and snack vending machines located within the hospital, these options are at your own expense.

MEMBERSHIP IN MEDICAL SOCIETIES
Family medicine residents are encouraged to join the following medical societies:

Twin Cities Medical Society
www.metrodoctors.com

American Medical Association
1-800-262-3211
www.ama-assn.org

MAFP AND AAFP
The Minnesota Academy of Family Physicians (MAFP) and the American Academy of Family Physicians (AAFP) promote the interest and concerns of practicing family physicians and residents training in the specialty of family medicine. Resident participation is encouraged in Academy activities. An initial year of membership is offered free to first-year residents (paid for by MAFP); and the membership fee for residents in the second and third year is paid for by the program. Among the benefits of membership in the Minnesota Academy of Family Physicians are free membership in the American Academy of Family Physicians and subscriptions to the following publications: “American Family Physician,” “Minnesota Family Physician,” and “AAFP Reporter.”

PARENTAL-NEWBORN ELECTIVE
The parental-newborn elective may be taken by second or third year residents (male or female) who have a child born to them during their residency training, and must be completed within one year of the baby’s birth. The purpose of this elective experience is to augment the practical education one naturally receives in giving birth and caring for a newborn, with a more structured academic experience. A description of this elective follows:

1. The resident should discuss scheduling and other terms of the elective with the faculty advisor by at least 3 months prior to the resident’s estimated date of completion. A written proposal describing the elective and its academic content should be submitted to the program director and faculty advisor at least six weeks before the resident’s estimated date of completion. The proposal should specify the obstetric or neonatal topics(s) to be investigated by the resident, and a list of references that will be used.
2. The duration of the elective will be two to six weeks, and no more than six weeks of parental-newborn elective time will be allowed over the resident’s entire period of training. Because the first year of residency consists of required rotations, the elective will not be an option for that year. This elective experience, like other elective rotations, is part of the resident’s academic program, and therefore will not need to be made up at the end of residency.

3. The resident will be required to attend continuity clinics in the Family Medicine center for the duration of the elective. The resident will be required to attend continuity clinics in the family medicine clinic from 2 - 4 half days per week, depending on the PGY year.

4. At the end of the elective period, the resident will be required to submit a written document to the program director and faculty advisor which details the academic content of the elective experience. A reference list should be included. In addition, for residents taking more than two weeks of parental newborn elective, a presentation of this information should be given to an appropriate group (e.g., residents, staff physicians, nurses, or parenting groups) within the time frame of the elective. Completion of these requirements is necessary for the resident to receive a satisfactory evaluation of this elective, and residency certification.

5. The program director will complete a letter of evaluation of the resident’s performance on this elective and attach a copy of the written document that details the academic content of the elective experience.

RESEARCH RESOURCES
The Department believes that applied research is very important to the growth of individuals and the evolution of family medicine as a specialty. Residents are encouraged to take interest in research and do research with a faculty mentor. The following department resources are available:

- Advice on experimental design and financial sources
- Research assistant services
- Computer services including statistical analysis and interpretation
- Assistance with grant preparation
- Periodic writing workshops

See more research resources: http://www.familymedicine.umn.edu/research
Contact Angela Buffington, PhD, at 507-385-6500 or buffi021@umn.edu, or Carol Lange, MPH, Research Program Coordinator, 612-624-3125 or lange076@umn.edu with any questions.

MOVING EXPENSE REIMBURSEMENT
Moving expenses for newly appointed residents with a one-time maximum of $1000. The resident will pay for the move and apply for reimbursement after the move.

Qualified moving expenses include the reasonable cost of moving household goods and personal effects from former to new residence. Including services for packing, hauling, delivery, storage, unpacking as well as transportation and lodging during the move. Cost of truck rental or trailer rental along with mileage reimbursement up to 24 cents per mile, if you are moving yourself.
Nonqualified moving expenses include boats, hot tubs, firewood, satellite discs, campers, pet’s playhouses, utility sheds, swing sets, swimming pools and waterbeds, warrantees, contracts. The cost of settling an unexpired lease at a former residence or costs associated with the acquisition of a new residence, and house hunting trips.

Documentation required to obtain reimbursement includes; name, social security number, moving dates, place of departure, method of personal travel and shipments of goods. Original receipts for all expenses that are listed for reimbursement must be submitted with the payment reimbursement request.

ACADEMIC BUSINESS EXPENSE FUND
The Methodist Hospital Family Medicine Residency Program will pay up to $1000 reimbursement per year for PDA, personal computer, software, educational materials or conference expenses.

Please note that PDA or computers will not receive computer support from the department, Academic Health Center Information Services, nor Park Nicollet Health Services IT staff. These items are also considered taxable income (IRS rules).

If you have questions, please contact your residency coordinator at 952-993-7711.

III. INSTITUTION RESPONSIBILITIES
The Institution Manual is designed to be an umbrella policy manual. Some programs may have policies that are more rigid than the Institution Manual in which case the program policy would be followed. Should a policy in a Program Manual conflict with the Institution Manual, the Institution Manual would take precedence.

IV. DISCIPLINARY AND GRIEVANCE PROCEDURES

SCHOLASTIC STANDING COMMITTEE FOR REVIEW OF RESIDENT AND FELLOW PERFORMANCE

I. This committee will be composed of 16 voting members: 10 program faculty, two residents, one fellow, three at-large faculty members, and the Director of Medical Education (as an ex-officio non-voting member) – all appointed by the department head.

A. There shall be one faculty member and one alternate from each of the ten following post-graduate training programs:
   - Mankato Residency Program
   - Smiley’s Residency Program
   - Methodist Residency Program
   - St. John’s Residency Program
   - North Memorial Residency Program
   - St. Joseph’s Residency Program
   - St. Cloud Residency Program
   - Duluth Residency Program
   - Hospice and Palliative Care Fellowship Program
   - Sports Medicine Fellowship Program

B. Three additional at-large faculty members shall be appointed by the department head.

C. A representative from Human Resources in the department of Family Medicine and Community Health will serve on the committee as a non-voting ex-officio member.

D. The chair of the committee shall be appointed by the department head from the three at-large faculty committee members.
E. Two residents and one fellow, who will be alternated every other year between the two fellowship programs, shall attend the meetings and be voting members of the committee. The residents shall be from different training programs and should have completed at least one year of post-graduate training in Family Medicine, and be in current good standing.

F. One resident or fellow alternate shall be appointed from each program where there is a resident representative. The term of the appointment shall be for two years for residents, and one year for fellows.

G. Additional faculty, staff, and/or residents and fellows may be used as consultants to the committee.

I. The committee will meet on a regular basis at three-month intervals.

II. The purpose of this committee will be to review the performance of residents and fellows on at least a quarterly basis, and more frequently when required. This review shall include all aspects of resident and fellow performance including, but not limited to, the following: academic, clinical, professional, and personal issues related to performance. The committee will review low ITE scores as established each year by the CEC and support the Program Directors in implementing study plans as needed. The committee will make appropriate recommendations to the respective program director based upon its review.

A. The committee shall review data from the reports of program directors or their program representative regarding resident and fellow performance.

B. The committee shall serve as an appeal body to residents and fellows for local decisions regarding their performance. Final decisions by the committee may be challenged outside the Department of Family Medicine Department and Community Health as outlined under Protocol for Scholastic Standing Committee Review of Unsatisfactory Performance of Residents and Fellows, Sections III and IV.

C. The committee may serve as a consultant to program faculty in determining local decisions regarding resident and fellow status and remedial actions.

D. The committee will be responsible for providing recommendations to program directors or their program representative concerning any perceived resident or fellow deficiencies.

1. These deficiencies may be brought to the attention of the committee by the program directors or their program representative asking for advice and/or recommendations relative to performance deficits noted by program directors.

2. Program directors or their program representatives may remove from clinical service a resident or fellow whose performance poses a risk to patient safety or is deemed too deficient to continue responsibly in the rotation. This action shall be reviewed by the committee within 30 days.

III. The committee will uphold confidentiality of all student records and information and will not disseminate meeting materials, including agendas, review letters, or minutes, to anyone outside of the committee.
PROTOCOL FOR SCHOLASTIC STANDING COMMITTEE REVIEW OF RESIDENT AND FELLOW PERFORMANCE

I. Problems identified by the program directors will be reviewed by the committee and action will be recommended and or approved as needed. Program Director should provide documented evidence of academic deficiencies along with other appropriate evidence of deficiencies.

   A. If a reasonable action plan is given, no presentation to the committee is necessary.
   
   B. If no action plan is given, or the plan is deemed inadequate by the chair of the Scholastic Standing Committee, the case will be presented to the committee for action.

II. Problems previously identified will be reviewed again by the committee at the discretion of the program director.

III. Program director will be notified regarding the committee’s discussion and recommendations.

IV. The involved resident or fellow will also be notified of the committee’s recommendations.

PROTOCOL FOR SCHOLASTIC STANDING COMMITTEE REVIEW OF UNSATISFACTORY PERFORMANCE OF RESIDENTS AND FELLOWS

I. Any resident or fellow who fails a program requirement shall be considered by the committee for recommendation of probation to the program director, unless there are extenuating circumstances.

II. Any resident or fellow who fails more than one program requirement shall be considered by the committee for recommendation of dismissal to the program director unless there are extenuating circumstances.

III. When adverse action is proposed for academic reasons, the process shall be governed by the procedures outlined in the first section of the GME Policy Discipline/Dismissal/Non-Renewal of Residents/Fellows set forth in the Institution Policy Manual at:
http://www.gme.umn.edu/prod/groups/med/@pub/@med/@gme/documents/content/med_content_432305.pdf

   These decisions may be contested under University policy and procedures on Conflict Resolution Process for Student Academic Complaints outlined in the University Policy Library at:
   http://www-policy.umn.edu/Policies/Education/Student/STUDENTCOMPLAINTS_PROC01.html

IV. When adverse action is proposed for nonacademic reasons, the protocol outlined in the second section of the GME Policy on Discipline/Dismissal/Non-Renewal of Residents/Fellows set forth in the Institution Policy Manual shall be followed. See:
http://www.gme.umn.edu/prod/groups/med/@pub/@med/@gme/documents/content/med_content_432305.pdf
This protocol calls for notice before the action is taken, an opportunity for the resident to appear, and an appeals mechanism.

V. The committee will provide the opportunity for individual residents or fellows whose performance is in question to review the evidence relative to their performance and respond to those observations in person at a later meeting of the committee.

VI. The following fundamental requirements of the program must be demonstrated by the resident or fellow to remain in the program.

A. Display adequate achievement of the ACGME and/or AOA General Competencies (patient care, medical knowledge, practice-based learning and improvement, interpersonal skills and communication, professionalism, and system-based practice) as commensurate with the post-graduate level of training.

B. Ability to integrate academic knowledge, clinical skills, judgment, and interpersonal skills into a behavior commensurate with the usual and customary standards of the medical profession, and as appropriate for the associated post-graduate level of training.

C. In addition to those policies listed in resident and fellow manuals, compliance with all ACGME, Medical School (GME Office) and Department of Family Medicine institutional, departmental, and programmatic policies and procedures that are in effect for residents and fellows is expected.

D. Maintenance of all credentialing and licensure requirements as outlined by the office of Graduate Medical Education and the Department of Family Medicine and Community Health.

PATIENT GRIEVANCE POLICY

SUBJECT: REFERENCE NUMBER: A.64-HSM-8390-0898
Park Nicollet Methodist Hospital
Patient Grievance Policy
ORIGIN DATE: 10/1977

PURPOSE: To define the centralized process for responding to a patient grievance for Methodist Hospital.

OWNER: Director, Risk Management/Legal, Director Community Care and Palliative Medicine, Director, Behavioral Health, Director Quality & Patient Safety.

CONTACT/CONTENT EXPERT: Patient Relations, Risk Management/Legal, Quality and Patient Safety, and Compliance.

POLICY: Park Nicollet Health Services is required by the Centers for Medicare and Medicaid Services (CMS) and the Joint Commission (TJC) to maintain a policy and process for addressing patient grievances. Patient and Patient’s Representatives’ grievances will be resolved in a timely, reasonable, consistent and respectful manner, in compliance with state and federal regulatory
requirements. This policy applies to Methodist Hospital, Community Care and Palliative Medicine and the Melrose Center.

DEFINITIONS:

Complaint: A verbal expression of an issue, concern or complaint by a patient or a patient’s representative concerning the quality of care or service (for example, request to change bedding, housekeeping of a room and serving of food) provided by the Hospital which is remedied promptly by staff present.

Grievance: A formal or informal complaint that is made to the Hospital by a patient, or the patient’s representative involving care and services, that is not resolved promptly by staff present on/in the patient’s unit or by the involved department.

• Any verbal complaint
  ▪ Which is not resolved at the time of the complaint by staff present;
  ▪ Is postponed for later resolution;
  ▪ Is referred to other staff for later resolution;
  ▪ Requires investigation;
  ▪ Requires further actions for resolution;

Exceptions:
  Methodist Hospital In-Patient Post-discharge: Communications (in-patient or via telephone) about a matter that would routinely have been handled by staff present if the communication had occurred during the hospital stay do not constitute grievances.
  Methodist Hospital Homecare/Melrose Institute: Communications (in-person or via telephone) about a matter that would routinely have been handled by staff present if the communication had occurred during the staff’s presence at the patient’s home, do not constitute grievances.

• Any written complaint made by a patient or patient’s representative regarding Hospital issues is a grievance. Examples include:
  ▪ Written letters
  ▪ Emails
  ▪ Faxes
  ▪ Written attachments to a patient satisfaction survey if the patient writes on or attaches a written complaint to the survey and requests resolution

• Any written or verbal complaint alleging:
  ▪ Abuse
  ▪ Neglect
  ▪ Patient harm
  ▪ Non-compliance with Medicare Conditions of Participation

• Examples of grievances are:
  ▪ The Hospital did not meet the patient’s care expectations;
  ▪ The Hospital staff did not notify the physician of the patient’s concern;
  ▪ The patient was discharged from the Hospital too soon;
  ▪ The Hospital did not protect patient confidentiality;
  ▪ The Hospital did not obtain informed consent from the patient or patient’s representative;
  ▪ Any allegation of abuse, neglect or other behavior considered unethical.
Billing issues are not usually considered grievances for the purpose of these requirements. However, a Medicare beneficiary billing complaint related to rights and limitations provided by 42 CFR 489 are considered grievances.

Grievance Committee: A multidisciplinary team which may include, as appropriate, the following: Chief of Inpatient Services, Vice President Patient Care Service/Chief Nursing Officer, Compliance Officer, Director of Community Care and Palliative Medicine, Patient Financial Services, Director Quality & Patient Safety, service line chiefs, department chairs, department managers, physicians and nurse managers.

Hospital: Includes Methodist Hospital, Methodist Community Care and Palliative Medicine, and Melrose Center

Patient Representative: Patient’s alternate decision-maker, Healthcare or Financial Power of Attorney, Guardian, parent of a minor, family member, partner, friend or other interested party.

Resolution of Grievance: A grievance is considered resolved when the patient or patient’s representative is satisfied with the action(s) taken on their behalf or when appropriate and reasonable actions have been taken in spite of continued patient dissatisfaction.

Staff Present: includes any PNHS staff present at the time a complaint or grievance is made who can quickly be at the patient or patient representative’s location.

PROCESS:

A. Notice of Rights

All patients who are admitted to Methodist Hospital, Community Care and Palliative Medicine, and the Melrose Institute, shall receive written notice of their right to file a grievance, the right to complain to other state offices and their right to be free from provider retaliation. In the case of Methodist Hospital and the Melrose Institute, inpatients will have a Patient’s Rights brochure in their admission packet.

Upon admission to Methodist Hospital, Community Care and Palliative Medicine, and Melrose Institute, patients shall receive information explaining the process for filing a grievance with Methodist Hospital, or a State Agency. Brochures shall also be available at each Hospital department.

B. General Requirements

1. All Hospital grievances, except billing grievances should be submitted to the Patient Relations Department who will delegate to the appropriate staff/administrators for review, investigation and follow-up.
2. All billing grievances should be submitted to Patient Financial Services.
3. Grievances concerning situations that may endanger the patient (neglect, abuse) should be given highest priority and should be addressed immediately.
4. A report of patient grievances and complaints will be provided to leadership on a regular basis.

C. Methodist Hospital In-Patient Grievance Process
1. Any PNHS employee or staff member, who receives a grievance, shall notify Patient Relations immediately.

2. Patient Relations or an individual identified by Patient Relations, will notify the patient or patient representative that the grievance has been received, that it will be investigated and that the patient or patient representative will receive follow-up.
   a. Contact with the patient or patient’s representative can be made by written letter, by telephone or in person.
   b. Contact with the patient/patient’s representative to acknowledge receipt of the grievance will be made within seven (7) business days after receipt of the grievance.

3. Patient Relations will track and document the time frames for responding to grievances. The patient/patient’s representative will be notified in writing of the investigative outcome of all grievances (oral or written). This must be done within 30 days of completion of the investigation. If additional time is needed (for example, when it is necessary to obtain medical records from outside facilities), the patient or representative will be notified in writing.

4. The written notification to the patient or patient’s representative of the outcome of the investigation will include the:
   a. Name of the Methodist Hospital contact person who can provide additional information;
   b. Steps taken on behalf of the patient to investigate the grievance
   c. Results of the grievance process;
   d. Date of completion;

D. Methodist Community Care and Palliative Medicine
   1. All patient complaints/grievances will be directed to a manager or the director and documented on a complaint form to ensure adequate monitoring and follow-up.
   2. The manager or director will inform Patient Relations of the grievance.

E. Melrose Center
   1. Melrose employees are required to forward complaints or grievances to a patient care supervisor, manager or director.
   2. The patient or patient representative will be informed that if the patient or patient’s representative does not feel the complaint has been resolved they should contact the Patient Relations Department, Methodist Hospital.
   3. Investigation and follow-up of the grievance will be coordinated between the Melrose supervisor, manager or director.
   4. The supervisor, manager or director will keep a written record of the grievance, which will include the follow-and efforts toward problem-resolution.
   5. The supervisor, manager or director, in coordination with patient relations and/or Risk Management/Legal is responsible for written notification to the patient or patient’s representative of the outcome of the investigation which will include the:
      a. Name of the Melrose contact person
      b. Steps taken to investigate the grievance
      c. Results of the grievance process
      d. Date of completion
      e. Additional contact information as needed
   6. A copy of the resolution letter will be sent to Patient Relations.
F. Medicare/Medicaid Billing
   1. Grievances involving Medicare or Medicaid funding, will follow the process defined in the attached Patient Billing Complaint/Dispute Process Work Standard.

G. Approaches for Resolving Grievances. Approaches for resolving complaints and grievances include the following as well as any other approaches that support communication in a language and manner that the patient or patient’s representative understands:
   1. Face-to-face meetings with the patient and/or their representative;
   2. Referral for a biomedical ethics consultation
   3. Referral to appropriate nurse manager, department chair, department manager or administrator or any other designated individual who has responsibility for the area/individual that is at the basis of the grievance.
   4. Referral to the Grievance Committee for decision-making of the resolution to any grievance which cannot be resolved by Patient Relations or the designated responder.

REFERENCES:
42 CFR 482.13(a)
Centers for Medicare & Medicaid Services State Operations Manual
Appendix A: Survey Protocol, Regulations and Interpretive Guidelines for Hospitals
Joint Commission Standard RI.01.07.01
Melrose Patient and Authorized Representative Grievance Procedure AA.02

APPROVALS:
PNHS Quality Subcommittee of the Board – 2-21-14
PNHS Compliance Committee – 2-26-14

PATIENT SAFETY ERROR REDUCTION PLAN

| SUBJECT: Patient Safety Error Reduction Plan | REFERENCE NUMBER: F.04-HSM-8201-0601 |
| APPROVALS: | ORIGIN DATE: June 2001 |
| | REVISION NUMBER: 1 |
| | REVISION DATES: March 2003, July 2006 |

PURPOSE
To articulate Park Nicollet Health Services (PNHS) commitment to safe patient care.

RESPONSIBILITY
Chief Executive Officer and Chief, Patient Safety

POLICY
PNHS leadership accepts responsibility to our community to set the highest expectations for safe patient care.

**DEFINITIONS:** In the interest of consistency across the health care industry, PNHS utilizes definitions from the Institute of Medicine report published in 2000 for the following:

- **Patient Safety:** Freedom from accidental injury; ensuring patient safety involves the establishment of operational systems and processes that minimize the likelihood of errors and maximizes the likelihood of intercepting them when they do occur.

- **Error:** Failure of a planned action to be completed as intended or use of a wrong plan to achieve an aim; the accumulation of errors results in accidents.

- **Accident:** An event that involves damage to a defined system that disrupts the ongoing or future output of the system.

- **System:** Set of interdependent elements interacting to achieve a common aim. These elements may be both human and non-human (equipment, technologies, etc.)

- **Sentinel Event:** An unanticipated loss of life, limb, or permanent loss of bodily function, not related to the natural course of the patient's illness or underlying condition.

**PNHS Definition for the following:**

- **Defect:** An uncorrected error that is passed on is a “Defect” in care. Park Nicollet’s goal is to eliminate Defects.

- **Reportable Occurrence:** Errors, accidents or situations which did or could have resulted in an injury to a person, patient, employee or visitor.

**PROCESS**

1. PNHS provides an environment where every staff member is an inspector, checking each step of a care process for uncorrected errors, fixing those they can, or stopping the line to get help from their leaders to fix those they can’t in order to prevent a defect from being passed on. Each staff member welcomes the opportunity, and is expected to report errors or potential errors and defects:
   a. PNHS has committed to the above statement, as an organizational priority.
   b. An error or potential error, or defect is reported anonymously through the Quality Tracking System (intranet-based reporting tool), or on a paper format if there is not access to the quality-tracking tool. Reports may also be made directly to the Chief, Patient Safety, Quality Resources staff, or their designees.

2. PNHS recognizes risks to patient safety, and takes actions to reduce those risks, through proactive approaches:
   a. JCAHO Sentinel Event Alerts as well as other sources of patient safety information are reviewed to identify and correct potential risks to our patient population.
b. High-risk procedures/processes in our system are identified and proactive root cause analysis is conducted to reduce risks and improve patient safety.

c. Root cause analysis is used to review, identify, and correct root causes of Sentinel or potential Sentinel events.

d. Patient safety is incorporated into the credentialing process of the medical staff.

e. Patient Safety is incorporated into the job descriptions and performance reviews of all staff.

f. Vice Presidents/Directors/Managers/Chiefs/Department Chairs hold staff accountable in their work areas for improvements in patient safety and strategies to reduce errors and eliminate defects.

g. Staff at all levels of the organization are accountable for identifying high-risk processes or procedures, and implementing strategies to reduce errors, eliminate defects, and promote patient safety.

h. Patient Safety Specialists are employed in Quality Resources to manage the error reporting system, provide timely reports to all levels of the organization, and research “best-practice” and strategies to assist staff in improving patient safety in their departments.

i. PNHS uses aggregate error reports to identify trends and opportunities for process/system re-design to reduce errors and promote patient safety.

j. PNHS supports and encourages patients to be active, involved, and informed participants in their care in order to insure “nothing about me without me.”

3. PNHS focuses on process and system failures rather than blaming individuals in the following ways:

a. An anonymous error reporting system is in place, which supports a non-punitive culture at PNHS.

b. When conducting root cause analysis, either reactively or to evaluate an error proactively to reduce the risk of error, the facilitator clearly states "we are here to evaluate how the system or process failed the individual, and not to assign blame. Our purpose is to identify strategies to prevent errors like this from occurring in the future.”

c. Leaders at all levels seek to create an environment where individuals involved in errors are encouraged to make those errors known and become involved in actively seeking improvements to insure they will be prevented from happening again.

4. PNHS promotes organizational learning about health care errors and safety enhancement strategies. These efforts include, but are not limited to:

a. System-wide educational opportunities for leadership are provided at a Leadership Learning day

b. Participation in nation-wide and metropolitan-wide collaborative on patient safety

c. IOM report available for review

d. Patient safety education for all new and existing professional employees

e. Incorporating one-by-one inspection into workflow of all staff to stop and correct every error before passing it on as a defect or to get help from their leaders for those things they can’t fix.

f. Distribution of Sentinel Event Alerts and ISMP alerts to appropriate staff.

5. PNHS is accountable to our patients by involving them (and their families when appropriate) in their care, acknowledging when errors occur, apologizing to our patients, and taking steps to
prevent future errors.

6. Reporting to Clinical Board of Governors and the PNHS Board on patient safety issues occurs at every meeting.

REFERENCE MATERIALS:
"To Err is Human, Building a Safer Health System," from the IOM 2000 report

RELATED DOCUMENTS: Sentinel Event Policy F.02-HSM-8201
Managing Medication Events Policy C.02-HSM-7080-0197
Safety Management and Health Management Program H.06-HSM-8260-1198
Peer Review Process for Medical Staff F.03-HSM-8201-0301
Staff Competencies and Requirements L.66-HSM-8250-1299
Product Review M.15-HSM-8072-0301

PATIENT SAFETY DEFECT ELIMINATION PLAN

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PURPOSE:
To articulate Park Nicollet Health Services (PNHS) commitment to safe patient care.

OWNER:
Chief Medical Officer/Chief Nursing Officer

CONTACT/CONTENT EXPERT:
Director Quality and Patient Safety, Manager Patient Safety/Quality Assessment

POLICY:
PNHS leadership accepts responsibility to our community to set the highest expectations for safe patient care.

DEFINITIONS:
In the interest of consistency across the health care industry, PNHS utilizes definitions from the National Patient Safety Foundation (NPSF):

Patient safety: (1) The avoidance, prevention and amelioration of adverse outcomes or injuries stemming from the processes of health care. These events include “errors,” “deviations,” and “accidents.” Safety emerges from the interaction of the components of the system; it does not reside in a person, device, or department. Improving safety depends on learning how safety emerges from the interactions of the components. Patient safety is a subset of healthcare quality. (Cooper et al.); (2) Freedom from accidental injury; ensuring patient safety
involves the establishment of operational systems and processes that minimize the likelihood of errors and maximize the likelihood of intercepting them when they occur. (Kohn): (3) Actions undertaken by individuals and organizations to protect health care recipients from being harmed by the effects of health care services. (Spath)

**Error:** (1) Failure of a planned action to be completed as intended or use of a wrong plan to achieve an aim; the accumulation of errors results in accidents. (Kohn); (2) Failure to complete a planned action as intended, or the use of an incorrect plan of action to achieve a given aim. (NHS); (3) The failure of a planned action to be completed as intended or the use of a wrong plan to achieve an aim. Errors can include problems in practice, products, procedures, and systems. (QuIC)

**Accident:** (1) A series of events that involves damage to a defined system disrupting the ongoing or future output of the system. (Kohn); (2) An unplanned, unexpected, and undesired event, usually with an adverse consequence. (Zipperer et al.)

**System:** (1) Set of interdependent elements interacting to achieve a common aim. These elements may be both human and non-human (equipment, technologies, etc.). (Kohn); (2) A regularly interacting or interdependent group of items forming a unified whole. (QuIC)

**Sentinel event:** An unexpected occurrence involving death or serious physical or psychological injury, or the risk thereof. Serious injury specifically includes loss of limb or function. The phrase “or the risk thereof” includes any process variation for which a recurrence would carry a significant chance of a serious adverse outcome. Such events are called “sentinel” because they signal the need for immediate investigation and response. (JCAHO 2001)

**PNHS Definition for the following:**

**Defect:** An uncorrected error or mistake that is passed on is a “Defect” in care. Park Nicollet’s goal is to eliminate Defects.

**AHE: Adverse Health Events:** Minnesota state law requires hospitals, ambulatory surgical centers, and community behavioral health hospitals to report 29 specific adverse events into the Patient Safety Registry. Root cause analysis (RCA) is the standardized method that all reporting organizations use to help identify one or more human factors or systematic causes that led to an adverse health event (AHE).

**Patient Safety/Quality Event:** Errors, accidents, defects or situations which did or could have resulted in an injury to a person, patient, employee or visitor.

**PROCESS:**

A. Each staff member is expected to report errors or potential errors and defects in order to learn from them, understand their root causes and correct them:

1. PNHS has committed to the above statement as an organizational priority.
2. An error, potential error, or defect may be reported directly through the Quality Tracking System, to the Patient Safety staff, their designees, or via the QT alert pager in Facets (7am-3:30 pm 952-231-4087 or from 3:30 pm-7am M-F, or weekends and holidays 952-231-4701
B. PNHS recognizes risks to patient safety, and takes actions to reduce those risks, through proactive approaches:
1. Joint Commission Sentinel Event Alerts as well as other sources of patient safety information are reviewed to identify and correct potential risks to our patient population.
2. High-risk procedures/processes in our system are identified and proactive risk assessment is conducted to reduce risks and improve patient safety.
3. Root cause analysis is used to review, identify, and correct root causes of Sentinel or potential Sentinel events, reportable AHE’s, and other selected reported events.
4. Patient safety is incorporated into the credentialing process of the medical staff.
5. Patient safety is incorporated into the job descriptions and performance reviews of all staff. Staff at all levels of the organization are accountable for identifying high-risk processes or procedures, and implementing strategies to reduce errors, eliminate defects, and promote patient safety.
6. Park Nicollet leaders hold staff accountable in their work areas for improvements in patient safety and strategies to reduce errors and eliminate defects.
7. Patient Safety Analysts manage the error reporting system, provide timely reports to various levels of the organization, utilizing “best-practice” and strategies to assist staff in improving patient safety in their departments.

C. PNHS focuses on process and system failures rather than blaming individuals in the following ways:
1. An error reporting system is in place, which supports a non-punitive culture at PNHS; users can report events anonymously.
2. When conducting root cause analysis, either reactively or to evaluate an error proactively to reduce the risk of error, the facilitator reinforces we are here to evaluate how the system or process failed the individual, and not to assign blame. Emphasis is to identify strategies to prevent errors like this from occurring in the future.
3. Leaders at all levels seek to create an environment where individuals involved in errors are encouraged to make those errors known and become involved in actively seeking improvements.
4. All employees are accountable for avoiding reckless or unsafe behaviors.

D. PNHS promotes organizational learning about health care errors and safety enhancement strategies. These efforts include, but are not limited to:
1. Participation in nation-wide and metropolitan-wide collaboratives on patient safety
2. Patient Safety education for all new and existing professional employees
3. Incorporating one-by-one inspection into workflow of all staff to stop and correct every error before passing it on as a defect or to get help from their leaders for those things they can’t fix.
4. Distribution of Sentinel Event Alerts and ISMP alerts to appropriate staff.
E. PNHS is accountable to our patients by involving them (and their families when appropriate) in their care, acknowledging when errors occur, apologizing to our patients, and taking steps to prevent future errors.

*The Patient Safety Department is a Review Organization as defined under MN Statute 144E, Subdivision 2 to gather and review information relating to the care and treatment of patients for the purposes of: Evaluating and improving the quality of healthcare a) Reducing morbidity or mortality b) Participating in a standardized incident reporting system, including Internet-based c) applications, to share information for the purpose of identifying and analyzing trends in medical error and iatrogenic injury.

All information discussed or produced from this department is to be used for quality assessment purposes and is confidential and privileged information protected under MN Statute 145.61-145.67.

REFERENCE MATERIALS:
National Patient Safety Foundation (NPSF)
Print Date: 6/9/14 12:19 PM

RELATED DOCUMENTS:
Sentinel Event Policy F.02-HSM-8201-0101
Managing Medication Events Policy C.02-HSM-7080-0197
Peer Review Process for Medical Staff F.03-HSM-8201-0301
Staff Competencies and Requirements I.66-HSM-8250-1299
Product Review M.15-HSM-8072-0301

DISCLOSURE OF UNANTICIPATED OUTCOMES AND MEDICAL ACCIDENTS

SUBJECT: Disclosure of Unanticipated Outcomes and Medical Accidents
REFERENCE NUMBER: J.43-HSM-8201-1202
ORIGIN DATE: 5/2002
REVISION NUMBER: 2
REVISION DATE: 3/10, 10/13
MOST RECENT REVIEW DATE: 3/10, 10/13

PURPOSE:
To clarify Park Nicollet Health Service’s (PNHS) philosophy and approach to patient communication, by providing guidelines for communicating unanticipated outcomes and medical accidents.

RESPONSIBILITY:
Chief Medical Officer and Chief Nursing Officer

CONTACT/CONTENT EXPERT: Chief Compliance Officer, Risk Manager, Director Quality & Patient Safety, Manager Patient Safety

POLICY:
Patients or the appropriate guardian or representative will be informed of medical accidents when there are clinical consequences resulting from the medical accidents.

DEFINITIONS:
In the interest of consistency across the health care industry, PNHS utilizes definitions from the National Patient Safety Foundation (NPSF) for the following:

Patient Safety: Avoidance, prevention, and amelioration of adverse outcomes or injuries stemming from the processes of healthcare. cooper et al, npsf

Error: Failure of a planned action to be completed as intended or use of a wrong plan to achieve an aim; the accumulation of errors results in accidents (Kohn)

Accident: A series of events that involves damage to a defined system disrupting the ongoing or future output of the system (Kohn) System: Set of interdependent elements interacting to achieve a common aim. These elements may be both human and non-human (equipment, technologies, etc.) (Kohn)

Sentinel Event: An unexpected occurrence involving death or serious physical or psychological injury, or the risk thereof, serious injury specifically includes loss of limb or function. The phrase “or the risk thereof” includes any process variation for which a recurrence would carry a significant chance of serious adverse outcome. Such events are called “sentinel” because they signal the need for immediate investigation and response. (JCAHO 2001)

Categories of Events: (Taken from—National Coordinating council for Medication Error Reporting and Prevention (NCC MERP) Index for Categorizing Errors)
Category A: Circumstances or events that have the capacity to cause error
Category B: An error that did not reach the patient
Category C: An error that reached the patient but did not cause harm
Category D: An error that reached the patient and required monitoring or intervention to confirm that it resulted in no harm to the patient
Category E: Temporary harm to the patient and required intervention
Category F: Temporary harm to the patient and required initial or prolonged Hospitalization
Category G: Permanent patient harm
Category H: Intervention required to sustain life
Category I: Patient death

PROCESS:
A. Patient Rights
Patients have a right to receive a prompt, truthful and compassionate explanation for unanticipated outcomes and medical accidents. Situations where disclosure should occur include when:
   1. An outcome of care varies significantly from what was anticipated;
   2. A medical accident has occurred that has resulted in clear or potential clinical consequences;
   3. A medical accident has occurred that has not resulted in clinical consequences, but information about the accident might assist patients in planning future care; or
   4. A near medical accident has occurred that has reached the patient’s awareness.

B. Responsibility for Disclosure of Medical Accidents when there are Clinical Consequences
1. PNHS providers have a legal and ethical duty to disclose medical accidents when there are clinical consequences resulting from the medical accidents.

2. **At a minimum, Harm Categories E through I are disclosed** (see definitions above).

3. The licensed independent practitioner caring for the patient at the time of the event or his or her designee is responsible for ongoing communication with the patient or appropriate guardian or representative.

4. In some instances it may be appropriate for the caregiver involved in the incident to disclose the information (Pharmacist or Registered Nurse). The primary physician should be made aware of the disclosure.

5. If the responsible licensed practitioner or caregiver is unable or unwilling to explain the outcomes, a designated physician leader will provide such explanation.

6. Where there is negligible harm to the patient, another individual may be designated as the primary person to communicate the event.

**C. Communications**

When a medical accident has occurred, there should be an open dialogue of the resolution(s) available to the patient.

1. Communications should be in non-technical terms so the patient or the appropriate representative can understand.

2. Patients or the appropriate representative will receive information on the steps taken to ameliorate the clinical consequences of the medical accident. There may also be open dialogue of non-clinical resolutions available to the patient, such as financial compensation if such remedies are appropriate.

3. PNHS will provide necessary tools when special types of communication are needed. Persons with limited English proficiency, individuals with a dramatically different cultural framework for healthcare services, persons with language, auditory or visual challenges and those with diminished or cognitive impairment fall into this category.

4. PNHS will protect the privacy of patient identifiable information. When it is deemed appropriate for family members to participate in discussion about outcomes, the patient's permission will be obtained. When a patient is deemed to be unable to understand information about his or her outcomes, or when the patient is an unemancipated minor, a legal or otherwise appropriate surrogate decision-maker will be informed.

**D. Procedure for Disclosure**

1. To assure continuity and appropriate perspective in discussion, the licensed independent practitioner caring for the patient or his/her designee will handle the disclosure of information and subsequent discussions with the patient or his/her representative.

2. **In the case of a harm category of G- I, or if the practitioner needs collaboration on how to disclose, the appropriate administrative personnel shall be contacted before any discussion with the patient** (see Attachment) **for the purposes of:**
   a. Reviewing what should be discussed,
   b. Mentoring the individual on how to handle the discussion, and
   c. The initiation of the organization's support, risk management, and quality assurance functions as may be required.

3. Consideration should be given to having a second individual present during the initial conversation with the patient or the appropriate guardian or representative of the patient to assist with documentation of the conversation and to provide continuity and clarity.
4. Facts will be reviewed and shared with the patient or appropriate guardian or representative without unnecessary delay. In rare instances where disclosure of a medical accident will have a deleterious effect on the patient’s well being, disclosure may be withheld until such a time that the benefits of disclosure are greater than the harm.

5. For discussions anticipated being complex or difficult, patients or appropriate guardian or representative should be given the option of having another person with them as support during the discussion.

6. During initial and follow-up discussion, the following subjects may be discussed. Discussion of each subject on the list is not required nor is discussion limited to these topics:
   a. The hospital and its staff regret and apologize that a medical accident has occurred;
   b. The nature of the medical accident;
   c. The time, place, and circumstances of the medical accident;
   d. The proximate cause of the medical accident, if known;
   e. The known, definite consequences of the medical accident for the patient and potential consequences;
   f. Actions taken to treat or ameliorate the consequences of the medical accident;
   g. Who will manage ongoing care of the patient;
   h. Planned investigation or review of the medical accident;
   i. Who else has been informed of the medical accident (in the hospital, review organizations, etc.) and the facility’s confidentiality policy;
   j. Actions taken to identify systems issues that may have contributed to the medical accident and to prevent the same or similar medical accident from re-occurring;
   k. Who will manage ongoing communication with the patient or appropriate guardian or representative;
   l. The names and phone numbers of individuals in the hospital to whom the patient or appropriate guardian or representative may address complaints or concerns about the process around the medical accident;
   m. The names and phone numbers of agencies to which the patient or appropriate guardian or representative could communicate about the medical accident;
   n. How to obtain support and counseling regarding the medical accident and its consequences both within the hospital and from outside; and
   o. The organization’s process to establish compensation for harm, as appropriate or contact person’s name.

E. Documentation
The following documentation should be considered:
   1. Documentation of time, date, and place of the discussion;
   2. Record the names and relationships of those present;
   3. Documentation that there was a discussion of the unanticipated outcome;
   4. Documentation of any questions posed by the patient, family or legally authorized representative, and the answers provided by the caregiver;
   5. In specific cases in which a decision is made to withhold some or all of the information, appropriate documentation is made of the reason(s) for this decision; and
   6. Any follow-up discussions should be documented including time, date, place, and the names and relationships of those present.

F. Support for Caregivers
1. A Bioethics consultation should be considered when there are situations in which there may be legal, regulatory, or psychological factors that mitigate toward withholding some or all information about the unanticipated outcome.
2. Consideration of consultation for the involved caregiver with the Employee Assistance Program in cases where the caregiver may be devastated by the occurrence.
3. Patient Care Conferences may be used to share the patient's current status and make plans for the future. This provides added support by all disciplines involved in the patient's care.
4. Ancillary services are available to assist the physician or designee in discharging their responsibility including but not limited to social services, chaplains, patient relations.
5. Training is available for those who find it difficult to discuss unanticipated outcomes and medical errors and by virtue of their position may be called upon to do so.

RELATED DOCUMENTS:

REFERENCES:
Patient Bill of Rights
American Society for Healthcare Risk Management 'Perspectives on Disclosure of Unanticipated Outcome Information'
JCAHO Patient Safety Standards, Effective July 1, 2001
National Patient Safety Foundation Statement of Principle

National Patient Safety Foundation Statement of Principle
Talking to Patients About Health Care Injury:

Statement of Principle
When a health care injury occurs, the patient and the family, or representatives are entitled to a prompt explanation of how the injury occurred and its short- and long-term effects. When an error contributed to the injury, the patient and the family or representative should receive a truthful and compassionate explanation about the error and the remedies available to the patient. They should be informed that the factors involved in the injury will be investigated so that steps can be taken to reduce the likelihood of similar injury to other patients.

Health care professionals and institutions that accept this responsibility are acknowledging their ethical obligation to be forthcoming about health care injuries and errors. The National Patient Safety Foundation urges all health care professionals and institutions to embrace the principle of dealing honestly with patients. The National Patient Safety Foundation Board of Directors approved this statement of principle on November 14, 2000.

ATTACHMENT

Checklist for Sentinel Event and Potential Patient Harm Response and Disclosure Process

Critical Event Occurs – person who identifies critical event or patient harm will:
Notify Immediately:
Operations Administrator on call/Administrator on call assesses situation and determines appropriate action.
Notification of others might include:
CMO, CEO, COO, CNO, CIO
Service Line VP/Chief
CND of the inpatient care unit involved or Clinic Manager of clinic involved
Clinic Practice Director or Physician Administrator on-call

In the first hour, the Operations Administrator on call will:
- Determine and implement any needed action to insure patient safety from further harm.
- Assess the facts of the incident, who has been involved, what has been done and communicated, and to whom.
- Assure that any equipment or devices that may have been involved are secured.
- Give direction as to immediate communication needs.
- Determine need for presence on site, self or appropriate others.
- Designate host for patient/family for ongoing communication (Patient Relations/Chaplain).
- Commit to prompt meeting when facts are known.
- Assess need for and call in additional expertise. Consider, Director of Risk Management, Marketing & Communications, Patient Relations, Spiritual Care and Employee Health.
- Continue to collect and access facts as they become available.
- Identify spokesperson(s) for the organization, generally a caregiver (preferably the involved caregiver) and at least one other with administration authority.
- Meet with patient/family to apologize and provide disclosure as per policy.
- Agree with patient/family whether additional meeting and disclosure is appropriate, when and with whom.

Later:
- Assess need for critical stress debriefing for any affected staff or providers and refer as needed. (Call Director of EOHS to coordinate CISD and EAP provider.)
- Collaborate with Marketing and Communications as needed.

Within next 45 days:
The Patient Safety Department will conduct a Root Cause Analysis, with a Corrective Action Plan and counter measures to reduce the likelihood of such an event occurring again.

WORKER’S COMPENSATION

Reporting Work-related injury or illness:
1. Report the incident immediately to your supervisor.
2. If injured, report to the EOHS (Employee Occupational Health and Safety) Office to obtain medical evaluation or referral (non-life threatening injuries), or report to the Emergency Center at Methodist Hospital or Park Nicollet Urgent Care.
3. Contact the EOHS department within 24 hours and complete an Employee Injury Report Form.

Exposure to Blood, Body Fluids, or Other Potentially Infectious Materials
Call the 24-hour Pager at 952-231-5223. Obtain and complete BBF Report Form.
V. GENERAL POLICIES AND PROCEDURES

VISA SPONSORSHIP
The J-1 alien physician visa sponsored by ECFMG is the preferred visa status for foreign national trainees in all UMN graduate medical education programs; therefore, UMN family medicine residency programs sponsor only J-1 visas. We do not sponsor H-1B visas. More information on the J-1 visa can be found on the UMN-GME webpage.

PROGRAM CURRICULUM
Faculty and rotation preceptors have developed a teaching module for each rotation offered to residents. The residency program coordinator maintains the master copy of these teaching modules. A copy is available in the residents’ room and is on the computer network under “i:creekside:manual.” Please review the module prior to beginning your rotation. Questions should be addressed with faculty or the rotation preceptor.

First-Year Required Rotation

<table>
<thead>
<tr>
<th>Rotation</th>
<th>Duration</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cardiology</td>
<td>1 month</td>
</tr>
<tr>
<td>Emergency Medicine</td>
<td>1 month</td>
</tr>
<tr>
<td>Family Medicine</td>
<td>3 months</td>
</tr>
<tr>
<td>Heme/Oncology</td>
<td>1 month</td>
</tr>
<tr>
<td>Neurology</td>
<td>1 month</td>
</tr>
<tr>
<td>Obstetrics</td>
<td>1 month</td>
</tr>
<tr>
<td>Pediatrics</td>
<td>2 month</td>
</tr>
<tr>
<td>Pulmonary</td>
<td>1 month</td>
</tr>
<tr>
<td>Surgery</td>
<td>1 month</td>
</tr>
</tbody>
</table>

Second and Third-Year Rotations

Required Rotations

<table>
<thead>
<tr>
<th>Rotation</th>
<th>Duration</th>
<th>Year(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cardiology</td>
<td>1 month</td>
<td>3rd year</td>
</tr>
<tr>
<td>Chief, Assistant</td>
<td>2 months</td>
<td>3rd year</td>
</tr>
<tr>
<td>Critical Care</td>
<td>1 month</td>
<td>3rd year</td>
</tr>
<tr>
<td>Orthopedics - General</td>
<td>1 month</td>
<td>3rd year</td>
</tr>
<tr>
<td>Obstetrics</td>
<td>1 month</td>
<td>3rd year</td>
</tr>
<tr>
<td>Pediatrics - Outpatient</td>
<td>1 month</td>
<td>3rd year</td>
</tr>
<tr>
<td>Psychiatry</td>
<td>2 months - ½ time, consecutive</td>
<td>3rd year and 2nd year</td>
</tr>
<tr>
<td>Family Medicine Center</td>
<td>1 month</td>
<td>3rd year</td>
</tr>
<tr>
<td>Community Health</td>
<td>1 month</td>
<td>2nd or 3rd year</td>
</tr>
<tr>
<td>Surgery</td>
<td>1 month</td>
<td>2nd or 3rd year</td>
</tr>
<tr>
<td>Dermatology/Radiology</td>
<td>1 month - ½ time each</td>
<td>2nd or 3rd year</td>
</tr>
<tr>
<td>Gynecology</td>
<td>1 month</td>
<td>2nd or 3rd year</td>
</tr>
<tr>
<td>SubSpecialty rotation</td>
<td>2 months</td>
<td>2nd and 3rd year</td>
</tr>
<tr>
<td>Gastroenterology</td>
<td>1 month</td>
<td>2nd year</td>
</tr>
<tr>
<td>Obstetrics</td>
<td>1 month</td>
<td>2nd year</td>
</tr>
</tbody>
</table>
Orthopedics - Tria 1 month 2nd year
Pediatrics – Children’s Minneapolis 1 month 2nd year

Elective Rotations (4 months)
Eating Disorders 1 month
Emergency Medicine 1 month
   (January - June only)
Endocrinology 1 month
High Risk OB 1 month
Infectious Disease 1 month
Obstetrics 1 month
Oncology/Hematology 1 month
Palliative Care 1 month
Procedures 1 month - full or ½ time
P M & R 1 month - full or ½ time
Rheumatology 1 month - ½ time
Sports Medicine 1 month - full or ½ time
Surgery - Outpatient 1 month

PROGRAM GOALS AND OBJECTIVES
Please see separate goals and objectives documents that you will receive prior to each rotation.

TEACHING MEDICAL STUDENTS

Residents are an essential part of the teaching of medical students. It is critical that any resident who supervises or teaches medical students must be familiar with the educational objectives of the course or clerkship and be prepared for their roles in teaching and evaluation. Therefore, we’ve included in this manual the clerkship objectives for the Family Medicine Clerkships as well as the overall Educational Program Objectives.

Family Medicine 7600
This is a 4-week outpatient clinic-based experience in Family Medicine working with practicing family physicians, colleagues from other disciplines who are working in family medicine clinics, and at some sites, Family Medicine residents. The core of the rotation is the 14 days (four days per week excluding first Monday, final Friday and every Wednesday) spent in clinic. This is a very hands-on, active patient-contact clerkship. Students will spend their four weeks either at a residency clinic or at a community or private practice clinic. We strive to actively involve students in direct patient care with the expectation that a student is directly involved in over 50% of patient encounters in a given day. Students should write up 2-3 notes per half day. During the four weeks, students also attend weekly seminars and skills workshops on Wednesday mornings. There is a comprehensive online curriculum and a well evaluated clerkship textbook.

Competencies and Objectives
The goals of this course are to identify, model, and teach the various elements of Family Medicine in an outpatient setting. Family Medicine for many physicians includes inpatient care and obstetrical care, but in this course we focus predominantly on outpatient care. In some situations, this may include home,
group or after hours visits. The emphasis is upon evidence-based clinical approaches to common medical problems, clinical problem-solving in a busy ambulatory setting, the refining of clinical skills, and experiencing the various roles of the primary care physician.

Additional information on the required course FMCH 7600: Family Medicine Clerkship can be found at: http://www.meded.umn.edu/clerkships/FMCH_7600.php Visit https://www.meded.umn.edu/curriculum/competencies/ for Medical School competencies, and find goals and objectives for medical student education here.

TRAINING/GRADUATION REQUIREMENTS
The following programmatic requirements need to be met prior to completion of the residency training program and in order to receive a graduation certificate:

Completion of the following required workshops in the specific years:

I. First-Year Workshops
   - Advanced Life Support Obstetrics (ALSO®)
   - Basic Colposcopy
   - Primary Care Psychiatry
   - Sexual Medicine for Residents
   - Sports Medicine: Basic Musculoskeletal Assessments

II. Second-Year Workshops
   - Practice Management/System-based Practice
   - Community Health

III. Completion of the Community Health Rotation and Community Health Project

IV. Sitting for ABFM In-Training Examinations

V. Certification in ACLS, BLS, PALS, or APLS and NRP

VI. Complete all evaluations, submit procedures and patient logs.

RULES FOR ATTENDANCE AT PROGRAMMATIC COURSES
The programmatic courses help to fulfill a number of important areas of the family medicine curriculum and are required for residents. Attendance at these courses in their entirety is mandatory for graduation and attendance will be closely monitored. Residents will be required to sign in at the beginning of the day and out at the end of the day. Any absence will need to be made-up in order to receive full credit for the course. Program directors will be responsible for documenting and deciding how missed time will be made-up. Programs are asked to pay particular attention to scheduling so that call and duty hour restrictions do not conflict with programmatic courses.
# 2015-2016 PROGRAMMATIC COURSES

<table>
<thead>
<tr>
<th>Required Courses for G-1 Residents</th>
<th>G-2 Required Courses</th>
</tr>
</thead>
</table>
| Advanced Life Support Obstetrics (ALSO)  
Directors: Manuel Idrogo, MD & Tom Satre, MD  
Location: UMN St. Paul Conference Center  
1st – Thursday, August 20, 2015 (8:00 - 4:30 pm)  
Friday, August 21, 2015 (8:00 - 4:30 pm)  
2nd – Thursday, February 4, 2016 (8:00 – 4:30 pm)  
Friday, February 5, 2016 (8:00 – 4:30 pm) | Community Health  
Director: Mark Yeazel, MD, MPH  
Location: UMN West Bank Office Building  
1st – Thursday, September 24, 2015 (8:00 - 4:30 pm)  
Friday, September 25, 2015 (8:00 – 12:00 noon)  
2nd – Thursday, January 21, 2016 (8:00 – 4:30 pm)  
Friday, January 22, 2016 (8:00 – 12:00 noon) |
| Primary Care Psychiatry  
Director: Bob Levy, MD  
Location: UMN West Bank Office Building  
1st - Thursday, November 19, 2015 (8:00 - 4:45 pm)  
2nd - Thursday, April 21, 2016 (8:00 – 4:45 pm) | Practice Management / Systems-based Practice  
Directors: Dave Hunter, MD / Kirby Clark, MD  
Location: UMN West Bank Office Building  
1st – Thursday, October 22, 2015 (8:00 – 4:30 pm)  
2nd – Thursday, April 7, 2016 (8:00 – 4:30 pm) |
| Sexual Medicine for Residents  
Director: Jamie Feldman, MD, PhD  
Location: UMN West Bank Office Building  
1st – Thursday, December 10, 2015  
2nd – Thursday, June 16, 2016 | Elective Courses for G-2 & G-3 Residents |
| Sports Medicine I: Basic Musculoskeletal Assessments  
Director: Pat Morris, MD  
Location: UMN West Bank Office Building  
1st – Thursday, January 7, 2016 - (8:00 - 4:30 pm)  
2nd – Thursday, May 19, 2016 (8:00 – 4:30 pm) | Basic Colposcopy  
Director: Pita Adam, MD, MSPH  
Location: UMN West Bank Office Building  
Thursday, May 5, 2016 (8:00 – 4:45 pm) |
|  | Advanced Colposcopy  
Director: Pita Adam, MD, MSPH  
Location: UMN West Bank Office Building  
Thursday, November 5, 2015 (8:00 – 4:45 pm) |
|  | Sports Medicine II: Procedures in Sports Medicine  
Director: Pat Morris, MD  
Location: UMN West Bank Office Building  
Thursday, June 9, 2016 (8:00 – 4:45 pm) |
|  | Family Medicine Ultrasound  
Director: Tim Ramer, MD  
Location: Broadway Family Medicine Clinic  
1st – Thursday, October 8, 2015 (8:00 – 4:30 pm)  
2nd – Thursday, March 3, 2016 (8:00 – 4:30 pm) |
|  | Osteopathic Medicine (for D.O. residents)  
Directors: Erin Westfall, DO / Andrew Slatengren, DO  
Location: UMN West Bank Office Building  
Thursday, March 24, 2016 (8:00 - 4:45 pm) |
|  | Dermatology Procedures  
Director: Neat Foman, MD, MS  
Location: VA Simulation Center, Minneapolis  
Friday, February 26, 2016 (1:00 – 5:00 pm) |
|  | USA Soccer Cup  
Director: Bill Knopp, MD  
Location: UMN West Bank Office Building  
Lectures: Wed-Thurs, July 8-9, 2015 (8:00 – 4:30 pm)  
Friday, July 10, 2015 (8:00 – 12 noon)  
Rotation: Friday - Saturday, July 10-18, 2015 |

**NOTE:** Residents are strongly encouraged to enroll in the **required** ALSO, Primary Care Psychiatry, Sports Medicine Basic MSK, and Sexual Medicine courses during their first year, and the **required** Community Health and Practice Management courses during their second year.

Elective courses should be taken during resident’s second or third year, with the exception of Derm Procedures, which is oriented towards G-1/G-2s. All required courses are offered twice during the academic year. **Please have your program’s residency administrator register you for courses.** For further information, call Erik Solberg at (612) 626-3124 or e-mail at esolberg@umn.edu

Rev 10-16-14
GLOBAL FAMILY MEDICINE PATHWAY
The pathway is open to all family medicine residents with an interest in international health. Residents can formally enroll in the pathway, work with a faculty mentor and complete a structured track of activities, including an international elective rotation; or participate in activities at their discretion. Details at: http://www.familymedicine.umn.edu/education-training/residency-programs/global-family-medicine-pathway

GPS ALLIANCE
GPS Alliance is a central office and resource for faculty, staff, and students traveling abroad. Register travel--required for all UMN Residents doing International Electives, whether enrolled or not enrolled in the GFM Pathway--and purchase required travel insurance. Details at: http://global.umn.edu/travel/insurance/outgoing.html

ACGME COMPETENCIES
All University of Minnesota Medical School Residency/Fellowship training programs define the specific knowledge, skills, attitudes, and educational experiences required by the RRC to ensure its residents/fellows demonstrate the following through the Family Medicine Milestones:

Patient Care - Residents must be able to provide patient care that is compassionate, appropriate, and effective for the treatment of health problems and the promotion of health.

Medical Knowledge - Residents must demonstrate knowledge of established and evolving biomedical, clinical, epidemiological and social-behavioral sciences, as well as the application of this knowledge to patient care.

Practice-based Learning and Improvement - Residents must demonstrate the ability to investigate and evaluate their care of patients, to appraise and assimilate scientific evidence, and to continuously improve patient care based on constant self-evaluation and life-long learning. Residents are expected to develop skills and habits to be able to meet the following goals:

- identify strengths, deficiencies, and limits in one’s knowledge and expertise;
- set learning and improvement goals;
- identify and perform appropriate learning activities;
- systematically analyze practice using quality improvement methods, and implement changes with the goal of practice improvement;
- incorporate formative evaluation feedback into daily practice;
- locate, appraise, and assimilate evidence from scientific studies related to their patients’ health problems;
- use information technology to optimize learning; and,
- participate in the education of patients, families, students, residents and other health professionals.

Interpersonal and Communication Skills - Residents must demonstrate interpersonal and communication skills that result in the effective exchange of information and collaboration with patients, their families, and health professionals. Residents are expected to:
• communicate effectively with patients, families, and the public, as appropriate, across a broad range of socioeconomic and cultural backgrounds;
• communicate effectively with physicians, other health professionals, and health related agencies;
• work effectively as a member or leader of a health care team or other professional group;
• act in a consultative role to other physicians and health professionals; and,
• maintain comprehensive, timely, and legible medical records, if applicable.

Professionalism - Residents must demonstrate a commitment to carrying out professional responsibilities and an adherence to ethical principles. Residents are expected to demonstrate:
• compassion, integrity, and respect for others;
• responsiveness to patient needs that supersedes self-interest;
• respect for patient privacy and autonomy;
• accountability to patients, society and the profession; and,
• sensitivity and responsiveness to a diverse patient population, including but not limited to diversity in gender, age, culture, race, religion, disabilities, and sexual orientation.

Systems-based Practice - Residents must demonstrate an awareness of and responsiveness to the larger context and system of health care, as well as the ability to call effectively on other resources in the system to provide optimal health care. Residents are expected to:
• work effectively in various health care delivery settings and systems relevant to their clinical specialty;
• coordinate patient care within the health care system relevant to their clinical specialty;
• incorporate considerations of cost awareness and risk-benefit analysis in patient and/or population-based care as appropriate;
• advocate for quality patient care and optimal patient care systems;
• work in interprofessional teams to enhance patient safety and improve patient care quality; and
• participate in identifying system errors and implementing potential systems solutions.

For more information on Institutional Requirements (ACGME), visit [http://www.acgme.org/acgmeweb/](http://www.acgme.org/acgmeweb/)

**DUTY HOURS**

Duty Hours are defined as all clinical and academic activities related to the training program, i.e., patient care (both inpatient and outpatient), administrative duties related to patient care, the provision for transfer of patient care, time spent in-house during call activities, and scheduled academic activities such as conferences. Duty hours **DO NOT** include reading, travel time and preparation time spent away from the duty site.

• Duty hours should not exceed 80 hours per week, averaged over a four-week period, inclusive of all in-house call and moonlighting activities.
• PGY-1 residents must not exceed 16 hours per shift
• PGY-2 & 3 residents must not exceed 24 hours per shift
• PGY-2 & 3 are entitled to a 4 hour transition period after a 24 hour shift to ensure continuity of care but must not provide care to new patients, participate in new procedures, or be assigned to outpatient clinics during this period.
• Call should not occur more than every third night.
PGY-1-3 residents should have 10 hours – and must have 8 hours free of duty between scheduled duty periods

Residents must have 1 day in 7 free from all educational and clinical responsibilities, averaged over a 4-week period, inclusive of call.

Internal and external moonlighting must be counted toward the 80 hour weekly limit.


EVALUATIONS AND DOCUMENTATION OF PROCEDURES

While in residency training, all residents are required to use the internet-based New Innovations Residency Management Suite (RMS) program located at www.new-innov.com for the tracking of rotation and preceptor evaluations. Residents will be given a unique ID during orientation and instructions. Residents will then be expected to fill out at least two evaluations at the end of each rotation; one evaluation on the preceptor and one evaluation on the rotation (please note that multiple preceptors will require multiple evaluations). Evaluations must be filled out consecutively (i.e. February cannot be done before January’s evaluations are completed). Please contact your residency coordinator with questions.

Satisfactory completion of the residency is contingent on the passing of all rotations in each year of the residency by evidence of at least a satisfactory rating on the completed evaluation forms, or as an exception to this rule, verification of satisfactory completion by the program director. Resident evaluations will be reviewed semi-annually by the Clinical Competency Committee.

Procedure Documentation

PROCEDURE TRACKING IS DESIGNED FOR YOUR BENEFIT and it is a program requirement!! Procedures are documented in New Innovation RMS. Properly completed over the three-year residency program, this log case your “ticket” for privileges in the hospital where you choose to practice. They do not guarantee that you will be granted the privileges you request, but will greatly enhance the probability. Also, with such documentation, there is a much greater chance that you would be able to appeal if privileges are initially denied. In addition to your privileges, the faculty can use this information to keep track of many aspects of the program. We can see which physicians admit to our teaching floors, what diagnoses are being admitted, what procedures are being performed by residents, etc. You will be trained in the procedure logger in RMS at orientation.
ON-CALL SCHEDULES

1. **G1**: Shift is 7q5 (14 hour shift); 7:30 am – 9:30 pm
   - Expected to complete at least 40 hours in the emergency room during call hours; hours must be logged in RMS

2. **G2 & 3**: on call overall q 12
   - Call day: daytime is usual schedule.
   - Evening 5 pm to 9:30 pm: home call & admissions; PNHS provides “direct supervision” to G1 house call.
   - 9:30 pm to 7:30 am: in-house coverage plus admits/clinic call. G1 is gone.
   - Post-call day is off. (Allowed 4 hours transitional care time.) (FMI residents therefore cannot take call Sunday through Thursday; could be on Friday or Saturday.)
   - Backup call resident will take call a week at a time; can be called in by the call faculty as needed.
   - On weekends:
     - Call from home with coming in for admits, from 8 am until 10 pm. (PNHS is providing “direct G1 supervision” from 8am to 10 pm for weekend house coverage.) 10 pm to 8 am in house, same as weeknights.
     - During July, the on-call G2/G3 will be in-house at all times on call, with the G1 when they’re present.
   - OB rotation: 7 am – 9 pm in L&D. OK to stay as late as 11 pm to complete a delivery.

3. When to call in backup:
   - If on-call resident has to do a delivery
   - If house call demand is delaying timely admissions
   - Back up call is 24 hour call. When you are on backup the expectation is that you are available to come in for the entire day. On weekdays this will start as soon as your rotation is done (5:00PM) and on weekends it starts at 7:30AM and goes all day. This does mean that you are expected to be within 20 minutes of the hospital so could come in quickly if called.

4. OB rotation:
   - 7 am – 9 pm in L&D. (May stay as late as 11 pm to complete a delivery without an hours violation.) followed by 8-10 hours off.

During your first month of house call, the clinic call resident will stay in the hospital to assist with emergencies and as needed. To maximize learning opportunities and minimize stress, other contacts to seek out and use as resources are: Park Nicollet attending in-house, Critical Care fellow, nursing supervisor, and the emergency room physicians.

Our answering service is at Methodist Hospital. G2 & G3’s may ask the operators to call you directly at home in the evening, otherwise they will page you. They will page the preceptor on call for you. If you have switched call days with another resident, check in with the operator to ensure correct information. All call switches must be approved by the residency coordinator.

The chief or Family Medicine G1 sign out hospital patients each afternoon to the resident on-call in person, by phone, or by voicemail. Sign out any new admissions back to the Family Medicine service at 7:30 a.m. the next morning or the next person on clinic call (weekend or holidays).
POLICY ON TRANSITIONS OF PATIENT CARE

Providers We Cover For
- All Creekside residents
- Creekside faculty who see pts at Creekside clinic or NH: Jeremy Springer, Mary Wagner, Shannon Neale, Steven Kind, Mike Dukinfield, Teresa Quinn, Selam Kifleyesus
- Prairie Center Providers: David Olson, Paul Kaldor, Sally Kline, Aaron Timmerman, Dean Kaihoi
- Morningside Family Medicine: Phil Sidell
- myHealth

Providers We Do Not Cover For
- Creekside faculty/rounders who see pts elsewhere: Bill Knopp, Lynn Manning, Greg Dukinfield, Julie Farias, Virginia Kakacek, Emmy Erp, Tanya Henke-Le
- Dr. Chris Johnson
- Dr. Dave Wilkins (faculty cover prescription refills during the days he’s away)

Transition Of Care Policy
1. Inpatient Transitions
   a. Weekday rounding team to weeknight call resident (5pm Mon-Fri)
   b. Weeknight call resident to weekday rounding team (7:30am Mon-Fri)
   c. Weekend rounder to weekend call resident (after rounds on Sat and Sun)
   d. Weekend call resident to weekend rounder (7:30am on Sat and Sun)
      i. Evening transitions (items a and c above) will be done via an electronic sign out sheet that is updated each day after rounds by the rounding resident(s). The sign out sheet is an Excel document housed on a secure shared drive that is accessible to all residents and faculty. The document is written in SBAR format. It also includes the patient’s name, room number and code status. The daytime rounder will email the sign out sheet to the on call resident and faculty at the end of daily rounds. That way, the on call resident and faculty can access the sign out sheet from home, and the on call resident is aware that the rounder has finished rounding for the day and has officially transitioned care to the on call resident. If there are any unstable patients or specific items for the on call resident to follow up (labs, etc.), the rounder will page the on call resident and verbally discuss those issues prior to leaving the hospital.
      ii. Morning transitions during the week (item b above, Mon-Fri) consist of in-person verbal sign out. The resident on call the previous night meets the rounding team in the hospital at 7:30am each weekday to provide updates on new admissions overnight and other overnight events.
      iii. Morning transitions on the weekend (item d above, Sat-Sun) vary based on the weekend rounder. If the weekend rounder is a G1 resident on call, the resident on call the previous night will meet the G1 at 7:30am in the hospital to give verbal sign out of overnight events. If the weekend rounder is a G2 or G3 resident or a G1 resident not on call, the resident on call the previous night will page the rounder at 7:30am and given verbal sign out of overnight events over the phone.
2. Clinic Transitions  
a. If there is a medical matter that occurs at Creekside Clinic, Prairie Center Clinic or Morningside Family Clinic during clinic hours that needs follow up after clinic hours, the resident or physician who is managing the issue during clinic hours will page the on call resident that evening to verbally inform him or her of the matter and give direction about what to follow up on.

3. Transitions between the inpatient team and primary care providers of patients that are admitted to the Creekside Inpatient Service  
a. Admissions: The admitting resident will inform the patient’s primary care provider about the admission when the patient is admitted.  
   i. For Park Nicollet patients – route the H&P to the PCP  
   ii. For Dr. Sidell’s patients – call his office during clinic hours (8am-5pm Mon-Fri) or page him about the admission if it is outside of clinic hours  
 b. Discharges: The discharging resident will inform the patient’s primary care provider about the discharge and post-discharge follow up plan.  
   i. For Park Nicollet patients (Creekside and Prairie Center) discharging to home  
      1. Route DC summary to PCP via Epic (EHR). Include comments if applicable.  
   ii. For Dr. Sidell’s patients discharging to home  
      1. Inform Dr. Sidell of the discharge via phone if during clinic hours or via page if outside of clinic hours. Send him the discharge summary via routing to HIM.  
   iii. For patients with PCP out of system discharging to home  
      1. Send the discharge summary to the patient’s PCP via routing to HIM.  
   iv. For all patients discharging to long term care facility covered by Park Nicollet MD (nursing home or TCU)  
      1. Route DC summary to covering MD/NP via Epic (EHR)  
      2. Route DC summary to PCP based on criteria above (i, ii, or iii)  
      3. Print the DC summary prior to patient discharge and send with patient at time of discharge  
   v. For all patients discharging to long term care facility not covered by Park Nicollet MD  
      1. Call or page the covering MD or NP at the LTC facility and inform him/her of the discharge/transition  
      2. Route DC summary to PCP based on criteria above (i, ii, or iii)  
      3. Print the DC summary prior to patient discharge and send with patient at time of discharge

4. After Hours Phone Calls: The on call resident documents all phone calls with patients via Epic EHR and updates the patient’s primary care provider about the discussion.  
a. For Park Nicollet patients (Creekside or Prairie Center), create a phone note encounter to document the phone call and route to the patient’s PCP.  
b. For Dr. Sidell’s patients, page him with the patient’s name, MR number, the discussion and any necessary follow up.  
c. For patients of myHealth, call their secure after-hours number and leave a message with the patient’s name, the discussion and any necessary follow up.
We will evaluate this process by routinely surveying the residents, rounding faculty and the physicians that we admit for to assess how the process is going.

ON-CALL ROOMS
The G2/G3 resident on call in the hospital has a call room with a private shower on the fourth floor of the hospital near the Pediatrics nursing station. This room has a combination-lock keypad to secure the room and its contents. The second or third year residents take their clinic call from home. If they wish to stay at the hospital during all or part of their call day there is a faculty call room that has a bed and bathroom facilities and is secured by a keyed lock in the door. This office is located in 4NW that is patrolled and secured by hospital security personnel. OB/GYN Labor and Delivery call has its own call room on the Labor and Delivery Unit. If you have a problem with the call room facilities, please contact housekeeping or the residency coordinator.

SUPPORT SERVICES
Patient support services, such as intravenous services, phlebotomy services, and laboratory services, as well as, messenger and transporter services, are provided by Methodist Hospital employees not residents.

LABORATORY/PATHOLOGY/RADIOLOGY SERVICES
Laboratory, pathology, and radiology services are provided by Park Nicollet Clinics or Methodist Hospital. The family medicine center (PNC - Creekside) has a moderate complexity laboratory, with pathology and reference and high complexity laboratory services available by courier from Methodist Hospital, a radiology suite and operator for plain film radiography is also located within the family medicine center. Other radiologic services are available at Methodist Hospital.

All patient laboratory, pathology, and radiology data is available on the electronic medical record that can be accessed from any computer terminal within Park Nicollet Clinic or Methodist Hospital.

MEDICAL RECORDS 952-993-7600
The complete patient medical record is available 24 hours / day, 365 days / year though the electronic medical record system or, for information not yet contained in the electronic record, from the medical records departments of both Park Nicollet Clinic and Methodist Hospital.

SAFETY/SECURITY 952-993-1501
Safety and security services are available through the safety security department of Park Nicollet Clinic and Methodist Hospital. These services that include security patrols and escort services are available at all clinic sites, Methodist Hospital buildings and campus to include offsite parking.

MOONLIGHTING
- Moonlighting requires a prospective, written statement of permission from the program director that will be made part of the residents’ file.
- Residents are not required to engage in moonlighting.
- First-year residents and trainees on J-1 visas are not permitted to moonlight.
- Moonlighting activities will not be allowed to conflict with the scheduled and unscheduled time demands of the educational program and its faculty.
The resident’s performance will be monitored for the effect of these activities upon performance and that adverse effects may lead to withdrawal of permission.

- All moonlighting must be counted toward the 80-hour weekly limit on duty hours.
- Residents moonlighting will need to be in compliance with the institutional GME moonlighting policy.

**SUPERVISION**

- All patient care must be supervised by qualified faculty. The program director will ensure, direct, and document adequate supervision of residents and fellows at all times.
- Residents will be provided with rapid, reliable systems for communication with supervising faculty.
- Residents must be supervised by teaching staff in such a way that the residents assume progressively increasing responsibility according to their level of education, ability, and experience.
- On-call schedules for teaching staff must be structured to ensure that supervision is readily available to residents on duty.
- The teaching staff must determine the level of responsibility given to each resident/fellow.
- Faculty and Residents are educated to recognize the signs of fatigue and will adopt and apply policies to prevent and counteract the potential negative effects.

**GRADED RESPONSIBILITY**

The Program Director, faculty, and rotation preceptors provide resident physicians with direct experience in progressive responsibility for patient management through one on one precepting and quarterly scholastic standing counseling. Residents are evaluated based on accomplishment of rotation objectives and demonstration of attainment of competencies of patient management in in-patient and outpatient care delivery.

**MONITORING OF RESIDENT WELL-BEING**

Resident well-being and stress levels are monitored on a regular basis through a number of ways. Work hours and moonlighting activities are closely monitored and are kept in compliance with the ACGME institutional standard for resident duty hours. These are monitored monthly and quarterly. Residents meet with a faculty advisor quarterly to discuss among other issues the resident well-being and stress. Residents meet monthly with the non-faculty physician without other faculty for the purpose of discussing their stress and well-being. Residents get together as a large group monthly to discuss residency issues and daily for didactics. Residents are allowed five discretionary days each year for unexpected emergencies and illness. Maternity and paternity leaves are granted as needed. Residents who are too fatigued or stressed to provide safe patient care can contact the program director, behaviorist, other faculty, or program coordinator in order to find appropriate care and evaluation for both residents and resident’s patients.

**NRP/ACLS/BLS/PALS or APLS CERTIFICATION REQUIREMENTS**

NRP, ACLS and BLS certification will be provided during orientation and recertified as needed. PALS or APLS certification course will be during the first year of residency.
Programs pay or reimburse residents for *required* certification(s). Residents interested in obtaining elective certifications, e.g. ATLS, may cover these expenses with their CME/technology funds.

**MEDICAL RECORD COMPLETION**

**POLICY for Methodist Hospital:**
In order to provide excellent care to our patients, hospital medical records must be complete (dictated, transcribed, and authenticated) within 15 days of a patient’s discharge.

**DEFINITIONS:**
- **Complete** – All documents required for support of quality care, as outlined by hospital bylaws, rules and regulations, and are required for appropriate reimbursement have been created and authenticated.
- **Authentication** – Legible hand signature or electronic approval of a document by the author.
- **Suspension of Full Privileges** – The clinician will not be able to admit patients to the hospital, schedule procedures or admit or schedule patients under the name of any other staff member. Complete information on this policy can be found on Park Nicollet’s Intranet - Facets

**POLICY for Ambulatory Care:**
A medical record is initiated for every patient assessed or treated in the organization. The medical record contains sufficient information to identify the patient, support the diagnosis/condition, support billing for the services provided, justify the care treatment and services, document the course and results of care, and promote continuity of patient care among health care providers.

**DEFINITIONS:**
- **Authentication:** Legible hand signature or electronic approval of a document by the author.
- **Health Care Provider:** Clinicians, such as Physicians, Nurse Practitioners (NPs), Physician Assistants (PAs), Clinical Nurse Specialists (CNSs), Certified Nurse Mid-Wives (CNMs), Licensed Psychologists, Licensed Independent Clinical Social Workers, Licensed Marriage and Family Therapists.

Complete information on this policy can be found on Park Nicollet’s Intranet - Facets

**DICTATION COMPLETION**

**POLICY:**
All clinic and hospital staff must use the approved documentation methods based on the documentation need. Failure to use approved documentation methods may lead to progressive disciplinary action including loss of privileges.

This policy includes, but is not limited to: Clinical documentation associated with a Park Nicollet Health Services’ clinic or hospital visit, requires online documentation via approved processes.

These processes include:
- Park Nicollet Health Services’ contracted transcription vendor
- Typing directly into a transcription window in the electronic medical record
- Use of speech recognition directly into a transcription window or
- Via an application with a transcription interface to the electronic medical record.
DEFINITIONS:
Loss of Privileges – Disciplinary action may include, but is not limited to restriction of admitting patients to the hospital, scheduling patients for surgery, seeing patients under the name of any other staff member or see patients or bill for patient visits in the clinic.

PROCESS:
1. All online clinical documentation tools will have approved processes and guidelines.
2. Approved processes and guidelines will be updated and available via the Health Information Management site on Facets or through the processes (standard work) created by the team implementing the online documentation tool.
3. Failure to use approved documentation methods will be reviewed by the CIM committee.
4. The CIM committee will forward ongoing lack of compliance to the appropriate entities for progressive disciplinary action.

Complete information on this policy can be found on Park Nicollet’s Intranet – Facets.

LICENSURE
Licensure Application
For on-track residents, licensure application packets are requested from the MN Board of Medical Practice and given to the residents in January of PGY1.

We will reimburse residents their application fee for MN medical licensure, provided they have applied for licensure as soon as they are eligible and there are no delays for reasons within their control. Please submit a completed reimbursement form and your receipt to the program coordinator.

This policy does not apply to those residents who enter the program with an active MN license.

Licensure Policy
All residents must obtain a Minnesota medical license when they become eligible. United States and International Medical Graduate requirements are listed below:

- United States graduates must:
  - Pass USMLE Step III within three attempts and within five years of passing Step 2 (CK)
  - Take exam during first year of residency
  - Complete at least one year of residency training
  - Complete and submit licensure application
    - Graduates of approved LCME medical schools are eligible for licensure at the end of their first year of residency training. It is expected that US graduates will obtain their medical licenses near the beginning of the second year of residency.
    - The deadline for application is April 1 or the date specified by your residency coordinator. You must check with your coordinator for the correct date.

- International Medical Graduates must:
  - Pass USMLE Step III within three attempts and within five years of passing Step 2 (CK).
  - Take exam during first or second year of residency
  - Complete at least two years of residency training
  - Complete and submit licensure application
Graduates of non-approved LCME medical schools (international graduates) are eligible for licensure at the end of their second year of residency training. It is expected that IMGs will have their medical licenses near the beginning of their third year of residency training.

The deadline for application is April 1 or the date specified by your residency coordinator. You must check with your coordinator for the correct date.

If a resident does not follow the above timeline, he/she will be requested by the program director to take either vacation time or a leave of absence to complete the application process and sit for the examination. Residents will not be allowed to continue in their programs if they fail to pass USMLE Step III in three attempts and/or are unable to obtain licensure for any other reason.

Each program will reimburse residents for application and renewal fees until resident program completion.

UNITED STATES MEDICAL LICENSURE AND COMLEX EXAMS

USMLE Application
In Minnesota the USMLE Step 3 exams are administered through the national Federation of State Medical Boards (FSMB) and not the MN Board of Medical Practice (MBMP). Application materials are given to residents by the residency coordinator.

USMLE and COMLEX Policy
International and US graduates must complete their USMLE Step 2 exams within two attempts.

Successful completion of USMLE Step 3 within three attempts and within five years of passing the USMLE Step 2 (CK) is a requirement for MN state medical licensure.

All residents must pass the USMLE Step 3 or COMLEX-USA Level 3 examination by January 1 of their PGY-2 year to be eligible for a resident contract at the PGY-3 level or beyond. Residents are encouraged to take the Step 3 or Level 3 exam early in their training to permit adequate time to re-take the exam if more than one attempt is needed.

Residents should register for the USMLE Step 3 or COMLEX-USA Level 3 exam no later than August of the PGY-2 year to allow for scheduling, grading and notification of exam results by the January 1 deadline. Residents who do not notify their program of a passing score by January 1 forfeit their continuing position in the training program and are subject to contract non-renewal.

Residents who transfer into a University program (PGY-3 and beyond) will be required to report their USMLE Step 3 or COMLEX-USA Level 3 results upon application to the program.

Residents currently enrolled in a UM GME training program, beyond the PGY-2 level, are required to obtain a passing score on the Step 3 or Level 3 exam within 12 months of the effective date of this policy. As this is a requirement, programs must allow non-vacation time off to take this examination.

Each program will reimburse residents for application and renewal fees until resident program completion.

If a resident fails USMLE Step 3 or COMLEX-USA Level 3 the first time, then it must be retaken and resident will be reimbursed for half of the cost of taking the exam again. If a third attempt is required, reimbursement will be based on current policy.
DEA APPLICATION AND NUMBER
All residents are required to attain a DEA number (certificate) within three months of obtaining their medical license. The online DEA application information is given to the residents at approximately the same time of licensure application. Programs will reimburse the residents for the full DEA fee. For reimbursement, please submit a completed reimbursement form with a copy of your check taped to 8x11 piece of paper for the application cost.

RESIDENT REGISTRATION POLICY
All residents/fellows must maintain a current or unencumbered status with the University of Minnesota to remain in good standing and progress with our programs. If a resident has a hold or other encumbrance on his/her record which prevents registration for any term, s/he will be billed and held personally responsible for fees. Any outstanding balances must be paid before s/he can graduate.

RESIDENT SELECTION
All residents will be selected through the National Resident Matching Program (NRMP). If the program does not fill through the NRMP then candidates may be selected through the Supplemental Offer and Acceptance Program (SOAP) administered by the NRMP. Applicants will meet the following minimum criteria:

Required
1. Graduated from medical school within five years of application or have patient care experience within five years of application. Medical schools must appear in one of the following directories:
   - American Osteopathic Association
   - Liaison Committee on Medical Education
   - World Directory of Medical Schools
2. Be eligible for a Minnesota Board of Medical Practice license
   - View license eligibility and requirements
3. Have a maximum of two failed attempts on all USMLE or COMLEX exams across all exam portions
4. Have verified U.S. clinical experience
5. International medical school graduates have ECFMG certification
   - Current international medical school students certified by residency start date.
   - Past international medical school graduates certified for interview selection.

Preferred
USMLE Step 2 or COMLEX Level 2 exam results are not required for current students, but preferred for interview selection. There is no minimum score requirement. Applicants are strongly encouraged to submit Step 2 or Level 2 results as soon as the score becomes available to be considered for ranking by the rank list due date (mid-January for AOA Match candidates and mid-February for NRMP Match candidates).

Please note: USMLE Step 3 or COMLEX Level 3 to be passed within five years of Step 2 (CK) / Level 2 (CE).

Preference may be given to those candidates that fit our residency mission.
IN-TRAINING EXAMINATION
All residents will participate in the In-Training Examination given each year by the American Board of Family Medicine. This test is a required element of the program and is given the week of October 26th. No vacation is allowed on during this week, unless approved by the program coordinator!

This test will not assess the total spectrum of knowledge and many of the skills essential to achieving competency as a family physician. However, it will provide some indication to individual residents of their level of performance compared with the total group in their own program and comparisons of their performance with that of the national group. The test has been designed to provide residents with feedback upon completion of the test. It will also provide faculty with the opportunity to compare the outcome of some of their efforts with those of others around the country, and will provide the opportunity for the identification of weaknesses which might indicate the need for curricular changes and provision of additional resources in certain areas.

The examination will be used to aid in:
- Program curriculum development
- Curriculum and teaching planning
- Resident curriculum planning (electives)
- Resident individual study
- Practice for certification exam
- Evaluation of performance and cognitive knowledge

The results of this examination will not:
- Replace the current evaluation system
- Be used for letters of recommendations
- Be used for recruitment of new residents

Residents who score at or below the level determined by the Scholastic Standing Committee for their year level will be asked to submit a plan for remediation and study. PLEASE NOTE: Residents may access their previous years ITE questions and answers in preparation for their board certification examination. They are available online at the ABFM website at https://www.theabfm.org/cert/ite.aspx. Log in with your ABFM username and password using the box in the upper right corner of the web page.

WEB LINKS TO ADDITIONAL RESOURCES

Family Medicine Residency Program Requirements
http://acgme.org/acgmeweb/Portals/0/PDFs/Milestones/FamilyMedicineMilestones.pdf

The American Board of Family Medicine
www.theabfm.org/cert/cert.aspx
## VI. ADMINISTRATION

### DEPARTMENT PHONE DIRECTORY

<table>
<thead>
<tr>
<th>Role</th>
<th>Name</th>
<th>Phone</th>
</tr>
</thead>
<tbody>
<tr>
<td>Department Head</td>
<td>Macaran Baird, MD, MS</td>
<td>612-624-0539</td>
</tr>
<tr>
<td>Director of Education</td>
<td>Joseph Brocato, PhD</td>
<td>612-624-4464</td>
</tr>
<tr>
<td>Senior Administrative Director of Medical Education</td>
<td>Melissa Stevens, MA</td>
<td>612-626-2312</td>
</tr>
</tbody>
</table>

### PROGRAM PHONE DIRECTORY

<table>
<thead>
<tr>
<th>Role</th>
<th>Name</th>
<th>Phone</th>
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<tbody>
<tr>
<td>Program Director</td>
<td>Jeremy Springer, MD</td>
<td>952-993-7706</td>
</tr>
<tr>
<td>Program Administrator</td>
<td>Tammy Pederson</td>
<td>952-993-7711</td>
</tr>
<tr>
<td>Administrative Assistant</td>
<td>Kelly Davis</td>
<td>952-993-7716</td>
</tr>
<tr>
<td>BioMedical Library</td>
<td>Tammy Pederson</td>
<td>952-993-7711</td>
</tr>
<tr>
<td>Community Health Rotation</td>
<td>Erik Solberg, MA, MEd</td>
<td>612-626-3124</td>
</tr>
<tr>
<td>Computer Services Help Line</td>
<td>Mary Wagner</td>
<td>952-993-3635</td>
</tr>
<tr>
<td>Continuing Medical Education</td>
<td></td>
<td>612-626-7600</td>
</tr>
<tr>
<td>Contracts (G-1/G-2/G-3 year)</td>
<td>Melissa Stevens, MA</td>
<td>612-626-2312</td>
</tr>
<tr>
<td>Course Completion Reports</td>
<td>Erik Solberg, MA, MEd</td>
<td>612-626-3124</td>
</tr>
<tr>
<td>Courses &amp; Workshops, Registration</td>
<td>Erik Solberg, MA, MEd</td>
<td>612-626-3124</td>
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<tr>
<td>DEA</td>
<td>Tammy Pederson</td>
<td>952-993-7711</td>
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<td>Evaluations</td>
<td>Tammy Pederson</td>
<td>952-993-7711</td>
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<tr>
<td>Graduation Certificates</td>
<td>Laura Pham</td>
<td>612-626-0194</td>
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<td>Insurance Questions (health, dental, life)</td>
<td>Tammy Pederson</td>
<td>952-993-7711</td>
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<td>Insurance Changes - requesting forms on facets OR contact</td>
<td>Tammy Pederson</td>
<td>952-993-7711</td>
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<td>ITE Exams</td>
<td>Erik Solberg, MA, MEd</td>
<td>612-626-3124</td>
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<td>Leaves of Absence</td>
<td>Tammy Pederson</td>
<td>952-993-7711</td>
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<td>Long Term Disability</td>
<td>Tammy Pederson</td>
<td>952-993-7711</td>
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<td>Malpractice Insurance, Claims, Reports</td>
<td>Park Nicollet Human Resources</td>
<td>952-993-1600</td>
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<tr>
<td>Payroll</td>
<td>Park Nicollet Human Resources</td>
<td>952-993-1600</td>
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<tr>
<td>Recreation Center, U of MN (Mpls. campus)</td>
<td></td>
<td>612-625-6800</td>
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<td>Recruitments</td>
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<td>612-625-8283</td>
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<tr>
<td>Registration, U of M Student</td>
<td>Laura Pham</td>
<td>612-626-0194</td>
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<td>Registration, Program Courses &amp; Workshops</td>
<td>Erik Solberg, MA, MEd</td>
<td>612-626-3124</td>
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<tr>
<td>Scholastic Standing Committee</td>
<td>Liz McEligott</td>
<td>612-625-0953</td>
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<tr>
<td>Travel Reimbursement</td>
<td>Tammy Pederson</td>
<td>952-993-7711</td>
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<td>W2 and W4 Forms (Park Nicollet Human Resources) OR</td>
<td>Tammy Pederson</td>
<td>952-993-7711</td>
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<tr>
<td>Workers’ Compensation</td>
<td>Tammy Pederson</td>
<td>952-993-7711</td>
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