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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 Paris Fayerweather, 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.

The Institution Manual ([http://z.umn.edu/gmeim](http://z.umn.edu/gmeim)) 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 will be followed. Should a policy in a Program Manual conflict with the Institution Manual, the Institution Manual will take precedence. References and/or links to Institution and Department-level policies have been added in all applicable sections of this manual.

DEPARTMENT MISSION STATEMENT

See details at: Department-Level Policies: General (under Department Mission Statement)

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.
SECTION 1: STUDENT SERVICES

EMAIL AND INTERNET ACCESS
See details at: Department-Level Policies: General (under Email and Internet Access)

Each resident will be given two 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 emails.

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. Residents will receive a Park Nicollet Laptop to use during their residency. Prior to graduating from the program, all laptops need to be returned. 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.

MAIL
See details at: Department-Level Policies: General (under Campus Mail and Address Changes)

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.

It is critical that we have your current home address and phone number at all times. If you move, please contact your residency coordinator, Paris Fayerweather at (952) 993-7711 and let her know your new mailing information. She will also email Laura Pham, residency programs coordinator, at the DFMCH. You will also need to complete a Change Form on Park Nicollet’s Facets page (Employee Self-Service that will go directly to Human Resources. The addresses, main phone and fax numbers for the U of M Department of Family Medicine &
Community Health Graduate Medical Education are included in the Department Level Policy: Campus Mail and Address Changes.

Shipping and Mailing address for Creekside:
6600 Excelsior Blvd, Suite 160
St. Louis Park, MN 55426

NAME CHANGES
See details at: Department-Level Policies: General (under Name Changes)

OCCUPATIONAL HEALTH, SAFETY AND IMMUNIZATION REQUIREMENTS
See details at: Institution-Level Policy

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, Paris Fayerweather, with any questions.

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.
SECTION 2: PAYROLL AND BENEFITS

RESIDENT ACADEMIC BUSINESS EXPENSE (ABE) FUND POLICY

The purpose of the Resident Academic Business Expense Fund is to provide new and continuing Methodist Hospital Family Medicine residents with continuing medical education resources to facilitate ongoing clinical and academic training through an annual reimbursement of each year of residency.

Funds of $1,000 will be available for each resident each Program Graduate Year (PGY). Unspent funds from each PGY year are carried over and are available to be spent during the next PGY year. Residents funds will be available up to $3,000 (a total of $3,000 per residency duration) over three years for the purchase of academic, clinical, or technology items (in support of patient care). All purchases must be compliant with this policy. All expenses should be submitted for reimbursement before the end of March in the academic year in which the expense occurred.

Academic Business Expense Fund Eligible Expenses

- Taxable Items include smartphone or mobile devices, computer hardware or accessories (laptop, desktop, tablets, e-book readers, monitors, flash drives, storage devices), stethoscopes, educational or clinical software/apps, or any item that will be the property of the individual trainee (processed through payroll and will appear on paycheck less any withheld applicable taxes).
  - Items taxable to the individual are the property of the individual trainees and do not need to be returned to the department either at the completion of residency or prior to completion if on leave or as part of termination from the residency program.
- Non-Taxable Items include clinical or educational conference expenses, including web-based CME courses, medical or professional journals, professional membership dues, ABFM certification exam fees, (reimbursed as processed through direct deposit or check; non-payroll payment).

Academic Business Expense Fund Non-Eligible Expenses

- Non-Reimbursable Items include monthly access and internet service charges, software and hardware updating and maintenance, including warranties, device insurance, travel and car insurance. These items are the responsibility of the resident.
Parameters and Process for Academic Business Expense Reimbursement:

- All expense reimbursement allowance begins July 1 of each program year.
- Borrowing from future year funds is not permitted.
- All purchases must be made after the first day of employment to qualify for reimbursement.
- Consult with the hospital and/or clinic IT department prior to purchasing new technology to ensure purchases are compatible and meet local network and resource configurations and requirements.
- All technology purchases must be made by January 1 of the PGY 2 and must be used in support of patient care.
- All reimbursement requests (other than technology purchases) must be submitted at least 30 days prior to completing residency.
- All resident expense reimbursement requests must be submitted through the Park Nicollet ChRIS System. Please see the Park Nicollet ChRIS Reimbursement System in Facets for expense guidelines.
- Residents must submit a legible itemized receipt for purchases when submitting for reimbursement through Park Nicollet ChRIS System.
- Expense justification within the Park Nicollet ChRIS System must be included with each reimbursement expense.

Residents Academic Business Expense (ABE) qualifications

If a resident has a poster accepted or presenting at a conference, the residency program will pay for the following (this will **not** come out of your ABE funds):

- Registration fee
- Hotel fee
- Transportation fee (excludes elite forms of transportation)
- Per Diem (in accordance of the IRS approved per-diem rate for meals)
- Resident will not be charged PTO to attend
- Parking for local conferences

If a resident is required to attend or volunteers to recruit for a conference, the residency program will pay for the following (this will **not** come out of your ABE funds):

- Registration fee
- Hotel fee
- Transportation fee (excludes elite forms of transportation)
- Per Diem (in accordance of the IRS approved per-diem rate for meals)
- Resident will not be charged PTO
- Parking for local conferences
If a resident attends a conference that is not part of a required activity, the resident will be responsible for the expenses. (Academic Business Expense funds will be used towards these expenses.)

- Registration fee
- Hotel fee
- Transportation fee
- Food purchased
- We would charge resident PTO
- Parking for local conferences

According to the American Board of Family Medicine, time away from the residency program for educational purposes, such as workshops or continuing medical education activities, are not counted in the general limitation on absences but should not exceed 5 days annually.

Car rental is approved only if other means of transportation are not available and the conference is a significant distance from the airport, or are more costly, or impractical. Most hotels offer shuttle service or the use of a taxi may be used for short destinations.

If you have questions, please contact your residency coordinator at 952-993-7711.
## BENEFIT SUMMARY – CREEKSIDES RESIDENTS 2018

### Park Nicollet

**Benefit Summary - Creekside Residents**

### 2018

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<th>BENEFITS</th>
<th>WHO'S COVERED</th>
<th>WHEN ELIGIBLE</th>
<th>BENEFITS DESCRIPTION</th>
<th>YOUR COST</th>
</tr>
</thead>
</table>
| Health care program | Park Nicollet First Plan or Personal Choice Plan both administered by HealthPartners | Regular full-time and part time staff (50% time or more) and eligible dependents (*see Spouse Eligibility). | Date of hire | Two plan options.  
- The Park Nicollet First Plan provides network access to Park Nicollet’s Care System & HealthPartners providers & clinics  
- The Personal Choice plan offers a more extensive provider network with coverage that varies based on the provider you see | Premium cost sharing.  
See premium table.  
Premium deducted on pre-tax basis. |
| Dental care program | Park Nicollet dental plan administered by HealthPartners | Regular full-time and part time staff (50% time or more) and eligible dependents (*see Spouse Eligibility). | Date of hire | 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. | Premium cost sharing.  
See premium table.  
Premium deducted on pre-tax basis. |
| Optical program | Optical & Contact Lens Benefit | All regular full-time and part time staff (50% time or more) | Date of hire | 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. | See premium table.  
Premium deducted on pre-tax basis. |
| Flexible spending accounts (FSA) | Health Care, Dependent Care Reimbursement Accounts | All regular full-time and part time staff (50% time or more) | Date of hire | Elect a pre-tax salary reduction to cover IRS eligible expenses.  
Health – annual min $100/ max $2650  
Dependent - annual min $100/ max $5000 | Health and dependent care pre-tax election divided equally and deducted on each paycheck |
<table>
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<th>Income protection</th>
<th>Sick Time</th>
<th>Regular full-time and part time staff (50% time)</th>
<th>Date of Hire</th>
<th>As allowed by the American Board of Family Medicine.</th>
<th>Park Nicollet paid.</th>
</tr>
</thead>
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<tr>
<td>Short-Term Disability</td>
<td></td>
<td>Regular full-time and part time staff (50% time)</td>
<td>After 6 months of employment</td>
<td>For medically related disability: Full salary, first 12 weeks; 80% salary, next 14 weeks with medical certification.</td>
<td>Park Nicollet paid.</td>
</tr>
<tr>
<td>Long-Term Disability</td>
<td></td>
<td>Regular full-time and part time staff (50% time)</td>
<td>Upon approval of carrier</td>
<td>For disability due to injury, accident or illness: 60% of monthly earnings after 26 weeks of disability with approval by insurance carrier.</td>
<td>Park Nicollet paid.</td>
</tr>
<tr>
<td>Survivor’s protection</td>
<td>Basic Life Insurance Group Term Policy</td>
<td>Regular full-time and part time staff (50% time)</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)</td>
</tr>
<tr>
<td></td>
<td>Supplemental Group Term Life Insurance (Optional-paid by team member)</td>
<td>Regular full-time and part time staff (50% time)</td>
<td>Same as basic life</td>
<td>1 to 4 X basic annual earnings*</td>
<td>Premium based on age and 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>Regular full-time and part time staff (50% time)</td>
<td>Same as basic life</td>
<td>* 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>Accidental Death &amp; Dismemberment (Optional-paid by team member)</td>
<td>Regular full-time and part time staff (50% time)</td>
<td>Same as basic life</td>
<td>Spouse - choice of $25,000, $50,000, $75,000, $100,000, $125,000, $150,000, $175,000, $200,000</td>
<td>Premium based on coverage selected. See premium table.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Children - $10,000</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Optional amounts between $25,000 and $500,000 available. Coverage for family members also available.</td>
<td></td>
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<td></td>
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**WHEN**
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<tr>
<th>BENEFITS</th>
<th>WHO'S COVERED</th>
<th>ELIGIBLE</th>
<th>BENEFITS DESCRIPTION</th>
<th>YOUR COST</th>
</tr>
</thead>
<tbody>
<tr>
<td>Retirement plans</td>
<td>Park Nicollet 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 18 and completion of 1 year of employment (at least 1,000 hrs)</td>
<td>PNHS Automatic contribution. 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>Sick child care discount</td>
<td>Discounts &amp; Cost Sharing</td>
<td>All regular full-time and part time staff (40+ hrs/pd)</td>
<td>Date of hire</td>
<td>Under the Weather child care for Sick Kids (in home care)</td>
</tr>
<tr>
<td>Other</td>
<td>Vacation</td>
<td>Full-time and part-time staff</td>
<td>Date of hire</td>
<td>Years 1 -3: 15 days/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>Benefits Category</td>
<td>Eligibility</td>
<td>Description</td>
<td>Payment Responsibility</td>
<td></td>
</tr>
<tr>
<td>-------------------------------------------</td>
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<td>-----------------------------------------------------------------------------------------------</td>
<td>------------------------</td>
<td></td>
</tr>
<tr>
<td>Relocation Reimbursement</td>
<td>All matched applicants</td>
<td>Up to $1000 reimbursement for moving expenses (must be submitted by 12/31)</td>
<td>Park Nicollet paid.</td>
<td></td>
</tr>
<tr>
<td>Professional Liability</td>
<td>Full-time and part-time staff</td>
<td>Coverage for all professional services as a provider.</td>
<td>Park Nicollet paid.</td>
<td></td>
</tr>
<tr>
<td>Medical &amp; DEA License</td>
<td>Full-time and part-time staff</td>
<td>State &amp; DEA Licenses paid.</td>
<td>Park Nicollet paid.</td>
<td></td>
</tr>
<tr>
<td>Professional Association Dues</td>
<td>Full-time and part-time staff</td>
<td>State &amp; County Association dues paid.</td>
<td>Park Nicollet paid.</td>
<td></td>
</tr>
<tr>
<td>Hospital Staff Dues</td>
<td>All staff</td>
<td>Hospital Staff dues necessary to your Practice paid.</td>
<td>Park Nicollet paid.</td>
<td></td>
</tr>
<tr>
<td>Board Exams</td>
<td>All staff</td>
<td>Board exams taken prior to graduation are paid by Park Nicollet. Exams taken after graduation will be paid if Resident has signed a contract to continue working at Park Nicollet.</td>
<td>Park Nicollet paid. (Paid time off for study comes out of Academic time.)</td>
<td></td>
</tr>
<tr>
<td>Voluntary Benefits &amp; Company Discounts</td>
<td>All scheduled 0.5 FTE staff for voluntary benefits, all staff receive discounts.</td>
<td>Identity Theft, Legal Services, Metlife Auto &amp; Home ins., Metropass tickets, are available at discounted rates among other benefits. See Facets/Human Resources/Benefits/see more about benefits/scroll down to Additional benefits where you will see further options/discounts such as reduced cell phone rates and pre tax parking ramp.</td>
<td>Based on services requested.</td>
<td></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 Nicollet” 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
GLOBAL FAMILY MEDICINE PATHWAY
See details at: Department-Level Policies: Payroll, Reimbursements, and Benefits (under Global Family Health)

LAUNDRY SERVICE
Each resident will be given two white coats during orientation. If coat needs to be replaced, please contact the residency coordinator.

LEAVE POLICIES & PROCEDURES

BEREAVEMENT LEAVE POLICY & PROCEDURE
See details at: Institution-Level Policy: Leave policies & procedures-Bereavement

FAMILY MEDICAL LEAVE ACT (FMLA) POLICY & PROCEDURE
See details at: Institution-Level Policy: Leave policies & procedures-Family Medical Leave Act

HOLIDAYS POLICY & PROCEDURE
See details at: Department-Level Policies: Leave & Time Off (under Holidays)

Please see Park Nicollet/Facets page for specific Park Nicollet holidays

LEAVE OF ABSENCE POLICY & PROCEDURE
See details at: Department-Level Policies: Leave & Time Off (under Leave of Absence)

All leaves must be approved by the program director and submitted to Paris Fayerweather, Program Coordinator prior to all resident leaves. If you are on an unpaid leave of absence and you want your benefits to continue, you must contact Paris immediately. If you fail to notify Paris about continuing your benefits, they will be discontinued.
**MEDICAL LEAVE POLICY & PROCEDURE**

See details at: [Department-Level Policies: Leave & Time Off](#) (under 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 the residency coordinator 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.

**MILITARY LEAVE POLICY & PROCEDURE**

See details at: [Institution-Level Policy: Leave policies & procedures](#)-Military Leave

**PARENTAL LEAVE POLICY & PROCEDURE**

See details at: [Department-Level Policies: Leave & Time Off](#) (under Parental Leave)

Parental leave includes maternity and parental leave (i.e, adoption or foster care). Time away from the residency in excess of one (1) month will require a request to the Program Director for a leave of absence and it will require extension of residency training. Every effort should be made to schedule rotations and call in a manner that will meet the resident’s individual needs as well as the needs of the resident’s peers. Any days covered by PTO will not extend residency.

**PERSONAL LEAVE POLICY & PROCEDURE**

See details at: [Department-Level Policies: Leave & Time Off](#) (under Personal Leave)

- Five (5) paid personal days are available for residents to use for sick time, urgent appointments, and emergencies.
- Requests for Personal Leave are evaluated on a case by case basis and are at the discretion of the Program Director.

**PROFESSIONAL AND ACADEMIC LEAVE POLICY & PROCEDURE**

See details at: [Department-Level Policies: Leave & Time Off](#) (under Professional and Academic Leave)

Academic leave to present at or attend conferences may be granted at the discretion of the program director. A maximum of five days is allowed away by the ABFM.
SICK LEAVE POLICY & PROCEDURE
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, resulting in more than 21 working days away 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.

UNAUTHORIZED LEAVE POLICY & PROCEDURE
See details at: Department-Level Policies: Leave & Time Off (under Unauthorized Leave)

VACATION POLICY
No more than fifteen (15) paid working days are granted for vacation, each academic year. Vacations must be submitted to Paris Fayerweather by the first of the month, two months prior to the requested day(s) (see schedule below). Residents are allowed only ONE late notification per year. Anything past the deadlines below will be considered late. Scheduling vacation at the beginning of the resident’s year is strongly encouraged. However, do not make final arrangements, purchase airline tickets, etc., until you receive this completed form back.

<table>
<thead>
<tr>
<th>JULY</th>
<th>AUGUST</th>
<th>SEPTEMBER</th>
<th>OCTOBER</th>
<th>NOVEMBER</th>
<th>DECEMBER</th>
<th>JANUARY</th>
<th>FEBRUARY</th>
<th>MARCH</th>
<th>APRIL</th>
<th>MAY</th>
<th>JUNE</th>
</tr>
</thead>
</table>

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.
- No more than one week (i.e., 5 weekdays) of vacations can be take per rotation.
- July vacation requests will be determined on a case by case basis due to lack of coverage.
- Limited vacation will be granted in the last two weeks of the third year.
Residents will not be permitted to take more than 2 days off from ER & Ped 2 rotation.

No vacation will be allowed during Peds 3, Family Inpatient and OB.

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 three 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.

WITNESS OR JURY DUTY LEAVE POLICY & PROCEDURE
See details at: Department-Level Policies: Leave & Time Off (under Witness or Jury Duty Leave)

See also: Institution-Level Policy: Leave policies & procedures - Witness or Jury Duty Leave

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 employ room and other beverage and snack vending machines located within the hospital, these options are at your own expense.

MEMBERSHIP IN MEDICAL SOCIETIES
See details at: Department-Level Policies: Payroll, Reimbursements, and Benefits (under Membership in Medical Societies)

MOVING EXPENSE REIMBURSEMENT POLICY
See details at: Department-Level Policies: Payroll, Reimbursements, and Benefits (under Moving Expense Reimbursement)
Moving expenses for newly appointed residents with a one-time maximum of $1,000. 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 move. Cost of truck rental or trailer rental. Mileage reimbursement will be based on the Internal Revenue Service standard mileage rate.

Nonqualified moving expenses include boats, hot tubs, firewood, satellite discs, campers, pet’s playhouses, utility sheds, and swing sets. 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.

Each resident will submit for reimbursement electronically through the ChRIS system. Once that account is set up residents will receive an email confirmation and will be sent a Webinar training on how to submit for reimbursement. Original receipts for all expenses that are listed for reimbursement must be submitted at the time of requesting reimbursement. Please see Paris Fayerweather, Residency Coordinator, if you have any questions regarding reimbursement or how to submit for reimbursement.

**MYU PORTAL** ([www.MyU.umn.edu](http://www.MyU.umn.edu))

See details at: [Department-Level Policies: Payroll, Reimbursements, and Benefits](http://www.MyU.umn.edu) (under MyU Portal)

**PARENTAL-NEWBORN ELECTIVE**

See details at: [Department-Level Policies: Payroll, Reimbursements, and Benefits](http://www.MyU.umn.edu) (under Parental-Newborn Elective)

**PROFESSIONAL LIABILITY (MALPRACTICE) INSURANCE INFORMATION**

Park Nicollet Health Services has a comprehensive insurance program that provides various types of coverage for the entire organization, including Methodist Hospital, Park Nicollet Clinics including TRIA, Melrose Institute, Park Nicollet Institute and Park Nicollet Foundation.

Responsibility for oversight of the insurance program is Jeremy Sundheim, Director of Risk
Management. Responsibility for the daily management of the insurance program is Jill Thrasher, Project Manager of Insurance and Business Continuity.

Please contact Jill Thrasher at (952) 883-7191 for all insurance related questions.

**Professional Liability**
PNHS provides professional liability (malpractice) coverage for clinicians for care provided in the course and scope of employment, or for claims that arise after you leave employment when the care occurred while you were our employee. Please [click here](#) for more information regarding tail coverage.

**General Liability**
General liability coverage provides coverage for bodily injury or property damage as a result of our negligence (not related to patient care). If someone is injured on our property, please attend to their immediate needs and get them the help they need. Then, contact Risk Management so we can help determine next steps. Do not promise to write off care until we have had a chance to investigate.

**Foreign Travel**
PNHS offers foreign travel insurance for anyone traveling outside the United States on authorized PNHS business. Please [click here](#) for a wallet card that will explain the services available and who to contact if you need assistance.

**RESEARCH RESOURCES**
See details at: [Department-Level Policies: Payroll, Reimbursements, and Benefits](#) (under Research Resources)

**STIPEND**
See details at: [Department-Level Policies: Payroll, Reimbursements, and Benefits](#) (under Stipend Rates)

See also Institution-Level Policy at: [https://www.med.umn.edu/residents-fellows/current-residents-fellows/stipends-benefits](https://www.med.umn.edu/residents-fellows/current-residents-fellows/stipends-benefits)

**WORKERS’ COMPENSATION INJURIES**
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.
SECTION 3: 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.

SECTION 4: DISCIPLINARY AND GRIEVANCE PROCEDURES

See details at: Department-Level Policy: Disciplinary & Grievance Procedures

SECTION 5: GENERAL POLICIES AND PROCEDURES

ACGME COMPETENCIES

See details at: Department-Level Policies: General (under ACGME Competencies)

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. G1 has their own call room to use in the hospital for the day. These call rooms are located on 4NW and 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.
CALL RESPONSIBILITIES

SUBJECT: On-Call Responsibilities of Family Practice Residents

REFERENCE NUMBER: ADM-MS-13

ORIGIN DATE: 11/72

REVISION NUMBER: 5

REVISION DATES: 7/91, 2/00, 2/10

MOST RECENT REVIEW DATE: 2/10

PURPOSE:
To clearly define the responsibilities of the housecall Family Practice Residents.

RESPONSIBILITY:
Program Director for Creekside Family Practice Residency Program

POLICY:
Residents in the family practice program at Methodist Hospital will be scheduled “on-call” on a rotating basis to cover medical emergencies, which occur in the hospital in the absence of the patient’s physician. (exception: PNC surgical on-call resident covers emergencies which occur with the PNC surgical patients).

PROCESS:
A. Residents will attend classes and maintain competency in adult and pediatric advanced cardiac life support and neonatal resuscitation upon entering the program and every two years thereafter.

B. Residents will be expected to provide care, including procedures within the scope of their training and experience as indicated by the urgency of the medical situation.

C. After each patient visit, residents are expected to document on the patient’s medical record an appropriate progress note indicating their observations, interventions and medical orders or complete the appropriate medical record forms.

D. The responsibilities and priorities of the Family Practice Resident “on-call” are:
   1. Respond to “Code Blue” and assume responsibility for managing the Code until relieved by a qualified attending or consulting cardiologist.
   2. Respond to “Code99” stroke codes and “Code Green” events as member of team.
   3. Respond to RET codes and evaluate patients whose conditions have changed, notify the attending physician, institute treatment and when appropriate transfer to critical care units.
   4. Read stat EKGs and call attending physician with results.
5. Evaluate patients who fall when nursing assessment indicates possible injury.
   Explanation: If, in the nurse’s judgement, he/she feels confident that the chance of any significant injury is unlikely, the resident need not be called.
   a. The following guidelines will be used by the nursing staff in determining if the resident should be called to examine the patient. All patients will be seen:
      (1) Who suffer a blow to the head;
      (2) Who have had recent bone surgery;
      (3) Who have sustained significant bruising, cuts or lacerations;
      (4) Who complain of pain following the fall;
      (5) Who show any evidence of a fracture; or
      (6) Who show a change in vital signs or change in level of consciousness.
   b. If none of the above apply, but the supervisory staff has concerns about the possible injury or potential legal implications, the resident will be asked to see the patient.
   c. The decision to call the resident to see the patient or to wait for the next visit by the attending physician will be made by the nurse assigned to the patient. The nurse should also notify the nurse manager or nursing supervisor of his/her decision to call the resident.

6. Administer IV medications not included in staff responsibilities as described in Nursing Administration policy “Medication Administration by Nursing Personnel” (CC.10-MH-8500-0798)

7. Check x-rays for line placement and endotracheal or feeding tube placement.

8. Femoral artery or vein puncture for arterial blood gases or blood work when the lab staff is unable to obtain.

9. Discontinue subclavian and central lines.


E. SPECIAL NOTES:
1. The resident may occasionally scrub in the OR during his/her call hours; however, if he/she is needed for one of the above reasons, his/her first responsibility is in-house service and he/she will break scrub and respond to the need without delay.

2. The on-call resident is not responsible for:
   a. Routine medication orders, i.e., analgesics, hypnotics, sedatives, anti-pyretics, anti-emetics, and laxatives. This is responsibility of the attending physician.
   b. Admission evaluation of patients, except for those on the service to which the resident is currently assigned.
   c. In acute emergencies, it is appropriate for the resident to evaluate and stabilize the patient, giving the attending time to come to the bedside. The resident may transfer a patient to the critical care unit in an emergency or when the patient’s condition warrants it, but the attending is responsible for critical care management and communications with consultants regarding their patients.
   d. Questions on routine management and laboratory work should be directed to the attending.
Title: On-Call Responsibilities of Family Practice Residents

Policy Number: ADM-MS-13

PURPOSE:
To clearly define the responsibilities of the housecall Family Practice Residents.

RESPONSIBILITY:
Program Director for Creekside Family Practice Residency Program.

POLICY:
Residents in the family practice program at Methodist Hospital will be scheduled “on-call” on a rotating basis to cover medical emergencies, which occur in the hospital in the absence of the patient’s physician. (Exception: PNC surgical on-call resident covers emergencies which occur with the PNC surgical patients).

PROCESS:
A. Residents will attend classes and maintain competency in adult and pediatric advanced cardiac life support and neonatal resuscitation upon entering the program and every two years thereafter.

B. Residents will be expected to provide care, including procedures within the scope of their training and experience as indicated by the urgency of the medical situation.

C. After each patient visit, residents are expected to document on the patient’s medical record an appropriate progress note indicating their observations, interventions and medical orders or complete the appropriate medical record forms.

D. The responsibilities and priorities of the Family Practice Resident “on-call” are:
   1. Respond to “Code Blue” and assume responsibility for managing the Code until relieved by a qualified attending or consulting cardiologist.

   2. Respond to “Code99” stroke codes and “Response Team Requested” events as member of team.

   3. Respond to RET codes and evaluate patients whose conditions have changed, notify the attending physician, institute treatment and when appropriate transfer to critical care units.
4. Evaluate patients who fall when nursing assessment indicates possible injury.
   Explanation: If, in the nurse’s judgement, he/she feels confident that the chance of any significant injury is unlikely, the resident need not be called.
   a. The following guidelines will be used by the nursing staff in determining if the resident should be called to examine the patient. All patients will be seen:
      (1) Who suffer a blow to the head;
      (2) Who have had recent bone surgery;
      (3) Who have sustained significant bruising, cuts or lacerations;
      (4) Who complain of pain following the fall;
      (5) Who show any evidence of a fracture; or
      (6) Who show a change in vital signs or change in level of consciousness.
   b. If none of the above apply, but the supervisory staff has concerns about the possible injury or potential legal implications, the resident will be asked to see the patient.
   c. The decision to call the resident to see the patient or to wait for the next visit by the attending physician will be made by the nurse assigned to the patient. The nurse should also notify the nurse manager or nursing supervisor of his/her decision to call the resident.

6. Administer IV medications not included in staff responsibilities as described in Nursing Administration policy “Medication Administration by (PNMEH and Medrose)” (IP-MEDS-01).

7. Check x-rays for line placement and endotracheal or feeding tube placement.


E. SPECIAL NOTES:
1. The resident may occasionally scrub in the OR during his/her call hours; however, if he/she is needed for one of the above reasons, his/her first responsibility is in-house service and he/she will break scrub and respond to the need without delay.

2. The on-call resident is not responsible for:
   a. Routine medication orders, i.e., analgesics, hypnotics, sedatives, anti-pyretics, anti-emetics, and laxatives. This is responsibility of the attending physician.
   b. Admission evaluation of patients, except for those on the service to which the resident is currently assigned.
   c. In acute emergencies, it is appropriate for the resident to evaluate and stabilize the patient, giving the attending time to come to the bedside. The resident may transfer a patient to the critical care unit in an emergency or when the patient’s condition warrants it, but the attending is responsible for critical care management and communications with consultants regarding their patients.
   d. Questions on routine management and laboratory work should be directed to the attending.
CALL SCHEDULES

1. **G1**: House call shift is q 5 (14 hour shift); 7:30 am – 9:30 pm
   - OB Rotation: 7:00 am to 7:30 am (24 hours) in L&D. Post Call next day.
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, if possible; can be called in by the call faculty as needed.
   - On weekends:
     - Call from home with coming in for admits, from 7:00 am am until 9:30 pm. (PNHS is providing “direct G1 supervision” from 7:30 am to 9:30 pm for weekend house coverage.)
     - 7:30 am to 9:30 pm 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.
3. When to call in backup:
   - If on-call resident has to do a delivery
   - If house call demand is delaying timely admissions
   - Backup 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. No moonlighting when you are on backup.

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.
The Senior on Service or Family Medicine G1 or G2 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).

**DEA CERTIFICATE**
See details at: [Department-Level Policies: General](#) (under *DEA Certificate*)
DISCLOSURE OF UNANTICIPATED OUTCOMES AND MEDICAL ACCIDENTS
SUBJECT: Disclosure of Unanticipated Outcomes and Medical Accidents

Policy Number: ADM-PS-04

PURPOSE: To clarify Park Nicollet Health Service’s (PNHS) philosophy and approach to providing patient or their surrogate timely and accurate information, especially when there is a need to disclose an unanticipated outcome of care. An unanticipated outcome does not necessarily mean an error has occurred.

OWNER: Executive Medical Director Caregroup and President, Methodist Hospital

CONTACT/CONTENT EXPERT: Vice President Medical Affairs, Risk Manager, Senior Director Quality & Safety, Manager Patient Safety & Patient Relations.

POLICY:
Disclosure of an unanticipated outcome of care will occur in the following circumstances:

1. Unanticipated outcome of care (typically affecting one patient): Disclosure is appropriate when an actual or potential outcome differs significantly from the anticipated outcome, whether the outcome results in harm or not.

2. Unanticipated process variation (typically affecting multiple patients): Disclosure is appropriate when a process differs significantly from the anticipated process and there is a reasonable likelihood of actual or potential harm to the patient as a result of the variation.

3. If the emotional/psychological harm to the patient or surrogate from disclosure clearly outweighs the benefit of disclosure, then disclosure may be delayed until the harm of disclosure is diminished. In rare circumstances, disclosure may be indefinitely deferred under this paragraph.

DEFINITIONS:
Accident - A series of events that involves damage to a defined system disrupting the ongoing or future output of the system.

Error – An act of commission (doing something wrong) or omission (failing to do the right thing) that leads to an undesirable outcome or significant potential for such an outcome.

Harm – An impairment of structure or function of the body and/or any deleterious effect arising therefrom, including disease, injury, suffering, disability and death, and may be physical, social, or psychological.

Unanticipated outcome - A negative unexpected result stemming from diagnostic test, medical treatment, or surgical intervention. For purposes of this policy, unanticipated outcomes include death, serious physical or psychological injury, or any outcome which results in an increased length of stay or a substantive change or medication in the patient’s orders or treatment plan.
PROCESS:

A. Determine who will lead the disclosure of the unanticipated outcome and who should be part of the discussion. The person(s) performing the disclosure should be the individual(s) who is (are) in the best position to answer patient and family questions about the outcome and next steps.

B. Determine when and where the disclosure should occur. Consider any special accommodations or requests of the patient or surrogate.

C. Determine the contents of the disclosure, taking into consideration the uniqueness of each situation. The following items may or may not be part of the discussion:
   1. Objective statement of what happened (without speculation as to causes);
   2. Clear, honest communication of regret and apology (if appropriate);
   3. Discussion of changes in the patient’s plan of care (if any);
   4. Steps taken to take care of the patient (if appropriate);
   5. Steps taken to prevent recurrence (if appropriate);
   6. Identification of whom the patient or surrogate will hear from next or next steps they have to take;
   7. Offer of appropriate support services to patient or surrogate. Questions about compensation will be referred to Risk Management.

D. Develop a plan for follow-up conversations with the patient or surrogate (if appropriate).

E. Document the disclosure in the patient’s electronic health record. Documentation should include:
   1. The facts given during the disclosure, including outcomes of the event and changes in treatment course;
   2. Who participated in the conversation.
   3. Key questions asked and answers given;
   4. Next steps;
   5. Services offered and accepted; and
   6. Content of the apology.

F. Discuss the event and outcome of the investigation with the appropriate medical staff and quality and peer review committees as warranted. Patient Safety and/or Risk Management may discuss the event and disclosure plan with the Senior Leadership Team.

G. The Risk Management Department and Patient Safety Department are available for consultation on the steps listed in Procedures A-F.

H. Support for Caregivers
   1. Consideration of consultation for the involved caregiver with the Employee Assistance Program in cases where the caregiver may be devastated by the occurrence.
   2. 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.
   3. Ancillary services are available to assist the physician or designee in discharging their responsibility including but not limited to social services, chaplains, patient relations.
   4. 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:
- Near Miss, Sentinel Event, Adverse Health Event Policy
- Safe Medical Device Reporting Policy
- “Leaders: Getting organized during a crisis” resource document

REFERENCES:
- AHRQ Communication and Optimal Resolution (CANDOR) Toolkit

APPROVAL:
- Methodist Hospital Patient Care Committee, February 2018
- Executive Medical Committee, March 2018
I. PURPOSE: To provide Park Nicollet employee’s with the minimum acceptable standards regarding the type of dress and grooming that is appropriate at Park Nicollet Health Services. The appearance of employees greatly impact patients’ perceptions and consequently, their impression of Park Nicollet.

II. RESPONSIBILITY: The Park Nicollet Health Services Vice President of Human Resources is responsible for the personnel aspects of this policy.

A. Content Expert/Contact: Employee/Labor Relations Director

All employees are responsible, as a condition of employment to comply with all aspects of this policy. Each employee is responsible for seeking clarification of this policy if the employee is unsure about its meaning or application.

All leaders are responsible for:

Developing department specific standards regarding personal appearance/dress code which meet the department’s business need and that are in compliance with Park Nicollet appearance/dress code standards. Such department specific standards may include standard work attire or uniforms.

Implementing and training employees regarding the personal appearance/dress code standards, which have been set for the organization and individual departments. This includes informing candidates and new hires of these standards.

Monitoring, counseling and disciplining employees whose personal appearance does not meet these department/organizational standards.

Consulting with Human Resources regarding the policy as needed.

Park Nicollet Health Services
HUMAN RESOURCES POLICY

Subject: Personal Appearance of Employees (Dress Code)
Reference Number: L19-HSM-8250-0197
Approval: Origin Date: PNC 11/85
Revision Number: 9
MH 7/86
Revision Date: 1/98, 12/98, 04/00, 9/00, 3/05, 7/05, 4/06, 12/07, 11/11, 11/16, 6/17
Most Recent Review Date: 11/16, 6/17

Total Pages: 5
III. POLICY: It is the expectation that all employees of Park Nicollet Health Services will dress in such a fashion as to create a positive impression on patients, customers, visitors and others. Each employee’s dress, grooming and personal hygiene must be appropriate to the work situation. Departure from expected dress or grooming standards may result in disciplinary action up to and including termination of employment.

These standards do not constitute a contract or guarantee of employment in any respect. Park Nicollet Health Services may change the standards at any time with or without notice.

To the extent this policy conflicts, in whole or in part, with a term or condition of an applicable collective bargaining agreement, the collective bargaining agreement will control for those union employees.

IV. PROCESS:

A. General Appearance/Attire Standards.  
When developing department specific standards leaders must consider the following personal appearance standards as minimum standards. Department leaders may establish more stringent standards for their departments.

1. All employees are required to wear their Park Nicollet Health Services nametag at all times while on duty. Nametags must be worn at or above the waist. If an employee loses or damages the nametag, it should be reported to Safety and Security immediately. Employees are responsible for the cost of replacing a lost nametag.

2. Good personal hygiene practices are expected of all staff. Odors and lack of good personal hygiene practices that interfere with individual or team performance are not acceptable.

3. Perfume/cologne, perfumed products (hand/body lotion, etc) and aftershave are discouraged due to the prevalence of allergies and sensitivities and may be prohibited in department specific standards. Smoke odors are prohibited.

4. Hair must be clean and neat at all times. Extreme styles and unusual colors may be prohibited in department specific standards.

5. Makeup is to be worn in moderation.

6. Mustaches and beards are to be kept neat and well groomed.

7. Jewelry may be limited per department specific standards.
8. Visible body piercings other than earrings, if considered offensive to patients, visitors or employees, must be covered or removed while on duty.

9. Visible tattoos, if offensive to patients, visitors or employees, must be covered while on duty.

10. Artificial nails are prohibited from being worn by any employee who provides direct patient care, prepares equipment or instruments for patient use, or prepares food, medications, blood or blood products for patients. Fingernails are to be kept clean and neatly trimmed and extend no further than ¼ inch beyond the fingertip. Fingernail length and color should be appropriate to perform job duties. Department specific standards may prohibit artificial nails for all staff members.

11. Appropriate undergarments must be worn and should not be visible through clothing.

12. All clothing including shoes must be clean and in good repair. Clothes must be neat and wrinkle free. Clothing should fit well and allow for comfortable movement. Excessively baggy or tight attire is not considered appropriate.

13. Clothing should not be transparent, revealing, tight fitting, must cover the midriff area and not interfere with performing job function.

14. Shoes must be clean and in good condition. The selection of shoes worn must be based on safety, the type of work being performed and department specific guidelines. Leaders are responsible for establishing department specific guidelines related to appropriate footwear. Conservative open toed shoes may be permitted from late spring to early fall. Flip-flops and similar casual sandals are prohibited. High heel or platform shoes may be prohibited for safety reasons per department specific guidelines. If wearing open-toes conservative shoes without nylons or socks, toenails must be clean and neatly trimmed.

15. Hosiery or socks are required except from late spring to early fall. However, the wearing hose or socks at all times is strongly encouraged and may be required by department specific guidelines, as determined by the department leader.

16. Cropped pants / ankle pants are allowed but must not be more than 3 inches above the ankle. Capri pants are prohibited. Shorts are prohibited with the exception of departments whose uniform standard includes conservative, longer shorts. This standard is intended for employees who
must work a significant part of their day outdoors in the summer months. Leaders who are considering such a uniform standard must first consult with Human Resources.

17. Skirts and dresses should be conservative in length and appropriate for a business atmosphere.

18. Neckline of shirts, sweaters and dresses should be conservative and not revealing in nature.

19. All denim or denim look-alike attire including jeans, jean skirts, jean skirts etc. of any color is prohibited. Please see Leader’s Discretion section of policy regarding limited exceptions to this provision.

20. Sleeveless shirts, sleeveless/strapless dresses and dresses/blouses/shirts with spaghetti straps are prohibited, unless worn under a sleeved jacket or blouse.

21. With the exception of departments whose dress code includes scrubs, collarless shirts are prohibited for men. Turtleneck/mock turtleneck shirts are considered to be collared.

22. T-shirts and sweatshirts are prohibited.

23. Attire must be free of words/slogans and corporate logos. Park Nicollet Logo Wear may be appropriate per department specific standards as long as the PN logo wear meets all other minimum standards listed in this policy.

24. Lapel buttons/pins with political or controversial messages are not permitted while on duty.

25. Employees may elect to wear head attire due to their religious convictions provided the head attire does not pose a safety or infection control risk and does not interfere with performing the employee’s job duties.

26. Costumes, holiday specific outfits or other special event outfits that do not comply with the standard dress code are acceptable for predetermined special occasions/holidays upon pre-approval by Senior leader.

27. The cost and maintenance of work attire and uniforms is at the employee’s expense.

V. LEADER’S DISCRETION:
Department leaders must be sensitive to the impact of dress standards on the perceptions of patients, visitors and other customers. Exacting and consistent standards for personal appearance, uniforms or dress are particularly important in patient care areas. Area leaders are responsible for the development and monitoring of such standards, which may include a standard uniform.

Park Nicollet Health Services is sensitive to the fact that there are certain benefits associated with periodic relaxation of the personal appearance dress code standards. In such cases a department may elect to designate a “casual” or “dress down day”. Under such circumstances it is still necessary that a level of professional dress be maintained and that the relaxation of the standard does not impact patient care or customer perceptions. Therefore approved attire for such a “dress down day” must continue to comply with the organizational standards outlined in this policy.

The following two exceptions exist regarding the prohibition of denim and denim look-alike attire. These exceptions require senior leader approval and may be revoked at any time. Any denim or denim look-alike attire worn in these two situations must be clean, neat, and non-torn and non-faded. These relaxed standards apply only to denim and denim look-alike attire and not to other components of this dress code policy. When considering participation in these exceptions employees should dress according to their planned work day (will they be traveling to other sites, will they be meeting with customers etc.).

**Non Patient Care Facilities - Casual Friday’s**

Park Nicollet facilities without patient traffic may allow employees to wear such attire on Fridays.

**Foundation Sponsored Casual Days**

The Park Nicollet Foundation will on occasion sponsor a casual dress day in which employees may wear such attire in exchange for making a specified donation to the Foundation.

VI. NOTE: This policy is a combination of the following policies:  
Methodist Hospital Human Resources 5.04  
Park Nicollet Clinic Human Resources 8.2

End
DUTY HOURS
See details at: Institution-Level Policy: ACGME institutional policies and procedures - Duty Hours Policy


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 http://www.new-innov.com/login 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.

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.
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 of inpatient and outpatient care delivery.

IN-TRAINING EXAMINATION

See details at: Department-Level Policies: General (under In-training Examination)

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.

LIFE SUPPORT CERTIFICATION REQUIREMENTS

See details at: Department-Level Policies: Payroll, Reimbursements, and Benefits (under Life Support Certification Reimbursement)

Certification in ACLS, BLS, PALS, or APLS and NRP. Residents attend BLS and ACLS training during orientation in late June. Administration arranges for recertification in BLS and ACLS during their PGY2.

MEDICAL LICENSURE APPLICATION

See details at: Department-Level Policies: General (under Medical Licensure Application)
MEDICAL RECORD COMPLETION
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
3. Management site on Facets or through the processes (standard work) created by the team implementing the online documentation tool.
4. Failure to use approved documentation methods will be reviewed by the CIM committee.
5. 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.

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.
MOONLIGHTING
See details at: Department-Level Policies: General (under Moonlighting)

See also Institution-level policy here: ACGME institution policies and procedures-Moonlighting

PATIENT GRIEVANCE POLICY
Please see details at: Park Nicollet Methodist Hospital Patient Grievance Policy.pdf

PATIENT SAFETY DEFECT ELIMINATION PLAN
SUBJECT: Patient Safety Defect Elimination Plan
REFERENCE NUMBER: F.04-HSM-8201-0601
APPROVALS: ORIGIN DATE: 6/01
REVISION NUMBER: 6
REVISION DATES: 3/03, 7/06, 6/09, 1/13
MOST RECENT REVIEW DATE: 1/13, 10/13

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 healthcare 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.
   8. PNHS uses aggregate error reports to identify trends and opportunities for process/system redesign to reduce errors and promote patient safety.
   9. PNHS supports and encourages patients to be active, involved, and informed participants in their care.

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
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 healthcare 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 nonhuman (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 no 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 redesign 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 1.66-HSM-8250-1299
Product Review M.15-HSM-8072-0301

PROGRAMMATIC COURSES
UMN RESIDENCY TRAINING PROGRAMS -FAMILY MEDICINE & COMMUNITY HEALTH
See details at: Department-Level Policies: General (under Programmatic Course Calendar)

PROGRAMMATIC COURSES, RULES FOR ATTENDANCE
See details at: Department-Level Policies: General (under Programmatic Courses: Rules for Attendance)

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\Residency\Rotation & Curriculum Manual.” Residents will also receive a copy of the curriculum prior to the start of each rotation via RMS. Please review the module prior to beginning your rotation. Questions should be addressed with faculty or the rotation preceptor.

First-Year Required Rotation
Cardiology 1 month
Emergency Medicine 1 month
Family Medicine 3 months
Hematology/Oncology 1/2 month of each
Neurology 1 month
Obstetrics 2 month
Pediatrics 2 month
Surgery 1 month

Second and Third-Year Rotations

Required Rotations
Cardiology 1 month 3rd year
Chief, Assistant 2 months 3rd year
Community Health 1 month 3rd year
Critical Care 1 month 2nd year
Family Medicine Center 1 month 3rd year
Family Medicine Inpatient 3 months 2nd and 3rd year
Gynecology 1 month 2nd
Infectious Disease 1 month 2nd year
Orthopedics - General 1 month 3rd year
Obstetrics 1 month 2nd year
Orthopedics - Tria 1 month 2nd year
Pediatrics – Children’s Minneapolis 1 month 2nd year
Pediatrics - Outpatient 1 month 3rd year
Psychiatry 2 months - ½ time, consecutive 3rd year and 2nd year
SubSpecialty rotation 2 months 2nd and 3rd year
Surgery 1 month 2nd

Elective Rotations (4 months)
Colposcopy
Dermatology
Eating Disorders
Endocrinology
Gastroenterology
Geriatrics
Global Health
Infectious Disease
Obstetrics
Oncology/Hematology
Palliative Care
Parental Procedures
P M & R
Rheumatology
Sports Medicine
**PROGRAM GOALS AND OBJECTIVES**
Please see separate goals and objectives documents that you will receive prior to each rotation. Information regarding each rotation can also be found at:
I:\Creekside\Residency\Rotation & Curriculum Manual\Curriculum Goals and Objectives

**RESIDENCY PERMIT APPLICATION**
See details at: Department-Level Policies: General (under Residency Permit Application)

**RESIDENT REGISTRATION POLICY**
See details at: Department-Level Policies: General (under Registration Policy)

**RESIDENT SELECTION**
See details at: Department-Level Policies: General (under Resident Selection)

**RESIDENT WELL-BEING**
See details at: Department-Level Policies: General (under 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.

**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
SUPERVISION
See details at: Institution-Level Policy: ACGME institutional policies & procedures - Supervision Policy

- 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.

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.

TEACHING MEDICAL STUDENTS
See details at: Department-Level Policies: General (under Teaching Medical Students)
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:

1. Completion of the following required workshops in the specific years:
   a. First-Year Workshops (strongly encouraged to enroll in PGY-1)
      i. Advanced Life Support Obstetrics (ALSO®)
      ii. Primary Care Psychiatry
      iii. Sports Medicine: Basic Musculoskeletal Assessments
      iv. Sexual Medicine
   b. Second-Year Workshops (strongly encouraged to enroll in PGY-2)
      i. Leadership and Finance
      ii. Community Health
      iii. Sexual Medicine
2. Completion of the Community Health Rotation and Community Health Project
3. Sitting for ABFM In-Training Examinations
4. Certification in ACLS and BLS
5. Complete all evaluations, submit procedures and patient logs, timely review and approval of duty hours, satisfactory completion of all rotations and rotational activities, compliance with ABFM rules regarding time off.
6. Completion of Board Certification Requirements

TRANSITIONS OF PATIENT CARE POLICIES

PATIENT CARE -TRANSITIONS OF CARE COVERAGE POLICY

Providers We Cover For
- All Creekside residents
- Creekside faculty who see pts at Creekside clinic or Nursing Home: Jeremy Springer, Shannon Neale, Steven Kind, Amy Bonifas, Teresa Quinn, Selam Kifleyesus, Kumba Kanu.
- Prairie Center Providers: David Olson, Paul Kaldor, Sally Kline, Aaron Timmerman, Dean Kaihoi, Tiffany Armstrong, Kaitlyn Henkelman, Alice Macdonald, Jared Mell, Brittany Solc
- Morningside Family Medicine: Dr. Phil Sidell (952) 926-3002
- myHealth for Teens and young Adults Clinic: (952) 474-3251 X13. Secure voicemail
- Catalyst Medical Clinic Providers: Scott Jensen, M.D., Melinda Ament, C.N.P, Curtis Whisler, M.D., Kristin Olson, C.N.P. (952) 955-1963
- OB faculty providers: Jeremy Springer, Julie Farias (schedule coordinator), Tanya Henke-Le, Amy Bonifas, Jean Tiffany if sharing a patient with a resident.
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, Rick Mitchell
- Dr. Chris Johnson
- Dr. Dave Wilkins (faculty cover prescription refills during the days he’s away)

PATIENT CARE - TRANSITION OF CARE POLICY - (UPDATED MAY 2015)

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 signout. 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.
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 – automatically routes to the PCP in Epic
      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. Leave voicemail or page receiving NP with signout
         2. Route DC summary to covering MD/NP via Epic (EHR)
         3. Route DC summary to PCP based on criteria above (i, ii, or iii)
         4. 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
   c. 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.
      i. 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.
ii. For Dr. Sidell’s patients, page him with the patient’s name, MR number, the discussion and any necessary follow up.

iii. For patients of My Health Teen Clinic (formerly West Suburban Teen Clinic), call their secure after hours number and leave a message with the patient’s name, the discussion and any necessary follow up.

1. OB patients:
   i. Residents may be involved in coverage and co-management of faculty patients
   ii. First call resident is listed on the sticky note and/or at the top of the OB “episode of care”
   iii. Transitions of care beyond these clinicians needs to involve person to person communication, documentation In the EHR and verbal communication with nursing (if inpatient)
   iv. Communicate with senior resident rounding plan for Mom and baby

We will evaluate this process by routinely surveying the residents, rounding faculty and the physicians that we admit to assess how the process is going.

**USMLE AND COMLEX EXAMS**
See details at: [Department-Level Policies: General](#) (under USMLE and COMLEX Exams)

**VISA SPONSORSHIP**
See details at: [Department-Level Policies: General](#) (under Visa Sponsorship)

**WEB LINKS TO ADDITIONAL RESOURCES**
See details at: [Department-Level Policies: General](#) (under Web Links to Additional Resources)
[Methodist Hospital Family Medicine Residency Program](#)

**SECTION 6: ADMINISTRATION**
See details at: [Department-Level Policies: Administrative Contacts](#)

Program Specific Contacts
• Program Coordinator: Paris Fayerweather
  ○ Email: paris.fayerweather@parknicollet.com
  ○ Office phone: 952-993-7711