

MS-FAC Recommendations re. “What the Medical School Should Look Like Post-COVID”

Items were discussed at MS-FAC meetings on October 26, January 25, and May 24 and by MS-FAC subcommittees at other times. Approved by MS-FAC June 28, 2021.

Executive Summary

MS-FAC recognizes the challenges faced by faculty, staff and students of the Medical School through the COVID-19 pandemic. We deeply appreciate all of the hard work and thoughtful planning by Dean Tolar and his administration as they have led us through these difficult times.

This document is offered in response to a request by Dean Tolar in August of 2020 that MS-FAC imagine what a post-COVID Medical School should look like. We have focused on evaluating the positive and negative changes of most significant concern to the faculty that occurred during the pandemic, and on proposing potential solutions. Six major areas of Medical School function were considered: research, education, the clinical enterprise, MHealth Fairview interpretative services, Medical School communication and wellness. A total of 119 recommendations are offered.

The COVID-19 crisis offered opportunities to streamline operations and eliminate bureaucracy, to pivot toward a more online and asynchronous mode of operation, and to pay attention to issues of diversity, equity and inclusion. The identified changes that should continue will improve the working environment for faculty, staff and students of the Medical School.

There were two common themes to areas of Medical School operations that need further improvement. The first is that many large decisions were made by very small groups of people, and the second is that consultation and communication about decisions was not consistent across the organization. While MS-FAC members recognize that having small groups make decisions facilitates the speed of response that is needed in an emergency, the prolonged nature of the pandemic makes it clear that it will be critical to develop mechanisms that an appropriate balance is found between the demands of short-term vs. long term planning in the future.

RESEARCH

Positive changes resulting from COVID that should continue:

1. Increased availability of “rapid response grants” (i.e. 10K grant with a approval timeline of a couple weeks) for both COVID **and non-COVID** related research

2. Fast tracking IRB approvals for both COVID and non-COVID related research
3. Increased focus on health and healthcare disparities
4. Increase coordination of recruitment efforts across studies.

Negative changes resulting from COVID that should be stopped/modified:

1. Large decisions often made by small groups of people

Potential solutions:

- a. Ensure that there are multiple, diverse stakeholders involved in decision making, particularly regarding the return to normal research activity
- b. Include Equity Analyses as part of the decision-making process
- c. Consult widely, paying attention to the diversity of voices that are involved. Diversity needs be considered both with respect to individuals (gender, race, level of experience/tenure), and with respect to departments/units/campuses
- d. Stagger return of normal decision making; recognize that some units/ departments may function normally while others may still need restriction

2. Slow return to research activities compared to other Universities/Institutions

- Administrative support when working remotely was disconnected and slower than usual due to decreased personal contact

Potential solutions:

- a. Keep essential administrative services on campus
- b. Set specific office hours for administrative staff

3. Difficulties with restarting undergrad/grad/postdoc research

- Some of delays in returning undergraduates to labs were due to restrictions imposed at the University level

Potential solutions:

- a. Encourage the Senate Research committee and Medical School Research Council to work together to develop a standing plan for how to bring undergraduate students safely into labs if a future disruption occurs
- b. Survey researchers, grad students, and postdocs to determine what barriers were; develop a standing plan for how to avoid these in the future

4. Difficulties for early stage investigators (ESIs):

- ESI programs were slower to come back online as smaller research groups were on pause for longer (larger studies got preference)
- Hiring freeze delayed start-up of labs
- Delays in implementation impacted application for future funding, and ability to produce publications based on pre-existing data that could not be developed

- Gaps in funding could delay promotion
- Many investigators drop out of science when applying for a K or transitioning K to R. Identifying why and addressing the loss of excellent scientists at these early stages may significantly broaden the type of science performed at UMN

Potential solutions:

- a. Similar to the extra support/incentives for investigators applying for 2nd R01s, consider similar programs for initial Ks and K to R faculty.
- b. Provide small amounts of funding for fellows and ESIs launching new projects.
- c. Identify junior research faculty who would benefit from additional support such as assistance with setting up REDCap databases, study websites, and/or other promotional materials for enrolling study participants

5. Backlog in centralized core services such as flow cytometry.

Potential solution: Focus on ensuring that staff are able to return to centralized core services, over more specialized services, as soon as safely able.

6. Decreased ability to train new lab members due to difficulty in having a trainer and learner in the facility together.

Potential solutions:

- a. Provide methods for opening up training opportunities as vaccination of faculty/staff improves. Open early training opportunities to those vaccinated
- b. Increase IT support for development of online training videos

7. Communication between researchers and clinicians was limited, particularly when the Tier 1 Return to Research process created bottlenecks.

- Long delays in responding to tier 1 proposals
- Information flow appeared unidirectional
- No clear mechanism for how to respond to denials of return to research

Potential solution: Have both online and identified individual(s) involved with this process who can keep applicants informed of Return to Research progress

What else still needs to be improved?

1. Functioning of SPA

- Backlog (both pre- and post-award) at SPA serves as a disincentive to grant submission and administration (current 5-6 month backlog).
- Delays in account establishment leads to inadequate progress reports, and the risk for grant monies being returned to funding agencies.
- SPA suggested that money be spent off of other accounts and transferred to the appropriate grant account when that account is established. This approach has

limitations including doubling work of accounting staff, only serving those with other resources, and using substandard and unacceptable accounting practices increases risk of error or misappropriation of funds)

Potential solutions:

- a. Have SPA managed within each Department/Unit
- b. Evaluate how decisions were made to incentivize retirement of SPA members as a cost-saving measure and why retirements were not staggered while new individuals were on-boarded.
- c. Reward SPA members; allow further advancement into leadership roles

2. *Process and guidelines for grant writing incentive programs (\$30,000) were unclear*

Potential solutions:

- a. Greater transparency/instruction in how this program works
- b. Include other funding categories (i.e. larger grants such as R61/33 or P01) and/or specify a dollar amount (i.e. \$350,000/year) rather than specifying category.

3. *Research that was deprioritized during pandemic may need help getting back on track*

- Due to increased difficulty collecting preliminary data for grants and resultant slower review of publications that need to be cited for grants.

Potential solution: Develop bridge funding mechanisms specifically designed to address non-COVID research projects.

4. *Inconsistent/incorrect use of race in research protocols*

Potential solutions:

- a. Develop and offer online training modules for learning of best practices in using race in research
- b. Explore the possibility of modifying determination forms to include a question similar to: Does your study collect or analyze human race or ethnicity data?

5. *Lack of community voice in developing research agenda.*

Potential solutions:

- a. Develop dedicated infrastructure, including:
 - i. Technical tools to support research consenting for non-English research participants.

- ii. Work with internal/external experts on communication tools and presenting research opportunities to marginalized communities
 - iii. Update research recruitment software to track self-reported race of each participant enrolled by MHFV recruitment office
 - iv. Use Practice-Based Research Network practice facilitator network to increase inclusion of clinics in underserved and/or racial and ethnic minority communities
- b. Explore opportunities for partnership in this work with Center for Antiracism Research for Health Equity

EDUCATION

Positive changes resulting from COVID that should continue:

1. Increased availability of online education materials designed to incorporate best practices for online education
2. Remote-attendance options for meetings are highly valued due to increased flexibility and decreased time commitments (e.g. eliminating travel time)
 - o Improved collaboration between between Twin Cities and Duluth campuses (and with other institutions) by having all meetings with remote-attendance options
3. Increased collaboration and engagement among clerkship students at different clinical sites allowed students and faculty to collaborate in the online space
4. Increased diversity of curricular delivery methods and activities optimizing learning gains made by students
5. Ability to recruit graduate and medical students from across the country (eliminating travel expenses) has benefit from an equity lens perspective
6. Increased emphasis on holistic admissions process with less emphasis on MCAT/GPA
7. Increased opportunities for trainee insight into health system operations
8. Increased opportunities for multidisciplinary learning using online platforms helps to overcome structural barriers (geographic or institutional) that often exist and prevent learners of different fields from being in classes together
9. Increased emphasis on weaving social determinants of health and population health disparities throughout the curriculum.
10. Students with new children this year have highly appreciated the ability to do virtual learning and have additional flexibility and ability to see their families (reported in new PEDS 7000 course)

Negative changes resulting from COVID that should be stopped/modified:

1. ***Large decisions often made by small groups of people***
2. ***Reduced student/instructor interactions (learning) and high proportion of pre-recorded (asynchronous) lectures.***

- There has been a high demand for instructor time in creating online modules and much more limited student contact time

Potential solutions:

- a. Increase training and support for faculty on when a pre recorded lecture is appropriate and when coupled with other educational approaches, can meet desired learning objectives and may even be preferred.
 - b. Increase training and support for faculty in building curricula that supports student engagement, both in-person and online
3. ***Decrease in clinical shadowing experiences and other clinical experiences for pre-med pre-grad, and pre-professional students***
 - It was more difficult for UMN undergraduate students to develop competitive applications (important pathways to retain brightest students at our institution)

Potential solutions:

- a. Encourage and facilitate virtual shadowing, particularly for underrepresented minorities and those for whom getting to the physical space is more difficult.
 - b. Create asynchronous virtual shadowing experiences in conjunction with instructional designers to help pre-medical students access experiences and better decide if embarking on this career is the right choice for them.
4. ***Difficulties in building culture and community among students, and between faculty and students***

Potential solution: Recognize that options for in person peer-to-peer teaching, and faculty-to-student “hallway” instruction are significantly reduced; losing this can be challenging with respect to informal teaching and developing mentoring relationships

- Consider unstructured virtual gatherings, balanced with zoom burnout considerations
- Develop reintegration activities for when on-campus activities resume

5. ***Insufficient support for online activities***

Potential solutions:

- a. Increase access to administrative assistance and IT support for online education
- b. Increase education of faculty and staff regarding challenges and benefits of online assessments.

- c. Develop policy recommendations for syllabi around online and hyflex learning.
- d. Increase availability of educational materials to faculty
- e. Improve collaboration with the Center for Educational Innovation.

What else still needs to be improved?

1. *Reduced access to education for medical and graduate students from underserved (historically marginalized) communities*

Potential solutions:

- a. Recruitment and support for BIPOC faculty and residents for outreach to their communities
- b. Increase collaboration with community schools and programs to support pathways programs for students from K-16
- c. Increase supportive programs for underserved students in medical school
- d. Increase collaboration with Health Professionals Pathway Initiative
- e. Dedicate increased funding for underserved student initiatives
- f. Increase scholarship support for under-represented health sciences students
- g. Participate in an effort led by UMN/UMP/FHS HR/Legal to understand additional tuition reimbursement and deferred/forgiveness loan options

2. *Inadequate curricular content to prepare learners (and clinicians) to care for a diverse patient population.*

Potential solutions:

- a. Creation of a timeline for implementation of longitudinal curriculum around caring for diverse populations. Consider modular educational materials that can be adapted for faculty development
- b. Recruitment and support for BIPOC faculty and residents

3. *Cultural homogeneity (lack of inclusion) in facilitated discussions*

Potential solution: Have competency and knowledge assessments for small group facilitators in facilitating cross-cultural discussions (consider IDI), ideally supplemented with faculty development offerings

4. *Disparate assessments and unexamined bias in assessments*

Potential solutions:

- a. Create a collection of robust learner and assessor demographic data such that analyses can be made to examine and uncover bias in assessments and examine the relationship between preceptor/assessor diversity and equity and inclusion in training and learner experience.

- a. Link individual learner assessments to learning environment assessments
- b. Create dedicated learning environment assessments looking at equity and inclusion

5. *Lack of availability of educational materials for learners with disabilities*

Potential solutions:

- a. Work with instructional designers and academic technicians to ensure that all education is originally provided in formats that are the most accessible, in order to decrease the amount of adaptations that are needed by special request.
- b. In the CART revamp, consult directly with the Disability Resource Center (DRS) and Accessible U and include accessibility from the very beginning planning stages.
- c. Provide training and education for all teaching faculty on our legal obligation for accessibility and University Policies (could come from Accessible U, DRC, or other local partners)
- d. Best practices of inclusion would include having this training be required for content creators, with dedicated time for this incorporated directly into their positions as teachers.

6. *Lack of support for increased effort required to develop online (asynchronous) material*

- Developing online courses is more complex than merely translating written materials to an online format (Roddy, 2017). The lack of investment in course design and pedagogy leads some online education programs to fail (Rovai, 2003; Rovai, 2010). Creating this content relies heavily on increased academic workload allocations onto academic teaching staff, (Gregory, 2015). There are frameworks described by our faculty that we should aspire to effectively utilize (Haras et al., 2021).

Potential solutions:

- a. Allocate funds and facilitate access to education grants designed for development of novel teaching models that combine online learning and on campus/in-person classes
- b. Hire more Instructional Designers whose expertise in pedagogy (both in person and online) will support faculty in their educational innovations
- c. Develop an in-person/remote study system that will collect and analyze direct student feedback in order to include their own experience in a remote learning environment, and that will result in the best learning experience and demonstrated best outcomes.

CLINICAL ENTERPRISE

Positive changes resulting from COVID that should continue:

1. Increased availability of telehealth with more emphasis on virtual video visits rather than phone visits, allowing increased access, flexibility, and no travel to attend healthcare appointments, particularly for patient that are residing in skilled nursing facilities
2. Improved communication with patients and families
3. Improved work hour and location flexibility
4. Parking flexibility (i.e., reciprocal parking even during the day depending on clinical site)

Negative changes resulting from COVID that should be stopped/modified:

1. Large decisions often made by small groups of people

- Challenge in balancing nimbleness in decision making with collaborative/consultative process

Potential solution:

- a. Increase transparency from administration to faculty regarding how decisions are made (e.g. platform preference, service agreements around Holidays, etc.)

2. Challenges in time management for clinician scientists

- In addition to increased clinical demands, remote work also increased basic research demands

Potential solution: Increase support for pre-visit tasks, such as ensuring that Care Everywhere has been reliably updated and outside records obtained (including vaccination records)

3. Disruption in clinical support staffing

Potential solutions:

- a. Better balance in the providers to staff ratio (having enough staff to support the number of providers that we have)
- b. Increasing pool of backup clinical support staff willing to come in on more flexible basis

4. **Limited resources to deal with mental health concerns as more individuals are requiring treatment.**

Potential solution: Create task force charged with developing/improving a confidential care system for our employees

5. **Lack of representation of pediatric concerns at Incident Command**

- Limited ability to perform pediatric research, COVID drug trials/monoclonal antibodies for pediatrics)

Potential solution: Increase pediatric faculty on Incident Command Team

6. **For specialists seeing both hospitalized patients and outpatients, certain hospital facilities lack areas where the providers can perform confidential virtual visits while attending in the hospital.**

Potential solution: Consider more private work “pods” that can be utilized for multiple functions such as note writing, virtual clinics, or pumping for breastfeeding providers in addition to the open common provider spaces currently in use.

What else still needs to be improved?

1. **Lack of on-site child care and offsite child care capacity**

Potential solution: Increase child care capacity (issue preceding pandemic).

2. **Extra barriers in access due to telehealth visits for certain patient populations**

- Analysis of internal system data shows that video-visits, in particular, are widening the disparity in access (telephone visits less so) for certain populations (e.g. elderly, rural, inadequate access to devices/broadband, disabilities or communication disorders)

Potential Solutions:

- a. Offer patients options so they can choose their preferred type of care
- b. Make sure outreach options are not just limited to email/text; many of these populations only respond to direct mail messages

3. **Lack of access to affordable scribe services**

Potential Solution: Establish programs to hire people from underrepresented minorities as scribes. This strategy would have several potential advantages. First, it would improve communication with patients. Second, it would expand mentorship opportunities for all medical student applicants. Third, it could decrease stereotyping by clinicians, as providers often see and treat scribes differently than patients.

MHEALTH FAIRVIEW INTERPRETATIVE SERVICES

Preface: Low English Proficiency and Deaf communities have been disproportionately impacted by the pandemic and its socioeconomic effect. 30-40% of M Health Fairview's COVID-19 patients have needed an interpreter. The only in-person interpreters have been ASL during the pandemic as spoken language interpreters have transitioned to remote services. Pre-pandemic, 90% of spoken language interpreting was in-person onsite at MHealth Fairview. During the pandemic, 99% of spoken language interpretation was remote (ipad, phone). We must weigh risks/benefits of converting from on-site to virtual interpretation.

Positive changes resulting from COVID that should continue:

1. Increased access to interpreters overall: more encounters with interpreters than pre-COVID.
 - There is always a shortage of trained medical interpreters. However, the average daily encounters for 1 FTE MHealth Fairview Interpreter have increased from 3-5 sessions/day pre-pandemic to up to 25 sessions/day during the pandemic (Per Idolly Farjardo Oliva, MBA Director of Language Services at MHealth Fairview & CCHI Chair)
2. Virtual/telephone connections occur more quickly, and providers appreciate being able to connect to interpreters whenever needed

Negative changes resulting from COVID that should be stopped/modified:

1. **Virtual/telephone interpretation is of significantly lesser quality than in-person interpretation**
 - When an interpreter is not present in person, they cannot see body language, nonverbal cues and may not be able to hear the patient or provider due to ambient noise
 - In-person interpretations are rated significantly higher by providers and interpreters, followed by video then phone interpretation. Phone interviews are significantly shorter than in-person, which is concerning for loss of important communication (Locatis, 2010).
 - Video interpreters are preferred to telephone interpreters. (Antilla, 2017; Casey Lion, 2015).

Potential solution: Make "in-person interpreter services" available as an order similar to any other order that a provider might write. Include fields for time of interpretation, duration of interpretation, and if it will be repeated (e.g.. Daily/shift change, etc.).

2. Interruptions in provider-patient experience due to new platforms/digital environments (Zoom, Microsoft Teams, GoogleMeets, Webex, etc.).

- It is much easier to access a phone interpreter than iPad interpreter in the hospital setting, and often the video component does not work on iPad. Wifi connectivity and speaker augmentation are often faulty/missing.

Potential solutions:

- Ensure quality equipment - microphone, speakers, camera, internet connectivity, for all virtual interpreter visits - including when the internet/system has high volume of virtual interpretation.
 - Ensure that equipment for interpretation remains with the patient as they move/is on and working and as easy to access/use as possible.
- Increased interpreter fatigue with the drastic increase in the number of encounters, due to the introduction of virtual interpretation.

- Best practices for working with an interpreter include preparing the interpreter if the conversation is going to be difficult emotionally. This is impossible if the interpreter is only present virtually when in front of a patient.

Potential solution: Hire enough interpreters to meet actual demands in a manner that does not result in burnout.

What else still needs to be improved?

- Ability of all patients with low English Proficiency to have the assistance needed to fully understand their medical care.
 - Conversations with patients and communities suggest that access to interpreters and translated material decreased during COVID-19 due to increased demand and the lack of family/visitor support when accessing health care.

Potential solutions:

- As M Health Fairview updates phones/apps/contact information, ensure that all providers/caregivers know how to quickly access phone interpreters
- Provide additional education to providers/nursing staff on difficulties of accessing and understanding care across cultures and languages, including education on best practices for working through interpreters.

COMMUNICATION

Positive changes resulting from COVID that should continue:

- Increased ability to perform meetings remotely

2. Separation of asynchronous (providing information) vs synchronous (discussion) meetings
3. Different Departments/Divisions seemed to have different approaches, some of which were more effective than others.
 - a. Effective approaches:
 - Department of Pediatrics: using established meeting times in a format that built comradery and addressed department specific needs, having an already established newsletter, summarizing key changes that department faculty need to know
 - Hospitalist Group: email with link to pre-meeting question document for questions to be submitted in advance, rolling meeting notes document updated immediately after the meeting (allows those who could not attend the meeting to quickly and easily access updates and review previous information that may have been discussed and forgotten).

Negative changes resulting from COVID that should be stopped/modified:

1. There were significant differences in how efficiently information was shared across departments and units.

- Vast amount of information needed to be shared quickly and distributed simultaneously across the entire Medical School.
- Some departments had minimal communications to trainees (fellows in particular sometimes missed completely in communications for months)
- Faculty members often could not make 9 AM All-School Dean's forum.

Potential solutions:

- a. Consider separate onboarding for junior faculty in regards to the different communications that are used and for what purposes
- b. Consider an alternate time for the Dean's forum, with concise summaries/minutes more easily available

2. Large number of emails that often provided redundant/contradicting information.

Potential solutions:

- a. Consider other alternative formats to email: "listening sessions" (highly appreciated, although often difficult to attend), use of updated central repositories rather than constant email updates.
- b. Have standardized, concise, directed email subject lines, with some indication of urgency

3. Unsustainable number of meetings, particularly emergency meetings.

Potential solutions:

- a. Provide blocks of time where meetings are discouraged (should be supported at all levels)
 - b. As the urgency of change and the need for communication decreases, establish systems for establishing priorities
- 4. Streamlined communications has often meant that those in leadership positions have the ability to share but those not in leadership have not had similar opportunities.**

Potential solutions:

- a. Utilize Student, Staff, and Faculty Senators as alternative routes of communication.
 - b. Decrease the number of surveys, while having a standard place online, or physically in person, to leave feedback.
 - c. Provide anonymous mechanisms for feedback (e.g. message boards, google forms)
- 5. Response to questions was often to repeat the guidelines/rules, when the underlying question is often “what is the purpose of the rule” and/or “why is the rule necessary”**

Potential solutions:

- a. Follow CDC’s Crisis Emergency and Risk Communications guidelines more closely.
 - First step of the “Initial” phase of a crisis is to acknowledge emotion and express empathy. Second is to provide an explanation. Third is to provide action (which in this instance would be the guidelines and rules). Simply jumping to the action step often leaves people unwilling or unable to agree with the proposed solution.
 - Employ communications experts from our School of Public Health or School of Journalism
 - Provide training on communicating to larger groups (e.g. managerial training, or other communications training that would be appropriate for different levels such as middle management (e.g. Division Heads) vs more senior leadership (e.g. Dept Heads)
 - b. Provide links to the primary literature used in making decisions.
- 6. Lack of time to process material provided asynchronously.**
- Provision of asynchronous material has been helpful and could be further improved by providing time/scheduling time for going through the asynchronous

Potential solutions:

- a. Establish protocols that when meetings have information that should be reviewed prior to the meeting, the estimated amount of review time is included
- b. Providing “scheduled” meeting time to be off of zoom to asynchronously review materials.

7. Difficulty linking to secure and difficult to access sites for more details and protocols (difficult to find information on SharePoint/intranet and hard to access from cell phones).

- Important ID protocols were so secure that even the ID division could not find them. Some faculty got very frustrated trying to access SharePoint and stopped trying to access them

Potential solution: Partner MHealth Fairview with the UMN College of Design for improved approaches for optimizing the usability of M Health Fairview’s intranet and shared sites for the health professional schools on campus.

8. Increase transparency.

- Faculty members should not be informed **after** decisions are made on their behalf, particularly with respect to budget and clinical time decisions.

Potential solution: Improve consultation with governance committees and among departments.

9. Toxic Positivity

- Part of the “Minnesota Arc” includes meeting people where they are at, and this is a challenging balance for leadership. During difficult times, fears need to be acknowledged and emotionally processed. Too much positivity can make people feel as if their concerns are invalid.

Potential solution: Use Minnesota Arc or CERC guidance to start by acknowledging those who are most harmed, most vulnerable, and the worst circumstance that people are already thinking about - then encourage the faculty to be part of the leadership team that is working toward the positive. If you start and stay only in the best case scenarios, then the faculty, staff and students work their way to the negative.

10. Current workflow decreased the ability of mid-level leadership to respond to crises.

- In particular, speed of approval for language has been insufficient for leaders of divisions, departments, and residency and fellow programs when difficult circumstances arise.

- Waiting for approval has taken days to weeks to months from communications/legal. Therefore, mid-level leaders feel like they only have the option to say nothing. We understand that some things cannot be commented on by law, and that we need to be informed about what those things specifically are, and we need that information quickly.

Potential solutions:

- Provide faster approval of language for mid-level leaders to use.
- Provide better communication training for mid-level managers.

11. Communication regarding salary reductions was particularly poor early in the pandemic, and resulted in a lack of trust between the faculty and the administration.

Potential solutions:

- Utilize more streamlined communication with the faculty (using solutions outlined elsewhere in this document), and provide specific, defined endpoints and plans for remuneration.
- Increase consistency in messaging between the University and the Medical School.
- Increase involvement MS-FAC, utilizing the role of University Senators as liaisons

What else still needs to be improved?

1. Communication between MS-FAC and the Dean has been hampered by infrequent direct communication between the Dean and MS-FAC, and between the Dean and the MS-FAC executive committee.

Potential solutions:

- Dean should attend monthly MS-FAC meetings and meet routinely with the MS-FAC chair/vice chair and/or executive committee.
- Include MS-FAC chair/vice chair in Medical School leadership meetings

2. Communication between MS-FAC and the faculty has been restricted

Potential solutions:

- Allow MS-FAC leadership to send emails directly to the Medical School Faculty
- Keep MS-FAC portion of the governance website up to date with respect to meeting notes, and statements/reports that voted on by MS-FAC

3. Communications need to be streamlined and more easily accessible, especially for policies, guidelines, etc. that function as relatively permanent statements

Potential solution: Initiate a collaboration with Schools of Communication and Design, the Public Health School and the College of Education and Human Development to improve communications.

FACULTY HEALTH

Positive changes resulting from COVID that should continue:

1. Increased emphasis on wellness.
2. The ability to attend meetings remotely.
3. Some individual divisions chose to use their funds to cover salaries of healthcare workers who were home sick with COVID.
4. Vital Worklife Concierge Services and AirCare has helped increase the availability of confidential outpatient therapy and access to outpatient psychiatry for faculty members. We recommend that the Medical School should continue to create, advertise, and expect providers to have and use a confidential therapist as part of their job and continue to provide and normalize access to mental health therapy, and the MN Resilience Program.

Negative changes resulting from COVID that should be stopped/modified:

1. **Increasing clinical workload while talking about wellness.**
 - Many of us choose to be in academia due to the opportunities outside of clinical obligations. Therefore, changes that increase clinical time while not providing any sort of offset for what we are losing from our academic time hits at the reason for being a part of this organization and the sense of belonging.
 - Pololi (2012) found that 25% of all academics were considering leaving academic medicine, and most cited negative perception of the culture, including lack of engagement, unrelatedness, and moral distress as major factors. The COVID-19 crisis has likely exacerbated these factors.
 - Women in clinical tracks were more likely to leave academic medicine than men, and younger physicians currently report more burnout (Brod, Lemeshow, and Brinkley, 2017, Wen, 2021). It is too soon to have solid data, but likely more women are leaving medicine due to the pandemic (Johnson, MedScape, Internal Medicine 2020) and almost half (41%) of physician-mothers surveyed had moderate to severe anxiety (LInos et al, 2021).
 - The only available clinic space/time in the CSC to add additional patient care hours is situated in the early mornings, late afternoons/evenings, or on Saturdays. Similarly, academic hospitalists have been asked to increase their

- clinical duties in terms of the number of shifts they cover in the off hours and staffing additional inpatient services, including weekends and holidays.
- The timing of the clinical service agreement involving the Holiday Clinic Operations) is particularly hurtful.
 - Faculty members who are women and underrepresented minorities who have been most affected by the pandemics are also likely to be more affected by these requests for increased clinical time.
 - i. Women tend to hold more “mid-level” academic positions such as course director, clerkship director, small group facilitator (AAMC 2018). These roles generally have a modest amount of FTE support compared to program director, vice chair or other leadership positions. These trends have been demonstrated in literature and are not unique to our institution.
 - ii. Literature supports that women tend to hang on to more clinical time in order to keep their skill set current, compared to men who are more willing to reduce these activities as a result of securing a grant or obtaining a leadership position.
 - iii. Adding more clinical effort into an already full workweek will exacerbate burnout, and burnout scores are already higher for female physicians compared to male physicians.
 - i. Adding more clinical time requirements for mid-level physicians who hold onto more clinical time will likely have a greater negative impact on women and minorities for the above reasons.

Potential solutions:

- a. Do not increase academics’ clinical time at this point in time. It devalues the reasons they became academics in the first place, and the timing is particularly painful and devaluing.
- b. Include time for writing and scholarship in entry, and mid-level academic positions, and not just in senior positions. “Right sizing” these positions to a point where the work can also be recognized in our structure requires additional FTE.
- c. Consider maintaining some of the suggestions from Madsen (2020) on proposed solutions for equitable advancement during COVID-10 for frontline physicians, and consider how these may be adapted post pandemic such as:
 - Providing options for additional administrative or educational time
 - Appropriate lactation support
 - Facilitate team research - between non-clinical academicians and clinicians
 - Think beyond simply “stop the clock” performance measures for tenure and to ways of providing people with credit for the work they have done this year, or the work they were unable to do.
- d. Evaluate what of our policies disproportionately disadvantaged women of childbearing years (and likely other parents as well)
 - For grants that must be done within 10-years of finishing training, consider adding a year to that time frame per pregnancy for faculty

- Onsite child care & emergency back up child care, including care when there are covid restrictions
- Easy access to lactation rooms, with protected (compensated) time for all providers, as done by the Department of Medicine
 - Women tend to have less mentorship

2. Perception that UMP HR was functionally unavailable at the beginning of the pandemic, which was right at the time when it appeared that a lot of health care workers were going to be getting sick and likely needing HR services.

- Some faculty members were told they needed approval for long term accommodations through UNUM (this was not necessary per UNUM). This left faculty in very unclear positions as to their ability to be accommodated as required by the Americans with Disabilities Act.

Potential solution: Streamline filing for accommodations and services between UMP and UMN into one process to minimize redundancy. Employees should not have to fill out multiple versions of paperwork or go through additional approvals, including intrusive investigations into their health by UNUM in manners that are not actually consistent with the contract with UNUM (per UNUM representative).

3. Lack of sick leave.

- Individual divisions had to choose to cover salaries of healthcare workers who were home sick with COVID from their work. This inconsistency demonstrates a lack of respect for faculty health across the greater Medical School and system.

Potential solutions:

- a. Provide sick leave. If we are to care for others we should be able to care for ourselves. If we are sick and come to work we risk our patients lives and the lives of our colleagues.
- b. Demonstrate support for faculty members who contract illnesses from work - whether these illnesses are COVID-19, other infectious disease, or PTSD from the provision of care.

4. Wellness Committee Meeting Time (currently scheduled at 7 am)

- Currently scheduled for 7 AM. While this may work for people who do not have to care for children, it does not for many people for their own wellness. Therefore, the Wellness concerns that are heard are likely to only be the wellness concerns of a select group of highly supported individuals. .

Potential solution: Change the meeting time for the Wellness Committee and provide support for those on it, so that the Wellness Committee can include the people most likely to be negatively affected by our practices.

What else still needs to be improved?

1. Increase mental health support for all members of the Medical School.

- The majority of suicides do not happen at the time of a terrible event; they happen in the time of recovery. Have (2009) found that major life events increased risk for suicide for the next 2-3 years depending on whether or not there were already underlying conditions. As we enter into this time period of recovery, the most dangerous time period for mental health, we do not just need talk of Wellness, it is essential that we also create time for people to process. Access to a therapist is not enough. There must be time and space for processing and healing. The time and space must not be seen as an extra that someone must ask for. It must not be special treatment. It must be simply part of being a good doctor - we take the time to care for ourselves. And our institution should support this by considering:
 - Time for healing of providers has never been a part of Western medicine.
 - Embedding in our culture that we are not exceptions to the rules of being human - getting enough sleep, having rest times, eating healthy, having time to maintain relationships. These are some of the most effective treatments for helping people recover from trauma. It is time for our chosen careers to help us process and provide what is necessary for this - the lack of time for self care is the biggest obstacle our faculty face due to our work. We often know and have access to a lot of resources but do not have the time to appropriately access these resources.

Potential solutions:

- a. Establish policies that ensure that scheduling of clinical, education, and research commitments of faculty, staff, and trainees allow everyone to provide for their basic needs - especially during the recovery phase after this traumatic year.
 - i. This includes adequate sleep time between shifts and commitments, time for meals
- b. Work to right size requests of faculty to work that is actually accomplishable in a reasonable time frame, during business hours.
- c. Consider reframing, adjusting, or eliminating productivity expectations for faculty during this pandemic year. The additional burden, particularly on academic faculty, to have remained productive of scholarly material during such a stressful and exceptional period (or have an extraordinary explanation as to why they were not) is contributing to burn-out. A component of the annual review in GIM includes an Impact Assessment Tool to outline the ways an individual's career and personal goals were affected by the COVID-19 pandemic and associated changes. While helpful to outline impact on an individual scale, it should be more widely acknowledged by the Medical School that the expectations around productivity, research, and publications during this timeframe will not count against academic faculty aiming for promotion.

2. **When individuals ask for assistance, we should find easier ways to make it happen, without asking them to advocate for themselves above and beyond what is reasonable.**

- Per Dr. Meghan Rothenberger's grand rounds, she and other talented physicians have left our system and have cited the inability of our system to accommodate them as part of why they have left. Dr. Rothenberger stated that she asked to be able to work a specific FTE and maintain benefits, but that was denied. Others have left after starting through the accommodations process and finding it too onerous.

Potential solution: Provide training for all supervisors and HR on appropriate ways to handle requests for assistance from employees or trainees. DRC has not provided this training for supervisors and HR through UMN when asked.

3. **Credentialing wording regarding physician health.**

- Per the [Minnesota Board of Medical Practice Policy & Planning Committee Meeting](#) on February 1, 2021, the Minnesota Board of Medical Practice is considering changing the language on questions regarding physician health, in particular mental health. This report includes significant documentation on physician burnout and accessing mental health care including:
 - Our language for the State of Minnesota licensure, and likely credentialing at most facilities in our state, does not meet the best practices as described in the Americans with Disabilities Act (ADA) or as recommended by Federation of State Medical Boards (FSMB) Workgroup on Physician Wellness and Burnout.
 - Approximately half of physicians who commit or attempt suicide reference licensure and credentialing as part of why they did not seek treatment.
 - Physicians who seek treatment have better outcomes than the lay public
 - Currently our credentialing language requires providers to report if they are currently receiving treatment for any condition that may put them at risk to their patients. If a provider is not seeking treatment, they do not need to report. This discourages providers from seeking treatment and increases the risk that conditions may escalate to a severity that is a risk to patients and the provider.
 - i. We should encourage providers to access treatment. When appropriately treated providers should not need to report their own illnesses.
 - ii. We should treat all illnesses the same. For example, a provider who does not appropriately take their insulin is also a risk to their patients, but appropriately taking their insulin is not a risk.
 - Recommendations include:
 - i. Evaluate whether it is necessary to include probing questions about a physician applicant's mental health, addiction, or substance use

- ii. Carefully review applications to ensure that appropriate differentiation is made between the illness with which a physician has been diagnosed and the impairments that may result
- iii. Applications must not seek information about impairment that may have occurred in the distant past and state medical boards should limit the time window for such historical questions to two years or less, though a focus on the presence or absence of current impairment is preferred.
- iv. Questions that address the mental health of the applicant should be posed in the same manner as questions about physical health
- v. The FSMB recommends that they use the language: Are you currently suffering from any condition for which you are not being appropriately treated that impairs your judgment or that would otherwise adversely affect your ability to practice medicine in a competent, ethical and professional manner?
- vi. State medical boards should emphasize the importance of physician health, self-care, and treatment-seeking for all health conditions by including a statement to this effect on medical licensing applications, state board websites, and other official board communications.

Potential solutions:

- a. Position M Health Fairview as a leader in this field and amend our credentialing language now as we are expecting a high rate of physician burnout, PTSD, and other health concerns due to COVID-19.
- b. Strongly encourage the UMN Medical School to publicly advocate for changing the State licensing wording and credentialing wording at our partner sites to encourage safe practices, and to do so now as we are expecting a high rate of physician burnout, PTSD, and other health concerns in the wake of COVID-19.
- c. Explicitly clarify conditions, treatments, and accommodations that must be disclosed during credentialing, and provide preemptive HR and legal support to those navigating the system. We cannot advocate for our physicians to engage in mental health support services and then penalize those who do so by complicating the credentialing process around those services.

4. Potential lack of access to confidential inpatient mental health services for Medical School faculty members.

- o Currently, we have advertised to our trainees options within our system to engage with needed in-person mental health care in manners that do not involve other trainees in order to maintain confidentiality for the trainee. We do not currently have a clear, or advertised system for inpatient mental health care that does not risk a faculty member's confidentiality.
 - i. Faculty members have reported that, when seeking inpatient mental health services, medical students have been involved in their care, risking their confidentiality and increasing the risk that the faculty may not feel

comfortable seeking care when needed in the future, if students end up under the faculty members' supervision at a later date. As our trainees move between many sites, it is unclear to faculty members if there are places that would be more appropriate for them to access inpatient mental health services.

Potential solutions:

- a. Strongly encourage creation of pathways for faculty to have confidential inpatient mental health care that does not involve trainees who may end up later reporting to that faculty member.
 - i. For non-psychiatric faculty members, ensure that medical students are not involved in the faculty member's care, but residents who have already completed their non-psychiatric rotations could be involved in faculty's inpatient mental healthcare if that is the usual manner for providing care at a given site.
 - ii. For psychiatric providers, if inpatient psychiatric care is needed, then their trainees should not be involved in the faculty's care, including residents.
- b. Strongly encourage significant internal advertising for how faculty can and should access truly confidential mental health care for inpatient mental health concerns in addition to outpatient care.
- c. There are inpatient wards that do not have medical students on them. Additionally, we have established a mechanism in the ED to not have trainees involved in the mental health care of trainees. Should establish a similar mechanism for faculty.

5. Support for psychiatrists and psychologists.

- All faculty members were impacted by the COVID-19 pandemic. However, Medical School psychiatrists and psychologists have not had adequate support for a long time. While Minnesota has child psychiatrists (some states have none), we are still identified as having a severe shortage by the [American Academy of Child & Adolescent Psychiatry](#). The mental health of adolescents in particular has been exacerbated by COVID-19, and the increased need of these services is unlikely to ease any time soon based on the same factors listed above. Due to shortages in staffing, the inpatient pediatric services and emergency room services have needed to care for children with severe mental health concerns. Due to lack of training, COVID restrictions, and facilities not designed for these purposes, the providers know that the care given to these children is not appropriate, and is actually detrimental to these children's health.

Potential solutions:

- a. Strongly encourage adapting increased demands and wellness to the individual needs of different stakeholders and not trying to ask more of our psychiatrist colleagues at this time.
- b. Decrease punitive measures during this recovery time period.
- c. Prioritize hiring, retaining, and supporting our pediatric mental health providers

- d. Train and support providers who are not trained in mental health to better provide care
- e. Reinstate the ability for Emergency Medicine providers to be able to admit directly to psychiatry rather than needing to go through DEC assessors. Currently emergency medicine physicians are often waiting for 6-10 hours before the admission process is started for suicidal patients who need psychiatry admission before a DEC assessor arrives to start the process.
 - i. Hire psychiatrists who can see patients in the emergency room on weekends.
 - ii. Invest in appropriate space that is safe for suicidal patients (especially children) while they wait for inpatient psychiatry. A normal ER room, or hospital room is not ideal due to many factors that actually increase risk to patients.

SPECIAL FACULTY ADVISORY COMMITTEE (S-FAC) FOR COVID-19 RESPONSE

- NOTE: that S-FAC is a task force established by the Dean composed of MS-FAC members, but operates independently of MS-FAC.

Positive changes resulting from COVID that should continue:

1. Having a designated unique faculty task force to address the Medical School response to COVID-19 in an appropriately rapid manner
2. Close working relationship between faculty members of S-FAC and the Dean

Negative changes resulting from COVID that should be stopped/modified:

1. S-FAC was chosen by appointment, without consultation or official reporting to MS-FAC

Potential solution: Establish a mechanism for establishing similar groups for future emergencies that functions under a MS-FAC subcommittee structure.

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