University of Minnesota
Graduate Medical Education

2024-2025

Program Policy & Procedure Manual

Department of Anesthesiology

Critical Care Medicine Anesthesiology
Fellowship Program

Table of Contents

WELCOME TO THE PROGRAM

- Purpose
- Profile of Our Institution
- Statement of Commitment
- Statement of Goals for Graduate Medical Education
- Statement of Diversity and Inclusion
- Institutional Responsibilities
- Statement of Inclusion of Fellowship Program
- Department Mission Statement
- Program Mission Statement
- Program Description and Aims
- Departmental Organization

PROGRAM POLICIES

- Appointments and Reappointments
  - Eligibility and Selection Policy
  - Eligibility Requirements
  - Non-discrimination Policy
  - Program Specific Visa Policies
  - Appointment and Promotion
  - Requirements for Completion of Training and Graduation
  - Policy on Effect of Leave for Satisfying Completion of Program
- Trainee Responsibilities and Supervision
  - Clinical Responsibilities
  - Call Responsibilities
  - Non-clinical and Administrative Responsibilities
  - Trainee Supervision
  - Fellow Progress to a Supervisory Role
  - Effective Fellow Behaviors
  - Path of escalation for reporting concerns and conflicts of interest
  - Monitoring of Fellow Well-Being
  - Conference Attendance Requirements
- Program Curriculum
  - Program Curriculum/Training Site Information
  - Didactics
  - Clinical Education Requirements
  - Research Requirements
  - Evaluations and Outcomes Assessment
- ACGME General Competencies
- Clinical Rotations and Block Schedule
- Fellow Expectations
- Competency-based Goals and Objectives

Life Support Certification Requirements
Annual Evaluation of Program Goals and Objectives
Semi-Annual Evaluation

PROGRAM PROCEDURES

Attendance
Clinical and Educational Work Hours
Work Hours Policy
Work Hours (formerly known as Duty Hours)
Maximum Hours Per Week
Work Hour Exceptions
Mandatory Time Free of Duty
Institutional Leave Policies

- Administrative Leave of Absence
- Bereavement Leave
- Earned Sick and Safe TIme (ESST)
- Family Medical Leave (FMLA)
- Medical & Caregiver Leave
- Holiday Leave
- Military, Court Appearance, or Civic Duty Leave
- Parental Leave
- Personal Leave
- Professional Leave
- Vacation Leave
- Other Program Leave time
  - Academic/Education Leave
  - Sick Days
  - Departmental Disaster Plan

Moonlighting
Impairment/Fitness for Duty Policy
Inclement Weather
Grievance/Due Process
State Medical Board Licensure Requirements
Needlestick Procedures - Infection Control
Patient Safety Procedures
Institutional Committees
Social Networking Policy

BENEFITS, INFORMATION AND RESOURCES

Insurance
Systems and Communication

- Email Accounts
- Internet Access
- Pagers
- Campus Mail

Stipends
Employee Assistance Program (EAP)
Medical Records Procedures
Medical Records
Pharmacy Procedures
Payroll Information
Laundry Services
Parking
Professional Education Fund Policy (“Book Fund”)
ID Badges
Fatigue
PWC PeerConnect
Vital Worklife
State Medical Board Licensure Requirements

CONFIRMATION OF RECEIPT OF YOUR PROGRAM POLICY MANUAL

WELCOME TO THE PROGRAM

A. Purpose

a. The program manual is a tool with key policies and required procedures as well as general information to ensure a smooth transition to your institution and program.

b. At the department level, the Program Director is responsible for providing trainees with program-specific policies and procedures. This includes items such as ACGME Program Requirements, procedures to follow institutional policies, and other information specific to the department and the GME program.

B. Profile of Our Institution

a. Information about Graduate Medical Education at the University of Minnesota is available on this webpage.

b. The webpage includes our Statement of Commitment, Goals for Graduate Medical Education and our Diversity Statement.

C. Statement of Commitment

a. The University of Minnesota Medical School is committed to graduate medical education, which emphasizes education and training of physicians to meet the healthcare needs of our region, advancement of knowledge, and leadership in the biomedical sciences and in academic medicine.

b. With this commitment, the University of Minnesota Medical School will provide adequate funding for administration, personnel, educational, clinical resources, and faculty teaching time to be certain that every program under our institutional sponsorship offers the best possible training environment and educational opportunities.

D. Statement of Goals for Graduate Medical Education

a. Our goal is to provide the highest quality of graduate and post-graduate medical, professional and educational training to prepare physicians for the practice of specialty and/or subspecialty training, or for the pursuit of academic and research medicine.

b. The University of Minnesota is committed to the policy that all persons shall have equal access to its programs, facilities, and employment without regard to race, color, creed, religion, national origin, sex, marital status, disability, public assistance status, veteran status, or sexual orientation.

E. Statement of Diversity and Inclusion

a. The University of Minnesota Medical School is committed to excellence. Our mission will only be achieved through embracing and nurturing an environment of diversity, inclusiveness, equal opportunity, and respect for the similarities and differences in our community.

b. We strive to create an atmosphere where differences are valued and celebrated, knowing institutional diversity fuels the advancement of knowledge, promotes improved patient care and fosters excellence. We will train a culturally aware workforce qualified to meet the needs of the diverse populations we serve. We especially strive to have our community better reflect the broad range of identities in our state, including race, ethnicity, gender identity, gender expression, sexual orientation, disability, age, national origin, religious practice, and socioeconomic status.
c. Given the dynamic nature of our community, the [Medical School Diversity Statement and Policy] should be reviewed biennially to ensure it is current and reflective of our priorities.

F. Institutional Responsibilities

a. The Institution Manual http://z.umn.edu/gmeim is designed to be an umbrella policy manual. Some programs may have policies that are more tailored to their needs than the Institution Manual in which case the program policy will be followed.
b. Should a policy in a Program Manual conflict with the Institution Manual, the Institution Manual will take precedence.

G. Statement of Inclusion of Fellowship Program

a. The information contained in this Policy Manual pertains to everyone in the department's programs except as otherwise identified.

H. Department Mission Statement

a. With respect to the Critical Care Medicine Anesthesiology Fellowship Program, the missions of the Department are as follows:
    i. To provide excellent care to our patient population in the areas of preoperative patient assessment and preparation, surgical anesthesia, perioperative and postoperative pain management, and critical care.
    ii. To promote patient safety at the departmental and institutional level
    iii. To provide a strong clinical base employing excellence in clinical education along with clinical experience to anesthesiology fellows.
    iv. To supplement the clinical teaching with a strong didactic program of lectures, seminars, quality improvement projects, high-fidelity simulations, workshops, case conferences, and visiting professors.
    v. To provide a strong research program available to the fellows to complete their education.
    vi. To ensure that all graduates of the residency are consultant anesthesiologists capable of handling all types of clinical challenges and capable of becoming Board Certified in the specialty.

I. Program Mission Statement

a. Educate the next diverse generation of Critical Care Physicians who provide equitable and inclusive clinical care for patients, including the most medically complex patients. Educate residents who practice up-to-date evidence- based

practice of critical care, and who serve the state of Minnesota and its entire population.

b. Educate fellows who work towards providing compassionate, meticulous, methodical evidence-based management of critically ill patients at their most vulnerable and fragile period of their lives.
c. Educate fellows who work towards balanced pain management for patients with a variety of pain conditions with compassion and accountability. time balanced pain management for patients with a variety of pain conditions with compassion and accountability.
d. Develop innovative educational programs, including a robust quality improvement program, leadership and DIversity, Equity and Inclusion program to allow for the best learning of all residents.

Our mission aligns with the institutional mission of combining scientific and clinical strength to deliver innovative, accountable and compassionate care to patients in the state of Minnesota and surrounding states.

J. Program Description and Aims

a. Our program offers two 1-year Critical Care Anesthesiology Fellowship positions to provide the most up-to-date training in the area of adult critical care medicine and develop the clinical skills, confidence, expertise, and collaborative approach needed for the care of complex critically ill patients in a variety of settings.

K. Departmental Organization

Dept Chair: Michael H. Wall, MD, FASA, FCCM, JJ Buckley Professor & Chair	mhwall@umn.edu
Program Director: Monica Lupei, MD	lupei001@umn.edu
Associate Program Director: Anna Budde, MD	budd0034@umn.edu
Program Coordinator: Tammy Carpentier	carpe829@umn.edu
Teaching Faculty:	
Robert Gould, MD	rgould@umn.edu
Larry Lindenbaum, MD	lind1681@umn.edu
W. Kirk Rogers, MD	roger490@umn.edu
Sudarshan Setty, MD	settys@umn.edu
Dan Lotz, MD	lotzx010@umn.edu
Joss Thomas, MD	jjthomas@umn.edu
Jennifer Weinberg, MD	wein0165@umn.edu

PROGRAM POLICIES

A. Appointments and Reappointments

a. **Eligibility and Selection Policy**
    i. Prior to their program start date, residents and fellows must provide their program with documentation as listed in the Institutional Policies Manual.

b. **Eligibility Requirements**
    i. The fellowship selection committee will select from among eligible applicants based on their educational preparedness, ability, aptitude, academic credentials, communication skills and personal qualities such as motivation and integrity.
    ii. Eligibility requirements can be found on the department web site's Application Process page.
        1. The University of Minnesota Anesthesiology Critical Care Fellowship Program participates in the centralized Anesthesiology Critical Care Fellowship Match, organized by SF Match Fellowship Matching Services. All applicants must apply through SF Match. You can visit sfmatch.org for more information and to register as an applicant.
        2. The following documents need to be submitted to the SF Match Centralized Application Service:
            a. Centralized Application Service (CAS) Application for Anesthesiology Critical Care fellowships provided at the SF Match website
            b. Three (3) letters of recommendation to SF Match
            c. Distribution list of programs
            d. Registration payment and fees

c. **Non-discrimination Policy**
    i. The Department of Anesthesiology does not discriminate with regard to sex, race, color, creed, religion, national origin, age, marital status, disability, public assistance status, veteran's status or sexual orientation.

d. **Program Specific Visa Policies**
    i. The J-1 Alien Physician Visa sponsored by ECFMG is the preferred visa status for foreign national trainees in all UMN graduate medical education programs; therefore, this program sponsors only J-1 Visas.
    ii. Individual requests outside of this policy are reviewed by and at the discretion of the Program Director.
    iii. More information on Visa Sponsorship can be found on the UMN-GME Visa Sponsorship Policy and Eligibility and Selection Policy site.

e. **Appointment and Promotion**
    i. If the University reduces the size of a residency/fellowship program or closes a program, affected residents/fellows will be notified as soon as possible; and the University will make every effort within budgetary

constraints to allow existing residents/fellows to complete their education.

    ii. In the unlikely event that existing residents/fellows are displaced by a program closure or reduction, the University will make every effort to assist the residents/fellows in locating another residency/fellowship program where they can continue their education.

f. **Requirements for Completion of Training and Graduation**

    i. Fellows must complete a curriculum to include at least nine months of clinical experience providing critical care in an intensive care unit, to include:

        1. Preoperative evaluation, including respiratory, cardiovascular, and nutritional evaluation
        2. Pre-operative and post-operative care of surgical patients
        3. Advanced care of injured patients
        4. Care of patients requiring abdominal, breast, head and neck, endocrine, transplant, cardiac, thoracic, vascular, and neurosurgical operations
        5. Management of complex wounds
        6. Minor operative procedures related to critical care medicine, such as venous access, tube thoracostomy, and tracheostomy.
        7. In-depth knowledge and skills to manage complex critical care conditions, including acute cerebrovascular, respiratory, cardiovascular diseases, severe sepsis, acute kidney injury, coagulopathy, trauma, multisystem organ failure, critical postsurgical illness.

g. **Policy on Effect of Leave for Satisfying Completion of Program**

    i. A trainee can be absent from a program no more than 4 weeks per year. A Trainee who experiences an extended leave illness must extend his or her training program.

B. Trainee Responsibilities and Supervision (see Supervision Policy)

a. **Clinical Responsibilities**

    i. **Daily Expectations of the Fellow(s)**

        1. Arrive by 7am to the ICU to receive signout from the overnight team. The workday will end at 4, 5 or 6 PM depending on the clinical necessity, rotation and work hour guidelines.
        2. When assigned for "swing shift" in CVICU or Southdale ICU, arrive by 2 PM. The clinical duty will end at 10 PM or midnight depending on the rotation.
        3. Fellows should have 10 hours and must have eight hours free between work periods. There must be 14 hours free of work after 24 hours of in-house work.
        4. Pre-round as appropriate and prepare for formal rounds by obtaining information from the medical record and nursing staff.

5. Lead rounds under faculty supervision and formulate plans for patients by collaborating with nursing, consulting teams, pharmacy, and dietitian colleagues.
6. Review and interpret patient vital signs, laboratory data and imaging.
7. Lead care conferences and family meetings under the supervision of faculty.
8. Maintain a professional and collaborative relationship with other trainees, consultants, ICU team members, and nursing staff.
9. Utilize Point of Care Ultrasound (POCUS) to evaluate patients and adjust treatment plans.
10. Supervise residents performing procedures as appropriate under the direction of staff.
11. Identify signs of patient deterioration and maintain communication with staff at all times.
12. Prepare a handoff and signout to the oncoming fellow at the end of your rotation.

b. **Call Responsibilities**

i. CVICU - UMMC

1. The Anesthesiology CCM fellow will take Saturday night calls in CVICU from 7PM to 7AM biweekly, except for the first month of the Initial CVICU rotation.
2. Any fellow who comes in overnight will be excused from clinical responsibilities the following day or will receive a day off the following week if they cover weekend night.

ii. UMMC Night Float

1. Each fellow will take 2 weeks of night float Sunday through Friday at the UMMC covering MICU/SICU under the supervision of the ICU attending.The overnight call starts at 6 PM each night and ends at 7 AM the next day.
2. Any fellow who is in house overnight will be excused from clinical responsibilities the following day.
3. The fellows will have Saturday, Sunday, and two weekdays off after the Night float week.
4. The CCM fellow night float call pool will be split between the Anesthesiology, Surgery, and Pulmonary Critical Care fellows.

c. **Non-clinical Academic and Administrative Responsibilities**

i. The fellowship didactic curriculum will be available via google drive and fellows will receive notification of activities via Google Calendar.

ii. Academic Expectations:

1. Attend all fellowship didactics unless on vacation or other excused absence.
2. Attend Anesthesiology Department educational activities, including every Tuesday morning Grand Rounds or M&M at 6.30 AM.

3. Attend weekly Thursday afternoon combined CCM didactics from 3 to 5 PM.
4. Attend monthly combined CCM conference on Wednesday morning from 7.30 to 8.30 AM
5. Attend monthly CCM Journal Club on Wednesday morning from 8.30 to 9.30 AM
6. Attend monthly Critical Care M&M on Thursday afternoon from 4 to 5 PM.
7. Complete a QI project during the year.
8. Orient residents and medical students to the ICU.
9. Teach residents and medical students while on service including the preparation of at least one formal lecture per rotation to include relevant literature.

d. **Trainee Supervision**

i. Appropriate supervision means that a trainee is supervised by the teaching faculty in such a way that the trainees assume progressively increasing responsibility according to their level of education, proven ability, and experience. The training program is directed by Dr. Monica Lupei, who is dually certified in Anesthesiology and Critical Care Medicine by the American Board of Anesthesiology. Faculty in numerous specialties -- including surgery, anesthesiology, pulmonary medicine, internal medicine, neurology, and pharmacy -- participate in our educational program. These critical care teaching staff have privileges to admit, treat and discharge patients from the critical care units. While the critical care team at each affiliated site has a slightly different composition -- including residents from surgery, anesthesiology and emergency medicine, medical students, and advanced practice providers -- the common factor at all sites is faculty supervision following the principles of progressive responsibility to allow the best possible balance between trainee autonomy and patient safety.

Types of Supervision

Direct Supervision: The supervising physician is physically present with the resident or fellow during the key portions of the patient interaction; or, The supervising physician and/or patient is not physically present with the resident or fellow and the supervising physician is concurrently monitoring the patient care through appropriate telecommunication technology.

Indirect Supervision: The supervising physician is not providing physical or concurrent visual or audio supervision but is immediately available to the resident or fellow for guidance and is available to provide appropriate direct supervision.

Oversight: The staffing model of all ICUs includes faculty evaluation of all patients within twelve hours of admission. Therefore, opportunities for oversight supervision are limited. To address this, and to encourage graduated responsibility, the structure of sign-out of indirectly supervised patients is robust to encourage fellow ownership over patient care.

Escalation Triggers: Circumstances will arise during periods of indirect supervision when direct supervision is required. Fellows should always contact the supervising attending as soon as possible for all admissions, significant changes in status, unstable patients, patient social issues and/or deaths.

On-call schedules for teaching faculty must be structured to ensure that supervision is readily available to trainees on duty.
The level of responsibility accorded to each trainee must be determined by the program director and the teaching faculty.

1. Policy:
    a. All patient care is supervised by qualified faculty
    b. The Program Director will ensure, direct, and document adequate supervision of residents and fellows at all times for their appropriate level
    c. There must be sufficient institutional oversight to assure that trainees are appropriately supervised
    d. Levels of Supervision
        i. The fellowship program director and teaching faculty will determine the level of responsibility assigned to the fellow. Fellows will need faculty presence (direct supervision) for at least ten procedures each for endotracheal intubations, central venous lines, arterial lines, bronchoscopy, and pulmonary artery catheter placement.
        ii. The program director evaluates the fellow's abilities based on specific criteria (number of specific cases performed, directly observed performance by faculty, fellow review and evaluation, recommendations of CCC and per specific national standards-based criteria when available (such as SOCCA, SCCM and ASA guidelines).
        iii. Faculty supervision assignments will be of sufficient duration to assess the knowledge and skills of the fellow and delegate to him/her the appropriate level of patient care authority and responsibility. Regarding clinical competence, the fellows will be

supervised directly by Faculty for the first two to four months, indirectly for the next six to eight months, and with Faculty oversight for the last two months.

iv. At the end of training, the fellow should have acquired the skills necessary to function as an independent consultant in Critical Care Medicine Anesthesiology.

v. <u>Specifically:</u>

1. Each patient will have an identifiable, appropriately credentialed and privileged attending physician who is ultimately responsible for the patient's care. This information will be available to residents, fellows, faculty and patients. Fellows and faculty members will inform patients of the respective roles in each patient's care.
2. It is the department's general policy that all anesthetics and procedures are supervised by the physical presence (direct supervision) of a faculty member.
3. The supervising faculty will be clearly identified.
4. Exceptions to this policy can only be made after consultation with and approval by the supervising faculty.
5. At all times the faculty is fully responsible for all aspects of patient care.
6. Under no circumstances should a fellow proceed with any procedure unless they have been well trained in performing that procedure and has received approval by their supervisory faculty or program director.
7. On-call schedules for teaching faculty will be structured to ensure that supervision is immediately and always readily available to fellows on duty.

vi. Direct Supervision

1. The supervising physician is physically present with the resident or fellow during the key portions of the patient interaction; or,

2. The supervising physician and/or patient is not physically present with the resident or fellow and the supervising physician is concurrently monitoring the patient care through appropriate telecommunication technology.
3. The need for direct supervision by the attending physician is determined by the attending and the fellow's level of comfort and proficiency with a given situation. Frequently, there is more direct supervision early in the academic year and during the first weeks at a new clinical site. Anesthesiology critical care fellows have received a minimum of three years of clinical experience before starting fellowship, and are often board-eligible or -certified in their specialties.
4. Advanced ICU procedures with significant risk of complication, including but not limited to initiation of ECMO, challenging central line placement, femoral arterial lines, bronchoscopy, difficult airway management and thora-/paracentesis, should always be directly supervised by the attending physician outside of extraordinary circumstances.

vii. Indirect Supervision

1. The supervising physician is not providing physical or concurrent visual or audio supervision but is immediately available to the resident or fellow for guidance and is available to provide appropriate direct supervision.
2. As the fellow gains experience and confidence in the program, supervision can become more indirect. The specific degree of autonomy provided will vary depending upon the fellow's progress and the attending discernment, but in general the level of supervision can be reduced fairly quickly in the domains of data collection, assessments/plans and team communication.

viii. Oversight

1. The staffing model of all ICUs includes faculty evaluation of all patients within

twelve hours of admission. Therefore, opportunities for oversight supervision are limited. To address this, and to encourage graduated responsibility, the structure of sign-out of indirectly supervised patients is robust to encourage fellow ownership over patient care.

ix. Escalation Triggers

1. Circumstances will arise during periods of indirect supervision when direct supervision is required. Fellows should always contact the supervising attending as soon as possible for all admissions, significant changes in status, unstable patients, patient social issues and/or deaths.

e. **Fellow Progress to a Supervisory Role**

i. All ICU patient care will be done with direct or indirect supervision per departmental policy (please see above).

1. The privilege of progressive authority and responsibility, conditional independence, and a supervisory role in patient care delegated to the fellow will be assigned by the program director and faculty members.
2. For specific procedures in which the fellow lacks experience, direct supervision will be provided. Faculty will supervise the fellows directly and be present for the first two to four months (or at least ten procedures) to ensure adequate procedural skills and clinical competence.
3. Under indirect supervision, the faculty intensivist may assign a supervisory role to the fellow in certain tasks of the critical care, such as placement of an arterial line or a central line by the resident.
4. The goal is to allow the fellow appropriate levels of patient care, authority, and responsibility in decision making for all aspects of critical care of the patients.

f. **Effective Fellow Behaviors**

i. The fellow is expected to follow program policies with an understanding of their limits, scope of authority, and the circumstances under which he/she is permitted to act with conditional independence.

ii. The resident supervised by the fellow must know the limits of his/her scope of authority, responsibility, and the circumstances under which varying levels of supervision applied by the fellow and faculty.

iii. At any time the fellow may request the physical presence of an attending without refusal.

g. **Path of escalation for reporting concerns and conflicts of interest**
    i. Trainees should bring forward concerns of possible violations to their program (including but not limited to the Program Director, Associate Program Director, site director, Chief Resident, mentor, advisor, Vice Chair for Education, DIO, or Department Head)
    ii. If resolution is not achieved, the trainee should bring forward their concern to the Office of Graduate Medical Education (including but not limited to the Associate Dean for GME, Assistant DIO, Organizational Development Manager, or Vice Dean for Education). The trainee may complete a survey through this site.
    iii. Anonymous reporting to the institution can occur through a trainee survey or through the Office of Compliance (UReport).
    iv. Investigation of anonymous reports have been limited by the ability to collect detailed data around violations. Therefore, the DIO encourages confidential reporting to GME (to the DIO or to the Organizational Development Manager) over anonymous reporting to expedite investigation at gme@umn.edu.

h. **Monitoring of Fellow Well-Being**
    i. The Program Director is responsible for monitoring fellow stress, including mental or emotional conditions inhibiting performance or learning, and drug-related or alcohol-related dysfunction.
    ii. Both the Program Director and faculty should be sensitive to the need for timely provision of confidential counseling and psychological support services to fellows.
    iii. Situations that demand excessive service or that consistently produce undesirable stress on fellows will be evaluated and modified.
    iv. For more information, visit the UMN GME Health Task Force Resources: Monitoring of Wellbeing
    v. Fellows will participate in the online Wellbeing and Resilience for Physicians course through the Earl E. Bakken Center for Spirituality & Healing.

i. **Conference Attendance Requirements**
    i. The fellow is expected to attend one of the following conferences.
        1. SOCCA Annual Meeting (3 days)
        2. SCCM Annual Meeting (4 days)

C. Program Curriculum

a. **Program Curriculum/Training Site Information**
    i. Clinical Training Sites and Block Schedule
        1. University of Minnesota Medical Center (UMMC)
            a. UMMC provides a learning environment in several ICUs including:
                i. Cardiovascular ICU
                ii. Surgical ICU

iii. Neurosurgery ICU
iv. Medical ICU

b. Fellows will have opportunities to work with cardiologists, nephrologists, infectious diseases specialists, palliative care specialists, radiologists, neurologists and various other specialties.
c. The fellows will learn skills sets that include ICU procedures such as line placements, intubations, chest tube placements, bronchoscopy, ECMO management.
d. The exposure to a variety and complex cases means that fellows will become comfortable with taking care of extremely fragile and sick patients.
e. They will also learn how to manage lung, liver and kidney transplant patients both in the OR and in the ICU.
f. While the majority of support and supervision will be done by Critical Care anesthesiologists, the fellows will have ample opportunity to learn different management styles from surgical intensivists, cardiologists, acute care surgeons, and pulmonologists.
g. In addition, fellows will be exposed to and interact with surgical and medical subspecialty physicians such as nephrologists, gastroenterologists, vascular surgeons, trauma, ENT, thoracic and cardiovascular surgeons.
h. There is ample opportunity to participate in case presentations, supervision of residents and medical students and work alongside advanced nurse practitioners, and Physician assistants.
i. Fellows will master management of ECMO patients (both VV and VA). The fellows will have didactic presentations from ICU faculty, pharmacy, ECMO physicians, cardiologists, and pulmonologists.

2. Fairview Southdale Hospital
   a. Southdale has approximately 22 ICU beds which covers both medical and surgical ICU beds.
   b. The mixed nature of this ICU provides ample opportunity to see a variety of medical and surgical patients such as neurological, cardiac and general surgical cases.
   c. In addition there is a mix of medical patients that allow the fellow to be exposed to complex respiratory disease, cardiac disease, COVID patients, psychiatric and drug overdose patients as well patients with chronic disease and cancer.

d. The fellow works with two faculty who will supervise daily activities, including learning to do ICU procedures such as bronchoscopy, intubations, line placements, chest tubes.
e. Southdale is a referral center like UMMC and receives patients from multiple rural remote locations such as Fairview Range in Hibbing, and Grand Itasca.
f. The patient population is diverse in terms of geographic locations within Minnesota and also because of the Hmong, Somali and Native American populations.
g. In this location, the mix of medical and surgical patients provide a unique blend of case mixes that include acute and chronic lung disease, acute and chronic heart disease, neurological disease (Southdale is a designated stroke center).
h. Fellows function as physicians who are working in a semi private practice setting along with faculty.
i. There are no residents currently but we have medical students.
j. The fellow has independence and supervises medical students.
k. Transition to independent practice skills are seamless because the fellow will interact with hospitalists, and specialists who belong to a private practice setting.
l. In addition, fellows will have the opportunity to work alongside anesthesiologists in the OR and gain skills particularly on airway management and sedation.
m. Fellows will be exposed to bedside teaching and POCUS training in the ICU with ICU faculty.
n. End-of-life and palliative care is a challenging aspect of patient care, which is intimately related to most challenging and ethically demanding decisions, planning processes, management of pharmacological agents and most importantly honoring of patient and family wishes and is therefore at the core of the educational program in our fellowship.
o. Fellows will combine their medical knowledge, understanding of appropriate use of consultative services, interpretation of laboratory and imaging studies in an environment where progressive independence is emphasized and supported and the fellow always has the continuity of faculty support appropriate for the fellows' level of development.
p. Southdale Tele-ICU coverage provides an unique educational experience because fellows will learn alongside faculty how to handle triaging, consulting

services to multiple remote rural locations under the M Health Fairview system.

i. In the times of COVID crisis, the fellows would learn how to provide supervision and support to hospitalists and ER physicians who need help in managing COVID patients when there is a bed shortage in the city ICUs.
ii. Fellows also learn communications skills, and learn how to address resource issues, bed management, transferring patients and providing support to patients and physicians caring for patients in transit.

b. **Didactics**
   i. The program must demonstrate a judicious balance between didactic presentations and clinical care obligations.
   ii. Clinical responsibilities must not prevent the fellow from participating in the requisite didactic activities and formal instruction.
c. **Clinical Education Requirements**
   i. Academic Expectations
      1. Attend all fellowship didactics unless on vacation or other excused absence.
      2. Attend all departmental educational activities, including Tuesday morning Grand Rounds.
      3. Attend and organize Journal Clubs
      4. Attend multi-disciplinary conferences as directed by PD / APD / ICU faculty
      5. Complete a QI project during the year
d. **Research Requirements**
   i. Quality Improvement Project Requirements
      1. The fellow should be able to demonstrate the knowledge and skills necessary to effectively conduct or lead a CQI effort and demonstrate an appreciation for the need to improve quality in health care related to critical care anesthesiology.
      2. The project should be collaborative and interdisciplinary in nature and should aim to build teamwork skills and foster a sense of inquiry and personal responsibility for overall healthcare for our patient population. The fellow should do short (a few months) or long-term projects in groups with other residents, faculty, or other health care providers. The project will be presented at the departmental grand rounds and might be considered for publication in peer reviewed journals.
      3. Project proposal template
         a. Background Knowledge:

        i. Provide a brief, nonselective summary of current knowledge of the care problem being addressed, and the characteristics of organizations in which it occurs

b. Local Problem
    i. Describe the nature and severity of the local specific problem or system dysfunction that was addressed

c. Intended Improvement
    i. Describe the specific aim of the proposed intervention (changes/improvements in care processes and patient outcomes)
    ii. Specifies who (champions, supporters) and what (events, observations) triggered the decision to make changes

d. Study Question
    i. Specify specific AIM statement of the project
    ii. Details precisely the primary improvement-related question and any secondary questions that the study of the intervention was designed to answer

e. Implementation
    i. Fellow should follow the Plan Do Study Act (PDSA) cycle approach
        1. Plan
            a. Select the Opportunity for Improvement
            b. Study the current situation
            c. Define why improvement in this area is necessary
                i. Health risk of the patient
                ii. Inefficient delivery of health care
                iii. Financial
            d. Collect and/or review baseline data in the problem area and the current process
            e. Analyze the causes and determine factors contributing to the problem
            f. Develop a theory for improvement: Aim statement
                i. Specific
                ii. Measurable

iii. Processes for formulating ideas for change
iv. Critical thinking about the current system
v. Develop a theory for improvement: Methods
vi. Qualitative data: Subjective
vii. Quantitative: Objective
viii. Form an effective team
ix. Identify a QI mentor. Be sure to include members familiar with all the different parts of the process trying to improve.

2. Do
    a. Implement the QI plan and use it as a roadmap for implementing an integrated quality program system-wide. Identify and document problems and unexpected observations that you came across while implementing the plan.
3. Study
    a. Evaluate the QI plan and address the following questions: Did you do what you said you were going to do? Why? Why not? What were the results? How can next year be better? What modifications should be made?
4. Act
    a. On the lessons learned, revise the QI plan for next year, and monitor the plan regularly to determine whether it remains successful over time. Evaluate the QI plan annually.

e. **Evaluations and Outcomes Assessment**
    i. Evaluation Process
        1. Fellows will receive regular discussion and feedback on a case by case or daily basis from faculty.
        2. There will be a written evaluation after each rotation completed individually by attending faculty or as a consensus evaluation by the faculty who worked with the fellow during that rotation.

a. This is an assessment of the Fellow's performance during any clinical rotation and will become part of the permanent file and the Program Director will review with the fellow.

ii. Evaluation Tools
  1. Evaluation tools used may also include:
     a. Faculty evaluation of participant
     b. Program director evaluation of participant
     c. 360 degree evaluation of participant
     d. Participant evaluation of rotation
     e. Participant evaluation of faculty/program director
     f. Participant evaluation of program
     g. In-training exams

iii. Evaluation methods:
  1. Feedback and discussion during grand round presentation
  2. Discuss with QI mentor and team
  3. Feedback from peer review journal comments submission

D. ACGME General Competencies

a. The ACGME competencies are tied to all Goals and Objectives in the various CNP fellowship training tracks and rotations defined below.

i. Patient Care (PC) Fellows must be able to provide patient care that is compassionate, appropriate, and effective for the treatment of health problems and the promotion of health.

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

iii. Practice-Based Learning and Improvement (PBLI) Fellows are expected to develop skills and habits to be able to meet the following goals:
  1. Systematically analyze practice using quality improvement methods, and implement changes with the goal of practice improvement; and,
  2. Locate, appraise, and assimilate evidence from scientific studies related to their patients' health problems.

iv. Interpersonal and Communication Skills (ICS) Fellows must demonstrate interpersonal and communication skills that result in the effective exchange of information and collaborations with patients, their families, and health professionals.

v. Professionalism (Prof) Fellows must demonstrate a commitment to carrying out professional responsibilities and an adherence to ethical principles.

vi. Systems-based Practice (SBP) Fellows must demonstrate an awareness of and responsiveness to the larger context and system of health care, as well as the ability to call effectively on other resources in the system to provide optimal health care.

E. Clinical Rotations and Block Schedule

Critical Care Medicine Anesthesiology Fellowship Block Schedule

Block	**1**	**2**	3	**4**	**5**	**6**	**7**	**8**
Site	1	1	1	2	1	2	2	1
Rotation	CVICU - Initial	CVICU - Advanced	West - ICU	Tele - ICU	Neurocritical ICU	SH ICU - Initial	SH ICU - Advanced	Elective
% Outpatient	0	0	0	0	0	0	0	0
% Research	0	0	0	0	0	0	0	20%

Additional Information

Rotation Lengths	CVICU - Initial, Site 1= 3 months CVICU - Advanced, Site 1= 3 months West ICU, Site 1= 1 month SH ICU - Initial, Site 2= 1 month SH ICU - Advanced, Site 2= 1 month Tele - ICU, Site 2= 2 weeks Neurocritical ICU, Site 1= 2 weeks Elective, Site 1= 1 month UMMC Night Float = 1 month * see below	
UMMC Night Float Information	The fellow will rotate on two, 6 day blocks throughout the year and take Saturday night calls in CVICU to obtain a full month of experience.	
Electives	NSICU MICU POCUS Research Nephrology Infectious Disease Palliative Care	SICU ECMO ECHO Radiology Operating Room
Max # of vacation days per year	15 working days	
Sites	**1**= MHealth University of Minnesota Medical Center **2**= MHealth Fairview Southdale Hospital	
Abbreviations	**ICU**= Intensive Care Unit **CVICU**= Cardiovascular Intensive Care Unit **SH ICU**= Southdale Hospital ICU	
Schedule	The workday starts at 7 AM and ends at 4, 5, or 6 PM, depending on the rotation. Fellows also cover "swing shifts" from 2 PM to 10 PM or midnight. The Night float will last from 7 PM to 7 AM, Sunday through Friday. The Anesthesiology and Surgery fellows will overlap in CVICU and SH-ICU and cover weekends by rotation. The fellow who covers the weekend night will have 1 day off during the week.	

F. Competency-based Goals & Objectives

a. Cardiovascular ICU Initial Rotation - UMMC
b. Cardiovascular ICU Advanced Rotation - UMMC
c. West ICU Rotation - UMMC
d. Tele-ICU Rotation - UMMC
e. Neurocritical ICU Rotation - UMMC
f. Night Float ICU Rotation - UMMC
g. ICU Initial Rotation - Southdale
h. ICU Advanced Rotation - Southdale

G. Fellow Expectations

a. CTICU Fellow Expectations
b. West ICU Anesthesiology CCM Fellows Expectations
c. Night On Call PCCM Rotation Expectations

H. Life Support Certification Requirements

a. Fellows are required to have current certification in BLS and ACLS.

I. Annual evaluation of program goals and objectives

a. The Program Evaluation committee (PEC) including fellows meets annually and plays an active role in:
    i. Planning, developing, implementing and evaluating educational activities of the Program.
    ii. Reviewing and making recommendations for revision of competency-based curriculum goals and objectives.
    iii. Addressing areas of non-compliance with ACGME standards.
    iv. Reviewing the program annually using evaluations of faculty, residents, and others.
    v. Actively ensuring a continual quality improvement process regarding program outcomes

J. Semi-Annual Evaluation

a. The Clinical Competency Committee (CCC) will meet twice yearly to discuss fellow performance and complete the Milestone evaluation.
b. Each Fellow will meet with the Program Director or Associate Program Director semi-annually to discuss their performance.
c. The purpose of these meetings is to provide feedback to the Fellow, discuss areas of deficiency requiring special attention, and provide counseling on career development.

PROGRAM PROCEDURES

A. Attendance

- **a.** Fellows are expected to report for duty per the rotation specific instructions given above. In case of sickness or unexpected absence, fellows should notify attending staff at the rotation site as soon as possible.

B. Clinical and Educational Work Hours

- **a.** Work hours are defined as all clinical and academic activities related to the program; i.e., patient care (both inpatient and outpatient), administrative duties relative to patient care, the provision for transfer of patient care; time spent in-house during call activities, and scheduled activities, such as conferences. Work hours do *not* include reading and preparation time spent away from the work site.
  - i. Max Hours per Week
    1. Work hours must not exceed 80 hours per week averaged over a four week period inclusive of call and moonlighting activities
  - ii. Continuous Work Hours
    1. Fellows must not exceed 24 hours. Trainees may spend an additional 4 hours to hours to complete transitions in care. Trainees must have at least 14 hours free after 24 hours of in-house duty.

C. Work Hours Policy

- **a.** The purpose of this policy is to outline ACGME work hour requirements and the responsibilities of the fellows, the program, and the sponsoring institution.
- **b.** Policy Statement: all programs are required to adhere to and monitor compliance of their trainees with the ACGME duty hour standards as outlined in the revised ACGME Common Program Requirements. Programs must also follow the program-specific guidelines as outlined by their individual Review Committees (RCs). The sponsoring institution monitors program's adherence to the duty hour requirements through regular review of work hour violations in RMS, the Internal Review process as well as annual review of program manuals to ensure the proper policies are in place. Concerns about continuous work hour violations not adequately addressed by their program can be reported to the Designated Institutional Official at gme@umn.edu. Anonymous reporting of work hour violations can occur via a Qualtrics form. Trainees may also report violations directly to the ACGME.
- **c.** Principles:
  - i. The program must be committed to, and be responsible for promoting, patient safety, fellow well-being, and to providing a supportive educational environment
  - ii. The learning objectives of the program must not be compromised by excessive reliance on fellows to fulfill service obligations

iii. Didactic and clinical education must have priority in the allotment of fellows' time and energy
iv. Work hour assignments must recognize that faculty and fellows collectively have responsibility for the safety and welfare of patients
v. Responsibilities of Program:
    1. Programs must ensure that appropriate levels of supervision are provided to each trainee based on their level of training. Programs must enhance their current supervision policies to include the new ACGME requirements.

D. Work Hours (formerly known as Duty Hours)

- **a.** Work hours are defined as all clinical and academic activities related to the program, including patient care (both inpatient and outpatient), administrative duties relative to patient care, the provision for transfer of patient care, time spent in-house during call activities, and scheduled activities such as conferences.
- **b.** Work hours do *not* include reading and preparation time spent away from the work site.
- **c.** Providing trainees with a sound academic and clinical education must be carefully planned and balanced with concerns for patient safety and trainees' well-being.
- **d.** Each program must ensure that the learning objectives of the program are not compromised by excessive reliance on residents/fellows to fulfill service obligations.
- **e.** Didactic and clinical education must have priority in the allotment of trainees' time and energies.
- **f.** Work hour assignments must recognize that faculty and trainees collectively have responsibility for the safety and welfare of patients.

E. Maximum hours per week

- **a.** Work hours must not exceed 80 hours per week, when averaged over a four week period and inclusive of call and moonlighting activities; this will be taken very seriously.
- **b.** Fellows who are at risk of violating work hour rules have an obligation to inform program leadership so that coverage can be arranged to avoid violation.
- **c.** In the event that there is a pattern of persistent violations, corrective action will be taken by the Program Director and Chair.
    - i. In rare instances in which the fellow feels the violation relates to patient safety, unusual patient condition, or specific resident interest, the work hour violation will be tolerated only to a strictly limited extent and must be documented accordingly
    - ii. Fellows no longer need to record their own duty hours as the GME will ask the Program Director/Program Coordinator to attest to any duty hours violations quarterly

iii. Please notify the Program Director or Program Coordinator of any impending or possible violations so they can be resolved immediately

F. Work Hour Exceptions

- **a.** Work hour exceptions of 88 hours per week averaged over a four week period for select programs with sound educational rationale are permissible.
- **b.** Programs must obtain permission from the Designated Institution Official and Graduate Medical Education Committee prior to submission to their Review Committee.

G. Mandatory Time Free of Duty

- **a.** Trainees must have a minimum of one day free of duty every week, when averaged over four weeks. At home call cannot be assigned during this time.
- **b.** Fellows should have 10 hours and must have eight hours free between work periods. There must be at least 14 hours free of work after 24 hours of in-house work.

H. Institutional Leave Policies

- **a. Administrative Leave of Absence**
- **b. Bereavement Leave:** Policy details can be found at http://policy.umn.edu/hr/fmla.
- **c. Earned Sick and Safe Time (ESST)**
- **d. Family Medical Leave (FML)**
  - i. Per federal law, Family Medical Leave (FML) is only available to trainees who have worked at the institution for at least 12 months and who have worked 1,250 hours in the previous 12 months before the leave begins.
  - ii. The Family Medical Leave Act, or FMLA is a federal law that allows trainees, who are eligible, up to 12 weeks of protected leave per academic year.
  - iii. Trainees must consult with their program to determine if they are eligible.
  - iv. With the proper medical documentation and supervisor approval, FML can be used for:
    1. Your own serious health condition
    2. The serious health condition of an immediate family member
    3. Caring for a newborn or newly-placed adopted child or foster child
    4. The urgent need of an immediate family member who is on active duty in the military services
  - v. Leave shall not exceed 12 weeks in any 12-month period. The 12-month period is based on an academic year (ex: 07/31-07/30). The trainee may be eligible for Short Term and Long Term Disability benefits. Department Human Resources staff will determine FMLA eligibility and will provide the trainee with the appropriate paperwork.
- **e. Medical & Caregiver Leave**
- **f. Holiday Leave**
  - i. Holiday leave is dependent on the requirements of the rotation to which the trainee is assigned.

ii. The educational requirements and the 24-hour operational needs of the hospital are taken into consideration when scheduling holiday time off.
iii. Fellows are responsible to check with rotation/site directors for requirements reporting on holidays.
iv. Fellows are not eligible to receive an annual University of Minnesota issued personal holiday.

g. **Military, Court Appearance, or Civic Duty Leave**
   i. http://policy.umn.edu/hr/milcourtcivicleave

h. **Parental Leave**
   i. Please contact the Program Coordinator and Program Director when scheduling Parental Leave.
   ii. Compliance with the GME Leave of Absence is also required.

i. **Personal Leave**
   i. Please contact the Program Director and Program Coordinator regarding scheduling a Personal Leave of Absence or a Professional Leave of Absence
   ii. See http://policy.umn.edu/ for required compliance details

j. **Professional Leave**

k. **Vacation Leave**
   i. Anticipated days away from clinical duties MUST be requested in advance.
   ii. Only after the Program Director has signed off on a request and confirmed with the Program Coordinator is it considered approved.
   iii. All fellows are entitled to twenty days (excluding weekends and holidays) free of Departmental duties each academic year.
      1. Of these 20 days, 15 are normally used as vacation and five are available for sick leave.
      2. Sick leave exceeding beyond these five days *must* be made up either by use of vacation days or additional assignments beyond the normal completion of the program.

l. **Other Program Leave Time**
   i. **Academic / Educational Leave**
      1. Fellows are expected to attend conferences and have one presentation presented at one of these meetings.
         a. SOCCA annual meeting (1 day)
         b. SCCM annual meeting (4 days)

ii. **Sick Days**

1. All sick days must be reported by the Fellow. Email the program director, associate program director and program coordinator to report any unanticipated absences.
2. Single sick days require no proof of illness. Sick leave of two days or more may require a physician's statement of legitimate illness

iii. **Departmental Disaster Plan**

1. Initially fellows are expected to report to their originally assigned hospital/clinic location. In the event the hospital/clinic is affected by the disaster and unable to operate in the usual fashion or if the patient load is skewed by the disaster, some or all of the trainees may need to be reassigned by the DIO after discussion with the Program Director and approval of the DIO with the hospital officials.

I. Moonlighting

a. Per ACGME and Departmental policy Critical Care Medicine Anesthesiology Fellows are permitted to Moonlight with approval from the program director and GME office.

J. Impairment/Fitness for Duty Policy (see Resident/Fellow Fitness for Duty Policy)

K. Inclement Weather

L. Grievance/Due Process

a. The following describes the general process for resolving grievances within the residency/fellowship program at the departmental level. If a grievance cannot be settled at the department level, the program leadership or trainee can appeal to the GME office as explained in "GME Policy: Discipline, Dismissal, Failure to Advance".

i. This protocol calls for notice before the action is taken, an opportunity for the resident to appear, and an appeals mechanism.

ii. Possible areas of grievance to be resolved can include evaluation of resident/fellow performance, resident/fellow duties, resident/fellow assignments/schedules, resident/fellow conflicts with peers or faculty. It is understood that many potential areas of conflict can be avoided via discussions with mentors and/or faculty advisors.

1. The quarterly program meetings, and mentor meetings or meetings with the Program Director also provide opportunities for problem resolution.
    a. If these usual and customary means of resolving issues do not suffice, the chair of the department may assemble a grievance committee from appropriate membership.
    b. Membership can include the parties to the complaint, representatives from the resident/fellow class, administrative chief residents, faculty from services or sites concerned, mentors, and the Program Director.

2. If an outcome acceptable to principals in the complaint is achieved, no further action is necessary. If parties fail to achieve an acceptable resolution, the matter is carried forward to the Medical School grievance procedure.
3. Our program also encourages residents/fellows to directly address any issue or concern they may have with faculty or staff as it occurs, or within the appropriate space of time. However, in cases when this is not possible or not resolvable, the resident/fellow may bring their concerns to the Program Director for guidance and intervention as necessary.
4. If a grievance cannot be settled at the department level, the program leadership or trainee can appeal to the GME office as explained in "GME Policy: Discipline, Dismissal, Failure to Advance". There is also a Student Conflict Resolution Center which offers online tools or personal assistance through an ombudsman.
5. The Office of Equal Opportunity and Affirmative Action (EOAA) is also available to help resolve issues or concerns involving discrimination, harassment , sexual misconduct, nepotism and retaliation.
    a. Staff members of the EOAA are available to consult directly with fellows or supervisors/administrators.
6. Reporting of discrimination or harassment may be done through UReport anonymous online reporting system.
7. Residents & fellows may also review the program faculty yearly through an anonymous evaluation which is then reviewed by the Program Director(s).
8. Any concerns are then addressed with the PD, site directors and/or faculty members and can also be escalated as indicated.

iii. **Disciplinary & Corrective Action Policy**

1. Discipline/Dismissal for Academic Reasons
    a. Grounds

        i. As students, fellows are required to maintain satisfactory academic performance. Academic performance that is below satisfactory is grounds for discipline and/or dismissal. Below satisfactory academic performance is defined as a failed rotation; relevant exam scores below program requirements; and/or marginal or unsatisfactory performance, as evidenced by faculty evaluations, in the areas of clinical diagnosis and judgment, medical knowledge, technical abilities, interpretation of data, patient management, communication skills, interactions with patients and other healthcare professionals, professionalism, and/or motivation and initiative.
        ii. To maintain satisfactory academic performance, fellows also must meet all eligibility requirements throughout the training program. Failure or inability to satisfy licensure, registration, fitness/availability for work, visa, immunizations, or other program-specific eligibility requirements are grounds for dismissal or contract non-renewal.
    b. Procedures
        i. Before dismissing a fellow for academic reasons, the program must give the trainee:
            1. Notice of performance deficiencies;
            2. An opportunity to remedy the deficiencies; and
            3. Notice of the possibility of dismissal or non-renewal if the deficiencies are not corrected.
        ii. Trainees disciplined and/or dismissed for academic reasons may be able to grieve the action through the Conflict Resolution Process for Student Academic Complaints Policy. This grievance process is not intended as a substitute for the academic judgments of the faculty who have evaluated the performance of the trainee, but rather is based on a claimed violation of a rule, policy or established practice of the University or its programs.
2. Academic Probation

a. Trainees who demonstrate a pattern of unsatisfactory or marginal academic performance will undergo a probationary period.
    i. The purpose of probation is to give the trainees specific notice of performance deficiencies and an opportunity to correct those deficiencies.
    ii. The length of the probationary period may vary but it must be specified at the outset and be of sufficient duration to give the trainee a meaningful opportunity to remedy the identified performance problems.
    iii. Depending on the trainee's performance during probation, the possible outcomes of the probationary period are:
        1. Removal from probation with a return to good academic standing;
        2. Continued probation with new or remaining deficiencies cited;
        3. Non-promotion to the next training level with further probationary training required; contract non-renewal; or dismissal.

3. Discipline/Dismissal for Non-Academic Reasons
    a. Grounds
        i. Grounds for discipline and/or dismissal of a trainee for non-academic reasons include, but are not limited to, the following:
            1. Failure to comply with the bylaws, policies, rules, or regulations of the University of Minnesota, affiliated hospital, medical staff, department, or with the terms and conditions of this document.
            2. Commission by the trainee of an offense under federal, state, or local laws or ordinances, which impacts upon the abilities of the trainee to appropriately perform his/her normal duties in the fellowship program.
            3. Conduct, which violates professional and/or ethical standards; disrupts the operations of the University, its departments, or affiliated hospitals; or disregards the rights or welfare of patients, visitors, or hospital/clinical staff.
        ii. Procedures

1. Prior to the imposition of any discipline for non-academic reasons, including, but not limited to, written warnings, probation, suspension, or termination from the program, a fellow shall be afforded:
    a. Clear and actual notice by the appropriate University or hospital representative of charges that may result in discipline, including where appropriate, the identification of persons who have made allegations against the trainee and the specific nature of the allegations; and,
    b. An opportunity for the trainee to appear in person to respond to the allegations.
2. Following the appearance by the trainee, a determination should be made as to whether reasonable grounds exist to validate the proposed discipline. The determination as to whether discipline would be imposed will be made by the respective Medical School department head or his or her designee. A written statement of the discipline and the reasons for imposition, including specific charges, witnesses, and applicable evidence shall be presented to the trainee.
3. After the imposition of any discipline for non-academic reasons, a trainee may avail himself or herself of the following procedure:
    a. If within thirty (30) calendar days following the effective date of the discipline, the trainee requests in writing to the Dean of the Medical School a hearing to challenge the discipline, a prompt hearing shall be scheduled. If the trainee fails to request a hearing within the thirty (30) day time period, his/her rights pursuant to this procedure shall be deemed to be waived.

b. The hearing panel shall be comprised of three persons not from the residency/fellowship program involved: a chief resident; a designee of the Dean of the University of Minnesota Medical School; and an individual recommended by the Chair of the Graduate Medical Education Committee. The panel will be named by the Dean of the Medical School or his or her designee and will elect its own chair. The hearing panel shall have the right to adopt, reject or modify the discipline that has been imposed.

4. At the hearing, a fellow shall have the following rights:
    a. Right to have an advisor appear at the hearing. The advisor may be a faculty member, fellow, attorney, or any other person. The fellow must identify his or her advisor at least five (5) days prior to the hearing;
    b. Right to hear all adverse evidence, present his/her defense, present written evidence, call and cross-examine witnesses; and,
    c. Right to examine the individual's fellowship files prior to or at the hearing.
    d. The proceedings of the hearing shall be recorded.
    e. After the hearing, the panel members shall reach a decision by a simple majority vote based on the record at the hearing.
    f. The fellowship program must establish the appropriateness of the discipline by a preponderance of the evidence.

g. The panel shall notify the fellow in writing of its decision and provide the trainee with a statement of the reasons for the decision.
h. Although the discipline will be implemented on the effective date, the stipend of the trainee shall be continued until his or her thirty (30) day period of appeal expires, the hearing panel issues its written decision, or the termination date of the agreement, whichever occurs first.
i. The decision of the panel in these matters is final, subject to the right of the trainee to appeal the determination to the fellow's Student Behavior Review Panel.

5. The University of Minnesota, an affiliated hospital, and the department of the fellow each has a right to impose immediate summary suspension upon a trainee if his or her alleged conduct is reasonably likely to threaten the safety or welfare of patients, visitors or hospital/clinical staff. In those cases, the trainee may avail he or she of the hearing procedures described above.
6. The foregoing procedures shall constitute the sole and exclusive remedy by which a trainee may challenge the imposition of discipline based on non-academic reasons.

M. State Medical Board Licensure Requirements

N. Needlestick Procedures - Infection Control

i. All needle sticks must be reported via this GME site/form within the first 24 hours.
ii. Blood borne pathogens are serious business; please treat them as such for your own safety.
iii. Please encourage peer residents to report any incidents using the same site/form.

O. Patient Safety Procedures

a. Fellows should refer to patient safety procedures at each rotation site.
b. Information is available via the UMP Resources intranet.

P. Institutional Committees

   a. Graduate Medical Education Committee

Q. Social Networking Policy

1. While it is recognized that social networking websites and applications are an effective and timely means of communication, fellows must be aware of the importance of maintaining the confidentiality of all patient information and identifiers as well as not compromising the image of their profession and the institutions connected with them.
2. Please be aware of the Social Networking and Media Policy; fellows who violate University policies may be subject to adverse academic actions that could include a letter of reprimand, probation or dismissal from the program.

BENEFITS, INFORMATION AND RESOURCES

A. Insurance

a. Please see the Office of Student Health Benefits website with descriptors of the following insurance coverage:
   i. Health & Dental
      1. New academic year rates update on website end of April
   ii. Short and Long Term Disability Coverage
   iii. Professional Liability Insurance/Medical Malpractice Insurance
      1. Please visit this site for Professional Liability Insurance information, including policy numbers and coverage details.
   iv. Life Insurance
   v. Voluntary Life Insurance
   vi. Insurance Coverage Changes
   vii. Worker's Compensation

B. Systems and Communication

a. Email Accounts

   i. Email accounts are available for each fellow. Fellows are required to maintain a University of Minnesota email account which *must be checked* on a 24-hour basis (except in rare instances – travel, etc.), as this is the Department's preferred method of communication.
   ii. Due to HIPAA laws ALL transfers of possible restricted patient information must take place on an @umn.edu account that is encrypted. Fellows should not forward their @umn.edu account to other unsecure mail services for this same reason.

b. Internet Access

   i. Computers are available for the fellows to use in the Anesthesiology Fellow Lounge and throughout the medical center facility.

ii. Internet access for personal computers can be obtained by logging in with your x.500/password to the secure campus Wi-Fi or by plugging directly into a physical jack, logging in with your x.500 at this link, clicking on the register new address button, and then entering your hardware MAC address.

c. **Pagers**

i. Personal pagers are provided for each fellow.

ii. Pagers for call and code pagers are also provided on certain rotations.

iii. You will receive your personal pager in your orientation from the Program Coordinator. Thereafter, damaged or lost pagers can be reported at the front desk of the UMMC East Campus (directly in front of the Main Entrance on the 2nd floor). The fee for lost or damaged pagers (currently $65, subject to change at any time) will come out of any remaining educational funds, or withheld from bi-weekly stipend, if educational funds are not available.

d. **Campus Mail**

i. Individual mailboxes are available for fellows in the Department of Anesthesiology mailroom.

ii. Mail is distributed on a daily basis.

iii. Please note that fellows are responsible for checking their mailboxes weekly.

iv. Mailboxes should not be used as a storage area.

Department mail address:

Department of Anesthesiology
University of Minnesota
420 Delaware Street S.E.
MMC Box 294
Minneapolis, MN 55455

C. Stipends

a. Stipends paid to residents and fellows in Anesthesiology will be dependent on the range of remuneration negotiated between the Association of Teaching Hospitals and the University of Minnesota.

b. For the current stipend rates, please see the Stipend/Pay section here.

c. CCM Anesthesia fellows are paid at the Step 5 level.

D. Employee Assistance Program (EAP)

a. The Employee Assistance Program (EAP) provides confidential professional consultation and referral services to address any personal or work concern that may be affecting your wellbeing. You can receive up to eight sessions per issue at no cost.

E. Medical Records Procedures

a. Fellows are expected to use Epic to record all cases/procedures.

F. Medical Records

a. Fellows use the ACGME Case Logs to log all procedures conducted during their training. Complete, accurate and up to date record keeping is not only an essential part of their professional duties, but also for comprehensive patient care. In recognition of this case logs are reviewed regularly by the coordinator and Program Director for the above as well as progress. towards completion of the minimum clinical experience level required by the ACGME.
b. Comprehensive, timely and legible medical records are an element of their rotational and quarterly evaluations and are reviewed by the coordinator and Program Director and at regular Clinical Competency Meetings.
c. A medical records system that documents the course of each patient's illness and care must be available at all times and must be adequate to support quality patient care, the education of fellows, quality assurance activities, and provide a resource for scholarly activity.

G. Pharmacy Procedures

a. Fellows should follow all pharmacy and drug procedures as required at the site.

H. Payroll Information

a. Fellows are paid bi-weekly (every other Wednesday. If you have direct deposit (encouraged) your statement will be accessible on-line only.
    i. To access go to www.umn.edu/ohr/hrss. You will need your x.500 number (the beginning of your email address) and your own password.

I. Laundry Services

a. Fellows should use scrubs available in locker rooms on the outside East or West OR.

J. Parking

a. Fellows will be provided with parking cards for access to University lots. Parking will be paid by the department and access will be provided to the East River Road Garage or the Hospital/Patient Ramp.

K. Professional Education Fund Policy ("Book Fund")

a. Fellows will receive an allocation of $2,000 per year to be used for educational materials and education-related travel expenses. Unspent funds will carry forward each year and be available for use.
b. Fellows may be required to make purchases from their Education Funds for things such as a missing/lost pager. If Education funds are not available, fellows should understand they will be invoiced for these fees and will need to cover the expense out of pocket.
c. All purchases must show a clear benefit to supporting the educational growth of the resident/fellow, and therefore be in the interest of the University of Minnesota
d. All purchases/fees must be made/submitted 1 month prior to leaving the University (by 5/31 if graduating on schedule), to ensure appropriate accounting and use of funds; any remaining funds will revert back to the department
e. Please note that this fund can be temporarily suspended or permanently lost for becoming non-compliant with department requirements, regulations and/or policies (for example noncompliance with completion of training, completion of mandatory surveys, etc).
f. Examples of <u>allowable</u>* Education Fund expenses:
    i. Books and published materials
    ii. Equipment (electronic equipment purchases are the property of the University of Minnesota and must stay at the University once the trainee leaves)
    iii. Conference registration and attendance (requires pre-approval; details below)
g. Examples of <u>unallowable</u>* Education Fund expenses:
    i. Apparel (exceptions: stethoscope holder)
    ii. Gift cards
    iii. Professional licenses
h. Check with your Program Coordinator or ALRT accountant on allowability of items not listed above

L. ID Badges

a. You are required to wear both a University and University of Minnesota Medical Center badge at all times. Wearing of the University ID badge is a *condition of employment*, so do not be caught without it due to possible consequences of noncompliance-termination. Additional ID badges may be assigned by hospital sites. ID policies at those hospitals are also to be followed.

M. Fatigue

a. Once a patient care jeopardizing level of fatigue has been identified, the affected resident and/or identifying peer/staff should contact the Officer of the Day immediately (or, if after hours, the available attending or the senior resident on call) to arrange for an immediate transfer of care to another provider. Cab vouchers for residents too fatigued to drive will be provided by University of Minnesota Medical Center-Fairview and distributed in the following way:

    i. **<u>Monday-Friday Daytime Hours</u>**
    Contact Officer of the Day on OR floor or call numbers below
    University East Campus - contact the Anesthesia Control Room - (612) 273-2926
    University West Campus - (612) 273-4097 or (612) 273-2629

    ii. **<u>Evenings and Weekends</u>**
    University East Campus - Anesthesia Control Room - (612) 273-2926
    University West Campus - (612) 273-4097 or (612) 273-2629

N. PWC PeerConnect

a. PWC PeerConnect is a joint project between Minnesota Metro Council on Graduate Medical Education and the Physicians Wellness Collaborative and provides a confidential space for you to connect with a supportive colleague who understands what it's like to be a resident.

b. Download the PWC PeerConnect app and update your contact information and contact preferences.

c. Select who you want to be part of your Peer Support Team. All Peer Support Mentors are recent residency graduates and/or practicing physicians who are passionate about supporting resident's wellbeing.

d. You're ready to use the app! Anytime you want to talk with someone who has walked a similar path, click the "Connect" button and your Peer Support Team will be notified. You will receive a call or text (however you indicated you'd like to be contacted) within 24 hours.

e. NOTE: The Peer Support Mentors are not therapists, but if you would like additional support, there are extensive resources in the app with therapists and clinicians who specialize in providing care to healthcare workers. You can find more info and filter by location under the Resources tab.

f. If you have questions or are having any trouble accessing PWC PeerConnect, Please reach out to Amber Kerrigan at kerrigan@metrodoctors.com, Phone: 612-362-3706

O. Vital Worklife

a. Vital worklife offers 6 free confidential counseling sessions.

    i. Call Vital Worklife at 1-877-731-3949
    ii. Identify yourself as a University of Minnesota Fellow
    iii. More information on Vital Worklife services

P. State Medical Board Licensure Requirements

a. Fellows are required to obtain either a Residency/Fellowship Permit or a full Minnesota Medical License from the Minnesota Board of Medical Practice prior to starting the fellowship year.

Confirmation of Receipt of your Program Policy Manual

By signing this document you are confirming that you have received and reviewed your Program Policy Manual and Fellowship addendum, if applicable, for this academic year. This policy manual contains policies and procedures pertinent to your training program. This receipt will be kept in your personnel file.

Fill out the form online:

https://forms.gle/UrHbwWPeBdGmdAmu5

OR

Scan the QR code below: