

**Department of Otolaryngology
And Communicative Sciences
University of Mississippi Medical Center**

**2016-2017
Resident Manual
Policies and Procedures**

Lana L. Jackson, M.D.
Residency Program Director
Associate Professor

Andrea F. Lewis, M.D.
Associate Residency Program Director
Assistant Professor

Scott P. Stringer, M.D., M.S.
Professor and Chair

This manual is meant to provide guidelines to assist you during your residency. Read and familiarize yourself with these guidelines as you are responsible for all material in this manual and will be held accountable for this information. These requirements are necessary to allow us to run an orderly and effective residency program.

I. EDUCATION

A. Conferences

- Conferences will be held Monday, Wednesday, and Friday at 7 AM each week according to a published schedule to provide didactic and interactive teaching.
- All residents are expected to attend and to arrive early enough so that we can start exactly on time. If you are late for conference without an emergent patient care issue more than twice per quarter, you will be subject to disciplinary action. It is your responsibility to contact the program director if you are late and have a legitimate reason by the end of that working day.
- You should stay until the end of conference unless you are given prior approval to leave early from the faculty member in charge. Conferences should be planned to end at 7:50 AM to avoid conflicting with clinical schedules. One resident per operating service is allowed to leave 10 minutes prior to the scheduled start of the OR on operating days if necessary.
- Please complete evaluations of lectures as requested. The conference room should be left clean and in order after each use.
- No equipment is to be removed from the conference room without permission from the program director or chair. All equipment in the conference room should be turned off at the end of conference.

Courses covering specific aspects of the learning experience are outlined below and will be scheduled regularly as part of the normal monthly conference schedule. The remainder of the conferences will be used to cover core curriculum in each of the specialty areas.

1. Case Presentation (M&M) Conference

Monthly, we will discuss cases that involve morbidity, mortality, or unique learning experiences. The senior resident on each service is responsible for keeping track of all such cases, submitting them to the PI director, and ensuring that they are presented each month.

2. Journal Club

Each month in Journal Club we will primarily review a major otolaryngology journal or selected articles based on the supervising faculty member's instructions....

You are strongly encouraged to obtain subscriptions to and regularly review at least the following three journals: OTOLARYNGOLOGY-HEAD AND NECK SURGERY, JAMA OTOLARYNGOLOGY-HEAD AND NECK SURGERY, and LARYNGOSCOPE.

3. National Conferences

Per the resident travel policy outlined in a subsequent section, residents will be supported in their attendance at major national meetings such as the Academy and the COSM.

a) **Society of University Otolaryngologists-Head and Neck Surgeons Annual Meeting**

The department seeks to encourage residents to enter academic medicine and will fund one resident to attend the annual meeting each year. Priority will be given to those residents demonstrating a desire to enter a career in academic medicine and based upon who has not attended previously. If funds are available, additional residents attending will be considered on a case-by-case basis. Residents contributing scholarly to the program (e.g. presentation) will be given priority.

b) **Specialty Specific Conference and Courses**

The department will do its best to allow residents to attend specialty conferences or courses appropriate for their level in areas such as temporal bone dissection, allergy training, endocrine surgery, ultrasound, sinus dissection, or skull base dissection. Attendance is subject to approval based on coverage of clinical duties, funding availability, days off limits, current performance standing of the resident.

4. Performance Improvement Conference

Monthly, we will present performance improvement opportunities, review current projects, and review the results of completed projects. Each resident will be responsible for initiating and completing one PI project as team leader. Ideas for projects will be maintained on a departmental database. Each project will be facilitated by the Performance Improvement Director for the department. The project needs to be approved at the conference prior to initiation.

5. Research Conference

This conference will be held no less than every other month. The conference will be

used to review and approve resident research projects, keep the projects on track, and review final results. The conference will also be used to present research fundamentals and methodology concepts

6. Resident Presentation Development Conference

Annually, each resident will present a topic of their choice to the residents and faculty. Residents are encouraged to select a topic that they would like to learn more about. Presentations should focus on controversies or interesting aspects of a topic rather than being a regurgitation of a standard textbook chapter. It is acceptable to suggest readings in advance to provide a base for other residents on the topic to facilitate the focus on advanced concepts. Each resident will be expected to submit their slides and a brief learning module presenting their content (five pages or less) to the residency program coordinator for posting on the G drive to support future independent learning.

7. Resident Retreat

As long as funding remains available, we will send as many residents as possible to the annual Mississippi Society Otolaryngology conference. During this conference, we will hold a session devoted to improving the residency program.

B. Courses

1. Anatomic Dissections

All PGY2 residents will perform a comprehensive head and neck cadaver dissection and present this information to the other residents and faculty. In preparation for the last session, the PGY-2 residents will tag various anatomic structures to challenge the knowledge of the other residents.

2. Home Study

The Home Study Course will be provided to you. You are expected to read the entire issue and submit your self-study evaluation before the initial deadline for receipt. You are expected to achieve a score of at least 80%.

3. Surgical and Clinical Skills Simulation

Annually, all residents will be provided cadaver based dissection instruction in areas such as sinus surgery, soft tissue surgery, flap procedures, lateral canthotomy, parotidectomy and sleep surgery. All residents are expected to be in town and attend the entire course. Maxillofacial plating and balloon dilation training courses may be held during the year based on need. Surgical and clinical skills simulations will be held annually as well.

4. Temporal Bone Lab

A temporal bone anatomy and dissection course will be provided during the course of each year. Residents will be assigned laboratory sessions based on their level of training and satisfactory completion of fundamental exercises. All residents are expected to utilize the lab to refine their dissection techniques throughout their training apart from the course.

C. Independent Reading Assignments

It is essential, in order to progress in your otolaryngology residency, that you pursue an active course of independent reading. In order to benefit from regular journal review, Journal Club readings, and the Home Study Course, you need to form a firm foundation from standard texts as follows:

- During the junior years you are required to read Bailey's otolaryngology text. An equivalent text may be substituted with approval of the program director.
- In your senior years, you should read from the following types of texts: head and neck cancer, rhinology otology, pediatrics, laryngology, sleep, and facial plastics.
- Read for individual surgical cases and patient management issues.

D. Rotations

1. Resident Assignments

A junior and senior resident will be assigned to each of the five major clinical rotations: Head and Neck/Endocrine Surgery, Facial Plastics/Otology/Laryngology, Rhinology/Allergy/Sleep, Pediatrics, and VA.

2. Chief Year Elective Rotations

PG-5 residents will be granted two months of elective time in their last year of training if they are in good standing and can reasonably expected to complete their minimum case requirements by the end of the residency. Examples of acceptable rotations include: radiology, pathology, radiation oncology, medical oncology, oral surgery, allergy/immunology, oculoplastics, audiology, speech language pathology, private practice exposure, and medical subspecialties. The rotation may also be used for additional research projects or completion of previous research projects subject to approval of the research conference faculty membership. Plans for use of this time must be submitted and approved by the residency program director at least 4 months in advance of the first month of elective time. Requests for changes to the rotation content will be considered on a case-by-case basis.

3. Otolaryngology Specialties Experience

Otolaryngology residents are assigned regular time during their PGY-1 year to rotate with Communicative Sciences faculty members to learn about audiometry and impedance testing, ABR's, otoacoustic emissions, voice and swallowing evaluation and treatment, and hearing aids. Additional experience in these areas can be obtained through PGY-5 elective time if desired

E. Surgical Case Documentation

Each resident is expected to keep their ACGME case log up to date weekly. It is expected that you will appropriately unbundle all cases as instructed on the case log web site. You should be certain to include all cases in which you assisted or served as a resident teacher as well. The residency program director will review the case logs regularly and allocate cases if necessary to assure balance and compliance with minimum case numbers.

F. Resident Selection

1. Applications will be accepted via ERAS.
2. Applicants will be invited for interview based on a review of the following factors: performance on standardized tests, medical school performance, letters of recommendation, personal statement, community service activities, and research productivity.
3. Applicants will be ranked on the basis of the preceding factors in combination with an evaluation of the interpersonal, communication, and professionalism skills during interviews.
4. Residents will be accepted via the National Residency Matching Program.
5. If the program does not fill through the regular matching process, the position will be filled via the SOAP process based on the same factors as noted above.
6. Technical standards for Otolaryngology have been established to allow the resident candidate to determine their ability to perform the required duties in compliance with the Americans with Disabilities Act. An otolaryngology resident must have abilities and skills in five categories: observation, communication, motor, intellectual, behavioral and social. However, it is recognized that degrees of ability vary widely between individuals.
 - Observation: A candidate must be able to observe a patient accurately at a distance and close at hand. In detail, observation necessitates the functional use of the sense of vision and other sensory modalities. Full color vision and binocular vision are necessary for the successful performance of otolaryngologic surgery.

- **Communications:** A candidate must be able to communicate effectively and sensitively with patients. The focus of this communication is to elicit information, describe changes in mood, activity, and posture, and perceive nonverbal communications. Communication includes not only speech, but also reading and writing. The candidate must be able to communicate effectively and efficiently in oral and written formats with all members of the health care team.
- **Motor:** Candidates must have sufficient motor function to elicit information from patients by palpation, auscultation, percussion, and other diagnostic maneuvers. A candidate must be able to execute motor movements reasonably required to provide general care and emergency treatments to patients. Such actions require coordination of both gross and fine muscular movements, equilibrium, and functional use of the senses of the touch and vision.
- **Intellectual-Conceptual, Integrative and Quantitative Abilities:** These abilities include measurement, calculation, reasoning, analysis, and synthesis of complex information.
- **Behavioral and Social Attributes:** A candidate must possess the emotional health required for full utilization of his or her intellectual abilities, the exercise of good judgment, the prompt completion of all responsibilities attendant to the diagnosis and care of patients, and the development of mature, sensitive, and effective relationships with patients. Candidates must be able to tolerate physically taxing workloads and to function effectively under stress. They must be able to adapt to changing environments, to display flexibility, and learn to function in the face of uncertainties inherent in the clinical problems of many patients. Compassion, integrity, interpersonal skills, interest and motivation are all personal qualities that are assessed during the selection and education process.

G. Library

No books are allowed to leave the Otolaryngology resident work room library for any purpose. Books should be put back in the bookcases when you are not using them.

H. Resident Case Distribution

In general, cases are to be done by residents on the service of the attending physician of the patient. The level of the resident is determined by the complexity of the case in concert with the attending physician and the senior resident. Taking cases from residents on other services is not permitted without prior approval of the residency program director and only if there is a documented need for additional training for a senior resident for that particular case type. From time to time, the program director may need to reassign cases to residents in order to make sure all residents obtain minimum case numbers in all areas.

I. Non-programmatic Activities (Moonlighting)

1. The ACGME Common Program Requirements reads as follows:

“Patient care activities that are external to the educational program (moonlighting) and that exceed the weekly limit on resident duty hours are often inconsistent with sufficient time for rest and restoration to promote the resident’s educational experience and safe patient care. Therefore, these activities require prospective permission from the program director and sponsoring institution. Their effect on resident performance must be monitored, and permission be withdrawn if the activities adversely affect resident performance. “

2. The UMMC GMEC policy is as follows:

“In Mississippi, it is illegal and/or grounds for loss of temporary or limited medical licensure for any resident or fellow in training to engage in moonlighting unless in possession of an unrestricted license to practice medicine in the State. Residents are not required to engage in moonlighting; further, the University of Mississippi Medical Center (UMMC) discourages moonlighting or professional activity by residents or fellows apart from full-time UMMC-sponsored or ACGME-sanctioned postgraduate educational programs because these activities tend to interfere with the educational process and health of the physician-in-training. The program director must acknowledge in writing that a resident or fellow is moonlighting, and the information made a part of the resident’s folder. The effects of moonlighting on performance in the residency program will be monitored and adverse effects may lead to withdrawal of permission to engage in moonlighting activities.

The University of Mississippi Medical Center professional liability program for residents only applies to those professional activities within the course and scope of their employment while at UMMC and/or on official rotation at other hospitals or clinics. It does not apply to outside professional activities such as moonlighting.

The UMMC institutional DEA number must not be used while moonlighting.”

3. The department will abide by these guidelines. Moonlighting is strongly discouraged. Moonlighting may potentially interfere with resident education. Failure to abide by the policies in this handbook or to perform at the level outlined in this manual are grounds for suspension of moonlighting privileges at the discretion of the program director and the chair.

4. If you do choose to moonlight, a non-programmatic activity form, available from the house staff office, must be obtained, completed, and updated as prescribed. In addition, an outside activities form is required. This is the sole responsibility of the participating resident. These documents require the signature of the program director. Failure to do

so in a timely or regular fashion, without prompting, will result in immediate termination of this privilege.

5. Hours spent moonlighting must be counted towards the 80-hour work week and reported accurately by the resident. In addition, according to ACGME Duty Hours regulations and institutional policy, residents must report to work rested and “fit for duty.” Failure to follow these regulations and policies will require investigation by the program director and may result in action by the program director, department, or institution.

6. Our department only permits you to moonlight in an otolaryngology specialty setting with appropriate supervision and back-up subject to all state regulations and medical staff policies. Each moonlighting opportunity must be approved in advance, and are subject to the resident being and staying in good standing in the program.

J. Duty Hours

1. As per ACGME program requirements, our program works to ensure a culture of professionalism that supports patient safety and personal responsibility.

Residents and faculty members must demonstrate an understanding and acceptance of their personal role in the following:

- assurance of the safety and welfare of patients entrusted to their care;
- provision of patient- and family-centered care;
- assurance of their fitness for duty;
- management of their time before, during, and after clinical assignments;
- recognition of impairment, including illness and fatigue, in themselves and in their peers;
- attention to lifelong learning;
- the monitoring of their patient care performance improvement indicators; and,
- honest and accurate reporting of duty hours, patient outcomes, and clinical experience data.

2. All residents and faculty members must demonstrate responsiveness to patient needs that supersedes self-interest. Physicians must recognize that under certain circumstances, the best interests of the patient may be served by transitioning that patient’s care to another qualified and rested provider.

3. All residents will have at least one day in seven free from patient care responsibilities averaged over a four-week period and at home call cannot be assigned during those free days.

4. Residents will not be scheduled for more than 80 duty hours per week, averaged over a four-week period, inclusive of all in-house time and all moonlighting. Only time

actually spent in the hospital when on call will count towards the weekly duty hour limit. All moonlighting, whether internal or external, is counted towards duty hours.

5. Call is taken from home except when prescribed for specific cases at the discretion of the attending physician in consultation with the program director. First call will be no more than every third night, averaged over a four-week period.
6. Duty periods for PGY-1 residents must not exceed 16 hours in duration.
7. For PGY-2 residents and above, duty periods (actual time in the hospital) will be limited to a 24-hour period of continuous in-house duty. Any resident that exceeds this limitation or any resident that becomes unable to take or continue taking call due to any reason should notify the program director or the on-call physician so that the call back up plan can be instituted in the order outlined as required.
 - The second call resident will relieve the first call resident.
 - The attending will relieve the second call resident if the second call resident exceeds the limits.
8. Strategic napping, especially after 16 hours of continuous duty and between the hours of 10:00 p.m. and 8:00 a.m., is strongly suggested.
9. It is essential for patient safety and resident education that effective transitions in care occur. Residents may be allowed to remain on-site in order to accomplish these tasks; however, this period of time must be no longer than an additional four hours.
10. The interval for rest and personal activities after a call period should consist of a 10-hour time period.
11. Residents are actively encouraged to tell the program director if they exceed any of the duty hour guidelines or have any concerns regarding this issue. In order to ensure compliance, a log of a typical trauma call week will be compiled by all residents each quarter and reviewed by the program director. In the event that any resident exceeds 80 hours for that week, the monitoring period will be extended for the entire month. If any problem is encountered with the limit after the month long monitoring, weekly logs will be continued until an acceptable and steady state workload has been comfortably reached. Quarterly monitoring will then be resumed.
12. The Institutional Policy for Duty Hours, Patient Hand-offs, and Resident Supervision is on the G Drive, in addition to any supplemental policies for the Department on Duty Hours and Resident Supervision. A Global Preferences list is on the G drive to serve as guidance on communication with faculty, but as a general rule, when in doubt, please

contact your supervising or on-call attending physician. Individual Physician Preferences for patient care are posted on the G drive as well.

13. In addition to the policies outlined below, you are to comply with all applicable policies and procedures of the University of Mississippi Medical Center, the VA Medical Center, and any other affiliated clinical facilities.

II. CLINICAL

A. Rounding

Regardless of PGY level or rotation, each team will round with all resident members present. Patients within each team will not be split up among the residents of an individual team, but will be rounded on by the team as a whole. This is to improve patient care, increase learning, foster a sense of team “ownership” of patient care, reduce handoffs, and improve continuity.

Weekend rounds may be performed for all services by the on-call team if a complete and thorough check out procedure is used.

B. Duties

1. Junior

- Responsible for the daily care of the inpatient services
- Performs medical histories and physical examinations in the outpatient clinics, emergency departments, and for consultations
- Sees and evaluates consults as requested and discusses the case with the senior resident and attending physicians
- Performs common procedures as required such as endoscopy, blood drawing, IV access, and wound care
- Assures that inpatients are ready to go to the operating room
- Participates in all assigned surgical cases in the operating room
- Follows up on patient care data and issues
- Communicates with patients and family members if assigned this duty by attending physicians
- Shares relevant patient data with senior residents and attending physicians
- Presents cases at multidisciplinary patient management conferences

2. Senior

- Same duties as junior residents above
- Assists with the supervision and teaching of junior residents and medical students
- Assists with the coordination and scheduling of the activities of the service
- Develops the resident call schedules in concert with the program director
- Assures that all patients are ready to go to surgery

C. Distribution of Residents

1. Each faculty group will be assigned a group of residents. These residents will be available for these physicians for all scheduled clinical activities. They will be assigned to other services on days when there are no regularly scheduled activities on their assigned service. It is up to the attending physicians on a service as to how they want to split their assigned residents within the parameters of the resident assignment master schedule.

2. Any time residents are not actively engaged in the primary clinical care duties of your service, it is your responsibility to help out the other services without being called. When there are residents with no assigned duties, those residents will be used in the following order of priority:

- Cover UMMC vacations including APPs
- Cases outside normal schedule
- OR for regularly scheduled services
- Consults

3. Regularly scheduled activities will have first priority over all other activities except for urgent patient care.

4. Resident distribution conflicts will be handled solely between attending physicians.

5. Clinical use of the research resident must be approved by the program director or chair.

6. No resident or APP will be swung from another service to cover any vacations on another service except when residents or APPs are otherwise unoccupied or the schedule delineates such coverage. Therefore, it is the responsibility of the senior resident on each service to remain apprised of days out for residents and APP

providers. The senior resident should make changes in the OR schedules as needed after consultation with the affected attending.

7. In order to facilitate coverage, a PGY 5 resident at UMMC will be designated on a schedule to be determined by the residents to serve as the chief resident in this regard. This resident will be responsible at the end of each week at the latest for reviewing relevant information including days out and clinic and OR schedules for the next week to determine the availability of residents to fill in for all services which need resident coverage. This chief resident will then coordinate among the other senior residents on other services and the departmental chair to facilitate coverage. If coverage cannot be arranged, the affected attending will be notified as far in advance as possible. Any conflicts or unresolved issues should be referred to the departmental chair for advice and direction.

8. Unless you are on official leave (which requires the standard UMMC forms to be completed and signed by the program director and chair), then you are to be in the greater Jackson area and constantly accessible by pager or cell phone during normal work hours 8AM-5PM. If you are on call or actively engaged in patient care, you should of course be available at all times. You are also to be available until you have turned over all check out issues to the next resident on call or rounding for you. Even if you are not directly assigned to patient care issues, you are to check with your fellow residents to make sure that they don't need you before you leave campus.

9. The non-otolaryngology intern is assigned to the H&N service, unless otherwise designated, except when otherwise specified. The senior resident on that service is responsible for directing the intern to maximize educational experience.

D. Hand Offs

1. Procedure

- At the end of every working day or during periods of transition of care, the upper level and lower level residents on each service will sign out all pertinent patients to both the on-call upper level and the on-call lower level resident.
- All Inpatients on the otolaryngology/pediatric otolaryngology service should always be signed out to the on-call residents.
- Inpatients on whom we are consulted should also be signed out to the oncoming team if we are actively involved in the patient's management or if there is a reasonable likelihood that the primary team might contact the on-call physician with questions or concerns.
- Any other patient on whom the on-call physician will need to follow up should be signed out.

- At the conclusion of the overnight or weekend call shift any changes in patient status, significant events, or new patients should be communicated or “signed out” to the appropriate team.

2. Performing Effective Sign Out

- Communication during sign out should be face to face when possible.
- The sign out process should be interactive, allow opportunity for questions, and should be performed in a setting with limited interruptions.
- The receiving resident should read-back, or repeat back the information as appropriate to ensure accuracy of communication.
- Information signed out should be up to date and accurate.
- Communication to on-call resident should include:
 - Patient name, location, age/date of birth
 - Patient diagnosis/problems, impression
 - Important prior medical and surgical history
 - advance directives
 - Identified allergies
 - Medications, fluids, diet
 - Important current labs, vitals, cultures
 - Past and planned significant procedures
 - Specific protocols/resources/treatments in place
 - Plan for the next 24+ hours
 - Pending tests and studies which require follow up
- This information should be transferred in either written or verbal format.
- Written sign out can be documented under the sign out function in Epic. A smart phrase has been created and shared with all current residents. Residents are encouraged to use this as a standard format for written sign out.
- Patient lists within Epic for the different services should be kept up-to-date to facilitate written sign out.
- If you are the primary surgeon on any case that will require unique postoperative follow-up it is your responsibility to either perform that care or to check this care out explicitly to another resident or APP. Packing or drain removal is an example.

3. Monitoring

- The sign out process is subject to monitoring by faculty. The quality of both the written and verbal sign out will be subject to monitoring intermittently by faculty to ensure high quality patient hand off
- There will be a quarterly survey that you must complete documenting the quality of sign out.
- Sign out performed by the new otolaryngology interns will be directly supervised for the first few weeks of their ENT rotation to ensure competency in patient hand offs.

E. Communication of Changes in Status

Residents will call or email the on-call faculty member about all patient encounters (significant phone conversations, ER evals, etc.) while he/she is on call. The on-call resident will be expected to complete a note detailing the encounter. Attending physicians should be notified of all major treatment changes or issues on their patients at all times.

F. Record Documentation

Residents are expected to check their "In basket" in Epic daily while on duty and keep it up-to-date. All operative notes, discharge summaries, consultations, and history and physicals should be completed on the same date as the event. Clinic visits will be completed as soon as possible but no later than 48 hours after the visit.

1. Clinic and Consult Notes

- All new patients should have complete head and neck histories and exams appropriate for age.
- If a resident is seeing a patient with an attending in clinic or seeing a patient in consultation, the resident documents the note as to what they did. The resident should designate the attending of record as your cosigner. The resident does NOT use the compliance/scribe statement.
- Templates can be a time saver but they also introduce the potential for incorrect documentation. Please be sure your templates and their use meet the following tests:
 - The breadth of the history and physical elements were consistent with the visit type. You do a complete age specific specialty history and exam for new patients, but you would not do a complete history or specialty exam for a return patient unless there is a new complaint or a change that otherwise

dictated repeating the entire exam. Of course, any updates to the history can be added on returns.

- There should be nothing in a note that did not really occur. You should delete any parts of a template that were not performed.
- A ROS should be included for all new patients and must state that all other systems reviewed are negative to get credit for a ROS.
- Any patient that is seen as a consultation in any setting should have the HPI start with the statement “seen in consultation at the request of Dr.____ for _____”.
- Copying from old notes is a potential time saver in an electronic record, however, it must be done appropriately. Portions of the history of present illness from the old note such as the history of a prior treatment, initial presentation, response to treatment, a test result, surgery, or cancer treatment history do not change and are appropriate to copy forward. However, the remainder of the history of present illness should not be retained in the new note unless it is directly relevant to the new visit. Copying a past history, diagnosis, or physical exam may be appropriate if every portion copied is necessary for that visit and all retained portions are verified as currently accurate or changed as necessary to reflect the present visit state. Please be sure that you carefully read your notes prior to completion to make sure they are current, relevant, and clear as related to the present visit.

2. Clinic Procedure Notes

- Clinic procedures should either be documented with a separate and clearly identifiable heading within the body of the note or in a separate note depending on your attending’s preference.
- Flexible fiber optic laryngoscopy, rigid or flexible nasopharyngoscopy, and rigid or flexible nasal endoscopy are three separate CPT codes. (This does not apply stroboscopy with a rigid scope in clinic which is a separate issue.) Payers will not reimburse more than one per day. Occasionally, there is a reason to look at the larynx as well as the nose for instance, but in order to have clear billing documentation it is important to describe the procedure and label it as the main procedure you are doing that day. You can certainly describe that you viewed another in the course of your exam, but the main heading should be just the procedure you were doing such as nasal endoscopy, flexible laryngoscopy, or nasopharyngoscopy. For coding purposes, it does not matter if nasal endoscopy or nasopharyngoscopy is done with a rigid or flexible scope so you do not have to put the type of scope used in your procedure name.

3. Post-visit Care

All patient care incidents including phone calls and lab/radiology follow-up must be documented.

4. Methodist Rehabilitation Center

Due to the limited number of services performed there, these can be handwritten in the MRC chart.

5. Copying Referring Providers

The referring provider and primary care provider, if applicable, should receive a letter or a copy, depending on attending preference, of all clinic, consultation, and operative notes.

G. Appointment Scheduling and ED Follow-ups

1. Please have patients that need follow-up call the clinic for their appointments when at all possible, particularly in the case of ER follow-up patients. Patients that need follow-up care for treatment you rendered will be given appointments. It is helpful if you call or e-mail the appointment scheduler so that they know that you have approved the patient being seen. Please let them know the name and approximate date that they need to be seen. They will work with the attending if an overbook is required. Other patients will be required to go through normal departmental screening procedures.

2. Trauma is not to be sent to the clinic for scheduling without permission of the attending.

3. Post-op appointments are to be made at the time of pre-op whenever possible.

H. Surgery Scheduling

1. If you post an add-on case that will occur during regular business hours, please let the appropriate surgery scheduler know the name, MRN, and procedure.

2. An attending, resident, or APP must complete the six items that have a "!" in the box and sign the order. The surgery schedulers will continue to fill in everything else that is required for a case to be posted from the paper sheet you give them in the clinic.

3. Regarding the procedure name required, this is just a generic procedure list. In most cases, we still have to complete all the CPT codes on the paper sheet like we are doing now so our surgery schedulers will know what to really post it as. If the case is extremely simple and straightforward and completely covered in the procedure name

menu, your scheduler can work off of that alone if they know all of the other information for the case.

I. Identification of Role in Care

Anytime you see a patient, please be sure to let the patient know your role and which attending is participating in their care. When in clinic, please let the patient know that the attending will be in next.

J. Hand Cleansing

Please wash your hands or use a hand sanitizer before and after seeing patients. Please follow all gown, masking, and gloving precautions when applicable.

K. . Follow-up Issues

It is your responsibility to follow-up on all labs and imaging on any patient you see in the clinic, any patient that you care for in the hospital, or any patient upon which you perform a procedure. You are to notify the attending of the results and document the results and plans.

L. . Phone Message Return

All phone messages must be returned by the end of the day with appropriate documentation. Phone calls with patients are to be documented in the medical record. Residents are expected to participate actively in the phone call return pool with the nurses and APPs.

M. Consultation

When a referring provider of any type including the ED physicians and residents contact us, it is our job to see that patient in a professional and collegial manner. If the referring physician thinks they need to be seen, then we see them. Feel free to let the program director know about any referral abuses. We take providing outstanding customer service to our patients and referring physicians very seriously. Any time you have questions, you should contact your on call faculty member, the program director, or the chair.

All consults will ultimately be seen or reviewed by an attending. It is the responsibility of the otolaryngology resident covering consults to make sure that the note contains the appropriate information even if the intern documents it.

1. Normal Workday Consultation response (8AM to 5PM)

- Consults will be given to the resident by a direct page through either the Adult ENT or Pediatric ENT consult pager. It is important that this pager be on and

attended during normal work hours and get passed from the correct person to the next correct person without fail. The Pediatric ENT service will carry the Pediatric ENT consult pager. The Adult ENT consult pager will rotate between the three adult ENT services at UMMC by a predetermined scheduled rotation. The Adult and Pediatric Consult pagers are only under operation on weekdays from 8AM to 5PM. The intern will carry the pager and see non-urgent consults during their scheduled hospital times. They will discuss the consult with the resident on the consult service, and the APPs will staff the consults when they come to the hospital in the afternoons. The case should be reviewed as soon as possible with the specialty attending or the faculty members on that service as appropriate. If the consulting service is off campus, the resident called will work with the attending physicians on the assigned consult team to find a resident or APP on campus and free to see the patient.

- The office number is given as a back-up number in case the pager is down. If there is a call to the office staff, they will contact the responsible party.
- Consults will be followed by the initial consulting service of record until the case is no longer active unless the case is transferred by mutual agreement of the attending physicians.
- Calls from outside physicians should be given to a faculty member directly during work hours unless they specifically tell you otherwise.

2. Weekend and Night Consult Protocol

- The first call resident will take the initial calls and determine if the patient needs to be seen in the ED. When in doubt, come in. This resident will first call the senior resident to make sure no issues have been missed before proceeding with recommendations or therapy. The senior resident will come in if there is any question at all, if an intern in seeing a consult and has yet been determined to be competent to complete certain activities or procedures, if a lower level resident is performing a procedure he/she has never done before or is not competent to do unsupervised, or any other situation as dictated in ACGME Duty Hour requirements, Institutional and Departmental policies. One of the two residents (determined by the senior resident) will call the attending physician for input on any admissions, emergent cases, or anticipated interventional cases other than straight forward simple lacerations, simple nosebleeds, or peritonsillar abscesses.
- Urgent airway cases require that the senior resident and staff be called immediately.
- Level of autonomy for the consulting resident will be based on the on-call attending physician's judgment and preference as well as the current "Approved Procedures for Residents Without Immediate Supervision" document, ACGME Duty Hour requirements, and Institutional and Departmental Policies.

- Non-urgent or non-emergent issues at night can wait for discussion with the attending on the next day.
- All transfer decisions will be made by the attending physician. All transfer calls should go directly to the attending and should ideally be received through the Patient Transfer Call Center. Occasionally, this system breaks down, and a transfer call maybe directed to a resident. In this case, it is acceptable for the resident who received the transfer request to refer the call to the attending physician directly.

3. Pediatric Airway Emergencies

For emergency care during nights and weekends, please call the attending on call first and see if they agree that a different attending needs to be called. A list of the pediatric airway back up attendings is maintained in Contact U for your reference. If you feel that you do not have time to call the attending on call first and it is your judgment that another attending would be called in, you may call the other attending first and then notify the on call attending as soon as possible. Patient safety comes first.

4. EMTALA

- EMTALA is a federal regulation that requires our institution to accept any patient with an emergent condition when referred from another facility for a higher level of care. It applies to anyone that comes to our ED with an emergent condition in any other manner also. It does not matter if the other facility or physician is wrong. If they say it is an emergency and we are the next level of care, we have to take care of the patient. Our institution can investigate and report abuses after the fact. The requirements are that we evaluate the patient and render all necessary care until the patient's emergent condition is stabilized. If routine follow up is required after that, we can refer the patient back to their contracted provider. However, remember that it is important to make sure that we have completely finished our course of care.
- This applies to all patients, not just prisoners.
- We see any inpatient consults regardless of whether they are emergent or not and regardless of payer/prisoner status.
- When in doubt, put the patient first.

N. Supervision of Patient Care

1. All patients at any participating institution are the private patients of an attending regardless of payer status. The attending physician will ultimately be responsible for all aspects of the patient's care. Residents assist attending physicians and are actively

participating learners in the care of these patients. Residents should discuss all cases with attending physicians prior to instituting significant changes in patient management.

2. An attending will be present or immediately available for all scheduled clinics and OR sessions. If the attending is temporarily absent, they will be available by a published pager or phone number.
3. The on-call attending will be available by pager or phone (as listed by the monthly schedule) for all emergencies or urgent unscheduled visits/consults. The attending will assist the residents directly in the event that the level of expertise required is beyond the skills of the participating resident. Otherwise, the case may simply be discussed with the attending by phone to determine the management plan and the degree of supervision necessary.
4. The departmental chair or his/her designee is available for additional coverage as needed.
5. Our program has established guidelines for circumstances and events in which residents must communicate with appropriate supervising faculty. These are available on the G drive as Common or Group/Global Physician Preferences. In addition, each faculty member may have his/her own preferences which will also be available on the G drive.

O. Call Schedule

1. Junior residents will on average take primary call from home, which may range from every fourth weekday and every fourth weekend to every sixth weekday and sixth weekend. This number will vary with any residents out on vacation or on leave.
2. Senior residents will on average take every fourth weekday and every fourth weekend to every sixth weekday and every sixth weekend of secondary call from home. Again, this number will vary with any residents out on vacation or on leave.
3. Holiday and trauma call will be equally distributed among junior and senior residents respectively. Only in the case of a relatively equal number of holiday and trauma call days will seniority be allowed to determine the designation of call.
4. It is the responsibility of the chief residents to coordinate the call schedule and have it turned in to the chair's administrative assistant on a normal business day no later than 7 days prior to the end of the month. Any changes to the call schedule after that date must be approved by the program director or the chair.
5. In the rare event that it is necessary for a resident to stay in-house, a call room on 6 East is designated for use by the on call ENT resident.

P. ICU Bed Requests

It is the responsibility of the senior resident on the service to make sure that planned ICU

bed requests have been submitted prior to the day of the surgery.

Q. Care of diagnostic equipment

The residents are expected to treat all department or hospital supplied equipment with the highest level of care. Equipment should be kept under constant supervision to avoid loss. If any hospital issued scopes are found to be broken, this should be reported to OR administration immediately so that we maintain our goal inventory.

III. RESEARCH

A. Research Preparation

1. All PGY-1 residents must read the following two texts during their intern year:
 - “Statistical Analysis for Decision Makers in Healthcare” by Jeffrey Bauer, PhD
 - “Primer of Biostatistics” by Stanton Glantz, PhD
2. The books are available for borrowing from the clinical research director’s office.
3. At the end of the intern year, residents from that cohort will meet with Research Director to discuss study design and basic statistical analysis and to gauge knowledge
4. Other meeting and tutorials on research methods and biostatistics will be coordinated with residents during PGY-3 to help facilitate project development.

B. Project Requirements

As a requirement for successful completion of the residency program, each resident is required to complete a minimum of two projects, which must be submitted for presentation at a scientific meeting and for publication. The requirements for these projects are outlined below. During your PGY-3 and PGY-4 year, you are allowed a dedicated rotation for research. Any research tasks that are not completed by the end of this block time must be done during your free time. Note: Residents that choose to perform an MBA or other degree during residency, must still meet the minimum.

C. Project Selection

1. Your two projects must be of a rigorous, scientific nature. Acceptable formats include but are not limited to: basic science projects, randomized controlled trials/adaptive clinical trial or a systematic review (meta-analysis) of randomized controlled trials, prospective (cohort or outcomes) studies with an internal control group or a systematic review of prospective controlled trials, retrospective (case-control) studies with an internal control group,, population/cohort-based cross-sectional analysis (e.g. NHANES, JHS, ARIC), economic analysis, or performance improvement projects with clear outcome measures. Case reports or simple retrospective literature reviews do not qualify. The minimum standards of a scientific research study require the following: literature review + generation of testable hypothesis/research question + data

collection/analysis (either prospective or retrospective) + interpretation of data outcomes.

2. A list of available projects will be maintained by the research director and the program director for your convenience. Faculty members will forward their proposed projects to the designated departmental administrative assistant for posting on our web site and tracking. This database will be updated on a quarterly basis. Residents interested in a posted study should contact the faculty PI (principal investigator) listed for further information.
3. Residents may discuss projects with any faculty member, but prior to commencing any project, approval should first be obtained from the research program director, the program director, the chair, and the research committee. Forms for approval can be found at the department website under research tab.
4. You may do other studies or case reports if you wish. Approval should be obtained from the Research Director and normal departmental and institutional policies for the commencement and conduct of research apply.

D. Guidelines

1. The deadlines that follow are the latest possible dates acceptable. You are strongly encouraged to start on this process in advance so that you are eligible to submit your proposals for all applicable grant funding. This is beneficial for the entire department in general but also is beneficial to you in terms of your future fellowship and possible academic plans.
2. You must first identify a tentative research area and research sponsor. You should complete a one-page statement of research intention, which identifies an area of proposed research and its significance. The letter must be signed by the research mentor. This must be formally presented to the research review meeting no later than 6 months prior to your research rotation. A copy of this letter should go to all faculty members via the research director on or before the first day of the month of the meeting. Any requested revisions are due on or before the first day of the following month.
3. Each resident will complete a research proposal using the EXACT format provided in this manual (see Appendix A: NIH 6-page format) for project 1. This proposal must be presented to the research review group no later than start of Fall of PGY-3, prior to the start of your research rotation (Spring PGY-3). Copies are to be provided to all faculty members via the research director on or before the first day of the month of the meeting. The proposal will be presented in a formal presentation to the faculty in the fall (e.g. PowerPoint). Submission for extramural funding is encouraged; appropriate approval should be sought prior to submission. Forms for approval can be found at the department website under research tab.
4. Any suggested revisions should be investigated, and a revised proposal will be presented to the research review meeting no later than 3 months prior to the start of

your research rotation. The revised proposal is due on or before the first day of the month of the meeting with a similar distribution schedule as above.

5. In order to effect a more organized compilation of data and to focus research goals, you must arrange a regular meeting with your research mentor.

6. All IRB/IACUC materials should be approved prior to start of the research rotation. Please submit at least 10 weeks prior to start of research rotation.

7. Within two months after the completion of each research rotation, a summary (one page or less) of progress made to date must be presented at the research meeting along with plans to complete unfinished tasks including a timeline. This summary will be distributed in the same fashion as above.

8. Timeline example for project 1:

- | | |
|------------------------------------|-------------------|
| • Letter of intent due | June 1, 2017 |
| • Revised letter due | July 1, 2017 |
| • Formal proposal due (NIH format) | September 1, 2017 |
| • Revised proposal due (if needed) | October 1, 2017 |
| • Research rotation start date | January 1, 2018 |
| • Progress report due | May 1, 2018 |

Timeline example for project 2:

- | | |
|-----------------------------|------------------|
| • Letter of intent due | December 1, 2018 |
| • Revised letter due | January 1, 2018 |
| • Research proposal | March 1, 2018 |
| • Revised proposal | April 1, 2018 |
| • Research rotation 2 start | July 1, 2019 |
| • Progress report due | November 1, 2019 |

9. All research projects that have you listed as being the Primary Investigator must be satisfactorily completed with a summary, closing report to the research committee and the IRB if applicable (i.e., if IRB approval was required in any fashion) prior to graduation. Submission of revisions to the journal must also be completed prior to graduation. If for any reason projects are still ongoing or having not reached full completion that have you listed as being the Primary Investigator, arrangements for transfer of PI status or other arrangements must be completed to the satisfaction of your research mentor prior to your official graduation from the program. However, the requirement for submission of two approved projects for presentation and publication as a requirement for graduation remain.

10. The second project will follow a similar process for the proposal, but will not require the full prospectus NIH format document, nor the formal presentation. The requirements will include an LOI and a research proposal as in the EAXCT format (Appendix A: Research proposal) provided in this manual. The LOI will be submitted and discussed. After approval of the LOI, a research proposal will be completed and discussed at the monthly research meeting. Once approved the resident will then be able to initiate project 2 pending any IRB/IACUC approvals.

E. Research Proposal Examples

For project 1 prospectus see NIH 6-page format; Appendix A

For project 2 see research proposal template; Appendix A

Examples of proposals and IRB applications are located at http://www.umc.edu/Administration/Business_Services/Human_Research_Office/Templates_and_Samples.aspx

F. IRB and IACUC Application Tips

1. Start early, submit IRB and IACUC documents at least 10 weeks prior to starting research rotation.
2. <http://irbideate.umc.edu> -- must use Firefox
3. You should list Christopher Spankovich in the personnel sections and check off the three boxes so they can review the IRB application to help you. You should also list your research sponsor and all other collaborators.
4. IRB has a "walk-up" clinic on Thursday mornings.

G. CITI Training

You should complete this during your PG-1 otolaryngology specialties rotation since it is required to submit an IRB. You will also need any medical students or other collaborators to complete if including them in the IRB application. The training is <https://www.citiprogram.org/index.cfm?pageID=14>. If performing an animal study, you will have to complete IAUCUC training. Please discuss specific trainings with the PI/mentor on the study as they can be specific to animal species.

H. Other Helpful Information

Medical Librarian: Susan Clark, Library Director

I. Submissions and Awards

Research projects are eligible for the annual resident research award. Residents must submit manuscripts and present their work to the appropriate meeting and publication as described previously. In addition, residents must present at least one of their research projects in both their PG4 and PG5 years at the annual resident research forum as designated. Other residents may present other research projects they have completed if they wish. The winner will be determined by the faculty or the visiting professor. Your presentation topic should be discussed and approved by the Research Director by April 1st prior to June graduation.

J. Funding

Funding for resident research projects is available if needed from the department at a maximum of \$4,000 per resident, but every effort will be made to submit requests for outside funding when available and appropriate. Requests for funding greater than \$4,000 will be considered on an individual basis based on merits of the research and likelihood of success.

K. Submission of Proposals and Presentations

Grant applications, IRB proposals, abstracts, or manuscripts require advance written permission of the primary faculty mentor, all authors, the chair and the resident research director before submission. The required forms are on the G drive.

L. Biostatistics and Bioinformatics

A biostatistician will routinely have a percent of their effort dedicated to services to the department. In addition, consulting services are offered through the Center for Biostatistics and Bioinformatics in the Guyton Building. We strongly encourage you to take advantage of these services for your research projects, both when planning the project [particularly if you need a power analysis] and during data analysis. While appointments can be scheduled [and this is encouraged], there are also walk-in hours available every Friday morning from around 10 AM until Noon on a first come, first serve basis on the 6th floor.

M. Requirement to Follow Protocol Complete Projects

Your research time will be forfeited if the requirements for research are not followed in a timely manner. This does not release you from the responsibility of completing your research projects as a requirement for graduation from the program.

N. MBA program

Subject to continued granting of a tuition benefit by the institution, good standing in the residency program, and acceptance into the degree program, residents may work toward obtaining their MBA degree via the University of Mississippi.

1. The resident may start the program in their PG3 year. Prerequisites may be pursued in advance of that time.
2. Research and elective blocks may be used to facilitate completion of the program.
3. All research and presentation requirements remain in place, but course work can be used to meet these requirements.
4. A maximum of 6 hours may be taken per semester, totaling 18 hours annually. Textbook reimbursements are only available to those that have attended a national meeting, and are limited to the balance of their PDA.

IV. SERVICE OPPORTUNITIES

A. Humanitarian Mission Trips

1. Upper level residents are encouraged to take mission trips to areas faced with social, economic, and health challenges. To further support and encourage our residents in this endeavor, an Otolaryngology Resident Humanitarian Fund is available to offset residents' trip expenses subject to the availability of funds.
2. If you think you may be interested in pursuing a mission trip during your upper level years, here are the steps to follow:
 - Identify your interest in a trip with the Program Coordinator and Program Director at least 6 months ahead of any planned trips, or earlier if possible. This is to allow time for scheduling and any other necessary preparation.
 - Decide which organization/area of the world your mission trip will be through. There are a multitude of local, national, and international humanitarian organizations; however, there is also a wide range of quality and reliability. Our recommendations are to go with a well-established group, preferably one that another resident has gone with so you can discuss experiences and expectations.
 - Plan your trip—ideally, the trip will fall during a research or elective block. While accommodations might be made to allow for trips outside these rotations, there is no guarantee this will happen.

3. Understand that UMMC doesn't provide insurance or malpractice on international mission trips. These trips are at your own risk and the department does not assume any liability for any injuries, accidents, or other situations you may encounter.
4. All arrangements for these trips are your own responsibility. However, submit receipts so that you can be reimbursed from Humanitarian Mission Fund.

B. Community Service

The department encourages and will support resident participation in community service projects such as Habitat for Humanity, animal rescue, and food banks. All residents are encouraged to submit ideas for departmental/residency activities in these and other projects.

V. Expectations and Evaluation Process

A. Minimum Expectations

1. Perform all assigned operating room, clinic and ward duties for your level of training in a reasonable fashion.
2. Participate in all otolaryngology teaching conferences.
3. We expect you to achieve a score of at least the 5th stanine for your year on the Annual Otolaryngology Training Examination. If you do not achieve this goal, you will be provided an individualized instruction/reading program or any other guidance as needed. PGY2-5 residents are required to take this examination.
4. Check your departmental e-mail and Epic in-basket at least once every day of the work week and promptly respond to requests for replies from departmental personnel and faculty members.
5. Complete all assigned Healthstream modules on time.
6. Obtain and maintain appropriate licensure and credentials as required by the institution.
7. Keep the resident work/consult rooms clean and tidy at all times.
8. Achieve and demonstrate the following competencies:
 - Efficiently performs a complete history relevant to the clinical situation
 - Performs an appropriate physical examination and recognize relevant findings
 - Completes medical records assignments in a logical, complete, and timely manner

- Completes consultation, operative, and clinic notes within required deadlines and consistently follows the established guidelines for such
- Develops an appropriate treatment plan for the clinical situation
- Follows patient management plans through to implementation
- Counsel and educate patients and their families
- Provides patients clear information about treatment programs and options, health maintenance, and illness prevention
- Can complete graduate level relevant procedures using a correct sequence and demonstrating appropriate tissue handling
- Demonstrate an investigatory and analytic thinking approach to clinical situations
- Takes an organized and rational approach incorporating relevant medical knowledge into recognizing clinical conditions and formulating therapeutic plans
- Seeks out opportunities to do extra research, attain new skills, or to be involved in all phases of patient care
- Know and apply the basic and clinically supportive sciences which are appropriate to their discipline
- Pursues an active, independent reading program to develop and improve his/her knowledge base
- Actively engages in departmental educational conferences
- Arrives at conferences in time to start on time, is present throughout except for unavoidable situations, and behaves in a professional and respectful manner
- Attends and participates in learning at regional and national educational conferences
- Displays appropriate knowledge of relevant anatomy, physiology, and pathophysiology
- Performs above the 5th stanine for level on the Annual Otolaryngology Examination
- Independently completes and submits the Home Study Course and Self-Test on time with a score above 80%
- Analyze practice experience and perform practice-based improvement activities using a systematic methodology

- Able to describe the process of practice assessment: identifying key issues for improvement, analysis, implementing change, analysis of change
- Develops and maintains a willingness to learn from prior experience
- Uses feedback to identify areas for improvement
- Seeks opportunities to strengthen deficits in knowledge/skills
- Locates, appraises, and assimilates evidence from scientific studies related to his/her patients' health problems
- Obtain and use information about their own population of patients and the larger population from which their patients are drawn
- Applies knowledge of established clinical guidelines and procedural standards to his/her practice
- Actively participates in Journal Club and displays an increasing understanding of the medical literature
- Use information technology to manage information, access on-line medical information; and support their own education
- Performs critical appraisal of the literature utilizing basic biostatistical techniques and principles of evidence based medicine
- Researches and presents a clinical topic (approved by the residency director) in a written and presentation format to the department once per academic year
- Makes progress toward and completes two scholarly activities as prescribed and submits them for national presentation and publication as well as the Annual Resident Research Day
- Meet all mutually agreed upon deadlines for research proposals, presentations, and manuscript preparation and submission
- Facilitate the learning of students and other health care professionals
- Observed to develop an effective patient-physician relationship
- Communicates concern for others
- Performs effective patient and family interviews
- Listens well

- Effectively adapts communication style with patients to maximize accurate understanding
- Work effectively with others as a member or leader of a health care team or other professional group
- Communicates effectively verbally with peers and other members of the health care team
- Produces clear medical notes, requests for consultation, and responses to requests for consultation
- Actively fosters collaboration among team members and other disciplines
- Asks others on patient care team to share ideas and viewpoints
- Works effectively in team settings by identifying roles and assignments, planning and prioritizing, accepting responsibilities and assisting others
- Resolves conflict by listening and explaining, giving feedback, and establishing respect, trust, and consensus
- Keeps the faculty informed about relevant patient care issues in a timely fashion
- Demonstrate respect, compassion, and integrity; a responsiveness to the needs of patients and society that supersedes self-interest; accountability to patients, society, and the profession; and a commitment to excellence and on-going professional development
- Provides needed care with the same standards of quality for all patients, regardless of type of reimbursement or ability to pay
- Recognizes his/her responsibility to the patient and society
- Is neatly dressed and presents a professional image
- Is punctual and available when appropriate
- Displays an understanding of effective time management
- Strives to maintain professional and mutually respectful working relationships with both peers and subordinates.
- Completes all assigned academic, clinical, and administrative tasks as outlined in the residency manual in a timely fashion
- Keeps an up-to-date, complete, and accurate operative case log on the format provided by the ACGME

- Maintains personal composure, patience, professionalism in all situations
- Seen as a role model as a physician
- Demonstrate a commitment to ethical principles pertaining to provision or withholding of clinical care, confidentiality of patient information, informed consent, and business practices
- Displays sound moral/ethical judgment in patient care and business practice
- Keeps patient information confidential
- Acts in a trustworthy manner
- Demonstrates sensitivity and responsiveness to patients' culture, age, gender, and disabilities.
- Demonstrates appropriate knowledge and displays proper behaviors regarding gender discrimination, racial discrimination, and sexual harassment issues
- Demonstrates knowledge of issues of impairment, including alcohol and substance abuse, and reporting obligations for impaired physicians as well as the resources available for assistance
- Shows interest in and concern for patients in daily interactions
- Understands how their patient care and other professional practices affect other health care professionals, the health care organization, and the larger society and how these elements of the system affect their own practice
- Differentiates between various health care delivery organizations and payer systems
- Able to discuss common reimbursement methodologies
- Displays an understanding of documentation criteria for different levels of care
- Understands precepts of compliance and privacy regulations
- Identifies factors that contribute to rising health care costs and strives to lessen these when appropriate
- Practices cost-effective health care and resource allocation without compromising patient care
- Advocates for quality patient care and assists patients in dealing with system complexities

- Recognizes potential conflicts of interest between the individual patients and their health care organizations
- Anticipates problems patients/caregivers may face in negotiating the health care system and advocates when appropriate on the patient's behalf
- Partners with health care managers and providers to improve patient care
- Demonstrates the potential of becoming an independent and competent practicing otolaryngologist-head and neck surgeon

B. Evaluation Process

1. Faculty Teaching Evaluations

The residency program director will annually review anonymous faculty evaluations from residents with the academic faculty and approve or disapprove faculty members continued participation in the program. Faculty members are annually provided with the minimum criteria required to receive approval for continued participation in the residency program.

2. Program Evaluation

The Program Evaluation Committee will review the success of the program in meeting its goals and objectives in its regular monthly meetings and during a single annual session devoted exclusively to this once a year. Crucial to this review will be the annual confidential written review of the program by the residents, as well as by the faculty. The results of this review will be discussed with the entire faculty as well as the residents after the results are confidentially collated. Additional material considered will include: board pass rates; Annual Otolaryngology Examination scores; attainment of fellowships, academic positions, and suitable private practice positions; and operative case experiences.

3. Resident Evaluation Process

Evaluations will be completed at the end of each rotation for each resident. Additionally, each resident is evaluated semi-annually by the Clinical Competency Committee with milestone data completed for each resident at that time. 360 degree evaluations completed semi-annually will also be used to assess progress.

4. Feedback of Results

- The Clinical Competency Committee will meet semi-annually to assess the resident's progress in meeting the above performance criteria and assess progress in the resident's surgical/procedural competency. Faculty and external

reviewers will complete 360 degree evaluations of each resident. Residents will also complete self-evaluations and peer evaluations semi-annually. The results will be collated and reviewed with each resident individually by the program director. Residency operative experience will be reviewed as well to allow adjustments in resident rotations to achieve balance in case-load. The resident will have the opportunity to provide feedback about their progress at that time. A written summary will be reviewed with the resident and kept in their file. End of rotation evaluations by the faculty will be provided to residents as well.

- The program director will also meet with each resident on alternate quarters to allow the resident to provide feedback about the program and the resident's individual progress.
- The chair will meet at least annually to discuss career planning with each mid-level and any other resident who so desires.

C. Promotion of Residents

Specific criteria (Appendix A) have been defined by the Department faculty for advancement and promotion from each PGY level and for graduations from the PGY-5 year to independent practice. Those residents that have been successful in reaching these goals and fulfilling all the designated criteria for his/her applicable PGY level at the end of the year will be promoted to the next level as appropriate. Those residents that are not judged to have met these standards will be subject to the procedure described for probationary status, grievance, suspension, non-renewal or dismissal.

D. Probationary Status, Suspension, Nonrenewal, and Dismissal

The position of the resident presents the dual aspect of a student in graduate training while participating in the delivery of patient care. The Department of Otolaryngology & Communicative Sciences is committed to the maintenance of a supportive educational environment in which residents are given the opportunity to learn and grow. Inappropriate behavior in any form in this professional setting is not permissible. A resident's continuation in the training program is dependent upon satisfactory performance as a student, including the maintenance of satisfactory professional standards in the care of patients and interactions with others on the health care team. The resident's academic evaluation will include assessment of behavioral components, including conduct that reflects poorly on professional standards, ethics, and collegiality. Disqualification of a resident as a student or as a member of the health care team from patient care duties disqualifies the resident from further continuation in the program.

1. Probationary Status

- Failure to comply with departmental rules and guidelines or failure to meet the goals and objectives outlined for the given stage of training in the expected

manner will result in a probationary status for the resident. In addition to other behaviors listed herein and in general, unsatisfactory performance rating in two or more competency areas will be grounds for probationary status. A “needs improvement” rating in four or more competency areas will also be grounds for probationary status. The resident will be notified verbally and in writing.

- The goal of probation is to provide a learning environment that will allow the resident to focus on and improve deficient areas. To achieve this goal, the following will be implemented:
 - Written identification of areas of deficiency and expectations for improvement.
 - Assignment of a mentor.
 - Monthly meetings of the resident and the Program Director to evaluate progress
 - Additional didactic programs and individualized tutorials as determined by the program director
- Probationary status will be reviewed every 3 months, and the resident’s progress will be reviewed. The faculty may return the resident to regular status, recommend an extended period of probation, or recommend termination. The failure to remedy documented deficiencies while on probation constitutes grounds for dismissal from the residency program.

2. Suspension

- The Chief of Staff of a participating and/or affiliated hospital where the resident is assigned, the Dean, the President of the Hospital, the Chair or Program Director may at any time suspend a resident from patient care responsibilities. The resident will be informed of the reasons for the suspension and will be given an opportunity to provide information in response.
- The resident suspended from patient care may be assigned to other duties as determined and approved by the Chair. The resident will either be reinstated (with or without the imposition of academic probation or other conditions) or dismissal proceedings will commence by the University against the resident.
- Any suspension and reassignment of the resident to other duties may continue until final conclusion of the decision-making or appeal process. The resident will be afforded due process and may appeal as set forth below.

3. Nonrenewal

- In the event that the Program Director decides not to renew a resident's appointment, the resident will be provided written notice four months prior to the termination of their current contract which will include a statement specifying the reason(s) for non-renewal.
- If requested in writing by the resident, the Chair will meet with the resident; this meeting should occur within 10 working days of the written request. The resident may present relevant information regarding the proposed non-renewal decision. The resident may be accompanied by an advisor during any meeting held pursuant to these procedures, but the advisor may not speak on behalf of the resident. If the Chair determines that the non-renewal is appropriate, he or she will use their best efforts to present the decision in writing to the resident within 10 working days of the meeting. The resident will be informed of the right to appeal as described below.

4. Dismissal

- In the event the Program Director of a training program concludes a resident should be dismissed prior to completion of the program, the Program Director will inform the Chair in writing of this decision and the reason(s) for the decision. The resident will be notified and provided a copy of the letter of proposed dismissal; and, upon request, will be provided previous evaluations, complaints, counseling, letters and other documents that related to the decision to dismiss the resident. If requested in writing by the resident, the Chair will meet with the resident; this meeting should occur within 10 working days of the written request. The resident may present relevant information regarding the proposed dismissal. The resident may be accompanied by an advisor during any meeting held pursuant to these procedures, but the advisor may not speak on behalf of the resident. If the Chair determines that dismissal is appropriate, he or she will use their best efforts to present the decision in writing to the resident within 10 working days of the meeting. The resident will be informed of the right to appeal as described below.
- The following items are some but not all grounds for immediate suspension, probation, or dismissal:
 - Abandonment of a patient or patient care duties.
 - Illegal or grossly unprofessional conduct.
 - Malperformance of duties with potential for serious harm to patients.
 - Performance of duties while under the influence of drugs or alcohol.
 - Insubordination to faculty members or staff.
 - Absence from the program without prior approved leave.

- Breach of contract.
- Excessive moonlighting that interferes with the performance of resident duties.
- Misconduct as listed in the UMMC Employee Handbook Rules and Regulations.

5. Procedure for Appeal and Grievance

House staff shall have the rights of grievance procedures as detailed in the Handbook for Employees of the University Medical Center, the Medical Staff Bylaws, Rules, and Regulations of the University Hospitals and Clinics, and in the University of Mississippi Medical Center Graduate Medical Education Evaluation Policy and Grievance Algorithm.

All trainees at the University of Mississippi Medical Center will receive both formative and summative evaluation on a periodic basis. Attending physicians are expected to provide feedback and constructive criticism on all aspects of the trainee's performance, including but not limited to, clinical judgment, medical knowledge base, data gathering skills (history taking, physical exam, old record review, lab follow-up), procedural skills, humanistic attributes, professionalism, over-all patient care skills as well as all behaviors defined within the six ACGME descriptive areas of competency. *Trainees should expect direct constructive criticism and suggestions for improvement.* The Training Program Director or his/her designee will meet individually at least semiannually to review each house officer's overall performance and progress in the training program.

The details of the process of resident evaluation and grievance will vary appropriate to the requirements of the RRC or other accrediting agency for the resident's specialty or subspecialty. The process will typically include the elements described below.

The appeals process is as follows:

a) Attending Physician

If the trainee is performing at a low satisfactory or unsatisfactory level, the substandard performance should be brought to the trainee's attention as soon as possible. Performance problems should be documented with clear suggestions regarding appropriate conduct for such situations in the future. In addition to discussing the problem directly with the trainee, the attending physician should notify the program director (preferably in writing) of the nature of the problem as soon as possible. In some cases, changes in routine supervision on patient care services may be warranted. If a trainee is unhappy with an evaluation or feels it is unfair, he/she is encouraged to discuss the evaluation in detail with the attending physician. It is advisable that the resident initial and date all documentation to signify his/her awareness of the opinions

and actions recorded.

b) Program Director

If after additional discussion, the trainee feels the evaluation is unjustified, he is asked to put his complaint in writing and discuss the evaluation in detail with the program director, who will serve as a mediator. In most cases, after seeking input from all involved parties and reviewing the situation in detail with both the attending physician and the trainee, the program director will dictate a report to be included in the trainee's file along with the original evaluation and the trainee's rebuttal and explanation. In some cases, the attending physician may wish to file an amended evaluation. In all cases, the trainee is asked to define specific ways in which the behavior can be changed or improved. In the setting of continued marginal or unsatisfactory performance, a house officer may have clinical privileges revoked by the program director, and be asked to function in a remedial role in which all aspects of patient care must be immediately supervised by another physician including countersignature of all patient orders and notes. In general, a remedial program will be established which includes reading assignments and didactic conference attendance, (and in some cases language classes) in an effort to improve performance. A specific probationary period will be defined.

c) Department Chairman

Unsatisfactory trainee performance may result in the dismissal from the program of the House Officer. This decision will be made by the Program Director in consultation with the Chairman of the Department. If a House Officer wishes to contest the Program Director's decision for termination from the training program, appeal for review can be addressed to a constituted Departmental Grievance Committee composed of selected peers and faculty.

d) Appeal from Departmental Chair

House Officers may appeal grievable matters by petitioning in writing to the Vice Chancellor for Health Affairs within fourteen calendar days of notice of termination from the program director or chairman exclusive of University of Mississippi Medical Center holidays. Upon receipt of a formal written request from a resident for review of a Department Chair's / *Program Director's* action, the Vice Chancellor will select a member of the Graduate Medical Education Committee to chair an appeals committee. The appeals committee chair will appoint an appeals committee of four (4) additional GMEC or RRSC members, including at least one (1) member of the House Staff. The appeals committee chair will promptly convene the committee to hear the appeal, generally within ten (10 business days of the Vice Chancellor's appointment of the appeals committee chair. The decision of the appeals committee will be submitted to the Vice Chancellor. The decision of the Vice Chancellor shall be final in accordance with the by-laws and policies of the Board of Trustees of State Institutions of Higher Learning.

e) Grievable Issues

Per the University of Mississippi Medical Center, the following issues are considered “grievable”:

- Complaints against faculty;
- Disciplinary actions, including dismissals, demotions and suspensions;
- Application of personnel policies, procedures, rules and regulations, ordinances and statutes;
- Acts of reprisal against employees using the grievance procedure;
- Complaints of discrimination on the basis of race, color, creed, political affiliation, religion; age, disability, national origin, sex, marital status, veteran status; or
- Any matter of concern or dissatisfaction to an employee if the matter is subject to the control of institutional management.

Likewise, the following issues are considered “nongrievable”:

- Scheduling and staffing requirements;
- Issues which are pending or have been concluded by direct appeal through an administrative or judicial procedure;
- Temporary work assignments which do not exceed 90 calendar days;
- Budget and organizational structure, including the number of assignment of employees or positions in any organizational unit;
- The measurement and assessment of work through performance appraisal, except where the employee can show that the evaluation was discriminatory, capricious, or not job related;
- The selection of an individual by a department head or designee to fill a position through promotion, transfer, demotion, or appointment unless it is a violation of UMMC or Board of Trustees policy;
- Internal security practices established by the institution, department head or designee;
- Termination or layoff from duties because of lack of work, reduction of the work force, or job elimination;
- Voluntary resignation by an employee bars action under the grievance procedures;

- Any matter not within jurisdiction or control of the institution;
- Content of published UMMC policies or procedures;
- An action by the institution pursuant to federal or state law or directions from the Board of Trustees of State Institutions of Higher Learning; or
- Establishment and revision of wages and salaries, position classification and general benefits.

VI. Administrative

A. Lab Coats

All residents may get two lab coats at the start of each year; the GME office provides the PGY-1 residents with three lab coats. Lab coats must be clean and present a professional appearance. Lab coats will display the appropriate monogramming and departmental identifiers. The department will provide laundry service for lab coats. Additional lab coats will be provided on a case-by-case basis.

B. Professional Attire

1. Men and women shall dress professionally when seeing patients in the outpatient setting. All clothing including scrubs should be clean and neat in appearance. Hair, beards or other facial hair must be neatly groomed.
2. Lab coats should be worn over scrubs when seeing patients outside the OR.
3. Operating room head covers, masks, and shoe covers should not be worn outside of the OR.

C. Benefits (A complete description is available from Human Resources)

1. Medical and liability coverage are provided for the house staff free of charge. There is an additional charge for family medical coverage.
2. Optional Benefits (other less common benefits are available as well)
 - Life Insurance
 - Term Life
 - Supplemental Term Life
 - Whole Life
 - Universal Life

- Accidental Death and Dismemberment
- Disability: Short Term & Long Term
- Dental & Vision
- Tax Sheltered Annuities
- Deferred Compensation Plans
- Flexible Benefits Plan (Allows certain insurance benefits and parking to be taken as pretax dollars)

D. Meals

The UMMC and Wiser cafeterias and the Student Union give a 20% discount to UMMC employees. The Cornerstone Café at MMRC offers a 10% discount. The GME office provides meal tickets for those residents on call.

E. Sexual Harassment

1. Sexual harassment is covered under the policies of the University of Mississippi Medical Center. Sexual harassment is defined as unwelcome sexual advances, requests for sexual favors, and other verbal or physical conduct of a sexual nature when: submission to such conduct is made either explicitly or implicitly a term or condition of an individual's employment or academic performance; submission to or rejection of such conduct by an individual is used as the basis for employment or academic decisions affecting such individual, or; such conduct has the purpose or effect of unreasonable interfering with an individual's work or academic performance or creating an intimidating, hostile or offensive working or educational environment.

2. Any such conduct should be reported to the program director and/or the departmental chairman. If you are uncomfortable discussing this issue with either of these individuals or you do not feel your complaints have been or will be adequately addressed, contact the director for equal opportunity employment in HR at 601-984-1131.

F. Substance Abuse and Mental Health

1. The University of Mississippi Medical Center Faculty and Staff Handbook outline the details of this policy.

2. Substance abuse interferes with the skills and judgment required for appropriate patient care.

3. The faculty members and program director are responsible for monitoring residents for signs of impairment from substance abuse as well as signs of stress, emotional

disturbance, or mental impairment. The faculty members have been educated regarding this responsibility and the tenets of such monitoring. Any concerns are to be reported to the program director immediately.

4. Any resident suspecting that they or any member of the faculty or staff may have a problem with substance abuse should report this to the program director. All reports will be confidential, and the department will be fully supportive of recovery efforts.

5. Any resident with a substance abuse problem will be offered rehabilitation assistance to be arranged via the UMMC Human Resources office.

6. A resident with a current substance abuse problem will not be allowed to participate in patient care until the situation has been resolved.

G. Counseling

The Director of Student/Employee Health is available to meet with residents regarding issues pertaining to health, emotional or mental stress, substance abuse, or other related issues. The Director will make further referrals if necessary. The UMMC Employee Assistance Program is through LifeSync and is available to all employees and their families.

H. Work Environment

1. Patient support services, such as, intravenous services, phlebotomy services and laboratory services, as well as messenger and transporter services are provided for patient care.

2. An effective laboratory, medical records, and radiologic information retrieval system is in place to provide for appropriate conduct of the educational programs and quality and timely patient care.

3. Appropriate security measures are provided to residents in all locations including but not limited to parking facilities, on-call quarters, hospital and institutional grounds, and related clinical facilities. Any concerns in this regard should be brought to the attention of the program director.

I. Licensure, Privileges, and Memberships

1. Licensure and Privileges

- Appropriate Mississippi medical licensure must be maintained at all times so that the resident has all rights and privileges to practice medicine and prescribe medications in all departmental practice settings. Currently, an institutional medical license satisfies these requirements.

- Privileges at participating and affiliated clinical institutions must be obtained and maintained.

2. Memberships

- Residents will obtain and maintain resident membership in the American Academy of Otolaryngology-Head and Neck Surgery and the Triological Society. AMA membership is optional.
 - American Academy of Otolaryngology-Head and Neck Surgery at www.entnet.org (\$100.00). Membership includes a journal subscription to Otolaryngology-Head and Neck Surgery.
 - The Triological Society at www.triological.com. There is no membership fee for residents. Follow the Resident Membership Guidelines and use the Resident Membership Application. This will give you a complimentary print and electronic subscription to The Laryngoscope.
 - OPTIONAL: American Medical Association at www.ama-assn.org (\$45.00). If you are currently a student member, you will need to transfer to a Resident Member. Subscribe to the “print and online” type of JAMA- Otolaryngology Head and Neck Surgery through www.ama-assn.org .
- Please complete membership applications and return them with appropriate payment to the Program Coordinator. The program director verification and endorsements by faculty members will be obtained and then mailed. Once you get paid-in-full receipts, you can be reimbursed if you want (after July 1) out of your education fund for these membership and subscriptions fees. Please provide the program coordinator with either the actual receipt (often emailed) or a copy of your credit card statement or a copy of your canceled check – front and back.

J. Conflict of Interest

1. Any gifts from corporate sponsors accepted by residents individually should primarily entail a benefit to patients and should not be of substantial value. Accordingly, textbooks and other gifts which serve a genuine educational function are appropriate. Cash payments should not be accepted. Individual gifts of minimal value are permissible as long as the gifts are related to the resident's work (e.g., pens and note pads).
2. Subsidies to underwrite the costs of resident conferences or professional meetings can contribute to the improvement of patient care and therefore are permissible. Since the giving of a gift directly to a resident by a company's sales representative creates a relationship which could influence the use of the company's products, subsidies will be

accepted by the program director only who in turn will deposit the money into the resident education fund to improve the quality of the conference. Payments to defray the costs of a conference should not be accepted directly from the company by the residents attending the conference. Subsidies should not be accepted to pay for the costs of travel, lodging or other personal expenses, nor should they be accepted to compensate for the resident's time. All such support should be arranged via the program director and the use of such funds will be assigned to resident activities designated by the program director.

3. No gifts should be accepted if there are strings attached. For example, residents should not accept gifts if they are given in relation to the resident's prescribing practices. In addition, when companies underwrite conferences or lectures other than their own, responsibility for selection of content, faculty, educational methods and materials should belong to the organizers of the conference or lectures, who should act independently.

K. Days Out

1. Permitted Days Out

- All residents may take 15 days of personal annual leave subject to meeting the scheduling criteria.
- PGY4 and 5 residents may take an additional 3 days of annual leave for interviewing, specialty training courses, or moving purposes subject to the scheduling guidelines which follow (if you need more than this, plan your personal leave accordingly). The granting of and designation of specific days out for such leave are solely at the discretion of the program director based on care needs and existing approved absences for faculty members and other providers.
- PGY 2-5 residents may be granted up to 5 days of training leave for the purpose of attending an approved national meeting or presentation travel. All residents are expected to attend one national meeting per year as outlined in the educational fund section.
- PGY4 and 5 residents may also use their annual or training leave for approved humanitarian medical missions or international exchange programs.
- **Summary: All time away from work other than approved medical or family medical must fall within the following allocation of days: PGY 1: 15 days, PGY 2 and 3: 20 days, and PGY 4 and 5: 23 days.**
 - An additional day of leave will be granted to PGY 2-5 residents around the December/January holidays IF the residency program as a whole performs in or above the seventieth percentile on the Annual Otolaryngology Examination from the prior academic year. An additional day of leave will be granted during the same time period for a performance greater than the 90th percentile. In order for an individual resident to

receive these days, they must have performed at their target goal of at least the 5th stanine compared to their peer group. We will know what days will be available to choose from approximately 4-6 weeks in advance when we know the clinical coverage needs. Please do not make any travel plans prior to that time.

- Official holidays will be granted to those residents who are not on call according to the policy of the institution at which the resident is rotating on the day of the holiday.
- Applicable leave, for purposes of residency training, cannot be carried over to the next year.
- If a resident is out more than 30 days during the academic year for any reason including illness or FMLA, the required period of graduate medical education will be extended accordingly.

2. Scheduling of Leave

- In order to provide timely and reasonable care to patients and to promote resident education, a policy for scheduling leave is developed for PGY 2-5 residents. Leave scheduling for PG1 residents will be coordinated with the appropriate department in which they are rotating.
- Leave can only be granted from a request in writing with approval by the program director or his/her designee as well as the chair.
- Requests for scheduling any leave no matter what the type, even if assigned, must be submitted on the appropriate form to the program coordinator for approval by the program director and chair a minimum of 35 days in advance. Exceptions will be considered when circumstances are out of your control such as interviews.
- Annual leave must be taken in five-day blocks. This should be Monday through Friday. Exceptions may be allowed with approval of the Residency Director particularly in the case of residents needing to interview for a position. If a week of vacation includes a scheduled holiday period, you will not be allowed to take additional days subsequently.
- The requests for the three 5-day blocks of annual leave per resident will be compiled, coordinated and completed by July 15th of each year, by the chief residents' subject to the following guidelines:
 - Annual leave must be assigned in proportion to the number of PGY 2-5 residents rotating on a service, e.g. no more than 6 weeks from the H&N service.
 - PGY-1 residents may take a maximum of 1 week of vacation while on ENT

- rotation. While on other services, PGY-1 residents' leave must be approved by that service.
- No two residents may be gone on vacation from the same institution at the same time. Exceptions will not be made for this except in the instance of the major otolaryngology meetings when a large number of the faculty will be gone as well, emergencies, or in the case of chief residents interviewing.
 - No vacations will be allowed in July, in the last two weeks of June, or during major otolaryngology meetings. PGY 2 residents may not take vacation during the anatomy dissection. No residents may take vacation during the sinus/soft tissue course dates. Exceptions will be considered for unusual personal circumstances.
 - The vacation schedule is not final until all of the above criteria have been met and the program director has signed off on it.
 - Changes later in the year will only be considered by the program director if they fall within the guidelines outlined.
- For scheduling of interview dates, the following criteria will be considered:
 - Urgency of the need
 - No other residents or PEs out
 - Attending physicians on your service are out
 - Graduating residents will be expected to work through June 30th. Graduating residents required to start a fellowship on July 1st may leave early based on need with approval by the program director subject to the limitations of days out described above.
 - All residents are expected to be present for visiting professor related events unless leave has been approved in advance regardless of the day or time of the week.

4. Weekends

- From time to time educational events will be scheduled on weekends. Resident attendance at these events is required. You may assume that your weekends are free:
 - If you have not been given 90 calendar days' notice that your attendance is required.
 - All resident call is covered.

- If the weekend does not conflict with the annual otolaryngology examination, the Academy meeting, the COSM meetings, visiting professor related activities, or the holiday schedule.
- Otherwise, you should not assume that you are free without asking specific written permission for having the days free from duty.

5. Medical Leave

If you take medical leave, please inform the residency coordinator and program director. When you return, you will need to submit the appropriate paperwork detailing the exact dates that you were out. The full medical leave policy is available from the in the Faculty and Staff Handbook.

L. Educational Fund

1. Educational fund use is subject to the resident being in full compliance with all applicable departmental and institutional policies outlined in this document and university publications.

2. Each PGY 2-5 resident receives a \$1500 educational allowance. This is intended to be used for travel to educational meetings. Balances remaining may not be carried over to the next year. After attendance at an approved meeting(s), requests to use any remaining money for other educational purposes, such as books, journals, and educational equipment, will be considered on an individual basis. The request must be submitted by June 1. PGY 1 residents receive an educational fund of \$500 per year and do not have to attend a meeting.

3. All travel requests for which you wish to be reimbursed must be submitted at least 6 weeks in advance.

4. All hotel and airlines reservations must be arranged according to UMMC policies to ensure reimbursement.

5. Reimbursement is limited to registration, hotel, airfare or car allowance, and state per diem. Reasonable parking and local transportation costs such as taxi and subway may

be reimbursed as well. Receipts are required for these items. Meals will not be reimbursed above the state per diem. Travel advances for reimbursement are allowed.

6. Priority for attending desired meetings will be given based on seniority and whether or not you attended in the prior year.
7. PG2 and PG3 residents will attend either the Academy or combined otolaryngology spring meetings (COSM). Exceptions will be considered on an individual basis.
8. PG4 and PG5 may attend courses of their choice approved by the program director. Appropriate courses would include allergy, temporal bone, facial plastic, practice management, sinus, and facial trauma courses.
9. When attending educational meetings, you are expected to attend the meeting sessions in their entirety with minimal exception.
10. If you independently obtain travel funds via your own initiative, these funds should be sent directly to the department and the amount placed in your individual travel/educational fund for you to use as under the current guidelines. If you independently obtain funds or travel funds via a competitive process, such as a research award, you may choose to have these funds directly mailed to you, without need to have them go through your educational fund. Be aware, however, that you will be responsible for any applicable taxes on this additional income; this is your responsibility, and the program is not responsible for any additional applicable taxes, fees, or obligations. (Research grants, if awarded, will be used to fund research.) If the travel funds are offered to us without your initiative, these funds will be placed in the group resident fund which pays for all other resident expenses including presentation travel, in-service, home study, etc. These funds may have to be received under a single resident's name, however.

M. Presentation Travel

1. Resident presentations may be reimbursed by the department subject to the limitations under **Educational Fund** above if travel funds are available. Within standards of reason, you should arrange the lowest airfare. Eligibility for presentation travel will be considered on an individual basis regarding the merits of the presentations. Podium and poster presentations at national meetings and podium presentations at regional and state meetings are eligible. Case reports are not covered at any meeting. **A manuscript must be submitted to the appropriate journal no later than the beginning of the meeting or the specified meeting deadline for**

manuscript submission in order to be eligible for time off and travel reimbursement.

2. Reimbursement above your educational fund amount will be limited for presentations to up to three total nights around the presentation. The time off must fall within the limits outlined in the allocation of leave section.
3. If other residents room with the resident traveling on departmental presentation funds, all room expenses must be split evenly among those residents staying in the room.

O. Customer Service

1. Residents will be expected to adhere to departmental expectations for excellent customer service in all care settings including the perioperative environment, inpatient hospital, the ED, the ambulatory clinic and in phone conversations with patients. Patient satisfaction data and departmental expectations for patient communication and interaction will be shared with residents on an annual basis.
2. Residents will participate in efforts to improve customer service as applicable.

VII. APPENDIX A: Research Proposal Template (Core Project)

NIH Proposal Outline

Six Page Limit – For Activity Codes R03, R13, R21, R36, SC2, SC3

1. Introduction to Application (for Resubmission or Revision applications only) – LIMITED TO 1 PAGE

- For resubmissions, the introduction should summarize the substantial additions, deletions, and changes to the application. The Introduction must also include a response to the issues and criticism raised in the Summary Statement.
- For revisions, the introduction should describe the nature of the supplement and how it will influence the specific aims, research design, and methods supported by the current award.

2. Specific Aims – LIMITED TO 1 PAGE

- State concisely the goals of the proposed research and summarize the expected outcomes, including the impact that the results of the proposed research will exert on the field involved.
- List succinctly the specific aims of the research proposed (e.g., to test a stated hypothesis, create a novel design, solve a specific problem, challenge an existing paradigm or clinical practice, address a critical barrier to progress in the field, or develop new technology).

3. Research Strategy – LIMITED TO 6 PAGES (sections a-c)

- Organize the Research Strategy in the order specified below.
- Start each section with the appropriate section heading – Significance, Innovation, Approach.
- Cite published experimental details in the Research Strategy section and provide the full reference in the Bibliography and References Cited section.

(a) *Significance – Suggested length 1-2 pages*

- Explain the importance of the problem or critical barrier to progress in the field that the proposed project addresses.
- Explain how the proposed project will improve scientific knowledge, technical capability, and/or clinical practice in one or more broad fields.
- Describe how the concepts, methods, technologies, treatments, services, or preventative interventions that drive this field will be changed if the proposed aims are achieved.

(b) *Innovation – Suggested length 1 page*

- Explain how the application challenges and seeks to shift current research or clinical practice paradigms.
- Describe any novel theoretical concepts, approaches or methodologies, instrumentation or interventions to be developed or used, and any advantage over existing methodologies, instrumentation, or interventions.
- Explain any refinements, improvements, or new applications of theoretical concepts, approaches or methodologies, instrumentation, or interventions.

(c) *Approach – Suggested length 3-4 pages*

- Describe the overall strategy, methodology, and analyses to be used to accomplish the specific aims of the project. Include how the data will be collected, analyzed, and interpreted, and any resource sharing plans as appropriate, unless addressed separately in Item 15 (Resource Sharing Plan).
- Discuss potential problems, alternative strategies, and benchmarks for success anticipated to achieve the aims. You also may wish to include a discussion of future directions for your research, as well as a project timeline, in this section.
- If the project is in the early stages of development, describe any strategy to establish feasibility, and address the management of any high risk aspects of the proposed work.
- Point out any procedures, situations, or materials that may be hazardous to personnel and precautions to be exercised. A full discussion on the use of Select Agents should appear in Item 11, below.
- **Preliminary Studies for New Applications:** For new applications, include information on Preliminary Studies as part of the Approach section. Discuss the PD/PI's preliminary studies, data, and or experience pertinent to this application. Except for Exploratory/Developmental Grants (R21/R33), Small Research Grants (R03), and Academic Research Enhancement Award (AREA) Grants (R15), preliminary data can be an essential part of a research grant application and help to establish the likelihood of success of the proposed project. Early Stage Investigators should include preliminary data (however, for R01 applications, reviewers will be instructed to place less emphasis on the preliminary data in application from Early Stage Investigators than on the preliminary data in applications from more established investigators).
- **Progress Report for Renewal and Revision Applications.** For renewal/revision applications, provide a Progress Report as part of the Approach section. Provide the beginning and ending dates for the period covered since the last competitive review. Summarize the specific aims of the previous project period and the importance of the findings, and emphasize the progress made toward their achievement. Explain any significant changes to the specific aims and any new directions including changes to the specific aims and any new directions including changes resulting from significant budget reductions. *A list of publications, patents, and other printed materials should be included in Item 5 (Progress Report Publication List); do not include that information here.*

RESEARCH PROPOSAL FORM (Second Project)

| | |
|--|--|
| Title | |
| Faculty Sponsor | |
| Principal Investigator/Co-investigators | |
| Abstract | A brief (200 words or less) description of your project featuring research question, significance, design, and outcome determination |
| Background | What work exists that has led up to your research question? Has anything similar been done before? How would your work contribute to the knowledge base and possibly affect clinical practice? Do not exceed one page. Use no more than ten references and list the references in the reference section below. |
| Purpose | This should include your research question and could include a hypothesis, if appropriate. |
| Specific Aim(s) | Specific aim(s) is (are) the objective(s) of your research – what you want to accomplish. Specific aim(s) should be driven by your hypothesis. |
| Study Period (inclusive years) | Over what period of time will your study population be collected? |
| Study Design | What type of study are you designing? Cohort, case-controlled, case series? How is the study designed to answer your hypothesis and specific aim(s)? |
| Inclusion Criteria | Criteria that will identify the study population. |
| Exclusion Criteria | List all exclusion criteria (that might confound interpretation of results) |
| Number of Subjects (anticipated) | |
| Outcome Measures | How will the results be interpreted? How will your outcomes be measured? |

| | |
|--|---|
| Study Endpoints | At what point will you measure outcomes? |
| Private Health Information | How will private health information (PHI) be protected? How will PHI be de-identified or coded? How will your database be secured? Is all PHI that you will access necessary to answer your research question? |
| Statistical Methodology | This is important. You will want to consult with a statistician on this part. You want to reduce confounding variables, particularly in retrospective studies. A statistician will help you do this. Also, the statistician can help you determine the desirable study population and design outcome measures that will lend themselves to statistical inference. |
| References (not more than 10) | Pertinent references should be listed. Make sure your study has not already been done recently. If so, you must explain why your study is different and should be done. |
| Case Report Form (CRF) | This is a form that is used to record the patient information that will be collected and used in outcome measurements. The CRF can be used for individual patients or can be in the form of a database, such as a spreadsheet. The CRF should be included in your proposal. |
| Facilities and Major Equipment Required | Describe where your research will be performed, including the use of large or specialized equipment that will be needed to complete your project. |
| Budget | List any cost that will be incurred regardless of funding source. |
| Funding Source | Is funding necessary? If so, to what funding source have or will you apply? |

VIII. APPENDIX B: Criteria for Advancement and Graduation

A. Criteria for Advancement to PGY-2 Level from PGY-1 Level

- Successful completion of all ACGME required PGY-1 rotations as assigned by the Program Director of Otolaryngology in conjunction with the Departments of Surgery, Anesthesiology, Emergency Medicine, and Neurosurgery
- Leave time not exceeding a combined total of 30 days
- Achievement of a minimum of satisfactory on all faculty evaluations (performs at expectations for PGY level)
- Timely completion of all required medical records at UMMC and VA
- On-time attendance at all scheduled conferences (excepting leave periods and excused absences)
- Completion of all Institutional requirements for PGY-1 promotion, including invasive procedures credentialing

B. Criteria for Advancement to PGY-3 Level from PGY-2 Level

- Successful completion of all ACGME required PGY-2 rotations as assigned by the Program Director of Otolaryngology
- Leave time not exceeding a combined total of 30 days
- Achievement of a minimum of satisfactory on all faculty evaluations (performs at expectations for PGY level)
- Adequate performance on all milestones
- Attendance at a minimum of one national or approved regional otolaryngology conference
- Successful completion of the PGY-2 anatomy dissection course
- Timely completion of all required medical records at UMMC and VA
- On-time attendance at all scheduled morning conferences

C. Criteria for Advancement to PGY-4 Level from PGY-3 Level

- Successful completion of all ACGME required PGY-3 rotations as assigned by the Program Director of Otolaryngology
- Leave time not exceeding a combined total of 30 days

- Achievement of a minimum of satisfactory on all faculty evaluations (performs at expectations for PGY level)
- Adequate performance on all milestones
- Attendance at a minimum of one national or approved regional otolaryngology conference
- Timely completion of all required medical records at UMMC and VA
- On-time attendance at all scheduled morning conferences
- Completed all research assignments on time

D. Criteria for Advancement to PGY-5 Level from PGY-4 Level

- Successful completion of all ACGME required PGY-4 rotations as assigned by the Program Director of Otolaryngology
- Leave time not exceeding a combined total of 30 days
- Achievement of a minimum of satisfactory on all faculty evaluations (performs at expectations for PGY level)
- Adequate performance on all milestones
- Attendance at a minimum of one national or approved specialty otolaryngology conference
- Timely completion of all required medical records at UMMC and VA
- On-time attendance at all scheduled morning conferences
- Presentation of one research project at the UMMC ENT graduation ceremony
- Completed all research assignments on time

E. Criteria for Graduation from PGY-5 Level

- Successful completion of all ACGME required PGY-5 rotations as assigned by the Program Director of Otolaryngology
- Leave time not exceeding a combined total of 30 days
- Achievement of a minimum of satisfactory on all faculty evaluations (performs at expectations for PGY level)
- Adequate performance on all milestones

- Attendance at a minimum of one national or approved specialty otolaryngology conference
- Timely completion of all required medical records at UMMC and VA
- On-time attendance at all scheduled morning conferences
- Presentation of one research project at the UMMC ENT research day
- Successful completion of two approved research projects that have been submitted for presentation and publication
- Successful leadership of a Performance Improvement project
- Achievement of the ability to practice independently as determined by all physician faculty members of the Department of Otolaryngology and Communicative Sciences