Memorial

Memorial Hospital at Gulfport

Internal Medicine Residency Handbook

July 2024

Contents

Program Mission

The primary geographic area Memorial Hospital at Gulfport (MHG) serves is Harrison and Hancock Counties with a population of approximately 250,000. Its secondary service areas are the more rural Jackson and Stone counties with an additional 160,000 residents. Overall, Mississippi has been ranked as the unhealthiest state in the US. One in three Mississippi residents is obese and our state has the highest rate of childhood obesity in the nation. Mississippi also has one of the highest rates of diabetes, hypertension, chronic kidney disease and infant mortality. Furthermore, approximately 25% of the Memorial community live in poverty. Our program is prepared to meet these challenges.

Given the statistics, it should come as no surprise that the Mission of Memorial Hospital at Gulfport's Internal Medicine program is to build healthier communities. Our Internal medicine residency will do this through training and graduating well-balanced, compassionate physicians who are willing and dedicated to practicing the highest level of medicine of which they are capable. Physicians who truly understand the challenges of the community they serve, whether urban or rural, will be capable of implementing a patient centered approach to their practice of medicine. Internal medicine residents should universally be able to understand and apply the science of medicine while equally developing their own style within the art of practicing medicine. This is what will ultimately allow our physicians to give and receive within the community, regardless how diverse or ever changing it might be.

Facility Background

The Harrison County Board of Supervisors and the City of Gulfport adopted resolutions establishing Memorial Hospital at Gulfport on July 18, 1946. Now, more than seven decades later, Memorial continues to expand facilities and add new staff and equipment to keep pace with ever-changing technology and a rapidly growing community. Governed by a Board of Trustees, strategic decisions are based on four core strategies: Population-Based Services; Safety, Quality and Customer Satisfaction; Work Environment; and Finance.

Memorial Hospital at Gulfport is a not-for-profit medical complex in Gulfport, Mississippi, jointly owned by the City of Gulfport and Harrison County. Memorial's mission is to heal, inspire and transform the health of our community. Memorial is one of the most comprehensive healthcare systems in the state, licensed for 328 beds, including a state-designated Level II Trauma Center, three nursing centers, three outpatient surgery centers, satellite outpatient diagnostic and rehabilitation centers and more than 100 Memorial Physician Clinics.

Memorial offers several of the region's most comprehensive clinical programs, such as emergency medicine, women and children services, orthopedic services, cardiovascular services, neurosciences, and oncology. Additionally, Memorial provides medical specialties unique to the coast which include a Level III Neonatal ICU and Mississippi's first nationally certified Primary Stroke Center. Memorial offers 3D imaging and advanced surgical techniques, including the robotic assisted Specialty Surgery System. Memorial is accredited by The Joint Commission, the Commission on Cancer, the College of American Pathologists and the American College of Radiology.

Pre-Employment Requirements

Resident Eligibility and Resident Selection Requirements

Program directors must comply with the criteria for resident eligibility as defined in the Institutional Requirements [IR IV.A.], the Common Program Requirements [CPR III.A], and the applicable RC requirements. Applicants must meet one of the following qualifications to be eligible for appointment to an ACGME-accredited program:

1. Graduation from a medical school in the United States or Canada, accredited by the Liaison Committee on Medical Education (LCME); or,
2. Graduation from a college of osteopathic medicine in the United States accredited by the American Osteopathic Association (AOA); or,
3. Graduation from a medical school outside of the United States or Canada, and meeting one of the following additional qualifications:
   - **a.** holds a currently valid certificate from the Educational Commission for Foreign Medical Graduates prior to appointment, or,
   - **b.** holds a full and unrestricted license to practice medicine in a US licensing jurisdiction in his or her current ACGME specialty/subspecialty program or,
   - **c.** has graduated from a medical school outside the United States and has completed a Fifth Pathway program provided by an LCME-accredited medical school.

Application

All Memorial Hospital at Gulfport GME training programs are required to use the Electronic Residency Application Service (ERAS®) or other centralized application service if available in their discipline to receive and accept applications to the program. Programs in disciplines that do not use a centralized service may have applicants apply directly to the program. The list of Participating Specialties and Programs is available on the ERAS website. All appointments are made through the National Resident Matching Program (NRMP) in March. Applicants must register through the NRMP website in addition to submitting their application through ERAS.

Interview

Applicants invited to interview for a resident position must be informed in writing or by electronic means, of the terms, conditions, and benefits of their appointment to the ACGME-accredited program, as well as all institutional and program policies regarding eligibility and selection for appointment, either in effect at the time of the interview or that will be in effect at the time of his or her eventual appointment. This includes financial support, vacations, parental, sick, and other leaves of absence, and professional liability, hospitalization, health, disability and other insurance accessible to residents/fellows and their eligible dependents. These resources are posted on the Memorial Hospital at Gulfport's Intranet. Applicants who require a disability accommodation for the interview may request an accommodation from the Memorial Hospital at Gulfport Human Resources Department. In the event that such an accommodation is requested, the Memorial Hospital at Gulfport Human Resources Department will inform the GME Office and the Program of the request in order to facilitate an appropriate accommodation, if indicated.

Selection

Programs must select trainees among eligible applicants on the basis of training program-related criteria such as their preparedness, ability, aptitude, academic credentials, communication skills, and personal qualities such as motivation and integrity, as well as professionalism. Programs must not discriminate with regard to sex, race, age, religion, color, national origin, disability, or any other applicable legally protected status.

Before accepting a resident, who has previously completed residency training or who is transferring from another program, the Program Director must obtain verification of previous educational experiences and a summative competency-based performance evaluation of the transferring resident, as outlined in the Memorial Hospital at Gulfport GME Transfer Policy.

Matching

All Memorial Hospital at Gulfport GME training programs are required to participate in the National Residency Matching Program (NRMP) or other organized matching program where such is available in their discipline and to the fullest extent possible.

Sponsor Visa Category - J-1 Visa Only

MHG requires that Residents meet all federal standards as may be required by CMS and other regulatory agencies. Applicants that are designated by CMS as "Excluded Providers" shall not be eligible to apply or remain in an MHG residency program.

- Residents selected outside the normal matching process, whether through the match 'supplemental' or during the 'off-cycle', must be reviewed and approved by the DIO.
- Program directors should base their selection on the eligible candidate's ability, aptitude, and preparedness as evidenced by their academic credentials including, but not limited to, class rank, course evaluations, standardized licensure qualifying examination scores, communication skills both written and verbal, and letters of recommendation from faculty and the dean of their school verifying their ability, aptitude, as well as their motivation and integrity.

Employment

This is a three-year training program. Each resident/fellow receives two White Coats per year with their names embroidered and weekly dry-cleaning services for the coats. Each resident/fellow also receives a laptop and a department issued mobile phone.

Residents' Annual Salaries and benefits presented and approved by GMEC per ACGME requirements are as follows:

AY 2024 - 25
PGY 1 – $55,000
PGY 2 – $56,100
PGY 3 – $57,222

Living Quarters

Resident Trainees are responsible for providing their own living quarters.

Equal Employment Opportunity

Memorial Hospital at Gulfport shall make every effort to employ the most qualified residents available. The human resources policies and programs of MHG are designed to assure equal opportunity in employment and in all other human resources functions. They incorporate state and federal regulation and Executive Order pertaining to Equal Opportunity.

MHG, as an Equal Opportunity Employer, provides all qualified applicants an opportunity to enter in and continue in employment without regard to race, color, sex, religion, sexual orientation, age, gender identity, disability, national origin, marital status, disability, citizenship, veteran status, military or uniformed services, in accordance with all applicable governmental laws and regulations. MHG seeks to employ the best-qualified person available for a particular job. MHG strives to compensate each resident in an equitable manner.

In addition, the Facility complies with all applicable federal, state and local laws governing nondiscrimination in employment. This applies to all terms and conditions of employment including, but not limited to, hiring, placement, promotion, separation, transfer, leaves of absence, compensation, and training.

Background Investigations

At the time of employment, the Facility performs reference and background investigations which may include, but are not limited to: prior employment, education, Office of Inspector General's list of individuals who have been excluded or disbarred from government payer program(s), credential sanctions, criminal conduct and driving history or credit information. Applicants or residents whose background checks reveal adverse information, or who are found to have falsified information in the application process or during employment, are subject to non-selection for, or separation of employment. Periodically, updated background investigations may be performed at the Facility's discretion and/or as required by law. Residents will be required, as a condition of continued employment, to consent to additional background investigations.

Residents are asked annually to disclose any criminal, licensure and certification events that have occurred to them since their pre-employment background investigation. This includes government oversight events such as convictions, pleas, probation and loss or limitations of licenses or certifications. If such an event occurs before the annual disclosure, residents must report it to the DIO and Human Resources as soon as the resident becomes aware of the event. Note that each report is addressed individually – a report does not automatically bar continued employment. Human resources may be contacted by calling **228-865-3081.**

Mississippi Board Permits

Residents are required to be appropriately licensed in the state of Mississippi in order to participate in their Residency Program. The Mississippi Board requires that all Residents have training permits with the Board. It is the responsibility of the Resident to apply and obtain a permit before the start of the residency, as well as to keep it current throughout the residency. A Resident will not be permitted to start his/her residency until a copy of the permit is submitted to MHG. *Note: Mississippi Board permits fee will be reimbursed by MHG upon completion of the required documentation.*

Certifications

Residents are required to be ACLS and BLS certified and must remain certified throughout the entire duration of this program. If certification lapses, the Resident maybe subject to disciplinary action as deemed appropriate by the program director.

Food Stipend

Each resident receives a $300 monthly food voucher.

Educational Stipend

PGY – 1 – $500
PGY – 2 – $1000
PGY – 3 – $1000

Relocation Stipend

One-time relocation stipend up to $3000. This requires receipts.

Vacation

American Board of Internal Medicine Rule

The ABIM requires all internal medicine trainees to complete 33 months of training to be eligible for the internal medicine board exam; thus, cumulative leave of more than 3 months (thirteen weeks) for any reason will extend the period of training beyond the traditional 36 months.

Days Off

- Residents may take up to 4 weeks of vacation (20 weekdays) per academic year.
- 3 vacation periods must be requested in 5-day blocks (Monday-Friday).
- 5 personal days can be utilized as individual days or as another block.
- The weekend prior to and/or immediately following an approved vacation block are also included in the block but do not count as one of the 20 vacation days.

Process

- Time off requests must be submitted to the program coordinator using the vacation request form.
- Vacations must be submitted to the program coordinator 3 months in advance to ensure approval.

Limitations

- Night medicine, MICU, and Inpatient Medicine rotations are not vacation eligible months.
- Some calendar dates may be excluded from vacation/personal days as determined by the program.
- Vacation blocks and personal days must not conflict with previously scheduled continuity clinic patients.
- All time off request will not be granted until all required signatures are provided. Gene Moran (Program Coordinator) will record the dates in New Innovations.
- It is the resident's responsibility to find Cerner coverage for their time off requests.

- Time off requests must be submitted **90 days prior** to ensure enough time to block out your outpatient continuity clinic schedules.
- You will be allowed to take the weekend prior or the weekend after your vacation week requested.
- Please note that during certain rotations and time of the year, vacations will not be granted. PGY1s will generally not be permitted to take vacation time during the month of July of their PGY1 year.
- A vacation cannot be scheduled for more than 2 weeks.
- For the last 2 weeks of June, vacation days will be reserved for graduating residents for relocation purposes.
- Time off requests will generally be granted on a first come, first serve basis, and if there are 2 residents requesting the same time off, it will be the Program's discretion to approve both requests.

Absence Due to Minor Illness

- Absences due to a minor illness that extends beyond three (3) scheduled workdays requires physician documentation.
- Residents are responsible to keep the Program Coordinator appraised as to the status of their absence.

Bereavement Leave

Residents/fellows are permitted up to three (3) consecutive days for the death of an immediate family member. "Immediate family" is defined as: spouse, children, parents, siblings, grandparents, grandchildren, and corresponding step and in-law relationships or close relative of the employee. This definition may also include individuals who are not legally related but who reside with the resident.

Educational Leave

Education leave is provided at the discretion of the Program Coordinator for purposes of supporting educational activities that require the resident to be excused from clinical duty. Up to a maximum of seven (7) additional days can be approved during an academic year for the purpose of attending medical meetings or other medical education activities. Such meeting time may not be extended unless the additional time is counted as PTO. Educational leave time may not be accumulated and carried over to the following academic year. Education leave time may not be converted to PTO and shall not be used for other purposes.

Appointment Attendance

Residents will be excused for duties to attend appointments for dental, medical, and personal care. Efforts should be made to schedule these appointments on off hours but if this is not possible the resident's duties will be covered while they are excused. Residents are required to provide appointment information to their respective Program Coordinator either same business day or next business day once the appointments have been confirmed.

Family and Medical Leave of Absence (FMLA)

Call Employee Health at (228) 865-3406.

A leave of absence may be granted to residents who have completed at least one year of service and a minimum of 1,250 hours during the previous 12-month period.

Insurance

Disability Insurance Plans

Disability Plans

Short-Term Disability (STD) Insurance

Short-Term Disability (STD) benefits are available for purchase on a voluntary basis. STD insurance replaces 60% of your income if you become partially or totally disabled for a short time. Certain exclusions, along with pre-existing condition limitations, may apply. Please refer to plan documents for further details.

WEEKLY MAXIMUM BENEFIT	$1,500
ELIMINATION PERIOD	14 days
MAXIMUM BENEFIT PERIOD	91 days

Long-Term Disability (LTD) Insurance – 40%

Long-Term Disability (LTD) benefits are paid for by Memorial and are available to you at no cost. LTD insurance replaces 40% of your income if you become partially or totally disabled for an extended time. Certain exclusions, along with pre-existing condition limitations, may apply. Please refer to plan documents for further details.

MONTHLY MAXIMUM BENEFIT	$4,000
ELIMINATION PERIOD	90 days
MAXIMUM BENEFIT PERIOD	Payments will last for as long as you are disabled or until you reach your Social Security Normal Retirement Age, whichever is sooner.

(LTD) Insurance** – 60%

Voluntary Long-Term Disability (LTD) benefits are available for purchase on a voluntary basis. LTD insurance replaces 60% of your income if you become partially or totally disabled for an extended time. Certain exclusions, along with pre-existing condition limitations, may apply. Please refer to plan documents for further details.

ALL BENEFITS ELIGIBLE BENEFITS-ELIGIBLE STATUS AND PART-TIME EMPLOYEES	
MONTHLY MAXIMUM BENEFIT	$6,000
ELIMINATION PERIOD	90 days
MAXIMUM BENEFIT PERIOD	Payments will last for as long as your are disabled or until you reach your Social Security Normal Retirement Age, whichever is sooner

VOLUNTARY LONG-TERM DISABILITY RATES	
FOR ALL BENEFIT-ELIGIBLE FULL-TIME AND PART-TIME EMPLOYEES	$0.408 per 100 of covered payroll

**NOTE: If you are not a New Hire and Open Enrollment you want to buy up your LTD insurance you will need to go through Evidence of Insurability.

Voluntary Long-Term Disability

Please use the calculation below to get an estimate of what your premiums may look like.

TO CALCULATE HOW MUCH YOUR LTD COVERAGE WILL COST:							
	÷12=		xRate		÷$100		
Annual Salary		Monthly Covered Payroll		Amount		Bi-weekly Premium	

TO CALCULATE HOW MUCH YOUR STD COVERAGE WILL COST:							
	÷12=		xRate		÷$100		
Annual Salary		Monthly Covered Payroll		Amount		Bi-weekly Premium	

Note: Managers and Physicians, please refer to your schedule of benefits for additional benefit options.

Professional/General Liability Insurance

Memorial Hospital at Gulfport provides each resident/fellow with professional/general liability (malpractice) insurance coverage for the duration of training. Tail Coverage will be provided when the resident leaves MHG's programs for any reason from the last date of employment for up to one year.

Professional Liability Insurance. Memorial Hospital at Gulfport is self-insured with respect to professional and general liability.

The program of self-insurance is consistent with and approved by the State Tort Claims Board and takes advantage of the State Tort Claims Act, which provides for a maximum liability of $500,000 per claim.

As provided under Chapter 46, Title 11, Mississippi Code of 1972 (Specifically 11-46-1 through 11-46-20) hereinafter known as the "Tort Claims Act" is the basis of coverage under the plan. All provisions of the Tort Claims Act are hereby made a part of the plan.

The program is supported by claims administration and risk management, which is provided by Cannon Cochran Management Services, Inc. In addition, the program is supported with risk management efforts supplied by BXS Insurance (a division of Bancorp South).

E-Mail Addresses and Social Media

Due to the high risk of sensitive hospital, patient (HIPAA) and personal information potentially being accessed via personal email accounts, all Residents and core teaching faculty are required to use only assigned hospital email accounts as their primary account for communication. This e-mail will be listed as the primary account in New Innovations. All email communications to Residents and core faculty will be done via a hospital/Medical Office email account.

Social Media will not be monitored directly by the residency, but the Resident should use social media with caution. If social media accounts are found to be inappropriate or not in compliance with HIPPA, then disciplinary action maybe instituted by the program director.

Hospital Property

No x-ray films, instruments, medications, IV fluids or other hospital property shall be taken from the hospital unless permission is granted by the Director Medical Staff & GME. No instruments, medications or pharmaceutical samples may be removed from the continuity clinic without permission of the clinic director.

Promotion, Non-Renewal, and Dismissal

The Internal Medicine Residency follows Memorial Hospital at Gulfport GME Institutional Policy. See GME Policy 500.05 for details.

Due Process and Resident Grievance

The Internal Medicine Residency follows Memorial Hospital at Gulfport GME Institutional Policy. See GME Policy 500.46 Due Process and 500.47 Resident Grievance for details.

Benefits

All residents/fellows medical, dental, and vision benefits are effective the first day of their training for themselves and their dependents (dependents are limited to spouses and children under the age of 26).

Medical benefits are administered through Select Administrative Services (SAS). Consider the physician networks, premiums and out-of-pocket costs for each plan. Keep in mind your choice is effective for the entire plan year unless you have a qualifying life event.

2024 Memorial Health Benefit Basic Plan Rates

Premium contributions for medical are deducted from paychecks on a pre-tax basis. Premiums are deducted on a bi-weekly basis over a 24-pay period annual calendar.

Medical Premiums

Premium contributions for medical are deducted from your paycheck on a pre-tax basis. Your level of coverage determines the per 24 pay periods contributions.

Premiums for Non-Tobacco Users (Per 24 Pay Periods)

	ACCESS PLAN		ACCESS PLAN with WELLNESS CREDIT		HIGH DEDUCTIBLE HEALTH PLAN		HIGH DEDUCTIBLE HEALTH PLAN with WELLNESS CREDIT	
	You Pay	MHG Pays	You Pay	MHG Pays	You Pay	MHG Pays	You Pay	MHG Pays
EMPLOYEE	$73.00	$407.00	$55.50	$424.50	$33.00	$390.50	$15.50	$408.00
EMPLOYEE + SPOUSE	$282.00	$707.00	$264.50	$724.50	$195.00	$678.00	$177.50	$695.50
EMPLOYEE + CHILD(REN)	$172.50	$582.00	$155.00	$599.50	$101.50	$564.50	$84.00	$582.00
FAMILY	$373.50	$956.00	$356.00	$973.50	$248.50	$925.50	$231.00	$943.00

Premiums for Tobacco Users (Per 24 Pay Periods)

	ACCESS PLAN		ACCESS PLAN with WELLNESS CREDIT		HIGH DEDUCTIBLE HEALTH PLAN		HIGH DEDUCTIBLE HEALTH PLAN with WELLNESS CREDIT	
	You Pay	MHG Pays	You Pay	MHG Pays	You Pay	MHG Pays	You Pay	MHG Pays
EMPLOYEE	$87.60	$392.40	$70.10	$409.90	$39.60	$383.90	$22.10	$401.40
EMPLOYEE + SPOUSE	$332.00	$657.00	$314.50	$674.50	$234.00	$639.00	$216.50	$656.50
EMPLOYEE + CHILD(REN)	$207.00	$547.50	$189.50	$565.00	$121.80	$544.20	$104.30	$561.70
FAMILY	$423.50	$906.00	$406.00	$923.50	$298.20	$875.80	$280.70	$893.30

All employees have Prescription Drug Coverage that is included in the above plans.

Prescription Drug Coverage for Medical Plan

Our Prescription Drug Program is coordinated through Memorial Outpatient Pharmacy & Express Scripts. That means you will only have one ID card for both medical care and prescriptions. Information on your benefits coverage and a list of network pharmacies is available online at https://sas.vbagateway.com or by calling the Customer Care number on your ID Card. Your cost is determined by the tier assigned to the prescription drug product. Products are assigned as Generic, Preferred, Non-Preferred or Specialty Drugs.

	MEMORIAL OUTPATIENT PHARMACY	MHG ACCESS PLAN EXPRESS SCRIPTS	MEMORIAL HDHP OUTPATIENT PHARMACY	MHG HDHP PLAN EXPRESS SCRIPTS
RETAIL PRESCRIPTION (30-DAY SUPPLY)				
GENERIC	$5 Copay	$50 Copay	$5 Copay*	$50 Copay*
PREFERRED	$20 Copay	$75 Copay	$20 Copay*	$75 Copay*
NON-PREFERRED	$50 Copay	$125 Copay	$50 Copay*	$125 Copay*
SPECIALTY DRUGS	$75 Copay	20% Coinsurance up to a maximum of $350 at Accredo Specialty Pharmacy if not available at the Memorial Outpatient Pharmacy	$75 Copay*	20% Coinsurance up to a maximum of $350*
RETAIL PRESCRIPTION (60-DAY SUPPLY)				
GENERIC	$10 Copay	N/A	$10 Copay*	N/A
PREFERRED	$40 Copay	N/A	$40 Copay*	N/A
NON-PREFERRED	$100 Copay	N/A	$100 Copay*	N/A
SPECIALTY DRUGS	N/A	N/A	N/A	N/A
RETAIL PRESCRIPTION (90-DAY SUPPLY)				
GENERIC	$10 Copay	$100 Copay	$10 Copay*	$100 Copay*
PREFERRED	$60 Copay	$150 Copay	$60 Copay*	$150 Copay*
NON-PREFERRED	$150 Copay	$250 Copay	$150 Copay*	$250 Copay*
SPECIALTY DRUGS	N/A	N/A	N/A	N/A

***After Deductible**

Specialty Drugs must be filled at Memorial Outpatient Pharmacy. If a specialty drug is not available as determined by Memorial Outpatient Pharmacy and must be filled at Accredo Specialty Pharmacy, a copay of 20% up to $350 will apply.

Generic Drugs

Looking to save money on medication costs? You've most likely heard that generic prescription drugs are a more affordable option, so here's the skinny: Generic drugs are versions of brand-name drugs with the exact same dosage, intended use, side effects, route of administration, risks, safety, and strength. Because they are the same medicine, generic drugs are just as effective as brand-name drugs and undergo the same rigid FDA standards. But on average, **a generic version costs 80% to 85% less than the brand-name equivalent**. To find out if there is a generic equivalent for your brand-name drug, visit www.fda.gov.

Dental Plan Rates -- Premiums

Premium contributions for dental are deducted from paychecks on a pre-tax basis. Premiums are deducted on a bi-weekly basis over a 24-pay period annual calendar.

Dental Premiums and Dental Plan Summary

Premium contributions for dental are deducted from your paycheck on a pre-tax basis. Your tier of coverage determines the per 24 pay periods premium. This chart summarizes the dental coverage provided by Select Administrative Services.

	PLAN 1 DENTAL $500	PLAN 2 DENTAL $1000	PLAN 3 DENTAL $2000	PLAN 2 ADD'L $1.000 PRE-TAX**	PLAN 3 ADD'L $2000 PRE-TAX**
DEDUCTIBLE					
EMPLOYEE ONLY	$4.85	$9.33	$12.23	$50.99	$53.89
EMPLOYEE + SPOUSE	$9.96	$19.08	$25.03	$60.74	$66.70
EMPLOYEE + CHILD(REN)	$10.38	$19.92	$26.09	$61.59	$67.75
EMPLOYEE + FAMILY	$16.81	$32.20	$42.21	$73.86	$83.88
DEDUCTIBLE					
INDIVIDUAL	$50/person	$50/person	$50/person	$50/person	$50/person
FAMILY	$150/family	$150/family	$150/family	$150/family	$150/family
MAXIMUM COVERAGE					
PER PERSON	$500	$1,000	$2,000	$1,000	$2,000
COVERED SERVICES					
PREVENTIVE SERVICES Oral Exams, Routine Cleanings, Bitewing X-rays, Fluoride Applications, Sealant, Space Retainers, Panoramic X-rays	$0	$0	$0	$0	$0
BASIC SERVICES Full mouth X-rays, Fillings, Oral Surgery, Simple Extractions	20% Coinsurance*	20% Coinsurance*	20% Coinsurance*	20% Coinsurance	20% Coinsurance
MAJOR SERVICES Extractions, Denture Adjustments & Repairs, Root Canal Therapy, Periodontics, Crowns, Dentures, Bridges	Not Covered	50% Coinsurance*	50% Coinsurance*	50% Coinsurance*	50% Coinsurance*
ORTHODONTICS No waiting period	Not Covered	50% Coinsurance*	50% Coinsurance*	50% Coinsurance*	50% Coinsurance*
ORTHODONTICS LIFETIME MAXIMUM	Not Covered	$1,000/person per lifetime	$2,000/person per lifetime	$1,000/person per lifetime	$2,000/person per lifetime

***After Deductible**

Vision Plan Overview

Eye exams are an important part of overall health care for the entire family. The Vision Benefits Summary may help decide which plan best fits the needs of employees and their families. Premiums are deducted on a bi-weekly basis over a 24-pay period annual calendar.

Vision Premiums

Premium contributions for vision are deducted from your paycheck on a pre-tax basis. Your tier of coverage determines the per 24 pay periods premium.

PER 24 PAY PERIODS CONTRIBUTIONS	
EMPLOYEE ONLY	$3.39
EMPLOYEE + SPOUSE	$6.68
EMPLOYEE + CHILD(REN)	$6.78
EMPLOYEE + FAMILY	$10.35

Vision Plan Summary

This chart summarizes the vision coverage provided by VSP Vision Care.

	All PARTICIPATING PROVIDERS	OUT-OF-NETWORK ALLOWANCE	FREQUENCY
EXAMS			
COPAY	$10 Copay	Up to $41	Every calendar year
MATERIALS			
COPAY	$10 Copay	$10 Copay	Every calendar year
LENSES			
SINGLE VISION	Covered by Copay	Up to $50	Every calendar year
BIFOCAL	Covered by Copay	Up to $70	
TRIFOCAL	Covered by Copay	Up to $85	
LENTICULAR	Covered by Copay	Up to $125	
PROGRESSIVE	$95 - $175 Copay	Up to $40	
FRAMES			
ALLOWANCE	$160 allowance (Costco $90) **up to $180 for featured frames; 20% off balances over allowance	Up to $50	Every calendar year
CONTACTS (IN LIEU OF LENSES AND FRAMES)			
COPAY	$60 Copay then 15% discount	See allowances below	Every calendar year
ELECTIVE	Up to $150 allowance	Up to $150	
MEDICALLY NECESSARY	Covered in full	Up to $210	

Special payment and reimbursement terms apply for material purchases at Costco. **Some providers, such as Walmart, may charge for contact lens fit and evaluation separately from your contact lens allowance, leaving the entire allowance for materials.

Wellness Program

Wellness Program

You can reduce your cost of health insurance by $35 per month by participating in the Wellness Program. To take advantage of the Wellness Program, you will need to complete an attestation statement in PeopleSoft and complete the following required Wellness activities:

- Proof of an annual preventative physical exam within the past 12 months
- Receive influenza vaccination or have a flu declination on file with Employee Health; plus, complete of the required education in HealthStream.
    - If you wish to decline, complete Flu Declination form
- Participate in biometric health screening within the past 12 months (example: preventative screening labs, vital signs, weight, height, etc.)
- Completion of Health Risk Assessment (HRA) in the Wellness Portal (HClactive)

WHAT is needed to get credit:

Employee Health must receive one of the following for services received in the last 12 months:

1. Wellness Credit Verification Form signed by a provider acknowledging successful completion.

OR

2. Individual copy of proof of service - (examples: annual wellness visit summary, EOB, lab result, and copy of flu shot, if not vaccinated by Employee Health)
3. Sign into the Employee Wellness Portal and create an account.
4. Completion of a Health Risk Assessment (HRA) in the Wellness Portal

HOW to complete requirements:

- ✓ If you have already had your annual wellness visit within the last 12 months, request that your provider complete a wellness credit verification form for upload to the wellness portal.
- ✓ Schedule an appointment with your PCP/provider for annual wellness exam. Annual wellness exams do not require a co-pay. Your SAS insurance will be utilized, but at no cost to you. At the time of your visit, provide a wellness credit verification form for your provider to sign. Centralized Scheduling: 228-867-5270

OR

- ✓ Schedule an appointment with the Memorial Employee Health Center located in Employee Health (main campus). Appointments can be made with a Health Center provider at 228-575-1847 or 228-575-1901.

WHERE to send the information:

ELECTRONIC Submission via Wellness Portal.

WHEN is the wellness activities deadline:

- Current Employees During Annual Open Enrollment- A copy of completed services or the provider verification form must be upload once the portal no later than **March 1, 2024,** to be eligible for reduction in premium. If the validation documentation is not on file by March 1, 2024, the credit will end. Additionally, the wellness credit given for first quarter may be reversed.
- New Hires- New hires will not be eligible for the wellness credit until the required wellness actions have been completed and verified by Employee Health.

Internal Medicine Residency Goal

The overarching goal of the Memorial Hospital at Gulfport Internal Medicine residency training program is to produce physicians who can competently and independently practice general internal medicine and serve as a consultant to other physicians.

Residency Objectives

Following completion of the Internal Medicine residency training program, residents will be able to:

1. Apply established and evolving knowledge in the biomedical, clinical, epidemiological and social- behavioral sciences to the care of their patients. (**ACGME Competency: Medical Knowledge**)

2. Provide compassionate, appropriate, and effective patient care by:
    a. obtaining and using data about a patient (history, physical examination, laboratory and imaging studies) to create a differential diagnosis, plan for further evaluation, and comprehensively manage patients with a variety of disorders. **(ACGME Competency: Patient Care)**
    b. developing a therapeutic relationship with patients and their families, identifying and addressing health care needs collaboratively in a patient-centered context. **(ACGME Competency: Interpersonal and Communication Skills)**

3. Improve the patient care that they provide by continuously assessing their performance, incorporating feedback and pursuing learning related to identified improvement opportunities. **(ACGME Competency: Practice-based Learning and Improvement)**

4. Function effectively within the health care system beyond the clinical encounter, utilizing available resources to provide optimal health care for patients with a variety of disorders. **(ACGME Competency: Systems-based Practice)**

5. Conduct their professional life in accordance with the expectations of the profession of medicine and society, manifested through a commitment to carrying out professional responsibilities, adherence to ethical principles, and sensitivity to patients of diverse backgrounds. **(ACGME Competency: Professionalism)**

6. Pursue a career in medicine and developing as a leader in their chosen field, improving health in areas such as patient care, biomedical research, population medicine, health policy, or international health medicine

Specific Educational Level Objectives

Second-year residents (PGY-2) are expected to achieve all objective listed for first-year residents (PGY-1) in addition to those listed for the second year.

Third-year residents (PGY-3) are expected to achieve all objectives listed for first-year (PGY-1) and second-year residents (PGY-2) in addition to those listed for the third year.

Please note that stated objectives should never limit our achievement expectations. Residents of all training years should strive to continuously improve their competency in the diverse skills of consummate internists. These collected objectives simply guide faculty and resident progress expectations.

Patient Care

A. Obtain a medical history

PGY-1 residents will:

a) acquire accurate and relevant history from the patient in an efficiently customized, prioritized, and hypothesis driven fashion; and
b) seek and obtain appropriate, verified, and prioritized data from secondary sources (e.g. family, records, pharmacy).

PGY -2 residents will:

a) obtain relevant historical subtleties that inform and prioritize both differential diagnoses and diagnostic plans, including sensitive, complicated, and detailed information that may not often be volunteered by the patient.

PGY-3 residents will:

a) role model gathering subtle and reliable information from the patient for junior members of the healthcare team.

B. Perform a physical examination

PGY-1 residents will:

a) perform an accurate physical examination that is appropriately targeted to the patient's complaints and medical conditions; and
b) identify pertinent abnormalities using common maneuvers; and
c) accurately track important changes in the physical examination over time in the outpatient and inpatient settings.

PGY-2 residents will:

a) demonstrate and teach how to elicit important physical findings for junior members of the healthcare team.

PGY-3 residents will:

a) routinely identify subtle or unusual physical findings that may influence clinical decision making, using advanced maneuvers where applicable.

C. Clinical Reasoning

PGY-1 residents will:

a) synthesize all available data, including interview, physical examination, and preliminary laboratory data, to define each patient's central clinical problem;
b) develop prioritized differential diagnoses, evidence-based diagnostic and therapeutic plan for common inpatient and ambulatory conditions; and
c) formulate a comprehensive problem list for each patient.

PGY-2 residents will:

a) modify problem formulation, differential diagnosis, and care plan based upon the evolution of clinical data over time;

PGY-3 residents will:

a) recognize disease presentations that deviate from common patterns and that require complex decision making.

D. Perform invasive procedures

PGY-3 residents will:

a) appropriately perform invasive procedures required by the ABIM and provide post-procedure management.

E. Select and interpret diagnostic tests

PGY-1 residents will:

a) make appropriate clinical decisions based upon the results of common diagnostic testing, including but not limited to routine blood chemistries, hematologic studies, coagulation tests, arterial blood gases, electrocardiograms, chest radiographs, pulmonary function tests and urinalysis.

PGY-2 residents will:

a) make appropriate clinical decision based upon the results of more advanced diagnostic tests.

PGY-3 residents will:

a) consider the costs, risks, and benefits when recommending diagnostic tests.

F. Patient management

PGY-1 residents will:

a) recognize situations with a need for urgent or emergent medical care including life threatening conditions;
b) recognize when to seek additional guidance; and
c) with supervision, manage patients with common clinical disorders seen in the practice of inpatient internal medicine.

PGY-2 residents will:

a) provide appropriate care for health maintenance and disease prevention;
b) with supervision, manage patients with common clinical disorders seen in the practice of ambulatory general internal medicine; and
c) with minimal supervision, manage patients with common and complex clinical disorders seen in the practice of inpatient and ambulatory general internal medicine.

PGY-3 residents will:

a) initiate management and stabilize patients with emergent medical conditions;
b) manage patients with conditions that require intensive care;
c) independently manage patients with a broad spectrum of clinical disorders seen in the practice of general internal medicine, including gender-specific diseases;
d) coordinate the care of patients with complex or rare medical conditions; and
e) customize care in the context of the patient's preferences and overall health.

G. Consultative care

PGY-2 residents will:

a) provide specific, responsive consultation to other services.

PGY-3 residents will:

a) provide internal medicine consultation for patients with more complex clinical problems requiring detailed risk assessment.

Medical Knowledge

A. Knowledge of core content

PGY-1 residents will:

a) understand the relevant pathophysiology and basic science for common medical conditions; and
b) demonstrate sufficient knowledge to diagnose and treat common conditions that require hospitalization.

PGY-2 residents will:

a) demonstrate sufficient knowledge to evaluate common ambulatory conditions;
b) demonstrate sufficient knowledge to diagnose and treat undifferentiated and emergent conditions;
c) demonstrate sufficient knowledge to provide health maintenance and preventive care; and
d) demonstrate sufficient knowledge to identify and treat common medical conditions that require intensive care.

PGY-3 residents will:

a) demonstrate sufficient knowledge to evaluate and coordinate the care of complex medical conditions and multiple coexistent conditions at the level of a board-certified internist; and
b) demonstrate sufficient knowledge of socio-behavioral sciences including but not limited to health care economics, medical ethics, and medical education.

B. Knowledge about diagnostic tests

PGY-1 residents will:

a) Understand indications for and basic interpretation of common diagnostic testing, including but not limited to routine blood chemistries, hematologic studies, coagulation tests, arterial blood gases, ECG, chest radiographs, pulmonary function tests, urinalysis and other body fluids.

PGY-2 residents will:

a) understand indications for and has basic skills in interpreting more advanced diagnostic tests; and
b) understand prior probability and test performance characteristics.

Practice-Based Learning and Improvement

A. Improve the quality of care of a panel of patients

PGY-1 residents will:

a) appreciate the responsibility to assess and improve care collectively for a panel of patients;
b) perform or review audit of a panel of patients using standardized, disease- specific, and evidence-based criteria;
c) reflect on audit compared with local or national benchmarks and explore possible explanations for deficiencies, including doctor-related, system- related, and patient related factors; and
d) identify areas in resident's own practice and local system that can be changed to improve effect of the processes and outcomes of care.

PGY-3 residents will:

a) engage in a quality improvement intervention.

B. Ask answerable questions for emerging information needs

PGY-1 residents will:

a) identify learning needs (clinical questions) as they emerge in patient care activities.

PGY-2 residents will:

a) classify and precisely articulate clinical questions; and
b) develop a system to track, pursue, and reflect on clinical questions.

C. Acquire the best evidence

PGY-1 residents will:

a) access medical information resources to answer clinical questions and library resources to support decision making.

PGY-2 residents will:

a) effectively and efficiently search NLM database for original clinical research articles; and
b) effectively and efficiently search evidence-based summary medical information resources.

PGY-3 residents will:

a) appraise the quality of medical information resources and select among them based on the characteristics of the clinical question.

D. Appraise the evidence

PGY-1 residents will:

a) with assistance, appraise the validity, importance, and applicability of clinical research papers.

PGY-2 residents will:

a) with assistance, appraise clinical guideline recommendations for bias.

E. Apply the evidence to decision-making for individual patients

PGY-1 residents will:

a) determine if clinical evidence can be generalized to an individual patient.

PGY-3 residents will:

a) customize clinical evidence for an individual patient;
b) communicate risks and benefits of alternatives to patients; and
c) integrate clinical evidence, clinical context, and patient preferences into decision making.

F. Improve via feedback

PGY-1 residents will:

a) respond welcomingly and productively to feedback from all members of the health care team including faculty, peer residents, students, nurses, allied health workers, patients and their advocates; and
b) actively seek feedback from all members of the health care team.

PGY-2 residents will:

a) reflect on feedback in developing plans for improvement.

PGY-3 residents will:

a) calibrate self-assessment with feedback and other external data.

G. Improve via self-assessment

PGY-2 residents will:

a) maintain awareness of the situation in the moment, and respond to meet situational needs.

PGY-3 residents will:

a) reflect (in action) when surprised, applies new insights to future clinical scenarios, and reflect (on action) back on the process.

H. Participate in the education of all members of the healthcare team

PGY-1 residents will:

a) actively participate in teaching conferences.

PGY-2 residents will:

a) integrate teaching, feedback, and evaluation with supervision of interns' and students' patient care.

PGY-3 residents will:

a) take a leadership role in the education of all members of the health care team.

Interpersonal and Communication Skills

A. Communicate effectively with patients

PGY-1 residents will:

a) engage patients/advocates in shared decision-making for uncomplicated diagnostic and therapeutic scenarios;
b) utilize patient-centered education strategies; and
c) engage patients/advocates in shared decision-making for difficult, ambiguous or controversial scenarios.

PGY-2 residents will:

a) appropriately counsel patients about the risks and benefits of tests and procedures highlighting cost awareness and resource allocation.

PGY-3 residents will:

a) role-model effective communication skills in challenging situations.

B. Intercultural sensitivity

PGY-1 residents will:

a) effectively use an interpreter to engage patients in the clinical setting including patient education; and
b) demonstrate sensitivity to differences in patients including but not limited to race, culture, gender, sexual orientation, socioeconomic status, literacy, and religious beliefs.

PGY-3 residents will:

a) actively seek to understand patient differences and views and reflects this in respectful communication and shared decision-making with the patient and the healthcare team.

C. Transitions of care

PGY-1 residents will:

a) effectively communicate with other caregivers in order to maintain appropriate continuity during transitions of care.

PGY-2 residents will:

a) role-model and teach effective communication with next caregivers during transition of care.

D. Interprofessional team

PGY-1 residents will:

a) deliver appropriate, succinct, hypothesis-driven oral presentations; and
b) effectively communicate plan of care to all members of the healthcare team.

PGY-2 residents will:

a) engage in collaborative communication with all members of the health care team.

E. Consultation

PGY-1 residents will:

a) request consultative services in an effective manner.

PGY-2 residents will:

a) clearly communicate the role of consultant to the patient, in support of the primary care relationship.

PGY-3 residents will:

a) communicate consultative recommendations to the referring team in an effective manner.

F. Health records

PGY-1 residents will:

a) provide legible, accurate, complete, and timely written communication that is congruent with medical standards.

PGY-2 residents will:

a) ensure succinct, relevant, and patient-specific written communication.

Professionalism

A. Adhere to basic ethical principles

PGY-1 residents will:

a) document and report clinical information truthfully;
b) follow formal policies; and
c) accept personal errors and acknowledge them.

PGY-3 residents will:

a) uphold ethical expectations of research and scholarly activity.

B. Demonstrate compassion and respect

PGY-1 residents will:

a) demonstrate empathy and compassion to all;
b) demonstrate a commitment to relieve suffering; and
c) provide support (physical, psychological, social and spiritual) for dying patients and their families.

PGY-3 residents will:

a) provide leadership for a team that respects patient dignity and autonomy.

C. Provide timely and constructive feedback

PGY-1 residents will:

a) communicate constructive feedback to other members of the health care team.

PGY-2 residents will:

a) recognize, respond to and report impairment in colleagues or substandard care.

D. Maintain accessibility

PGY-1 residents will:

a) respond promptly and appropriately to clinical responsibilities including calls and pages; and
b) carry out timely interactions with colleagues, patients and their designated caregivers.

E. Recognize conflicts of interest

PGY-1 residents will:

a) recognize and manage obvious conflicts of interest, such as caring for family members and professional associates as patients.

PGY-3 residents will:

a) maintain ethical relationships with industry; and
b) recognize and manage subtler conflicts of interest.

F. Practice individual patient advocacy

PGY-1 residents will:

a) recognize when it is necessary to advocate for individual patient needs.

PGY-3 residents will:

a) effectively advocate for individual patient needs.

G. Comply with public health policies

PGY-2 residents will:

a) recognize and take responsibility for situations where public health supersedes individual health (e.g. reportable infectious diseases).

H. Demonstrate personal accountability

PGY-1 residents will:

a) dress and behave appropriately;
b) maintain appropriate professional relationships with patients, families and staff;
c) ensure prompt completion of clinical, administrative, and curricular tasks;
d) recognize the scope of his/her abilities and ask for supervision and assistance appropriately; and
e) recognize and address personal, psychological, and physical limitations that may affect professional performance.

PGY-2 residents will:

a) recognize the need to assist colleagues in the provision of duties.

PGY-3 residents will:

a) serve as a professional role model for more junior colleagues (e.g., medical students, interns).

I. Respect the dignity, culture, beliefs, values, and opinions of the patient

PGY-1 residents will:

a) treat patients with dignity, civility and respect, regardless of race, culture, gender, ethnicity, age or socioeconomic status.

PGY-3 residents will:

a) recognize and manage conflict when patient values differ from their own.

J. Respect patient confidentiality

PGY-1 residents will:

a) maintain patient confidentiality.

PGY-2 residents will:

a) educate and hold others accountable for patient confidentiality.

K. Recognize and address disparities in healthcare

PGY-1 residents will:

a) recognize that disparities exist in health care among populations and that they may impact care of the patient.

PGY-3 residents will:

a) embrace physicians' role in assisting the public and policy makers in understanding and addressing causes of disparity in disease and suffering; and
b) advocates for appropriate allocation of limited health care resources.

Systems-Based Practice

A. Works effectively within multiple healthcare settings

PGY-1 residents will:

a) understand unique roles and services provided by local healthcare delivery systems.

PGY-2 residents will:

a) manage and coordinate care and care transitions across multiple healthcare settings, including ambulatory, subacute, acute, rehabilitation, and skilled nursing.

PGY-3 residents will:

a) negotiate patient-centered care among multiple care providers.

B. Works effectively within a team

PGY-1 residents will:

a) appreciate roles of a variety of health care providers, including, but not limited to, consultants, therapists, nurses, home care workers, pharmacists, and social workers;
b) work effectively as a member within the interprofessional team to ensure safe patient care; and
c) consider alternative solutions provided by other teammates.

PGY-3 residents will:

a) demonstrate how to manage the team by utilizing the skills and coordinating the activities of interprofessional team members.

C. Effectively contributes to system improvement

PGY-1 residents will:

a) recognize system issues that increase the risk for error including barriers to optimal patient care.

PGY-2 residents will:

a) identify, reflect upon, and learn from critical incidents such as near misses and preventable medical errors; and
b) dialogue with care team members to identify risk for and prevention of medical error.

PGY-3 residents will:

a) understand mechanisms for analysis and correction of systems errors;
b) demonstrate ability to understand and engage in a system level quality improvement intervention; and

c) partner with other healthcare professionals to identify, propose improvement opportunities within the system.

D. Identifies forces that impact the cost of healthcare and advocates for cost-effective care

PGY-1 residents will:

a) reflect awareness of common socio-economic barriers that impact patient care.

PGY-2 residents will:

a) understand how cost-benefit analysis is applied to patient care (i.e., via principles of screening tests and the development of clinical guidelines).

PGY-3 residents will:

a) identify the role of various health care stakeholders including providers, suppliers, financiers, purchasers and consumers and their varied impact on the cost of and access to health care; and

b) understand coding and reimbursement principles.

E. Practices cost-effective care

PGY-1 residents will

a) minimize unnecessary care including tests, procedures, therapies and ambulatory or hospital encounters.

PGY-2 residents will:

a) identify costs for common diagnostic or therapeutic tests; and

b) demonstrate the incorporation of cost-awareness principles into standard clinical judgments and decision-making.

PGY-3 residents will:

a) demonstrate the incorporation of cost-awareness principles into complex clinical scenarios.

Curriculum

- Community based internal medicine continuity clinic with a dedicated empanelment for every resident.
- Rotating through community-based and health department clinics for community health experience.
- Dedicated procedural clinic to perform outpatient internal medicine procedures.
- Dedicated Point-of-Care ultrasound curriculum.
- Completing scholarly projects with financial support for conference attendance and presentation. Assistance with writing manuscripts for publication.
- Collaborating with local researchers such as the National Diabetes Obesity Research Institute (NDORI) or become part of the study team on one of our clinical trials being conducted at Memorial Hospital at Gulfport.
- Completing Quality Improvement projects to improve the care delivered to your empaneled patients, with a 2-week dedicated QI block in PGY3 year to investigate/improve a hospital wide process.
- Daily didactics (excluding weekends) 7-8am and 12-1pm. Attendance is required and will be recorded.

Rotation Organizational Structure

First Year (PGY-1)

- Inpatient Service – 6 months
- Infectious Disease – 1 month
- Ambulatory – 1 month
- Medical Intensive Care – 1 month
- Elective – 0.5 month
- Neurology – 1 month
- Cardiology – 1.5 month

Second Year (PGY-2)

- Emergency Medicine – 1 month
- Inpatient Service – 4 months
- Hospice & Palliative Care – 1 month
- Ambulatory – 1 month
- Geriatric Medicine – 1 month
- Medical Intensive Care – 1 month
- Elective – 3 months

Third Year (PGY-3)

- Elective – 7 months
- Q I Project – 1 month
- Medical Intensive Care – 1 month
- Inpatient Service – 3 months

Rotation Changes

Rotations will provide exposure and management to both inpatient and outpatient care. Residents follow an academic calendar in order to fulfill their curricular obligations and learning objectives. Rotations are provided primarily at Memorial Hospital at Gulfport.

- Residents are required and responsible for completing all rotations on their schedule.
- Changes to the rotation schedule may only occur under the following guidelines:
  - Changes within a hospital must have the approval of the hospital Program Director **PRIOR TO THE CHANGE**
  - Changes between two hospitals require the approval of the Program Director of both hospitals **PRIOR TO THE CHANGE**
  - Switching rotations with another Resident in the same hospital must have the approval of the hospital Program Director **PRIOR TO THE CHANGE**
  - Switching rotations with another Resident at another hospital requires the approval of the Program Director of both hospitals **PRIOR TO THE CHANGE**

Rotations Goals and Objectives

The goals and objectives for each rotation are available in New Innovations and should be reviewed prior to the beginning of a rotation to understand rotation structure, expectations, and evaluation methods.

Criteria for Promotion

Promotion to each subsequent year of training requires demonstrating competence that meets expectations on the specific learning objectives (listed above) of the evaluations across all clinical rotations during that year of training. Failing to meet this standard will be reviewed by the CCC which may elect to withhold promotions and remediate, or promote with an accompanying remediation plan. See GME 500.05 Promotion, Non-Renewal, and Dismissal Policy for details.

In addition, there are a variety of individual educational requirements that must be successfully completed as listed below.

PGY1 Promotion to PGY2

- Must take and pass USMLE step 3 or Complex level 3
- “Back to Basics” presentations
- EBM conferences
- Journal Clubs
- Scholarly project

PGY2 Promotion to PGY3

- EBM conferences
- Journal Clubs
- PSQI Conference
- Clinical Pathology Conference
- Scholarly project

PGY3 Graduation

- QIP project
- Grand Rounds
- Scholarly project

Program Standards

Advanced Life Support (ALS)

Residents must maintain an active (and in no way let it expire or lapse) ALS certification during all 3 years of residency. Failure to maintain this certification may cause removal from duty until the ALS certification is again deemed active which could prolong training or result in the forfeiture of pay for any time away from work.

Conference Attendance

Failure to meet a minimum of 80% attendance will result in referral to the clinical competency committee.

Absences/Late Arrivals

You are required to contact your supervising attending and the chief resident (or their assigned designee) concerning all absences or late arrivals from rotations.

Evaluation Completion

Every resident must evaluate each rotation, attending, assigned peers, and the program. These evaluations must be completed within 14 days of the completion of the activity.

USMLE Step 3/COMLEX Level 3

PGY-1 residents must take and pass USMLE step 3/Comlex level 3 before promotion to PGY-2. Residents must be registered to take the exam by 1 March of PGY-1 year in order to have results back in time for promotion.

Evaluation: Resident, Faculty, Rotations and Program

The attending is to verbally provide feedback to team members at a minimum of half-way through the rotation and at the end of the rotation; this is in addition to completing the final written evaluation (within the electronic evaluation system).

Residents will be evaluated by the responsible supervising physician after completion of each rotation using the appropriate Competency Based Evaluation form. The evaluation form will include pertinent ACGME sub-competencies as well as Entrustable Professional Activity (EPA) questions. The completed form will be submitted electronically, using New Innovations, immediately upon completion of the rotation. Residents are required to review and sign these evaluations in New innovations.

The Internal Medicine Residency Program expects all evaluators to complete evaluations within 14 days of rotation completion.

Evaluations Tools

- End of month Attending evaluations
- Multi-source evaluations (nurses, patients, peers, self)
- Mini-CEX
- Direct observation tools (DOTs)
- Continuity clinic evaluations
- Patient simulation
- Resident presentations that will be evaluated
    - Grand Rounds
    - Clinical Pathology Conference
    - Quality Improvement Project Conference
    - Patient Safety and Quality Improvement Conference
    - Journal Club
    - Evidence Based Medicine Conference
    - Back to Basics Conference

Resident Evaluations

- Residents are responsible for the completion of all evaluations of rotation, peers and faculty following each rotation.
- Residents are required to evaluate both the rotation/supervising physician(s) electronically following each rotation; batched data will be released every 6 months to protect anonymity.
- Residents are required to evaluate peers electronically following each rotation; batched data will be released every 6 months to protect anonymity.
- Residents are required to complete an anonymous evaluation of their training program on an annual basis. Aggregate results will be reviewed by the PD, APD(s), and core faculty and used for program improvement.
- Residents are required to complete ACGME program surveys annually.
- Graduating Residents are required to complete anonymous exit surveys via New Innovations
- Electronic copies of all resident evaluations will be kept on file in New Innovations

New Innovations

The residency manages much of its data using a software program called “New Innovations” (NI). We store our *curriculum material* and *rotation schedules* in NI. Lecture attendance is recorded in this data base. Evaluations are completed on-line for your rotational performance and faculty evaluations. Procedures are logged and can be done via your smartphone, which can be configured to automatically hot Synch your procedures over the Internet into New Innovations. Log in daily to see important department notices, complete outstanding evaluations, or review your progress toward curricular goals, procedure totals, or see feedback or performance. You can login using http://www.new-innov.com/ .

Your username is your first initial and last name (e.g. jsmith). Your password can reset if we have your active email account.

Duty / Work Hours

Residents are required to read the duty/work hours rules as set forth by the ACGME and provided in the Policies and Procedures manual and sign an attestation form indication their intention to comply with these rules. Residents are required to log duty/work hours on a weekly basis in order to monitor compliance with duty hour rules. All violations are review by the Program Director.

Duty Types Defined

Duty Type	Definition
Shift	Use for all rotations except if one of the others apply
Clinic	Use only for hours spent in your IM Continuity Clinic (use shift for hours spent in all other clinics)
Exceptional Circumstances	Use when on duty beyond scheduled hours for exceptional circumstances
Night Float	Use for night float shift
Conference	Use when traveling to. From and during conference
Moonlighting	Use when moonlighting
Vacation / Leave	This must be used for all paid time off so that duty hours are not counted in some of the other work rules.

On Duty Beyond Scheduled Hours

The resident and training institution must always remember that patient care responsibility is not precluded by the work hour policy. In cases where a resident is engaged in patient care which cannot be interrupted, additional coverage should be provided as soon as possible by the attending staff to relieve the resident involved. When these instances occur, the resident must document the work hours in New Innovations.

Duty Hour Exception

All hours logged that create a duty hour exception in New Innovations require the resident to document in the comment section why the exception occurred. Residents not doing so will be instructed to do so by program leadership.

Jeopardy System (AKA Backup Coverage)

The backup coverage system for vital clinical service roles termed historically as the jeopardy system exists to provide back-up for residents who find themselves unexpectedly unable to work their assigned rotation due to illness or personal emergency. Jeopardy system structure and rules:

1. Be professional, responsible, and conscientious.
    - This system is to be used ONLY when absolutely needed for sickness or personal emergency, so please use it responsibly.
    - Please do not abuse this jeopardy system and be mindful of your co-resident's time and life.
    - Any abuse to the system will not be tolerated and will have consequences.
2. The person assigned to jeopardy must be available 24 hours a day for the duration of their jeopardy coverage. That means:
    - Able to make it to the hospital within 1 hour.
    - Make sure your cell phone is on and working 24/7.
    - Be professional, responsible, and able to work.
    - Failure to answer jeopardy call is a breach to professionalism and has consequences (listed below).
3. Coverage
    - Interns will cover their co-interns, and seniors (2nd and 3rd years) will cover each other.
    - There will be a senior on First Call, a senior on Second Call, and an intern on First Call.
        - If more than one intern coverage is needed, coverage will be done as follows: intern on First Call, then senior on First Call, then senior on Second Call.
        - Senior coverage: senior on First Call then senior on Second Call.
        - If senior on First call was already covering for an intern and a senior coverage was needed, then senior on Second Call will cover.
        - If more coverage was needed at any given time, we will call other residents to cover as we see fit and appropriate based on schedule and availability.

4. Jeopardy call process:
    - Call the Chief Resident/PD to inform him/her of inability to work and reason.
    - You must CALL. Text messages and emails are not acceptable.
    - You must call before your scheduled shift. Please do not wait until your shift has already started, unless of course you have become ill during your shift.
    - Informing the Chief Resident/PD of absence from work after the work shift is done is not acceptable and will be considered a breach of professionalism.
5. Chief/PD will call the intern or senior on First Call
    - You will be called on your cell phone first (please make sure it's working 24/7).
    - If cell phone was not answered, your emergency contact will be called.

- You have 15 minutes to answer the jeopardy call. Failure to answer a jeopardy call within this time is a breach of professionalism.
- If First Call intern/senior did not answer or a 2nd coverage is needed, Chief/PD will call senior on Second Call.

6. Consequences
    - Any breach of professionalism by failure to answer jeopardy calls, not reporting to the assigned work shift, refusing to report the assigned work shift, and others will have consequences.
    - Consequences can include but not limited to: assignment of extra jeopardy call coverage to be determined by the program administration.
7. Jeopardy Exchanges
    - It's your job to find someone to switch jeopardy time with you. When you find someone agreeable to switch, email the Program Coordinator with the following:
        - Your name and jeopardy time.
        - Other resident name and his jeopardy time.
        - You must CC the other resident in email to ensure he/she agrees to the exchange.
        - The Program Coordinator will update/document the change.

Moonlighting

Moonlighting is allowed during PGY2 and PGY3 years only for residents that are in good standing. See GME Policy 500.06 for full details and procedure to request moonlighting privileges.

Supervision

Classification Levels of Supervision:

To promote appropriate resident supervision while providing for graded authority and responsibility, the program will use the following classification of supervision:

Direct Supervision:

1) The supervising physician is physically present with the resident during the key portions of the patient interaction.
    - PGY-1 residents must initially be supervised directly.
    - A supervising physician must be immediately available to be physically present for PGY-1 residents on inpatient rotations who have demonstrated the skills sufficient to progress to indirect supervision.

2) The supervising physician and/or patient is not physically present with the resident and the supervising physician is concurrently monitoring the patient care through appropriate telecommunication technology.

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

Oversight: The supervising physician is available to provide review of procedures/encounters with feedback provided after care is delivered.

Supervision in Patient Care and Clinical Education

Although the attending physician is ultimately responsible for the care of the patient, every physician share in the responsibility and accountability for their efforts in the provision of care.

Supervision in the setting of graduate medical education provides safe and effective care to patients; ensures each resident's development of the skills, knowledge, and attitudes required to enter the unsupervised practice of medicine; and establishes a foundation for continued professional growth.

The goal of the internal medicine residency program is to create physicians capable of independent medical practice. As such, upon completion of the program each resident will have demonstrated the ability to care for patients with general medical conditions without the need for oversight and modification of their work by faculty. During the residency program, faculty will encourage assumption of independence as expeditiously as the resident's increasing knowledge, experience and professional maturity permit, in keeping with both safe patient care and sound educational principles.

The responsibility of the attending physician for the patient is never relinquished but the amount of freedom to make decisions and implement them and the amount and timing of attending supervision will change depending on an individual resident's demonstrated performance as judged by ongoing faculty performance reviews and ACGME Milestones data as the resident progresses through the program.

PGY-1 residents begin the 1st year in a **Direct** supervision classification. As the developmental milestones are achieved, their level of responsibility will increase with a move into supervision classification **Indirect Supervision.**

PGY-2/3 level residents are in **Indirect Supervision** classification moving towards **Oversight**.

At any time, the attending physician can designate which supervision level is necessary for that rotation. The changing clinical care environment of medicine has meant that work compression due to high complexity has increased stress on residents. Faculty members and program directors need to make sure residents' function in an environment that has safe patient care and a sense of resident well-being. Some Review Committees have addressed this by setting limits on patient admissions, and it is an essential responsibility of the program director to monitor resident workload. Workload should be distributed among the resident team and interdisciplinary teams to minimize work compression.

Clinical Responsibilities

The clinical responsibilities for each resident will be based on PGY level, patient safety, resident ability, severity and complexity of patient illness/condition, and available support services.

Teamwork

Residents must care for patients in an environment that maximizes communication. This must include the opportunity to work as a member of effective interprofessional teams that are appropriate to the delivery of care in the specialty and larger health system.

There will be a multi-disciplinary approach to training which will include pharmacists, social workers, case workers, discharge planners, nutritionists, and psychiatrists which will occur during multi-disciplinary rounds.

Residents will actively participate in multi-disciplinary rounds when assigned to inpatient ward months to effectively communicate the plan of care and engage in collaborative communication with all members of the health care team.

Residents will be trained in effective, patient-centered communication including, how to talk with families, delivering bad news, code status discussions, and other common interactions, and locally created direct observation tool will be utilized in the inpatient and outpatient settings to assess for competency.

Transitions of Care

The IM residency will design clinical assignments to minimize the number of transitions in patient care and ensure and monitor effective, a structured hand-over processes to facilitate both continuity of care and patient safety. The program will ensure residents are competent in communicating with team members in the hand-over process.

- Transitions of care will occur face to face at the end of the shift at sign-out rounds.

- Transitions of care will occur in an organized fashion using the I-PASS Handoff system: Illness Severity, Patient Summary, Action List, Situational Awareness and Contingency Planning, and Synthesis by Receiver.
    - I-Pass: http://www.ipasshandoffstudy.com/

- For synthesis by receiver, the team/individual being signed out to, will briefly repeat a summary of what is heard, ask questions, and restate key actions/items to do. This will cover medical patients on inpatient services as well as inpatient consults.

- Transitions of care will always occur under the direct supervision of an attending physician to ensure information is not lost and to provide immediate resident feedback.

I	Illness Severity	• Stable, "watcher," unstable
P	Patient Summary	• Summary statement • Events leading up to admission • Hospital course • Ongoing assessment • Plan
A	Action List	• To do list • Time line and ownership
S	Situation Awareness and Contingency Planning	• Know what's going on • Plan for what might happen
S	Synthesis by Receiver	• Receiver summarizes what was heard • Asks questions • Restates key action/to do items

FIGURE 1

- A Direct Observation Tool will be utilized periodically to standardize the process and provide objective competency-based assessment and feedback.

Post Graduate Year 1 (PGY-1)

Trainees beginning their PGY-1 year will be closely supervised by their upper year residents and attending physicians. During the first six months of the PGY-1 year, all PGY-1 level residents will have direct supervision of their patients as defined above. PGY-1 level residents will then give a complete presentation of the history, their physical examination findings, interpretation of diagnostic tests, and intended interventions to their supervising resident or attending. The supervising resident or attending will confirm by interview/examination any key portions of history and physical exam and verify the intended interventions with the PGY-1 resident and patient. During the PGY-1 year with successful completion of skills and milestones, the resident may achieve an indirect supervision status. Historically this usually occurs around the mid-year evaluation. The supervising residents and attendings will be notified when an individual PGY-1 level resident has achieved indirect supervision classification.

The PGY-1 resident may carry out many supervised activities to include, but not limited to:

- Obtain a medical history
- Perform both a physical examination and a mental status examination
- Pronounce death
- Interpret the results of commonly used diagnostic procedures, including radiographs and laboratory results
- Write orders for admission, management and discharge
- Write prescriptions
- ALS team leader if certified
- Medical student supervision

- They may perform procedures independently once signed off by the internal medicine procedure committee.

Post Graduate Year 2 (PGY-2)

The PGY-2 year is an intermediate year of training in categorical internal medicine residency. The PGY-2 is designated as a supervising resident and should serve in a supervisory role to junior residents. The PGY-2 level resident may perform procedures independently once signed off by the internal medicine procedure committee and are expected to teach these skills to their more junior colleagues. They must present their patients (in person or phone) to their supervising attending within a reasonable time frame and at the end of every shift.

Post Graduate Year 3 (PGY-3)

The third year of categorical internal medicine training is the senior year. Residents at the PGY-3 level are assigned as supervising residents and should serve in a supervisory role to junior residents. The PGY-3 may perform procedures independently once signed off by the internal medicine procedure committee and are expected to teach these skills to their more junior colleagues. They must present their patients (in person or phone) to their supervising attending within a reasonable time frame and at the end of their shift.

Inpatient Admitting Rotations

The attending physician serves as a resource for residents and are available (by phone or in person) to residents for guidance or assumption of care as needed.

Residents are required to make rounds on all assigned cases as soon as possible when coming on duty and write his/her progress notes at the time the patient is seen or soon after.

Residents will make management rounds with the attending physicians. He/she will receive instruction, information, advice, suggestions and assistance from the faculty who thus contribute to his/her bedside training.

Management rounds occur at least once daily on all admitting services and all patients on a teaching service are discussed briefly again at the end of the shift.

A typical care team consists of

- A supervising attending
- One supervising resident (PGY-2/3 level)
- One or two PGY-1 level residents
- and often medical student(s)

Faculty members functioning as supervising physicians must delegate portions of care to residents based on the needs of the patient and the skills of each resident.

A hierarchy of increasing authority and responsibility as experience is gained is embedded in the team. The PGY-2/3 level resident should serve in a supervisory role to junior residents and students in recognition of their progress toward independence, based on the needs of each patient and the skills of the individual resident. Similarly, the supervising attending is expected to provide the appropriate amount of direct resident supervision necessary for safe and effective patient care. Judgments on delegation of responsibility are made by the attending; based on his or her direct observation and knowledge of each team member's skills and abilities. The degree of supervision may vary with the clinical circumstances and the developmental stage of the resident. Management and Attending Rounds provide a format for in-depth discussion of clinical presentations, pathophysiology, and management. All major clinical decisions are discussed, and all plans are reviewed with the supervising attending, either in management rounds, when appropriate throughout the day, and at the end of the resident shift.

General Outpatient Supervision

Residency training is an educational experience designed to offer residents the opportunity to participate in the clinical evaluation and care of patients in a variety of patient care settings to include the internal medicine clinic. All aspects of patient care rendered by resident physicians must receive close supervision.

All aspects of patient care are ultimately the responsibility of the supervising attending. The supervising attending' have the right to prohibit resident participation in the care of their patients without penalty, and when allowing care of their patients by residents do not relinquish their rights or responsibilities to: examine and interview; write notes; or to correct resident medical record entries deemed to be erroneous or misleading by crossing through the erroneous statement and initialing the change in the written document or entering a corrective statement at the end of the electronic document.
When a resident is involved in the care of a patient it is their responsibility to communicate effectively with their supervising attending regarding the findings of their evaluation, physical examination, interpretation of diagnostic tests, and intended interventions.

Internal Medicine Continuity Clinic Supervision

During the first six months of the PGY-1 year, all residents will have direct supervision of their patients as defined above. PGY-1 level residents will give a complete presentation of the history, their physical examination findings, interpretation of diagnostic tests, and intended interventions to the supervising attending. The supervising attending will confirm by interview/examination any key portions of history and physical exam and verify the intended interventions with the resident and patient. During the PGY-1 year with successful completion of milestones, the resident may achieve an indirect supervision status. Historically this usually occurs around mid-year evaluation. The internal medicine clinic supervising faculty will be notified when an individual resident has achieved indirect supervision classification.

Second year residents (PGY-2) will give a complete presentation whereas third year residents (PGY-3) may give a brief presentation on all new patients and on any follow-up patients. The supervising attending will interview and/or examine the patient at their discretion, the resident's request, or at the patient's request.

Residents must write/enter orders on patients for whom they are participating in their care.

Residents may perform procedures independently after signed off by the internal medicine procedure committee.

The ratio of residents to faculty for ambulatory care is not greater than 4:1.

Specialty Clinic Supervision

Resident supervision regarding patient care and the medical record will be the same for all residents rotating in the medicine subspecialty clinics. Residents may perform history and physical examinations. It is the responsibility of the resident to discuss their findings with the supervising attending immediately upon completion of their examination. The supervising attending will confirm key portions of the history and physical exam.

Residents will write/enter orders on patients for whom they are participating in their care.

Residents may perform procedures independently after signed off by the internal medicine procedure committee.

General Rules

- All resident levels can write/dictate daily progress notes on patients for whom they are participating in their care.

- All resident levels can write/dictate discharge/transfer summaries for patients for whom they are participating in their care. It is the responsibility of the resident to discuss discharge plans with the supervising Attending and/or consulting physician prior to discharging the patient.

- All resident levels will be able to identify an available supervising attending, at-all-times, during patient care. A supervising attending will be immediately available on site to provide direct supervision 24/7.

- Residents and faculty members must inform each patient of their respective roles in that patient's care when providing direct patient care.

- Residents service responsibilities must be limited to patients for whom the teaching service has diagnostic and therapeutic responsibility.

- Residents must write all orders for patients under their care, with appropriate supervision by the attending physician. In those unusual circumstances when an attending physician writes an order on a resident's patient, the attending or consultant must communicate his or her action to the resident in a timely manner.

Patient Cap Rules

- A first-year resident must not be assigned more than five new patients per admitting day; an additional two patients may be assigned if they are in-house transfers from the medical services.

- A first-year resident must not be assigned more than eight new patients in a 48-hour period.

- A first-year resident must not be responsible for the ongoing care of more than 10 patients.

- When supervising more than one first-year resident, the supervising PGY-2/3 resident must not be responsible for the supervision or admission of more than 10 new patients and four transfer patients per admitting day or more than 16 new patients in a 48-hour period.

- When supervising one first-year resident, the supervising PGY-2/3 resident must not be responsible for the ongoing care of more than 14 patients.

- When supervising more than one first-year resident, the supervising PGY-2/3 resident must not be responsible for the ongoing care of more than 20 patients.

Mandatory Attending Notifications

To ensure timely communication and patient safety the resident is required to immediately communicate directly (telephone or in person) with their supervising attending physician, regardless of the time of day. Such communication must be clearly documented in the medical record and includes:

- Emergency room consults that will be discharged to home
- Clinic consults that will be discharged to home
- Admissions
- ICU transfers from floor or from another hospital
- Discharges to include against medical advice
- Transfers to another hospital, skilled nursing facility, or inpatient rehab center
- Patient death
- Any significant clinical deterioration
- Prior to performing any invasive procedure
- Change in code status
- Any event that may compromise patient safety
- Questions or concerns
- Error in care
- Family request
- Palliative care discussion
- Transition of care within MHG
- Code situation
- Conflict with patient or family

- Conflict with staff member.

Competencies (training and evaluation)

Practice-Based Learning and Improvement

Residents will demonstrate competence in investigating and evaluating their care of Internal Medicine patients, appraising and assimilating scientific evidence, and continuously improving their patient care based on self-evaluation and lifelong learning.

All residents will participate in an internal medicine clinic data-based action plan bi-annually. The residents will receive data regarding a practice metric for their continuity clinic empanelment and a resident designed, faculty guided plan will be developed to improve chronic disease management and/or preventive health care, and the resident and clinic will track the progress to ensure sustainment.

Residents will be required to prepare and present the following items during residency which will directly and indirectly assess the PBLI competence and provide an opportunity to provide feedback and assess the resident's willingness to accept and incorporate feedback as he/she develops.

- PGY1 residents "Back to Basics" presentation
- PGY1/2 residents EBM conference
- PGY1/2 residents Journal Club
- PGY2 residents PSQI Conference
- PGY2 residents Clinical Pathology Conference
- PGY3 residents QIP project
- PGY3 residents Grand Rounds

End of rotation evaluations will be utilized and incorporate specific questions regarding the PBLI competency to provide a 360 degree perspective to assess the resident's ability to identify learning needs as they emerge in patient care activities, best acquire evidence, customize clinical evidence for an individual patient, communicate risk and benefits to patients, and integrate clinical evidence and patient preference into decision-making.

All residents will have an outpatient longitudinal continuity experience. This will allow the resident to serve as the primary physician and develop a continuous long-term relationship with the responsibility for chronic disease management, management of acute care, and preventative health care for their patients. The resident's continuity clinic sessions will be at the same location over his/her 36-month residency. The resident will be assigned and have the same faculty members for their continuity clinic supervision. This model will allow for a longitudinal relationship between the resident and supervising faculty which will promote quality resident clinic feedback and the ability to verify that incorporation of feedback has occurred. In addition, this model will enhance the value of the resident's quarterly continuity clinic performance review.

Residents are required to complete ACGME Reporting Milestones on themselves to use as self-assessment and feedback tools. These will be reviewed by their advisors with them during their bi-annual advisor meetings, or more frequently as necessary.

Evaluations will be discussed monthly in CCC meetings called “Resident Round-up.” These meetings give supervising faculty an opportunity to discuss resident development/progression with the resident’s advisors to provide another opportunity to enhance resident feedback after the rotation.

Interpersonal and Communication Skills

Residents will develop skills that result in the effective exchange of information and collaboration with patients, their families, and health professionals.

Residents will actively participate in multi-disciplinary rounds when assigned to inpatient ward months to effectively communicate the plan of care and engage in collaborative communication with all members of the health care team.

Transitions of care will occur face to face at the end of the shift at sign-out rounds. This will cover medical patients on inpatient services as well as inpatient consults. This will always occur under the direct supervision of an Attending to ensure information is not lost and to provide immediate resident feedback.

Residents will be trained in effective, patient-centered communication including, how to talk with families, delivering bad news, code status discussions, and other common interactions, and locally created direct observation tool will be utilized in the inpatient and outpatient settings to assess for competency.

Specific Direct Observation Tools (DOT)s:
- Code Status
- Delivery of bad news
- Life style modifications
- Age appropriate screening test
- Controlled substance contract
- Transition of care
- Risk/benefit/alternative treatment

End of rotation evaluations will be utilized and incorporate specific questions regarding the ICS competency to provide a 360 degree perspective to assess the resident’s ability to deliver appropriate, succinct, hypothesis-driven oral presentations, effectively communicate plan of care to all members of the health care team, engage in collaborative communication, and be a role model by utilizing effective communication skills in challenging situations.

Residents will participate in supervised mock code evaluations and complete standardized competency-based patient simulation cases quarterly. This will provide numerous opportunities to participate in simulated patient interactions to augment training, strengthen communication skills, and provide feedback. These cases will cover code situations, medical emergencies, and undifferentiated clinical deterioration cases which will require fast thinking to assess the resident’s ability to work effectively as a health care team leader in stressful situations.

Residents will be required to prepare and present the following items during residency which will afford an opportunity for the individual to demonstrate his/her ability to educate students, fellow residents, faculty, and other health care professionals.

- PGY1 residents “Back to Basics” presentation

- PGY1/2 residents EBM conference
- PGY1/2 residents Journal Club
- PGY2 residents PSQI Conference
- PGY2 residents Clinical Pathology Conference
- PGY3 residents QIP project
- PGY3 residents Grand Rounds

All H&Ps, notes, discharge summaries will be reviewed, edited and co-signed by the Attending to ensure legible, accurate, and thorough (that is congruent with medical standards) communication are completed in a timely manner.

Systems-based Practice

Residents will demonstrate an awareness of and responsiveness to the larger context and system of health care, including the social determinants of health, as well as the ability to call effectively on other resources to provide optimal health care.

There will be a multi-disciplinary approach to training which will include pharmacists, social workers, case workers, discharge planners, nutritionists, and psychiatrists which will occur during multi-disciplinary rounds.

All residents will receive didactics and/or hands on training covering:
-Coding
-Billing
-EHR
-Understanding how health care structure and systems (ambulatory care centers, physician office practices, inpatient units, home health care, laboratories and pharmacies) function as a whole and how actions within one component can affect all other aspects of the system.

Residents will be required to prepare and present the following items during residency which will provide an opportunity for the individual to demonstrate his/her awareness of and responsiveness to the various systems of health care delivery.

All residents will participate in an internal medicine clinic data-based action plan bi-annually. The residents will receive data regarding a practice metric and benchmark for their continuity clinic empanelment and a resident designed, faculty guided plan will be developed to improve chronic disease management and/or deliver preventive health care in a cost-effective manner. The resident will need to incorporate and reflect upon the common socio-economic barriers and health care disparities that impact patient care and their patients' health decisions.

All PGY2 residents will complete a PSQI conference. This conference is dedicated to identifying issues that affect patient safety or limit optimal health care delivery. The issues may be as varied as knowledge gaps in care for patients with unusual diseases to system errors that occur during delivered care. There is a discussion to implement potential system solutions or changes in training to prevention issues in the future.

PGY3 level residents will complete a Quality Improvement Project to engage in a systems level intervention with the aim to understand and recognize health care disparities and/or identify system errors to implement changes and improve processes to enhance the delivery of cost-effective patient

care. The resident will present the project during noon conference to report findings and make recommendations of potential process improvements to the Department of Medicine.

End of rotation evaluations will have specific questions regarding SBP competency addressing the resident's ability to effectively work within a team, appreciate the roles of various hospital team members, and demonstrate the skills needed to coordinate the delivery of patient care. This will help provide a 360 perspective of resident understanding and competency demonstration.

Chronic Disease Management/Prevention

Residents evaluate the chronic disease management and preventive health care they deliver to their panel of continuity patients.

All residents will have a continuity clinic experience at the same location and with the same core outpatient faculty. The residents will be directly empaneled with internal medicine patients for which they will have a longitudinal relationship. The residents will have weekly continuity clinics (4 clinic sessions per month) on every rotation (except MICU and Night Float) to ensure adequate appointment slots. The continuity clinic experience will focus on outpatient disease management, preventative health, patient counseling as well as acute ambulatory problems if necessary. All notes will be reviewed, edited and co-signed by the Attending to ensure legible, accurate, complete, and timely written communication (that is congruent with medical standards) are completed. In addition, the Mini-CEX and specific DOT will be utilized to observe resident patient interactions to augment feedback.

The residents will adhere to all of Mississippi's state mandates regarding prescription drug monitoring program. Since there is an ongoing prescription and illegal drug issue nationally, the program will have didactic sessions to provide all faculty, residents, and medical students with the latest information and simulation training sessions to enhance education and recognize abuse to provide patients with evidence based treatment plan options.

All residents will participate in an internal medicine clinic data based action plan bi-annually. The residents will receive data regarding a practice metric and benchmark for their continuity clinic empanelment and a resident designed, faculty guided plan will be developed to improve chronic disease management and/or preventive health care; the resident and clinic will track the progress to ensure sustainment. For example…develop a plan using the American Association of Clinical Endocrinology practice guideline to improve the delivery of cost effective, evidence based comprehensive diabetes management for all empaneled patients with type 2 diabetes.

Longitudinal Continuity Experience

The program ensures that all residents develop a continuous long-term therapeutic relationship with a panel of general internal medicine patients.

The residents will be directly empaneled with internal medicine patients for which they will have a longitudinal relationship. The residents will have weekly continuity clinics (4 clinic sessions per month) on every rotation (except MICU and Night Float) to ensure adequate appointment slots for the delivery of patient care for their empanelment. The resident's continuity clinic will have one acute appointment per clinic reserved for an acute ambulatory problem. The resident's continuity clinic will not be booked

with patients for which the resident is not their primary care manager except in the event the appointment is not filled within 48 hours of the appointment time. Open appointment slots within 48 hours of their appointment time will be converted to acute appointments to ensure the resident's clinics are filled with acute ambulatory problems as well. Faculty to resident ratio will not exceed 1:4 to ensure adequate time for resident education, performance of the Mini-CEX and DOTs, and feedback as necessary.

The resident's will be responsible for responding to patient questions and labs, and will be accessible to participate in the management and coordination of care across health care settings of their continuity panel of patients during all rotations except MICU and emergency medicine. The resident assigned to their ambulatory block and/or outpatient clinic faculty will provide back-up coverage for urgent issues as necessary.

All residents will participate in an internal medicine clinic data based action plan bi-annually. The residents will receive data regarding a practice metric for their continuity clinic empanelment and a faculty guided plan will be developed to improve chronic disease management and/or preventive health care, and the resident and clinic will track the progress to ensure sustainment. For example, a plan could be developed using the American Diabetes Association standards of care practice guidelines to improve the delivery of cost effective, evidence based comprehensive diabetes management for all empaneled patients with type 2 diabetes.

Cost-effective Practices

The program teaches residents to treat their patients with cost-effective practices.

The southern coastal area of Mississippi has a high underserved and homeless population with various disease processes. The residents will gain knowledge and training while working as part of a multi-disciplinary team. Team members will include pharmacy, social workers, case managers, psychiatrists, psychologists, specialty-based physicians, OT, PT and respiratory therapists. With this interaction, they will understand the complexities of working within a clinical/hospital settings and the various costs within those facilities.

PGY3 level residents will complete a Quality Improvement Project to engage in a systems level intervention with the aim to understand and recognize health care disparities and/or identify system errors to implement changes and improve processes to enhance the delivery of cost-effective patient care. The resident will present the project during noon conference and report findings and make recommendations to the internal medicine department.

The Internal Medicine residency will have a variety of didactic or bedside teaching experiences which will directly address cost effective practices, these include:

- Resident Morning Report (RMR)
- Senior Openers (SO)
- Teaching Attending Rounds (AR)
- Management Rounds (MR)
- Noon Conference (NC)
- Journal Club (JC)
- EBM conference (EBM)

The ambulatory clinic rotation will include low income and free clinics to offer the residents' an opportunity to treat and provide care to patients that are either homeless or have extremely limited resources.

All residents will participate in an internal medicine clinic data-based action plan bi-annually. The residents will receive data regarding a practice metric and benchmark for their continuity clinic empanelment and a faculty guided plan will be developed to improve chronic disease management and/or deliver preventive health care in a cost-effective manner.

Quality Improvement

The department's clinical quality improvement programs are integrated into the training program's curriculum.

The Internal Medicine residents will have the opportunity to participate in various hospital wide groups/committees to include the hospital's Patient Care/Quality Improvement (PC/QI) committee.

All residents will have training in the root cause analysis (RCA) team process and participate in RCA simulated cases. When available residents will have the opportunity to participate in formal hospital RCA teams.

Residents will have didactics in the core concepts of patient safety and quality improvement. They will be trained to recognize a patient safety event and how to submit a patient safety report. Outcomes of relevant patient safety reports will be reviewed during PSQI conference to provide feedback to "close the loop."

Residents will be required to prepare and present the following items during residency which will provide an opportunity for the individual to demonstrate his/her understanding of the quality improvement process and health care disparities.

PGY3 level residents will complete a Quality Improvement Project to engage in a systems level intervention with the aim to understand and recognize health care disparities and/or identify system errors to implement changes and improve processes to enhance the delivery of cost-effective patient care. The resident will present the project during noon conference and report findings and make recommendations to the internal medicine department.

PGY2 level residents will research clinical data and investigate hospital processes to present in PSQI conference to identify, reflect upon, and learn from critical incidents such as near misses and preventable medical errors.

All residents will participate in an internal medicine clinic data-based action plan bi-annually. The residents will receive data regarding a practice metric and benchmarks for their continuity clinic empanelment and a resident designed, faculty guided plan will be developed to improve chronic disease management and/or deliver preventive health care in a cost-effective manner.

Residents will have the opportunity to provide feedback to program/internal medicine department/sponsoring institution through house staff council meetings and annual Program Evaluation Committee reviews.

Didactic Experience

Formal didactics will be presented in morning report and noon conference (including visiting professors), board review, web-based content, simulation training, point of care ultrasound training, and sub-specialty conferences. There will be 1.5 hours of didactics everyday Monday thru Friday (excluding holidays). Didactics will be protected time for the residents to ensure maximal participation and effectiveness. Additionally, when possible, didactics will include a “flipped” classroom environment to enhance learning.

Patient based teaching will be included in Attending rounds. Here the faculty can teach professionalism through faculty modeling, bedside exam skills, point of care ultrasound exams, impromptu chalk talks on patient pathophysiology and therapeutic decisions.

Didactics will be recorded and uploaded to New Innovations so residents can review previous didactics whether for review or due to absence. Didactics will include virtual lectures via Microsoft Teams to capture experts who are not in the local area. Further, using Microsoft Teams will allow residents who may be on an out rotation to participate in these training opportunities. New Innovations will house all resources, handouts, case studies, etc. to make sure residents have easy access to any educational materials.

Conferences

- Resident Morning Report (RMR) – Monday thru Friday 0730 to 0800 AM Monday thru Friday, all residents and medical students attend this interactive chalk board discussion on a single patient. This venue is heavily dependent on PGY1 level engagement to ascertain a reasonable history and physical exam necessary to construct a practical differential diagnosis, to identify the necessary ancillary data, ultimately to conclude a central diagnosis.

- Senior Openers (SO) – Monday thru Friday 0700-0730, all residents and medical students attend this interactive conference where the supervising residents briefly discuss the previous day’s admissions. The focus of the discussion is selected by the presenting resident and may reflect differential diagnosis, specific management issues, cost-effective practices, or other topics. Faculty members include general internists and subspecialists.

- Teaching Attending Rounds (AR) – Attending rounds format will vary depending on the preference of the attending. There should be discussion of the patients with concurrent teaching to include beside rounds, point of care ultrasound exam, pathophysiology review, discussion on evidence-based medicine, cost effective practices and therapeutic decisions. This is the same Attending who supervises Management Rounds.

- Palliative Care and/or Ethics Rounds (PCR) – Once each month during noon conference a faculty member with special interest and expertise in medical ethics and palliative care conducts palliative care rounds for all residents. A particular patient or patients is/are selected for presentation. Discussion is directed and facilitated by the faculty member, emphasizing issues pertaining to death and dying, and relevant care and communication skills necessary for residents to develop.

- Noon Conference (NC) – Monday thru Friday 1200-1300 PM all residents attend a scheduled conference reviewing a core topic in Internal Medicine, except on days designated for GR, CPC, EBM, QIP or PSQI conferences.

- Journal Club (JC) – This conference will occur monthly (except July, Aug, and following June). PGY2 levels residents will pick an article to review. PGY1 residents will be divided into 2 groups randomly. Each group will meet independently to discuss the article. One group will focus on the pro stance, while the other group will emphasize the cons of the research article. On the day of journal club one member from each group will be randomly selected to be the team leader and facilitate their teams' arguments. At the end, the PGY2/3s will vote on which team presented the more compelling argument.

- EBM conference (EBM) – Following an annual presentation on the fundamentals of evidence-based medicine, residents assigned on their Infectious Disease will present an EBM conference. Residents are expected to investigate a clinical question that they do not have the answer for. They then formulate the question, search the literature for evidence, and present the answer/conclusions. Included in the presentation are the question, the search methods, the evidence found, and the conclusions derived.

- Grand Rounds (GR) – All PGY3 levels residents will create a patient-centered conference aimed at increasing clinician knowledge for treating unique cases. This is a capstone project which will incorporate the knowledge and skills developed from previous presentations.

- Quality Improvement Project Conference (QIP) – All PGY2 level residents will complete a Quality Improvement Project to engage in a systems level intervention with the aim to understand and recognize health care disparities and/or identify system errors and implement changes to enhance the delivery of cost-effective patient care. The resident will present the project during noon conference report findings and make recommendations to the internal medicine department.

- Clinical Pathology Conference (CPC) – All PGY2 residents will present a CPC. Goal is to present a single clinical case for which a pathologic diagnosis is known and discuss and explain radiologic and pathologic (microscopic and gross) findings of the case. Residents will work with pathology to facilitate discussions.

- Ambulatory Care Conference (ACC) – Once monthly during noon conference a faculty presentation will be delivered specifically tailored to enhance the concepts of primary ambulatory care.

- Back to Basics (BTB) – All PGY1 residents on their ward rotation (except July) will present a morning report and then the following day present the corresponding topic in medicine from pathophysiology to clinical manifestations and management. This will take place during morning report time slot.

- Patient Safety and Quality Improvement Conference (PSQI) – All PGY3 residents will complete a PSQI conference. This is conference is dedicated to identifying issues that affect patient safety or limit optimal health care delivery. The issues maybe as varied as knowledge gaps in care for patients with unusual diseases to system errors that occur during delivered care. There is a discussion to implement potential system solutions or changes in training to prevention issues in the future. If warranted an action plan is made with follow up at subsequent meetings.

- Autopsy Rounds (AuR) – When a death occurs on a teaching team the family is offered the option of performing an autopsy. If an autopsy is performed, we hold a multidisciplinary presentation of the findings that includes medicine, pathology, radiology and surgery residents and faculty that were involved.

- Patient Simulation (SIM) – All resident levels will participate in standardized patient simulation cases to assess knowledge, application, analysis, and synthesis of patient management.

Procedures in Internal Medicine Residency

The supervising staff must be notified before any procedure requiring consent is performed. Residents performing procedures that they are not yet certified to perform independently must be supervised by the physical presence of the physician or by exception, physician extenders (e.g., physician assistants or nurse practitioners) with particular expertise in certain diagnostic or therapeutic procedures who themselves are credentialed to perform the procedure independently. Ultimately, the supervising staff attending is ultimately responsible for the care of the patient.

Individuals may be “signed off” to perform these procedures independently by the procedure committee only after they have successfully completed the minimum number of required supervised procedures and when a member of the procedure committee has certified “signed off” the individual.

Safety is the highest priority when performing any procedure on a patient. There exists a wide degree in variability in the types and numbers of procedures performed by internists in practice. Internists who perform any procedure must obtain the appropriate training to perform that procedure safely and competently. It is expected that the internist be thoroughly evaluated and credentialed as competent in performing a procedure before he or she can perform it unsupervised.

Upon completion of the minimum required number for a particular procedure the resident may apply to the procedure committee to be “signed off” to perform the procedure with “Oversight” supervision responsibility. Oversight – the supervising physician (attending) is available to provide review of procedures/encounters with feedback provided after care is delivered. This will be documented in New Innovations.

For certification in Internal Medicine, the ABIM has identified a limited set of procedures in which it expects all candidates to be competent with regard to their knowledge and understanding.

This includes:

- Demonstration of competence in medical knowledge relevant to procedures through their ability to explain indications, contraindications, patient preparation methods, sterile techniques, pain management, proper techniques for handling specimens and fluids obtained, and test results.

- Ability to recognize and manage complications.

- Ability to clearly explain to a patient all facets of the procedure necessary to obtain informed consent.

ABIM requires all IM candidates to demonstrate competence and safe performance of these procedures during residency training. This requires at a minimum being an active participant in performing procedures either as primary operator or assisting primary operator.

ABIM Requirements

	Know, Understand and Explain				Perform Safely and Competently
	Indications; Contraindications; Recognition & Management of Complications; Pain Management; Sterile Techniques	Specimen Handling	Interpretation of Results	Requirements & Knowledge to Obtain Informed Consent	
Abdominal paracentesis	X	X	X	X	
Advanced cardiac life support	X	N/A	N/A	N/A	X
Arterial line placement	X	N/A	X	X	
Arthrocentesis	X	X	X	X	
Central venous line placement	X	X	N/A	X	
Drawing venous blood	X	X	X	N/A	X
Drawing arterial blood	X	X	X	X	X
Electrocardiogram	X	N/A	X	N/A	
Incision and drainage of an abscess	X	X	X	X	
Lumbar puncture	X	X	X	X	
Nasogastric intubation	X	X	X	X	
Pap smear and endocervical culture	X	X	X	X	X
Placing a peripheral venous line	X	N/A	N/A	N/A	X
Pulmonary artery catheter placement	X	N/A	X	X	
Thoracentesis	X	X	X	X	

Procedures

Procedures	Number required to be performed independently
ACLS/BLS	Current
ATLS	Current

Abdominal Paracentesis and interpretation	5
Acupuncture	5
Arterial line placement/arterial blood draw	5
Arthrocentesis and interpretation	5
Central venous line placement	5
Lumbar puncture and interpretation	5
Peripheral venous line placement/venous blood draw	1
Stress Test: Exercise treadmill testing	30
Stress Test: Pharmacologic stress test	10
Thoracentesis and interpretation	5
Nasogastric intubation	1
Incision and Drainage of an abscess	5
PAP smear and endocervical culture	1

Additional Procedures

Additional Procedures	Number required to be performed independently
Endotracheal Intubation (elective)	30
Bone Marrow Biopsy	N/A
HD/CRRT orders	N/A
Pulmonary Artery Catheter/Right heart catheterization	N/A
Cardioversion (elective)	5
Left heart catheterization and angiography	N/A
Pericardiocentesis	N/A
Transvenous pacer placement	N/A
Echocardiography	N/A
Thyroid ultrasound and biopsy	N/A
Toenail removal	5
Pleurocath/chest tube placement	5
Bronchoscopy	N/A
Calibration and operation of hemodynamic monitoring and recording systems	N/A
Use of ultrasound for procedures	N/A
Colonoscopy/EGD	N/A

Various Academic Items

Scholarly Activity

Our program promotes and nurtures resident scholarly activity with the following objectives in mind:

- Train the next generation of clinical investigators and physician-scientists
- Promote intellectual and academic curiosity
- Support academic subspecialty fellowship applications
- Lay the foundation for successful careers in general and academic medicine

Internists should be not only familiar with evidence based medicine and the foundations of research from bench to the bedside but are encouraged to participate in research while in residency as the academic structure of the college provides the needed resources for the learner to successfully engage in these activities.

Residents are required yearly to perform scholarly activity. Examples include poster or podium presentation at local, regional or national conference, original research proposal, abstract submission to journal, etc.

Completion of this requirement is mandatory without exceptions. Residents are responsible for providing to the program coordinator a copy of all abstracts, manuscripts, workshop handouts, etc. for which the resident desires credit for the scholarly activity requirement in a timely manner (within 30 days of completion or acceptance of the activity). All activities must comply with institutional IRB requirements and all projects must be overseen by a faculty mentor.

Funding of Scholarly Activity

Publication Costs

Some journals require submitting authors to pay for submission and/or publication costs. These fees may be a barrier to some residents and programs in maximizing the number of articles that can be submitted and published. As ACGME has a requirement for residents and faculty to produce scholarly works, the GME Office will provide support for residents who submit articles for publication. A request for support must be completed by the program and approved by the GME Office to provide support for publication fees.

Support Requirements:

- Maximum GME Office Support: $500 one-time allotment per academic year.
- Residents must speak with their Program Director, the DIO, GME and Clinical Research Manager or with the Director of Patient Safety and Risk to identify which journals are most appropriate for their submission.
- Residents must include name of intended journal, title of manuscript, authors, copy of abstract submitted in an email to your program coordinator.

- Residents must initially submit to a non-fee charged journal (i.e., Journal Mississippi Medical Association JMSMA SUBMISSIONS) etc. or another non-fee peer-reviewed journal.
- If rejected, the resident can resubmit to other journal options (which may charge a fee) but must provide the rejection notification prior to submitting to other journals
- MHG Faculty must be co-author (and cannot be 1st author) on publication.

Conference Support

It is expected that residents submit projects for presentations at local, regional, and national conferences. As such, the GME office will provide the following support:

- Up to $2,000 will be reimbursed for:
  - Program approved submission
  - **Residents must** have at least one program-specific faculty as co-author (i.e., FM resident with FM faculty and accordingly IM resident with IM faculty); other faculty from another program may be on the project as well
  - **Resident must be first author** (if both residents are doing an oral presentation, both residents will receive support.)
  - It must be accepted for either a poster or oral presentation

- Reimbursable expenses include:
  - Registration fee
  - Travel (airfare /mileage)
  - Hotel
  - Meals (per MHG guidelines)
  - Parking

All attempts should be made to register early at the most inexpensive registration rate. Additionally, **where there are options to apply for resident scholarships to attend a conference** (where hotel fees and / or registration fees are waived), **residents must show evidence of applying for this support (travel grants) before they will be reimbursed**.

Both the DIO and MHG Administration **must** approve all travel requests prior to registering for any conference. MHG cannot reimburse for international or non-domestic travel (travel within the Continental US) unless pre-approved by GME leadership and Administration. The link to access MHG's Travel Policy is MHG TRAVEL POLICY.

Program Directors or their designee **must** sign off on all projects before submission to any conference.

- Limit: One (1) conference per resident per academic year.
- Education stipend may be used toward conference travel, if available.

If any resident is asked to attend a conference by your program, GME will reimburse 100% and attendance will not apply towards your one conference presentation per academic year. This

will allow us to support our local and state professional organizations and provide important opportunities for residents to engage with local and State leaders along with networking opportunities.

For exemptions to this policy, an ad hoc Academic Conference Support Committee (ACSC) will review any requests. Members of this committee will include at least: 1 resident representing all ACGME programs, 1 faculty member, the GME and Clinical Research Manager and any other designated individuals as determined by the DIO.

Support for Scholarly Activity

Scholarly activity support and IRB provided by William Carey College of Osteopathic Medicine and Internal Medicine faculty.

MKSAP

Residents will be purchased MKSAP as part of their self-study program.

ACP

Residents will be purchased an annual membership to ACP.

UpToDate

Free access from the intranet home page

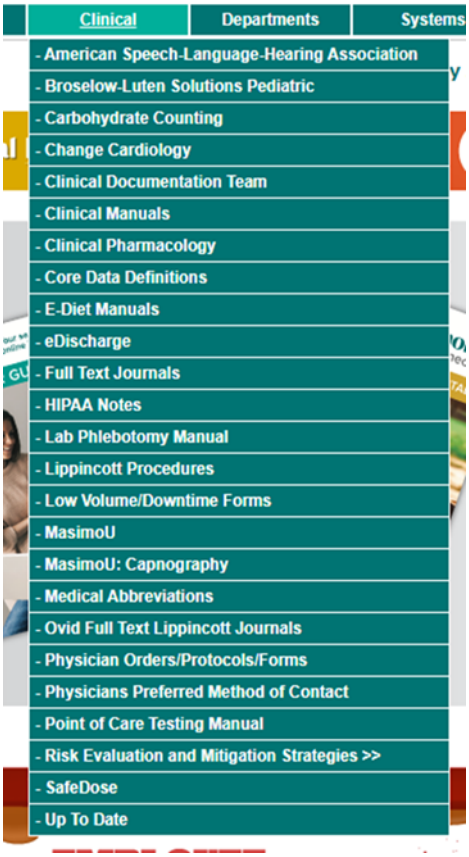
Ovid

Free access from the intranet home page

Resident Teaching Role

Each Resident will be required to deliver lectures to peers, medical students and faculty.

Residents that are on services with medical students are expected to take the lead in providing teaching specific to the medical cases to which each is assigned.



In-Service Exam

Each year Residents must take the in-service exam without exception. Performance on this exam will be compared to your peers. Performance that is < 30% percentile may incur remediation in patient care, reading and testing assignments in those areas of concern.

Independent Learning Activity

All residents will be required to do fifty (50) independent study questions per month. These will be assigned using the New England Journal of Medicine Knowledge + platform.

All residents will be assigned to view and complete modules, podcasts and other learning activities using the New England Journal of Medicine Knowledge + platform. These will vary from month to month but must be completed as directed. All required and assigned activities including questions and other learning activities must be completed by the end of the calendar month.

Residents scoring less than the 30th percentile on the ACP In-Training Examination will be assigned additional activities by program leadership and will be placed on a performance improvement plan (PIP) for medical knowledge to facilitate resource allocation and sustained monitoring/help for the resident's benefit.

Program leadership will track completion of questions assigned from New England Journal of Medicine Knowledge +.

Wellness

The Internal Medicine Residency program is committed to ensuring that residents and teaching faculty remain physically and mentally healthy. Wellness is an important part of resident training and faculty supervision to reduce fatigue, ensure patient safety, and enhance resident and faculty development.

Psychological, emotional, and physical well-being are critical in the development of the competent, caring, and resilient physician and require proactive attention to life inside and outside of medicine. Well-being requires that physicians retain the joy in medicine while managing their own real-life stresses. Self-care and responsibility to support other members of the health care team are important components of professionalism; they are also skills that must be modeled, learned, and nurtured in the context of other aspects of residency training.

Residents and faculty members are at risk for burnout and depression. Programs, in partnership with their Sponsoring Institutions, have the same responsibility to address well-being as other aspects of resident competence. Physicians and all members of the health care team share responsibility for the well-being of each other. A positive culture in a clinical learning environment models constructive behavior and prepares residents with the skills and attitudes needed to thrive throughout their careers.

The responsibility of the program, in partnership with the sponsoring institution, to address well-being must include efforts to enhance the meaning that each resident finds in the experience of being a physician, including protecting time with patients, minimizing non-physician obligations, providing administrative support, promoting progressive autonomy and flexibility, and enhancing professional relationships.

Residents and faculty will be given the opportunity to attend medical, mental health, and dental care appointments, including those scheduled during their working hours.

Residents and faculty will have access to confidential, affordable mental health assessment, counseling, and treatment, including access to urgent and emergent care 24 hours a day, seven days a week.

Wellness Activities

- Monthly wellness activities/conferences to include:
    - Resiliency training
    - Symptoms of burnout
    - Fatigue mitigation/sleep deprivation
    - Depression screening
    - Substance abuse screening
    - Stress management
    - Recognition of the above (symptoms) and how to seek care and when to alert the Program Director or other designated personnel
- Monthly house staff council meetings to address concerns and elevate resident suggestions for program growth
- Quarterly faculty development lectures
- Quarterly resident awards
    - "Resident of the Quarter" (selected by IM clinical competency committee)
    - "Resident Teammate of the Quarter" (selected by IM house staff council)
- Annual welcome picnic
- Annual PGY-1 winter retreat
- Annual holiday party
- Annual PGY1/2 spring retreat
- End of year resident and faculty awards ceremony and dinner

Fitness Center

Memorial Hospital at Gulfport has a fitness center for resident use that is adjacent to the hospital.

Fatigue Management

Providing medical care to patients is physically and mentally demanding. Night shifts, even for those who have had enough rest, cause fatigue. Experiencing fatigue in a supervised environment during training prepares residents for managing fatigue in practice.

The IM program will provide all appointed faculty members and residents information and instruction on recognizing the signs of fatigue and sleep deprivation, and information on alertness management, fatigue mitigation processes, and how to adopt these processes to avoid potential negative effects on patient care and learning.

Faculty members and residents will be educated to intervene when necessary to maintain the health and well-being of their colleagues and the safety of patients.

If a resident is unable to perform their patient care responsibilities due to excessive fatigue, they are too immediately inform their supervising attending and the IM Program Director or Associate Program Director. The patients under the care of the resident will be transitioned to another resident or attending for on-going care.

In the event of fatigue, illness, or other impairment, residents are required to utilize the sleep facilities/on-call rooms available for the GME department or utilize safe transportation home. Upon request, MHG sponsored residents can call a taxi for a ride home. The resident requiring the safe transportation home should submit receipt to the GME office for reimbursement.

Advisor Program

The program utilizes an active and dynamic advisor model. Our goal is that each resident's advisor will provide ongoing and active assistance in the resident's longitudinal development with the end goal being the accomplishment of personal and career goals while ensuring progression along the program requirements for graduation.

Every resident will be assigned a primary advisor or is also core faculty. Mentorship pairing is initially set based on the program leadership's assessment of fit, academic interest and compatibility amongst faculty. Assignments can be changed with communication between the advisor-advisee and program leadership.

Formal meetings will occur twice a year as part of reporting milestones feedback session. should occur regularly but are designed at a minimum to occur biannually.

Informal activities are encouraged but not mandated by the residency program. Opportunities for scholarly collaboration, wellness promotion, planning for study and board exam preparation, career planning, etc. are pursued based on the interest and initiative of the pair.

Clinical Competency Committee (CCC)

The Internal Medicine Residency Program Director will appoint a Chairperson and individual members to the Internal Medicine CCC. At a minimum, the CCC must include three members of the program faculty, at least one of whom is a core faculty member. However, all CCC members are core faculty and will serve as resident advisors as well. Residents may choose their advisor and may also request a change as availability permits.

Purpose/Responsibilities of CCC:

- Complete ACGME Milestone evaluations semi-annually.
- Ensure promotion/graduation requirements are satisfied.
- Advise the Program Director (PD) regarding resident progress, promotion (to include consideration for Credit in Lieu), remediation, probation, extension and dismissal.
- Develop shared mental model of what resident/fellow performance should "look like" and how it should be measured and assessed
- Ensure the right combination of assessment tools to effectively determine performance across the Competencies and specialty-specific Milestones
- Increase quality, standardize expectations, and reduce variability in performance assessment

- Contribute to aggregate data that will allow programs to learn from each other by comparing residents' and fellows' judgments against national data
- Improve individual residents'/fellows' progress along a developmental trajectory
- Identify early those residents/fellows who are challenged and not making expected progress so that individualized learning plans can be designed
- Identify advanced residents/fellows to offer them innovative educational opportunities to further enhance their development
- Identify weaknesses/gaps in the program as a first step in program improvement
- Model "real time" faculty development.

Roles/Responsibilities of CCC Chairperson

- Be the Milestones "expert" for the committee or designate another committee member who will serve in this role.
- Encourage a confidential positive working environment and open communication from all members.
- Ensure members know their roles, as well as the latest versions of the Milestones and the CCC process.
- Engage members in developing a shared mental model for the Milestones and the assessment tools.
- Use best practices in effective group processes; for instance, employ a structured format to gain information from each committee member; obtain input using the same order of members, get perspectives of the most junior member first.
- Keep meetings on task and move toward the common goal.
- Make certain the coordinator or designated member maintains documentation and meeting minutes.
- Understand the typical assessment methods used by the program, as well as their limitations.
- Develop a plan for the professional development of CCC members.
- Anticipate biases on the part of both oneself and committee members, and intentionally cultivate greater insight on biases and strategies to mitigate them.

Roles/Responsibilities of Program Coordinator

- Program coordinators frequently distribute and collect results from assessment tools.
- Participate in multisource feedback by using assessment instruments to share valuable and often unique perceptions of an individual resident's/fellow's abilities in interpersonal and communication skills, teamwork, and professionalism.
- Attend CCC meetings in an administrative role.
- Assist in the collection, preparation, organization, and distribution of assessment data.
- Take minutes; and capture key aspects of the discussion.
- Facilitate the communication of results to the program director (if not in attendance).
- Schedule meetings with individual residents/fellows and the program director or designated faculty member to review decisions.
- Electronically submit Milestones information on each resident/fellow to the ACGME.

Roles/Responsibilities of Individual CCC Members:

- Attend (in person or remotely) monthly CCC meetings to remain apprised of resident performance.
- Review resident evaluations with their assigned residents.
- Works with resident to ensure successful completion of developmental milestones.
- Assist in the development of remediation plans for their assigned residents.
- Ensures completion of remediation plans and reports back to CCC with objective documentation.
- Reviews resident evaluations semi-annually in preparation for ACGME Reporting Milestones.
- Completes Advising Worksheet semi-annually.
- Understand the purpose and responsibilities of the CCC
- Know role on the committee
- Recognize sources of likely biases and take steps to mitigate their impact
- Work with other members to develop a shared mental model of the Milestones
- Follow through with assigned tasks (such as pre-review and synthesis of resident/fellow performance data)
- Participate in ongoing professional development (the Milestones, best practices in assessment, effective group process, understanding and identifying bias)
- Facilitate a collegial, respectful atmosphere within the committee
- Use best practices to support a robust group process
- Ensure own honest “voice” is heard along with those of colleagues
- Maintain confidentiality
- Help orient new members
- Contribute to ongoing improvement of the CCC processes

Anticipating, Recognizing, and Mitigating Bias

Ensuring a fair and equitable assessment system constitutes a fundamental obligation of the CCC to ensure that learners are afforded maximal opportunities to learn and thrive in the program.

Previous research has shown.

- Learners who are not white or who are women receive lower numerical ratings and are less likely to be selected for the Alpha Omega Alpha Honor Medical Society. (Boatright, 2017; Mueller, 2017; Teherani, 2018)
- Women also receive less favorable ratings on some milestones than men in some specialties (Dayal, 2017; Klein, 2019; Santen, 2019).
- Pediatrics and some family medicine milestones, women scored higher. (Hamstra 2019)
- Review of narrative comments about learner performance shows how certain words may be systematically used more to describe individuals based on the groups to which they belong. (Mueller, 2017; Rojek, 2019)
- Milestones ratings showing higher assessment of men than women in certain milestones traditionally thought of as more ‘male’ characteristics. (Santen, 2019; Dayal, 2017)

Especially as the diversity of learners continues to increase, CCC members require awareness and training regarding bias in evaluations of learner performance.

To address this important risk of bias influencing resident performance ratings during CCC discussions, the following steps will be utilized when possible.

- CCC membership should include diverse members in terms of gender and race/ethnicity. Diverse groups outperform homogeneous groups in terms of the quality of their work and decision making. (Hong, 2004)
- All CCC members should participate in training on diversity, equity, inclusion, and bias. Training can entail deepening one's understanding of unconscious bias and racism that permeates health care and medical education.
- Through ongoing discussion and reflection, CCC members can share and address their own perspectives and biases in order to recognize and mitigate unconscious biases. (Morgan, 2018)
- The CCC will examine the program's data for any systematic group differences in performance that signal bias in the evaluation data. This review can uncover systematic differences, as have been observed in some

Resident Meetings

While the residents must meet with their advisor semi-annually, it is encouraged that more frequent meetings occur. The resident has the option to request a meeting with the PD and/or advisor. In addition, when necessary the PD may request to formally meet with the resident. Program feedback from both advisors and residents can be obtained as a result of these meetings

Program Evaluation and Improvement

The Internal Medicine Residency is committed to program evaluation with the goal of program and resident education improvement and faculty development.

In order to achieve its mission and train quality physicians, a program must evaluate its performance and plan for improvement in the Annual Program Evaluation. Performance of residents and faculty members reflects program quality and can use metrics that reflect the goals that a program has set for itself. The Program Evaluation Committee (PEC) utilizes outcome parameters and other data to assess the program's progress toward achievement of its goals and aims.

The Internal Medicine program director will appoint the PEC and chairperson to conduct and document the Annual Program Evaluation as part of the program's continuous improvement process.

The PEC will be composed of at least two program faculty members, at least one of whom is a core faculty member, and one resident from PGY level selected by their class.

PEC responsibilities include:

- Advisor to the program director, through program oversight
- Review of the program's self-determined goals and progress toward meeting them
- Guiding ongoing program improvement, including development of new goals, based upon outcomes
- Review of the current operating environment to identify strengths, challenges, opportunities, and threats as related to the program's mission and aims

Assessments Elements

- Curriculum
- Outcomes from prior Annual Program Evaluation(s)
- ACGME letters of notification, including:
    - Citations
    - Areas for Improvement
    - Comments
- Quality and safety of patient care
- Aggregate resident and faculty:
    - Well-being
    - Recruitment and retention
    - Workforce diversity
    - Engagement in quality improvement and patient safety
    - Scholarly activity
    - ACGME Resident and Faculty Surveys
    - Written evaluations of the program
- Aggregate resident:
    - Achievement of the Milestones
    - In-training examinations
    - Board pass and certification rates
    - Graduate performance
- Aggregate faculty:
    - Evaluation
    - Professional development

The PEC must evaluate the program's mission and aims, strengths, areas for improvement, and threats.

The annual review, including the action plan:
- Will be distributed to and discussed with the members of the teaching faculty and the residents
- Submitted to the DIO.

Teaching Medical Students

Asking Questions

Ask yourself, do you want your learners to learn concepts or factoids? If its concepts, you should ask questions accordingly (i.e. don't ask factoids). Similar to good interviewing skills, good teaching skills entails open-ended questions, so you can better assess your student's and intern's learning needs, to help them gain confidence in their knowledge as they answer your questions, and to help them reason to the correct answer, rather than "read my mind" questions or guess this esoteric questions. For example, let's say a patient is admitted with hypertensive emergency, was placed on a nitroprusside drip, then weaned from that and now transferred to the floor.

---Example of a factoid question: "Prolonged administration of nitroprusside can result in what type of poisoning?" (Cyanide)

---Example of a pretty good open-ended question: “Can you tell me the difference between hypertensive emergency and hypertensive urgency?”

---Even better open-ended question: “Tell me what you know about hypertensive emergency?”

The reason the last one is better is that for the first two questions, they will need to recite a factoid (question 1) or for question 2, would need to have some concept of urgency vs. emergency to answer the question. For the third question, they can just tell you what they know, and this can allow you to know what to teach, and to prompt them to reason to an answer. For example, the student may know all about hypertensive emergency, and reciting their knowledge on rounds is a great confidence builder for them, and makes them a part of the team teaching. But say they say they don’t know about hypertensive emergency. Your teaching options now are to wax eloquent yourself, or better yet, force them to reason: “Well, let’s think…what would be an emergency situation with high blood pressure”; or if they are more novice: “Hypertensive emergency is a situation where there is end-organ damage from the high blood pressure. What are some organs which might be damaged? Yes, the heart, they may have a heart attack, what else? Yes, the brain…..” etc.

Fastballs

Early in the month your students and interns are often a little nervous and unsure. My first questions of the month, and usually my first questions each day, are relatively easy, to help them build confidence in answering questions in front of an audience (“Tell me what you know about heart failure”).

Limits

A common mistake for novice teachers is, that in their excitement to teach everything they know, they never let a teaching moment go by. Certainly powerful teaching moments need to not be missed, but the powerful ones are usually in the context of the patient (such as an intense discussion with a patient or family; or sometimes, explicit description of how you arrived at a clinical decision). However, many topics come up time and time again on the wards (CHF, PE, COPD, etc.), and each of these conditions only has so many teaching points. There is no reason to drown rounds with too many teaching points – try to limit it to 5-10 major points per day at most.

Plan

Many approach teaching in a reactive fashion, the student or intern mentions something, a light bulb goes off as far as a question to ask in that situation, and so it goes. Certainly this reactor method is preferable to no teaching at all. But a risk of the reactor method is that you will drown rounds in too many facts, rounds won’t be efficient, and further, your teaching will be limited to what is mentioned by the student or intern – important topics won’t be broached. Better yet, you know the patients on your team ahead of time so plan for at least some of the points you are going to make on next day’s rounds.

A corollary to this is planning prior to seeing a patient. For example, if your focus of teaching is doctor-patient communication, one can usually anticipate intense discussions before you walk into the room. Ask the students and residents how they want to approach this situation (say a patient who is ready for discharge but is scared to leave the hospital). Then once discussed, model it (either you or your designee). AND THEN, reflect on what happened after the discussion, when you leave the room.

Reflect Aloud

To really make a teaching point stick, you need to reflect on what happened. You need to do this explicitly, aloud, so the students and interns can follow your reasoning and understanding. For example: "You see why we chose to empirically anticoagulate this patient with a suspected PE (until the CT or V/Q scan was finally done), he had all the risk factors for DVT…."; or if things go bad: "Looking back, you need to reflect on your decisions, and this patient did have a GI bleed after we empirically anticoagulated him for PE, was this the right decision, ……". We all reflect on medical decisions in our minds; for your learners, simply reflect aloud.

Think Out Loud

If you're making a complicated decision (say, not to give or to discontinue antibiotics for a patient with fever but no obvious infectious source), think out loud your decision process. Even if the decision seems straightforward, check your learner's understanding of the plan – "Do you understand why we're getting an ERCP for this patient with jaundice?"

It's Okay to Say "I Don't Know"

No one knows everything, so don't be fearful if you can't answer all of your learner's questions. By saying "I don't know, but I'm going to learn about this…." (or better yet, why don't WE all learn about this), you are not modeling inadequate knowledge, you are modeling lifelong learning.

Teach Your Self

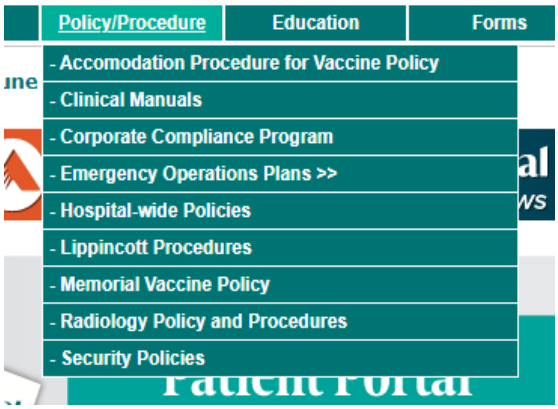
The most lingering thing you will teach your students is yourself, the way you comport yourself, the way you ARE as a doctor and a person.

Patient Safety

Patient safety and quality improvement are of paramount importance in Internal Medicine. If there is a patient care situation that is a near miss, error, or system issue that negatively impacts patient care please submit a report via the Midas+ link. The link is available on the Intranet Home page on the right-hand menu area. Use your computer network login and password to access.

Medical Staff Bylaws and Policies and Procedures

Members of the Residency Program through the General Medical Education Department are held accountable under the Medical Staff Bylaws and Policies and Procedures, although Residents are not members of the Medical Staff. Each Resident Trainee's scope of practice and privileges are determined by the General Medical Education program and the Residency Program Director. Residents are subject to quality oversight of the Memorial Medical Staff including standards of clinical quality and the behavioral code of conduct. Medical Staff Bylaws and Policies and Procedures are available for Residents to review from the intranet homepage.



HIPPA

Under no circumstances are any records or information to be given to unauthorized individuals. No protected health information is to be taken from the hospital.

Document Signing

Residents are not authorized to sign letters, insurance papers, death certificates, or statement of a patient's condition. Any or all such documents must be submitted to the attending physicians for his/her approval and signature. In addition, all related inquiries are to be referred to the attending physician. Residents are required to follow all hospital regulations that pertain to document signing.

Prescriptions

No prescription will be written by the Resident for themselves, family or friends. Residents are required to follow all hospital regulations that pertain to prescriptions.

Orders

All orders by residents must be approved and signed by the attending physician.

No orders will be written by the Resident for themselves, family or friends. Residents are required to follow all hospital regulations that pertain to orders.

No prescription will be written by the Resident for themselves, family or friends. Residents are required to follow all hospital regulations that pertain to prescriptions.

Unacceptable Abbreviations in Orders

UNACCEPTABLE	ACCEPTABLE
Trailing zero after decimal point (e.g. 1.0 mg)	Do not use trailing zeros for doses expressed in whole numbers
No leading zero before a decimal dose (e.g.) .5mg	Always use a zero before a decimal point when the dose is less than a whole unit.
MgSO4 K+ KCL HCTZ, etc.	Always use the complete drug name “Magnesium Sulfate”, “Potassium”, “Potassium Chloride”, etc.
MS, MSO4	Always use the complete drug name "Morphine Sulfate"
X10d	Write out "for 10 days" or "for ten doses"
Mg	Write "mcg"
AD, AS, AU	Write out "right ear", "left ear" or "each ear"
OD, OS, OU	Write out "right eye", "left eye" or "each eye"
Cc	Write out "ml"
q.d. or QD	Write out "daily"
q.o.d. or QOD	Write "use every other day"
q.i.d. Or QID	Write "four times daily"
SC, SQ or SubQ	Write "subcut" or write "subcutaneous"
IU	Write "units"
U or u	Write "unit"

Documentation

Residents will write/dictate history and physical examination reports, procedure notes, progress notes, and discharge summaries, for patients for which they are assigned and must be reviewed, edited if necessary, countersigned and attestation signed by their attending physician.

Patient Chart Completion

All in-patient charts must be completed within 24 hours of discharge. To be completed, all charts must have all required dictations and signatures on file, with the attending physician counter-signing all house staff notes within this period. This rule is in addition hospital procedures that state the time required to complete H&P's and consultations. Resident staff must complete their charts in a time from that allows attending physicians to remain in compliance with state regulations and MHG suspension provisions.

Delinquent Charts

- Any Resident who has any delinquent charts will be notified by medical records that they are delinquent.
- The Resident will have five (5) days to complete all delinquent charts.
- If any delinquent charts remain after the required hospital deadline, disciplinary action is at the discretion of the Program Director.

Graduation

Residents will be granted a training Certificate of Completion upon successful fulfillment of the specialty program requirements. The certificate will be awarded by Memorial Hospital at Gulfport. All graduates must demonstrate completion of all performance and administrative duty requirements and complete the required forms and paperwork in order to be officially released from the program. Residents are encouraged to work with their GME office Program Coordinator to ensure timely completion of all requirements and issuance of graduation certificates. Residents are required to attend their program's graduation ceremony.

Contact Information

Title	Name	Contact info	Email
Designated Institutional Official (DIO)	Gretchen Holmes, Ph.D.	228-867-5146 (Office) 228-990-5685 (Cell)	gholmes@mhg.com
Institutional Coordinator and GME Manager	Maria Prokop, C-TAGME	228-822-6513 (Office) 228-236-5518 (Cell)	mprokop@mhg.com

Program Director, Internal Medicine	Wayne Latack, MD	210-882-8754	wlatack@mhg.com
Residency Coordinator, Internal Medicine	Gene Moran	228-822-6512 (Office) 228-236-6932 (Cell)	gmoran@mhg.com

MHG GME Policies and Procedures

Policies and procedures are located on New Innovations at www.new-innov.com. Go to More → Resources → Department Manuals → MHG GME Policies & Procedures. See Appendix A below for a full list of MHG GME policies.

APPENDIX A

Policy Number	Policy Name
500.01	Supervision of Resident Physicians
500.01	Supervision of Residents - Addendum for Family Medicine
500.02	Code of Professional Conduct
500.03	Resident Transfer Policy
500.04	Resident Disciplinary Action Policy
500.05	Promotion, Non-renewal, and Dismissal Policy
500.06	Resident Moonlighting Policy
500.07	Disaster Policy
500.07	Disaster Policy - Addendum for Family Medicine
500.08	Residency / Fellowship Program Reduction and / or Closure Policy
500.10	Vacation and Resident Leave Policy
500.10	Vacation and Resident Leave Policy - Addendum for Family Medicine
500.11	Resident Eligibility – Selection Policy
500.12	Resident DEA Controlled Substance Policy
500.14	Clinical Responsibilities, Teamwork Transition of Care Policy
500.15	Clinical Competency Committee (CCC) Policy
500.16	Program Evaluation and Improvement Committee (PEC) Policy
500.17	Graduate Medical Education Committee (GMEC) Policy
500.20	Annual Institutional Review (AIR) Policy
500.21	Resident Agreement of Appointment Contract Policy
500.22	Vendor Interaction Policy
500.23	Special Review Policy
500.24	Resident Benefit Policy
500.25	Professional Liability Insurance Policy
500.26	HIPPA Policy
500.28	Reimbursement Policy
500.37	Resident and Faculty Well-being Policy
500.38	Audition Rotation Eligibility Policy
500.46	Adverse Actions, Grievances, and Due Process Policy
500.49	Non-Competition Policy
500.50	Resident Appointment Policy
500.51	Employment Onboarding Policy
500.54	Video Taping Consent Policy
500.55	Technology Policy
500.56	Accommodations for Disabilities Policy
500.57	Discrimination and Harassment Policy