

University of Alabama Family Medicine Residency-Tuscaloosa Program Handbook 2017-2018

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I. INTRODUCTION

This Handbook contains both general and specific information regarding the residency program, policies and procedures applicable to the residency program, and/or policy overviews, which are current as of the listed effective date. The University and College of Community Health Sciences (CCHS) reserve the right to revise policies and other information deemed necessary to meet the business needs of the residency program, the University and CCHS, provided such changes do not conflict with ACGME Institutional Requirements, as last amended. Moreover, this Handbook should not be construed as, and does not constitute, an offer of employment by the University for any specific duration, nor is it intended to state any terms of employment not otherwise adopted and incorporated as part of any Residency Agreement.

Equal Opportunity

The University of Alabama, the College of Community Health Sciences and the University of Alabama Family Medicine Residency-Tuscaloosa Program annually reaffirms their commitment to equal opportunity, acknowledging publicly its obligation to operate in a constitutional and non-discriminatory fashion, both as an Equal Opportunity Employer and as an Equal Opportunity Educational Institution. Applicable laws that are followed include, but are not limited to, Titles VI and VII of the Civil Rights Act of 1964, the Age Discrimination in Employment Act, Executive Order 11246, Title IX of the Education Amendments of 1972, Sections 503 and 504 of the Rehabilitation Act of 1973, the Vietnam Era Veterans Adjustment Assistance Act, the Age Discrimination Act of 1975, the Americans with Disabilities Act of 1990, the ADA Amendments Act of 2008, and the Genetic Information Nondiscrimination Act of 2008 and does not discriminate on the basis of genetic information, race, color, religion, national origin, sex, sexual orientation, age, disability or veteran status in admission or access to, or treatment of employment in, its programs and services.

A. History of the University of Alabama Family Medicine Residency-Tuscaloosa Program (UAFMR-T)

In the late 1960s, a public outcry arose in response to the country's acute need for more physicians. In response to that demand, the College of Community Health Sciences was established at The University of Alabama. Many areas of Alabama, particularly small towns and rural communities, suffered from a serious lack of health care. The distribution of doctors was not the only reason for the physician shortage. Many of the new doctors being trained were choosing various specialties and subspecialties of medicine, and were choosing to practice them in the more urban areas of the State.

With a mandate from the State Legislature to improve health care in Alabama, the College, founded in 1972, looked to family medicine to achieve its goals. What was needed were doctors trained in family medicine – general practitioners who would

practice in Alabama, including the State's small towns and rural communities, and who were equipped to treat the myriad of medical problems found there.

The College's University of Alabama Family Medicine Residency-Tuscaloosa Program was started in 1974, and the first class of residents graduated in 1977. Today, one in eight family medicine physicians practicing in Alabama graduated from the College's residency.

The Family Medicine Residency prepares physicians to provide exceptional care in family medicine. The curriculum emphasizes community-based continuity of care and leads to board certification in family medicine. It is an unopposed residency and the only one with a full-time presence at the 658-bed DCH Regional Medical Center in Tuscaloosa, which is the referral hospital for West Alabama. The residency is a university-based program with a large full-time faculty assisted by local physician volunteers, and residents typically test in the top 20 percent of the country.

In recent years, the College has developed fellowships through its Family Medicine Residency to enhance the education of family medicine physicians. The College offers fellowships in sports medicine, hospital medicine, obstetrics, behavioral health, and rural public psychiatry.

In 2012, the residency increased the number of residents it accepts each year from 12 to 15, and in 2015, the residency started another growth transition to a 16-16-16 program that will allow a total of 48 residents by July, 2017. The rationale for this growth in the program is to allow the College to further meet the expanding needs in Alabama's rural communities.

To date, the Family Medicine Residency has placed 449 physicians into practice in 29 states, including Alabama, Arkansas, Florida, Georgia, Louisiana, Mississippi, Tennessee, North Carolina, South Carolina, Oklahoma, Texas, and Virginia.

More than half of residency graduates are practicing in Alabama and the majority of those are practicing in rural and underserved communities and Health Professional Shortage Areas.

B. College of Community Health Sciences at The University of Alabama

1. Mission Statement

We are dedicated to improving and promoting the health of individuals and communities in Alabama and the region through leadership in medical education and primary care; the provision of high quality, accessible health care services; and scholarship.

We accomplish this mission by:

- Shaping globally capable, locally relevant, and culturally competent physicians through learner-centered, community-based medical education and mentoring.
- Addressing the physician workforce needs of Alabama and the region with a focus on comprehensive Family Medicine training.
- Engaging communities as partners, particularly in rural and underserved areas, in efforts that improve the health of Alabama's citizens.
- Providing high quality, patient-centered, efficient clinical services.
- Fostering scholarship in relevant and innovative community-oriented research to influence population health and support community providers.

Our core values are:

- Integrity
- Social accountability
- Learning
- Innovation
- Patient-centeredness
- Transparency
- Inter-professional collaboration

2. Strategic Plan

The College of Community Health Sciences completed its most recent strategic plan in 2013. The goal was to develop a five-year plan that builds on the College's deep roots in primary care and family medicine education while responding to the changing needs of the communities of Alabama.

There are four overarching Strategic Priorities:

- Build on the strong foundation of the University of Alabama Family Medicine Residency-Tuscaloosa Program
- Provide an innovative and community-oriented undergraduate medical education experience
- Transform the clinical enterprise to deliver exceptional patient-centered clinical care enabled by a culture of continuous learning at all levels
- Foster an interest in and passion for scholarly pursuit in line with the College's mission

For each Strategic Priority, the plan outlines a number of initiatives that will guide the College's day-to-day tactics to achieving the Priority. These Initiatives are presented in three phases. Phase One initiatives are well underway. Phase

Two initiatives were designed to start once the Phase One initiatives were operationally stable, as such, in 2015 we are well into Phase Two on many of the initiatives. Phase Three initiatives will be started as soon as Phase Two initiatives are operationally stable.

Strategic Priority A: Build on the strong foundation of the University of Alabama Family Medicine Residency-Tuscaloosa Program

Goal: Enhance the quality of the Family Medicine Residency-Tuscaloosa Program through expanded community-based practice and experience, with continued emphasis on rural communities, to prepare primary care physicians that will be equipped to meet the challenges of a new world of health care.

Initiatives

Phase One:

A1: Conduct a thorough needs assessment and environmental scan to determine the current state, educational priorities, and community-based opportunities for the residency; and then, transform the curricular structure of the residency to address the growth of the program and the evolution of family medicine training standards.

A2: Expand the family medicine faculty to meet the needs of a growing and high-quality residency by recruitment of additional full-time faculty, with specialty interest in obstetrics, procedures, emergency medicine, and population health, among others, as well as selecting and integrating community-based faculty.

Phase Two:

A3: Diversify clinical experiences by opening new continuity clinic sites to further serve rural, University, and other populations.

A4: Provide more comprehensive training, including in population health management skills, and faculty development for all preceptors.

Phase Three:

A5: Transform family medicine clinics to be exceptional learning labs, which are regarded as the cornerstone of training; develop and integrate practice management, team-oriented practice, and clinical quality throughout residency experience; incorporate technology, e.g. social media and telemedicine.

A6: Create a marketing plan to improve residency recruiting.

3. **Capstone Health Services Foundation (CHSF) and University Medical Center (UMC)**

The CHSF is a separate 501(c)-3 organization serving as the physician's practice plan. CHSF is an affiliated foundation of The University of Alabama and CHSF operates the UMC and UMC-Northport. UMC, located on the main campus of The University of Alabama is a large multi-specialty clinic serving the West Alabama region. Acting as a teaching facility for a variety of allied health fields, UMC primarily serves as a training site for medical students and our family medicine residents. One of our two continuity clinics is located at UMC, while the second is a short five miles away at UMC-Northport (UMC-NP). UMC-NP is an ACGME approved continuity clinic as well. Both clinics operate under a common set of UMC policies and procedures and fall under the oversight of CHSF and CCHS leadership personnel.

4. **Faculty:** CCHS has approximately 60 faculty members in the following departments:

- Community and Rural Medicine
- Family, Internal and Rural Medicine
- OBGYN
- Pediatrics
- Psychiatry
- Surgery

C. **Overview of Residency's Goals**

The residency requires its residents to obtain competencies before graduation in the six ACGME competencies at the level expected of a new practitioner. Toward this end, the residency will define the specific *knowledge*, *skills*, and *attitudes* required and provide educational experiences as needed in order for residents to demonstrate:

Patient Care that is compassionate, appropriate, and effective for the treatment of health problems and the promotion of health.

Medical Knowledge about established and evolving biomedical, clinical, and cognate (e.g. epidemiological and social-behavioral) sciences and the application of this knowledge to patient care.

Practice-Based Learning and Improvement that involves investigation and evaluation of patient care, appraisal and assimilation of scientific evidence, and improvements in patient care. Residents are expected to develop skills and habits to meet the following goals:

- Identify strengths, deficiencies, and limits in one's knowledge and expertise.
- Set learning and improvement goals.
- Identify and perform appropriate learning activities.
- Systematically analyze practice using quality improvement methods, and implement changes with the goal of practice improvement.
- Incorporate formative evaluation feedback into daily practice.
- Locate, appraise, and assimilate evidence from scientific studies related to patients' health problems.
- Use information technology to optimize learning.
- Participate in the education of patients, families, students, residents, and other health professionals.

Interpersonal and Communication Skills that result in effective information exchange and teaming with patients, their families, and other health professionals.

Residents are expected to:

- Communicate effectively with patients, families, and the public, as appropriate, across a broad range of socioeconomic and cultural backgrounds.
- Communicate effectively with physicians, other health professionals, and health-related agencies.
- Work effectively as a member or leader of a health care team or other professional group.
- Act in a consultative role to other physicians and health professionals.
- Maintain comprehensive, timely, and legible medical records, if applicable.

Professionalism, as manifested through a commitment to carrying out professional responsibilities and an adherence to ethical principles, with expected demonstration of:

- Compassion, integrity, and respect for others.
- Responsiveness to patient needs that supersedes self-interest.
- Respect for patient privacy and autonomy.
- Accountability to patients, society, and the profession.
- Sensitivity and responsiveness to a diverse patient population, including, but not limited to, diversity in gender, age, culture, race, religion, disabilities, and sexual orientation.

System-Based Practice, as manifested by actions that demonstrate an awareness of and responsiveness to the larger context and system of health care and the ability to effectively call on system resources to provide care that is of optimal value. Residents are expected to:

- Work effectively in various health care delivery settings and systems relevant to their clinical specialty.
- Coordinate patient care within the healthcare system relevant to their clinical specialty.

- Incorporate considerations of cost awareness and risk-benefit analysis in patient and/or population-based care as appropriate.
- Advocate for quality patient care and optimal patient care systems.
- Work in interprofessional teams to enhance patient safety and improve patient care quality.
- Participate in identifying system errors and implementing potential systems solutions.

Mental Health:

Medicine has its rewards and considerable stresses. Resident physicians are confronted for the first time with the loneliness of having responsibility for the lives and health of their patients. The effort to develop an attitude of detached concern for patients may be complicated by cynicism. Crises may occur when residents are nearing the end of their training and face major adjustments in choosing and establishing a practice.

Physicians have a higher frequency of drug abuse, affective disorders, and marital disharmony than other people of similar social standing. Suicide is more frequent among physicians, possibly because doctors are reluctant to acknowledge illness or difficulties. The faculty of the College of Community Health Sciences (CCHS) recognizes the potential for emotional difficulties among residents and the need for assistance.

Physicians in training who are suffering may bring this to the attention of the Residency Director or their Advisor without fear or disapproval. Confidentiality is important. Residents are encouraged to consult with the psychiatry faculty in CCHS. If there is interest in obtaining assistance outside the College, several good resources are available. A brief directory of community resources includes:

University of Alabama Employee Assistance Program (EAP) = (205) 759-7890

Indian Rivers Community Mental Health Center = (205) 345 – 1600

Psychology Clinic/Parents Anonymous = (205) 348 – 5000

UMC Psychiatry Department = (205) 348 – 1265

Alcoholics Anonymous = (205) 759 – 2497

D. Lines of Authority/Hierarchy

RESIDENCY LEADERSHIP: The University of Alabama Family Medicine Residency-Tuscaloosa Program (UAFMR-T) has a Residency Director (Richard Friend, MD), three Associate Residency Directors (Jared Ellis, MD, Cathie Scarbrough, MD, and Jane Weida, MD), and an Assistant Residency Director (Tamer Elsayed, MD), a Graduate Medical Education Coordinator (Stephanie Beers), a Residency Program Coordinator (Alison Adams) and a Residency Program Assistant (Genia Condra). The residency program is also assisted by the Assistant Dean for Medical Education (Harriet Myers, PhD) in many ways, to include intervention into certain Sponsoring Institution policies concerning appeals and due process.

SPONSORING INSTITUTION: The Residency's sponsoring institution is The University of Alabama's College of Community Health Sciences, whose Dean is Richard Streiffer, MD. Additionally, the Residency reports to the Associate Dean for Academic Affairs (Thad Ulzen, MD), and to the Designated Institutional Official (DIO), David Nichols, who also serves as the Chief Operating Officer for the College of Community Health Sciences. The Sponsoring Institution (SI) has an official Policy and Procedure manual consistent with ACMGE requirements. These Policies address all of the CCHS graduate medical education programs regardless of accreditation or certification status. Each training program adopts the same SI policies, however, the procedures to accomplish each policy may vary from program to program. It is the role of the SI's Graduate Medical Education Committee (GMEC) to review and approve each program's Handbook, which is the set of program-specific requirements and procedures.

ADMINISTRATION STRUCTURE: The Graduate Medical Education Committee, referred to as GMEC by the ACGME, is the Residency oversight committee. It is chaired by the Designated Institutional Official with voting members including the Residency Director, select Faculty, peer-selected Residents and Fellows, a Patient Safety/Quality Improvement Officer and a representative from our Major Participating Site (DCH Regional Medical Center). This committee deals with institutional and accreditation issues that affect all graduate medical education programs of the College.

The Curriculum Oversight committee is responsible for educational changes that may affect the Residency. It is chaired by the Residency Director, with voting members including a Faculty member from each discipline contained within the curriculum.

DCH Regional Medical Center is the major participating hospital that receives Graduate Medical Education funding from CMS (i.e., Medicare). These funds are partially passed on to the College for resident salary and benefits.

ACCREDITATION: The Accreditation Council for Graduate Medical Education (ACGME) is the accrediting institution for Allopathic residency programs in the United States. The UAFMR-T is fully accredited by the ACGME and complies with the rules and regulations required at an institutional level by the ACGME, as well as those specialty-specific requirements of its Review Committee for Family Medicine residencies. The Institutional Requirements, Common Program Requirements, and Program Requirements can be found on the [ACGME website](#).

The American Board of Family Medicine (ABFM) maintains its own set of requirements that must be followed in order for a resident to be eligible for obtaining board certification, including policies relating to continuity of care and leave of absence from Residency. Our internal requirements are also written to comply with the ABFM requirements, which can be found on the [ABFM website](#). In addition, the ABFM

administers the in-training exam (ITE) every fall; previous in-training exams can be accessed on its website. The in-training exam is an excellent predictor of initial certification exam passage.

The Alabama State Board of Medical Examiners (ALBME) and the Medical Licensure Commission of Alabama are the state agencies that regulate the issuance of all licenses to practice medicine or osteopathy in the state of Alabama. More information about their rules and regulations can be found on the [ALBME website](#).

For further information, contact us at (205) 348-1373 or tfmr@cchs.ua.edu

II. POLICIES

As previously stated, The Sponsoring Institution (SI) has an official Policy and Procedure manual consistent with ACMGE requirements. The Family Medicine Residency program has adopted the SI policies, however, the procedures to accomplish these policies are tailored to fit the residency program. In addition, there are some specific residency policies, procedures and practices which are applicable to the residency program. It is the role of the SI's Graduate Medical Education Committee (GMEC) to review and approve each program's Handbook, which is the set of program-specific requirements and procedures. The SI Policy Manual is maintained online and accessible via the CCHS Intranet Site. At any time, you may request a copy of a policy from the Residency Office, however, it is the resident's responsibility to ensure the paper copy is the same updated policy that is online. The online version is considered the official policy.

The SI Manual contains the following policies:

1. [Eligibility, Recruitment, and Appointment](#)
2. [Promotion, Appointment Renewal and Dismissal](#)
3. [Due Process](#)
4. [Grievances](#)
5. [Leave](#)
6. [Impairment](#)
7. [Harassment](#)
8. [Accommodation for Disabilities](#)
9. [Supervision and Accountability](#)
10. [Clinical and Education Work Hours](#)
11. [Moonlighting](#)
12. [Vendors](#)
13. [Non-competition](#)
14. [Disasters](#)
15. [Closures and Reductions](#)

16. [Drug and Alcohol](#)
17. [Probation-Remediation-Suspension](#)
18. [Professional Appearance Policy](#)

Residency Policies-These are policies that apply to residents in the University of Alabama Family Medicine Residency-Tuscaloosa Program in addition to the Sponsoring Institution Policies.

1. [Communications](#)
2. [Professionalism](#)
3. [Transitions in Care](#)
4. [Supervision and Accountability for FMR](#)

Residency Guidelines - These are guidelines that apply to residents in the University of Alabama Family Medicine Residency-Tuscaloosa Program.

1. [Inpatient Medication Guidelines](#)

The Residency Handbook is further sub-divided into the following sections containing information about our Clinical and Educational practices as well as Administrative issues you need to be familiar with.

III. CLINICAL PRACTICES

A. **General Supervision** (see also Supervision Guidelines from the [Policies and Procedures page](#))

The resident must not independently perform procedures or treatments, or management plans that he/she is unauthorized to perform or lacks the skill and training to perform.

The resident is responsible for communicating to the attending physician any significant issues regarding patient care.

B. **Communications**

1. **Pagers and Email:**

Professional behavior and responsibility is expected of all residents. The Residency Office, clinic personnel, the answering service and your rotation team members need to be able to reach you at any time, unless you are on approved leave. Our primary means of contact will be through your pager, cell phone and/or email. See the Residency Communication Policy.

2. **Faculty-Resident Communications, Feedback:**

Feedback is provided during rotations along with an evaluation completed at the end of the rotation by the attending physician. Each resident is also assigned an advisor to assist them with their educational goals.

C. **Outpatient Clinical Duties**

1. **Overview:**

The resident's patient panel in his/her continuity clinic is assigned for the duration of residency. The panel will increase over the three years in keeping with the

increased time spent in the Family Medical Practice site (located either within UMC or an external UMC clinic approved as a continuity clinic site by the ACGME). The initial panel is composed of patients from graduating residents' panels, patients new to UMC, and patients on follow-up from emergency departments. A resident may add family members of his/her currently assigned patients to his/her panel at any time by notifying the residency office.

2. University Medical Center and UMC-Northport:

a. General Practices Regarding Resident Continuity Practice at both UMC locations:

- i. Residents will not care for or write prescriptions for their own family.
- ii. CCHS Nursing and administrative staff may not be treated by a resident.
- iii. A resident's clinic schedule is determined by the rotation to which he/she is assigned. Clinic schedules are prepared by the Residency Office and are typically available six months in advance.
- iv. Residents are expected to be at his/her assigned clinic 15 minutes before their first patient. If the resident must be late for a scheduled clinic, he/she must notify, via email and telephone, the Residency Office and the suite charge nurse so that patients can be informed and arrangements can be made for rescheduling or for care by another physician, if necessary.
- v. If the resident must cancel a scheduled clinic, he/she must request the cancellation from the Residency Office via email or in writing 60 days in advance. Same-day cancellations may only occur due to emergency situations, and must be done with a personal call to the charge nurse as well as the Residency Office.

b. Precepting Patients in Clinic:

- i. First-year residents must consult with the attendings about each patient. Attendings must examine **EVERY** Medicare patient during the first six months of the resident's first year.
- ii. Licensed second- and third-year residents will have an attending available to address any questions.
- iii. All residents are required to consult with an attending when seeing Medicare patients. If the visit is a level 4 or 5, the resident should request that an attending see the patient. Caring for clinic patient independently is a progressive process.
- iv. If a resident finishes clinic early, he/she may leave if the volume and patient care needs for the day allow (meaning all chart documentation is complete), and if the attending approves. If approved, the resident must notify the nurses of his/her departure. Common courtesy

dictates that the resident also asks a colleague to see walk-in patients who arrive after the resident departs.

c. Release of Protected Health Information (PHI)

i. General Expectations and the Electronic Medical Record:

There is a 24-hour availability of University Medical Center records by computer. Residents are expected to comply with all UMC policies and procedures regarding the Electronic Medical Records System.

ii. Faxing/Receiving Confidential Patient Medical Records:

Facsimile transmission of health information should occur only when the original record or mail-delivered copies will not meet the needs of immediate patient care. Health records should be transmitted via facsimile only when: (1) needed for patient care; or (2) required by a third party payer for ongoing certification of payment for a hospitalized patient. The information transmitted should be limited to that necessary to meet the requestor's needs. The Medical Records Department should make routine disclosure of information to insurance companies, attorneys, or other legitimate users through regular mail or fax. Except as required or permitted by law, a properly completed and signed authorization should be obtained prior to the release of patient information. An authorization transmitted via facsimile is acceptable. Consult the Medical Records Department to assist with all release of information requests. Any release of information should be charted in the patient's medical record on PHI.

Each fax machine should have someone monitoring incoming documents. This individual should remove incoming documents immediately, examine them to assure receipt of all pages in a legible format, and send them in accordance with their instructions. Faxed documents will be scanned into the EMR by the staff of the Medical Records department. All actions will be in accordance with HIPAA regulation:

- Faxes should be sent/received using fax machines in a secure, limited area.
- Fax requests from unfamiliar sources should always be verified.
- Highly sensitive health information will not be faxes.
- Psychotherapy notes will never be faxed.

A printed confirmation record should be used to confirm that the fax was delivered to the correct number.

iii. Charting Expectations of Preceptors in the Family Medicine Clinic:

1. Primary Care Exception-The Primary Care Exception Rule allows residents to bill up to a Level 3 charge without an attending faculty member personally seeing the patient. This is only in effect for PGY-1 year residents after the first 6 months of their training.
2. Level 4 and 5 Visits and Procedures-An attending faculty member must personally see the patient to bill a Level 4 or 5 on all Medicare, Tricare, and Federal BCBS patients. An attending must also be present for all key portions of procedures in order to bill appropriately.

iv. Incomplete Charts

Within the residency program, incomplete is defined as any clinic visit note or procedure note not completed within 72 -hours of the encounter. The Residency Office receives a daily incomplete chart list. This list is emailed to the residents, who are given 72 hours to complete their incomplete charts. If the resident has not completed his/her charts within the 72 hours, he/she has until 8:00 am the following business day to complete them. At that time, if the charts are still not complete, the resident will be pulled off his/her rotation and docked a vacation day. The resident will also be required to meet with the program director. Any resident found to have a significant number of incomplete charts and/or a repetitive pattern of incomplete charts is subject to disciplinary action.

Timely completion of patient records is good patient care. Additionally, resident chart documentation is necessary before the attending can complete their documentation. Attendings are required to complete chart documentation within 15 days of the encounter otherwise, they are subject to a financial penalty. See also the [Chart Completion and Authentication Policy](#).

d. Charges

i. Patient Charges and Discounts:

At UMC, professional physician charges are competitive with those of local physicians. Resident should document the visit. The attending will submit the charges for billing. Residents shall be responsible for coordinating any questions or concerns on charges to patients. Specific policies are outlined below.

ii. Identification of all Services at University Medical Center:

Each patient who receives medical care at UMC should be billed in the computer. Residents are encouraged to document at the time of

the visit but are required to complete documentation within 48 hours of the date of service. In the event a special circumstance warrants a modification of this policy, the Chief Operating Officer (COO), the Chief Financial Officer (CFO), and the Director of Billing and Compliance should be consulted.

- iii. **Fee Adjustments:**
Residents may offer professional courtesy adjustments only after consultation with the Director, Billing and Coding Compliance in the Business Office
 - iv. **Uninsured/Underinsured Policy:**
Indigent patients should be referred to the Social Worker at 348-7195.
- e. **Other Clinical Procedures**
- i. **Medical Transportation:**
Patients who require transfer to DCH for emergency care or admission will be presented to an attending, and will not be transported to or from DCH without authorization from the attending. Notify the nurse staff in the clinic to call for transport.
 - ii. **Transfer of Patients:**
All patients who request a change in their assigned physician should be referred to an attending in that suite, who will arrange the transfer. Changes should be made according to a random list of physicians in each suite. The old physician and new physician should be informed of the change and the circumstances surrounding it.
 - iii. **Dismissal of Patients:**
UMC has a [specific policy on the dismissal of a patient](#) and all such dismissals must follow this policy. A resident physician may request that a physician-patient relationship be ended. Residents must get approval from an attending to terminate a patient. The attending must review the patient's chart carefully, ensuring compliance with the dismissal policy and that there are no omissions in the standard of care and that no indiscreet remarks have been made in the chart. The attending will then ask the clinic director and department chair to end the relationship. If the patient is being seen by a physician in another department, the attending must get termination approval from the other physician. The clinical director will request a form letter to be signed by the resident and attending. A copy of the signed letter will be placed in the patient's chart. Terminations do not affect the patient's immediate family members, except in the case of outstanding bills.

If administration initiates a request for patient termination due to an outstanding bill, an attending will be asked to review the patient's chart, as above. The clinical director will then request a form letter to be signed by the resident and attending.

A patient has 30 days from the date on the termination letter to find a new physician. If urgent medical care or prescription refills are needed during this time frame, the resident on referred call must see the patient, if the patient so desires.

iv. Referrals:

When a patient is referred to another physician in or out of UMC, the resident must complete a Referral Request Form and fax it to the consultant. The "Plan" section of the chart note should reflect why the patient is being referred. It is customary to refer primarily to physicians who are involved in the teaching of residents.

f. Home Visits

Home visits are required for all residents. These visits are appropriate for all debilitated or home-bound patients or any patient being followed by a home health or hospice agency. Residents will not graduate without an appropriate number (minimum- 2) of home visits. An attending must be present with the resident in order to bill for the services rendered in the Home.

g. Nursing Home Visits

Each resident will be assigned two nursing home patients at the beginning of PGY2. Following your assigned nursing home patients for the duration of your residency is a required part of your training. The resident will provide primary care to patients with Attending backup for PGY2 and PGY3 years. The resident is expected to visit his/her nursing home patients monthly. Residents will not graduate without obtaining 24 nursing home visits. An attending must be present with the resident in order to bill for the services rendered in the Nursing Home.

IV. EDUCATIONAL PRACTICES

A. Professionalism

Professionalism is one of the core competencies that the Accreditation Council of Graduate Medical Education (ACGME) has identified as being vital to the clinical practice of medicine and to resident development. The Professionalism Policy must be signed and turned into the residency office.

“Windfall” and Professionalism:

Occasionally you will be on a rotation where your preceptor takes a day off or releases you to go home early. Your preceptor being off does not free you from responsibility to your patients. You are expected to be reachable by pager during the workday, unless you notify the residency office that you will be taking leave.

B. Curriculum

1. Overview of the Curriculum: 13 blocks

- FM Inpatient-4 blocks total (2 blocks intern year, 1 for PGY-2, & 1 for PGY-3)
- Internal Medicine-2 blocks
- OB/GYN-3 blocks
- Peds-3 blocks
- Surgery-1 block (intern year only)
- Geriatrics-1 block
- EKG/VENT-1 block (intern year only)
- CM/PM-1 block (intern year only)
- GYN Clinic-1 block (PGY 2 or 3)
- Night Float-Adult Medicine-2 blocks
- Night Float-Pediatrics/OB-2 blocks
- Emergency Medicine-2 blocks (1 in 2nd year and 1 in 3rd year)
- Ambulatory Pediatrics-2 blocks
- EBM Pharmacy-1 block (2nd year preferably, but can complete I3rd year)
- Orthopaedics-1 block
- Psychiatry-1 block
- Rural Medicine-1 block
- Neurology-1 block
- Cardiology-1 block
- ENT/Urology/Ophthalmology-1 block
- Sports Medicine-1 block
- Radiology/Practice Management-1 block
- Electives-5 blocks

2. Rotations:

a. Scheduling Rotations:

Rotation schedules are prepared in one-year blocks from July to June by the Chief Residents. This schedule is subject to oversight and/or reassignment by the Residency Director, Associate Director, Assistant Director, and/or Coordinator. Any resident wishing to make a change in his/her rotation schedule should apply 90 days in advance to the Residency Director.

b. Elective/Subspecialty Rotations:

Before starting an elective or subspecialty rotation, the resident is required to contact the preceptor one month prior to the start date to notify him/her of clinic schedule and inquire about any requirements or preparations that should be completed for the rotation.

c. Starting Dates:

Monthly rotations, with the exception of Night Float, begin on the first day of the block. Night Float begins at 5:00 pm the night before the first day of the month. For primary services, if the new month begins on a weekend, the previous month's call teams will be required to cover call until 7:00 pm on Sunday (when the new month's night float team starts).

Dates for rotations: All rotations begin July 1st

Rotation 1: July 1st-25th

Rotation 2: July 26th-August 22nd

Rotation 3: August 23rd-September 19th

Rotation 4: September 20th-October 17th

Rotation 5: October 18th-November 14th

Rotation 6: November 15th-December 12th

Rotation 7: December 13th-January 17th

Rotation 8: January 18th-February 13th

Rotation 9: February 14th-March 13th

Rotation 10: March 14th-April 10th

Rotation 11: April 11th-May 8th

Rotation 12: May 9th-June 5th

Rotation 13: June 6th-June 30th

d. Incomplete Rotations:

The curriculum for this program is 36 months, including allotted vacation time. It is expected that each rotation, including electives, will be completed in a satisfactory manner, meaning adequate attendance (present no less than 15 working days) and performance.

e. Away Rotations:

The American Board of Family Medicine (ABFM) requirements allow a total of four months during the R2 and R3 years to be spent on away rotations.

These cannot exceed two months in any single year, be scheduled consecutively, or taken the last month of residency.

i. Supervised Practice Experience (SPE):

A Supervised Practice Experience (SPE) may be spent in a physician practice of the resident's choice with the prior approval of the Residency Director. The following criteria will be used to judge the acceptability of the proposed rotation.

- The resident will apply for the SPE a minimum of three months prior to the anticipated rotation. During this period, CCHS must determine the suitability and qualifications of the “away site” preceptor and ensure the environment meets ACGME’s expectations for an environment that promotes patient safety and quality improvement.
 - After obtaining the necessary internal approvals, The Residency Office will obtain agreement for the rotation from the “away site” preceptor. The Residency Office may ask the resident to assist in this process.
 - There must be a justifiable educational value to the away rotation experience.
 - The away site preceptor should have an appropriate amount of experience in medical education.
 - The away site preceptor must agree to evaluate the resident’s activity and performance.
 - The resident must be supervised during the rotation.
 - The College will not provide money for travel, lodging or meals.
 - There can be no conflict with the resident’s duties or responsibilities to UAFMR-T. The resident must not have delinquent/incomplete dictations or charts at DCH Regional Medical Center or University Medical Center. The resident must have seen an adequate number of patients per the ACGME requirements and be on track to meet all volume requirements for graduation in order to be granted leave from clinic to participate in the away rotation.
 - Unless previously discussed with the Residency Director, the preceptor should be Board Certified in Family Medicine.
- ii. Rural Rotation:
All residents are required to have a rural rotation. The resident will select the site from one of the available teaching sites. The Residency Office can be contacted for the list of approved teaching sites. The resident will be required to return to a University Medical Center FMP site for one day of clinic a week to maintain their continuity of patient care. Occasionally, a stipend is provided by the Alabama Family Practice Rural Health Board to help defray the costs associated with travel to the rural site. This stipend is dependent upon the favor of the state legislature and is not guaranteed.
- iii. Elective Remote Site Experience (ERSE):
Domestic and international humanitarian or mission experiences are encouraged during the R2 and/or R3 years of residency. It is possible

to receive academic (residency) credit for these experiences provided AAFP and RRC guidelines are met. An ERSE typically involves having a board-certified preceptor from a U.S. training program. A resident must apply for an ERSE a minimum of three months prior to the anticipated rotation. To complete the application, which is to be submitted to the Program Director in writing, a proposal (see first bullet below) must be prepared and a Leave Request indicating international travel has to be submitted. It is important to obtain Program Director, College and University approval for the international rotation and travel before incurring travel-related expenses. If approval is not granted, you are at risk for any expenses incurred. During this period, CCHS must determine the suitability and qualifications of the “away site” preceptor and ensure the environment meets ACGME’s expectations for an environment that promotes patient safety and quality improvement.

Humanitarian trips/rotations may be considered for reimbursement up to \$1,500. This benefit is available once during residency. To qualify for this benefit, the following must be done:

- A two to three page proposal for the experience must be written and submitted to the Residency Director prior to the ERSE.
- A summary of the experience must be written and submitted to the Residency Director after the ERSE.

If granted permission for reimbursement, UA travel guidelines must be followed. All expenditures must have receipts and supporting documentation. Typically, the maximum reimbursement allowed is \$200 per night for hotel accommodations and \$45 per day for meals. Please refer to [UA’s travel policy](#) for the most up-to-date rules for reimbursement.

3. Conferences and Scholarly Activity

a. Academic Afternoon and other Academic Conferences:

Academic Afternoon is every Tuesday afternoon and is a required part of the program. Standards have been set with a minimum attendance percentage (80%) expectation which is tied to promotion from one PGY level to another and successful completion of the training program (See Promotion, Renew and Dismissal Policy in Section II of this Handbook). Attendance is required of all residents, unless: 1) the resident is on approved leave; 2) duty hours prohibit such involvement; 3) urgent patient care precludes this; or 4) the resident is on an “away” rotation that does not have University Medical Center continuity clinic. Academic Afternoon should not be used for

personal activities without having approved leave. If urgent care does preclude attendance, please notify the Residency Office as soon as possible.

Other conferences, such as Academic Conferences, Emergency Medicine Series, and Special Emphasis Week, may be scheduled at various times throughout the year. The attendance policy for these lectures is the same as above.

In cases of ANY unapproved absences, the resident will be forced to use a day of annual leave. If no annual leave is available, the resident will be forced to take leave without pay and will be required to give a lecture from a list of topics within the next month.

Attendance and participation at Academic Afternoons, Grand Rounds, Outpatient Teaching Series, Emergency Medicine Series, etc... (list not all inclusive) is important and worthwhile, therefore we require a cumulative attendance rate of at least 80% at all such conferences during the PGY-1 year in order to progress to the next level. Attendance logs will be maintained and physical presence is required in the meeting room for at least half of each conference and lecture. Extenuating circumstances must be approved by the Program Director. Calculation of the 80% will not include when a resident is on night float or has approved leave.

Academic Afternoon is designed to further your professional development. Lecturers have been asked to take time from their schedules and deserve a respectful and attentive audience. Please put your cell phones and pagers on vibrate during this time.

Do not use Academic Afternoon to catch up on delinquent charts. Any other use of laptops and/or cell phones is strongly discouraged and may cause forfeiture of this privilege for the group.

Once a quarter, a special-called meeting of all residents and fellows currently in graduate medical education training programs within the College will be held during Tuesday Academic Afternoon. This "Forum" is consistent with ACGME requirements to ensure the availability of an opportunity for residents and fellows within and across the Sponsoring Institution's graduate medical education programs to communicate and exchange information with each other relevant to their programs and their learning and working environment. At the Forum:

- Any resident/fellow must have the opportunity to raise a concern at the Forum;

- Residents/fellows must have the option, at least in part, to conduct their Forum with the DIO, faculty members, or other administrators present; and
- Residents/fellows must have the option to present concerns that arise from discussions at the Forum to the DIO and GMEC.

Residents and Fellows are represented by peer-selected representatives on GMEC. These representatives have the responsibility to communicate with the DIO to 1) invite to a Forum meeting or 2) present the collective concerns or issues raised at the Forum that need the attention of the DIO and/or GMEC.

b. Behavioral Medicine – PGY-3 Presentations

The conference is a required part of the Residency Program. It involves each senior resident presenting a case/topic in Behavioral Medicine/Family Medicine for discussion and dialogue. Preparation of the topic and the case is done under the direct guidance of the faculty coordinator for the R3 conferences (Dr. Thad Ulzen) and/or the Residency Director. These conferences will have their own orientation at the end of the R2 year.

c. Scholarly Activities and Research

All University of Alabama Family Medicine Residency-Tuscaloosa Program residents are required to participate in scholarly activities/research throughout residency. These are graduation requirements. Opportunities for scholarly activities/research generally begin in the R2 year but you may begin during internship. If you would like to get started earlier, you may schedule time to discuss these projects at any time during internship.

The scholarly activity comes in many different formats and incorporates the core areas of academic medicine, such as research, teaching, patient care and organization/management/service. As defined by Boyer (1990), scholarship encompasses the full scope of academic work and includes:

- The *Scholarship of Discovery* - original research.
- The *Scholarship of Integration* - interdisciplinary work in which connections are made across disciplines.
- The *Scholarship of Application* - the application of theory to practice and the bidirectional relationship between theory and practice.
- The *Scholarship of Teaching* - communication of knowledge to learners and the creation and sharing of knowledge about the practice of teaching.

Each resident is required to accumulate 10 scholarly activity points. This system recognizes a variety of activities as scholarly; any of the four types of scholarship described by Boyer can potentially earn points.

The point system is weighted in such a way as to encourage residents to participate in the scholarship of discovery. Residents are free to collaborate with each other, as well as faculty, on projects.

The table shows the basic outline of the point system. Accumulations of 10 points are required to graduate. The research director, program director, and the faculty mentor determine the exact number of points earned for a project. For projects involving collaboration, full points can be given to each resident, or points can be assigned based on each resident’s level of contribution.

Additional information regarding this requirement will be formally given during an orientation session at the beginning of the R2 year.

Approved Scholarly Activity Requirements

<i>Type of Scholarly Activity</i>	<i>Maximum # of Points</i>
Completion of an IRB-approved research project	7
Acceptance (to peer review) of a manuscript describing a case report, clinical review, or research project; a systematic review to a medical journal; or a quality improvement project with evaluation	5
Publication of an edited book chapter or section	5
Family Practice Inquiry Network (FPIN) Clinical Inquiries	5
Prepare an enduring curriculum for use by the residency program, including needs assessment; goals & objectives; activities/template; evaluation; and presentation for incorporation into the curriculum	5
Completion and submission of a grant proposal with budget	3
Submission and acceptance of a podium or poster presentation at a state, regional, national, or international medical conference	3
Participation in state, regional, or national committees of medical or educational organizations	3
Family Practice Inquiry Network (FPIN) Help Desk Answer	3
Publication of a letter to the editor in a peer-reviewed medical journal	2
Publications for the lay public, such as newspaper articles, on medical topics or an article for the UA news	2
Submission without acceptance of a presentation at a state, regional, national, or international medical conference	1
Family Practice Inquiry Network (FPIN) PURLS Journal Club (1 total)	1

Presentation of a podium or poster presentation at a local medical or patient care conference (includes but not limited to CCHS Research Day, Grand Rounds, Scholarship Conference, etc.)	1
Special lecture outside of CCHS	1
Publication of an op-ed or letter to the editor in a local or state newspaper regarding a current public health concern	1
Completion of CITI/IRB training and identification of an approved scholarly activity topic with a faculty mentor by the end of intern year	1
Presentation at Academic Afternoon (required for all)	1*
Other activities deemed acceptable by the research director and residency program director	As assigned

*Requirement for graduation

4. Other Requirements

a. *Quality Improvement:*

Quality Improvement (QI) is increasingly becoming a part of private practice in the form of insurance-initiated pay-for-performance programs and annual American Board of Family Medicine Maintenance of Certification QI Chart Reviews. All Family Medicine Residents are required to participate in a QI project (AAFPs METRIC). This is a graduation requirement and is typically completed during the R2 year.

See also Sections on Nursing Home and Home Visits

C. Advanced OB Focus

Residents desiring to offer maternity services following graduation should take the advanced OB curriculum to comply with the AAFP/ACOG guidelines. Residents choosing these additional OB training months should consult with the Residency Director.

D. Library and Learning Resources

The Health Sciences Library is located on the ground floor of the College of Community Health Sciences and is available to residents 24 hours a day.

E. Assessment

1. Overview:

a. *Evaluation of the Resident:*

Residents evaluate the faculty and rotations. To preserve anonymity, these evaluations are compiled every four to six months and a composite average of the evaluations and comments are presented to the faculty. The evaluations remain completely anonymous.

Preceptors from each rotation evaluate residents in New Innovations monthly. These evaluations are released for the resident to review at his/her request. Each quarter, residents will meet with their advisor to review these evaluations. Quarterly Summative Evaluations are conducted by the Family Medicine faculty and are kept on file in the Residency Office.

- i. Formative, Summative, and Final: Residents will be evaluated securely and electronically by the faculty at the conclusion of each rotation. Access to these formative evaluations will be available securely and electronically online once the residents have completed their own evaluations of the faculty and rotation.

During the academic year, the Family Medicine faculty shall meet quarterly to consider the academic progress and promotion of all residents. The residents will be required to meet with their advisors to discuss their evaluations for that quarter. Any weakness or deficiency should be discussed during this time. The advisor will complete a Summative Evaluation on the resident and turn it in to the Residency Office.

Prior to the end of June, the Residency Director shall forward to each resident the decision reached, pending successful completion of the remainder of the academic year.

- ii. Faculty Advisor: Residents are assigned a faculty Academic Advisor to assist them in obtaining their educational goals.
 - a. Evaluation by the Resident of Rotations: Residents are required to complete an evaluation of each rotation in New Innovations.
 - b. Evaluation by the Resident of Teachers: Residents are required to complete an evaluation on each of their attendings at the end of a rotation in New Innovations.

2. Documenting Procedures

All procedures done should be documented in New Innovations. This list is used to write an official letter documenting your competency in procedural areas to all future employers, hospitals, and/or insurance companies. Occasionally, some rotations require a certain number of procedures to graduate.

Each resident must perform a minimum of 40 deliveries over the three-year program, of which a minimum of 10 must be continuity deliveries. At least 30 of the total deliveries must be vaginal deliveries. Two residents may be given credit for the same delivery if one of those residents is supervising. The experience of each resident

must be documented as to the role played in the delivery. For the minimum of 10 continuity patient deliveries, each resident must assume responsibility for provision of antenatal, natal, and postnatal care during their three years of training.

Interns must log 15 ICU patient encounters, 10 advanced airway procedures, place 3 Foley catheters, complete 3 phlebotomies, draw 3 ABGs, and participate in 5 ACLS codes in order to promote to the PGY-2 level.

Every resident must attend at least one ACLS Emergency Simulation session given by Dr. Ellis. These are typically every other Monday afternoon. Sessions can be attended while on inpatient medicine, cardiology, and FM Clinic, but it is not limited to these rotations. Contact Genia Condra at 348-1373 for scheduling simulations.

Other procedures required for graduation include:

To be completed by June 1 of PGY3 year except as noted		
Procedure Name	Required	Comments
ABG (perform)	2	
Adult Code/ACLS (lead +2) or participate)	10	Lead 2, participate in 10
Bladder Catheterization – Female	2	
Bladder Catheterization – Male	2	
Orthopedics – Casting and splints	4	
Cerumen Disimpaction	5	
Circumcision	5	Except by prior statement of conscientious objection
Contraceptive Subdermal Implant	3	2 insertions and 1 removal required
Delivery of Bad News Discussion	2	Document with details at least 2, Inpt or Outpt
ECG (Perform)	1	(ECG reading is in curriculum)
End of Life Discussion	2	
Fluorescein Exam without Slit-Lap	2	
Home Visit	2	
I/D Abcess	5	
ICU Patients	15 during PGY1	
Ingrown Toenail	2	
Intubation (Advanced airway)	10	
IUD – IntraUterine Device	2	Except by prior statement of conscientious objection
IV Access (Venous) perform	2	
Joint Aspiration/Injection	10	Includes all joints
Laceration Repair	10	

Meaningful Encounters/PCP Inpatient	Up to 150	May log up to 150, counting toward 1800 visit continuity requirement
Nursing Home Visits (continuity patients)	24	During PGY 2-3
OB – Total Deliveries	40	Perform or directly participate
OB – Continuity Deliveries	10	
OB – C-Section (assist)	10	
OB – Vaginal Deliveries	30	
Placement of NG or enteral feeding tube	2	
Removal of Foreign Body from Any Orifice	1	
Skin – Tag Removal/destruction	2	
Skin – Biopsy/Excision (punch, shave, scoop)	4	
Skin – Cryotherapy destruction (not skin tag)	3	
Spinal Tap (Lumbar Puncture)	1	
Spirometry (perform)	1	
UA with Micro (Prepare and View)	2	
Wet Mount/KOH Prep (Prepare and View)	2	

3. In-training Exam

The [American Board of Family Medicine](#) administers the In-Training Exam (ITE) annually in the fall. The purpose of the examination is to provide an assessment of each resident's progress, while also providing programs with comparative data about the program as a whole. The examination consists of 240 multiple-choice questions and uses a content outline that is identical to the blueprint for the ABFM Certification Examination.

It is the goal of the University of Alabama Family Medicine Residency-Tuscaloosa (UAFMR-T) to create an environment that fosters scholarship and lifelong learning. Thus, preparation for the ITE and for Boards is highly emphasized.

The following criteria are considered internal benchmarks for the UAFMR-T:

- PGY-1: 390 mean scaled score
- PGY-2: 410 mean scaled score
- PGY-3: 440 mean scaled score

Scores will be discussed with the resident's Academic Advisor and the Residency Director. If scores are lower than the internal benchmark listed above, formal

assistance with examination preparation will be provided via a remediation plan. (NOTE: This is NOT academic probation. It is anticipated that several residents may not be at this benchmark level early in the respective training years. The goal of the remediation process is to identify those struggling with standardized tests and to formally provide assistance and training for improvement.)

A typical remediation plan will follow the procedures outlined below:

- Meeting with resident's academic advisor outlining a 12-week plan.
- Weekly meetings with advisor (at advisor's discretion).
- Advised to use CME fund on board-review course. (NOTE: R2s who remediate on the ITE will not be allowed to use their R3 CME funds until successfully passing the R3 ITE. If the R3 ITE is not passed, the CME funds must be spent on an approved board-review course).
- Completion of the Board Review Simulator Course on either Challenger or Exam Master. At the conclusion of the 12-week period, the resident will retake an exam on Exam Master with the goal of a score at least 10 percent higher.

No academic probation will be prescribed SOLELY on the results of the ITE or follow-up test. The Residency Director will review the results of the ITE with confidentiality, professionalism, and a view of the big picture of the resident as a physician in training. Failure to work with academic advisor on the ITE will result in academic probation.

F. Working with Medical Students

The College of Community Health Sciences serves as an academic and clinical home for the Tuscaloosa Regional Campus of the University Of Alabama School Of Medicine. Third- and fourth-year medical students are assigned to the various specialty services at University Medical Center. While the ultimate responsibility for students' education remains with the faculty, residents are expected to be involved in the teaching of medical students.

Residents are to allow and expect medical students to perform histories and physicals, formulate ideas concerning impressions and diagnoses, and suggest treatments. Residents are to see the patients either with or following the students to make sure findings and assessments are accurate and to provide opportunity for necessary instruction. Residents and students also present patients to faculty in OB/GYN and Pediatrics. Residents are expected to assist students with these presentations whenever time permits. Students will be allowed to perform procedures under direct supervision of residents. Orders are to be countersigned immediately in all instances by the resident responsible for the patient.

Residents should familiarize themselves with the rotation goals and objectives for each medical student rotation for which they are assigned. Residents will also attend a lecture/seminar on providing appropriate feedback and teaching skills directed towards medical students.

The residents may require the student to do reasonable reading and research on a patient. The student should be familiar with all pertinent laboratory and clinical facts. Ideally, the student should present the patient to the attending for comments and guidance, with the help of the resident on rounds. Both residents and medical students are to present patients during morning report on the Internal Medicine rotation and/or Family Medicine rotation. Interns must perform and dictate a separate H&P from that of the medical student. The senior resident is to write a RAN note.

At University Medical Center, a senior resident or attending must review all patients seen by a medical student. All orders and prescriptions must be signed by a licensed resident or attending. Under no circumstances is a patient to be allowed to leave University Medical Center until the student's findings and plans are confirmed and approved by a senior resident or Attending.

Evaluations of students' performance may be requested from residents for each student under his/her instruction. These are to be filled out online and returned to the clerkship directors.

V. ADMINISTRATIVE PRACTICES

A. Resident Agreement

The Residency Agreement (contract) is issued to the resident prior to commencement of the initial year. While only one Agreement is issued, it is intended to cover the entire training period provided the Resident receives a renewal letter to advance to the subsequent years of training. Each resident will receive a copy of the fully signed Agreement. Originals are available in the Residency Office for reference. After the first Agreement is signed, any subsequent renewal is communicated in writing to the resident. Any resident who does not wish to renew his/her Agreement must notify the Residency Office 120 days prior to the renewal date.

B. Other Handbooks

In addition to the Residency Agreement and the Handbook, residents are required to comply with:

- [UA HR Handbook](#)
- [UA Staff Handbook](#)

C. Compliance Training

1. **HIPAA, Infection Control, Confidentiality Agreement:** CCHS requires mandatory training in certain essential areas at the beginning of employment and annual renewal thereafter. Certification is documented via the resident signing and submitting an acknowledgement form. These training courses and the acknowledgement form can be found on the CCHS Intranet site.
2. **Harassment:** The University of Alabama is committed to providing an environment for employees, students, and campus visitors that is free from illegal harassment based on race, color, religion, ethnicity, national origin, sex, sexual orientation, age, disability, or veteran status. Such illegal harassment violates federal civil rights laws and University nondiscrimination policy and may lead to personal liability of the results of such behavior. Residents should become familiar with the University's Harassment Policy, which is also the same policy adopted by CCHS in its role as the Sponsoring Institution for the residency program (see the Harassment Policy. The Designated Harassment Person in the College of Community Health Sciences is Allison Arendale; complaints about harassment may be directed to her.

Pornographic material of any kind (videos, screen savers, posters, etc.) is prohibited in any portion of the College or other sites in which the resident is assigned.

3. **Working with Minors:** Minors are a part of your patient panel as well as the possibility of shadow students; therefore, training is required to protect yourself as well as the minor child. All University training courses regarding child protection training must be completed as required.
4. **Other courses** can be deemed mandatory and required to be completed by the resident as determined by the College and/or University.

D. Benefits

The College of Community Health Sciences (CCHS) and the Capstone Health Services Foundation (CHSF) will provide the residents with the following:

1. Advanced Cardiac Life Support (ACLS)
2. Advanced Life Support in Obstetrics Certification (ALSO)
3. Advanced Trauma Life Support Certification (ATLS)-up to \$400
4. Alabama Academy of Family Physicians membership (optional)
5. Alabama Controlled Substance fees
6. Alabama Medical Licensure Commission fees
7. Alabama State Board of Medical Examiner fees
8. AMA Introduction to the Practice of Medicine web-based program

9. American Academy of Family Physicians membership
10. American Board of Family Practice In-Training Assessment Exam fees
11. American Medical Association membership fees (included)
12. Board Exam Fees
13. Copays are waived for services provided at University Medical Center for you and your dependents who are on UA's Blue Cross/Blue Shield Health Insurance plan. Resident is responsible for any applicable deductibles and non-covered services.
14. DCH Regional Medical Center Meals-provided during months with inpatient call; on call residents receive \$196 per month, night float residents receive \$252. A maximum of \$20 per day may be deducted for food (approximate; subject to change).
15. DCH Regional Medical Center Medical Staff privileges
16. Educational Reimbursement (CME funds)-up to \$1000 for each of the three years
17. Examination and Board History Report
18. Federal Drug Enforcement Agency (DEA) license-one time only
19. Lab Coats (2)
20. Neonatal Resuscitation Program Certification (NRP)
21. Occurrence Malpractice Insurance
22. Pager- to be returned at completion of residency
23. Parking permit codes to DCH parking lot
24. Pediatric Advanced Life Support Certification (PALS)
25. Portable disability insurance (with buy-up plans available at extra cost to the resident)
26. Relocation Reimbursement- up to \$1500
27. University of Alabama Business Cards
28. University of Alabama Parking Pass
29. University of Alabama Staff ACT card
30. USMLE 3/COMPLEX Level 3 Application fees

If a resident receives a bill/statement from any of the above, he/she should promptly submit it to the Residency Office for payment.

The University of Alabama offers an array of benefits for the residents, about which details may be found on the [UA Benefits website](#). UA has also provided a [Benefits Summary Guide](#), and page three shows a convenient one page summary of the benefits.

Residents are responsible for completing their benefit enrollment process on line within the first 30 days of employment. Failure to do so will result ineligibility status until official open enrollment period.

Residents are responsible for paying:

1. Alabama Academy of Family Physicians Resident Chapter Dues – \$20 annually (optional)
2. Moonlighting Malpractice Insurance – PGY-2 and PGY-3; also involves membership in the Medical Association of the State of Alabama

3. DEA Renewal – PGY-3
4. TFPRA Dues – \$125

E. Salary/Paychecks

The University of Alabama allows residents to be given a graduated salary. The current salary is specified in the Residency Agreement. Residents will be paid in 12 equal monthly installments on the last day of each month and will be subject to such withholdings as required by law or authorized by the resident. Any questions concerning monthly paychecks should be directed to the University of Alabama Payroll Office at 348-7732. Residents are considered staff of The University of Alabama with regard to participation in fringe benefit programs, athletic/social/cultural events, use of University facilities, participation in University governance, parking privileges, and University services. Residents are neither employees nor agents of the University, and the University assumes no liability for negligence or other wrongful acts of the resident.

Salaries are determined each year based on the budget of the Residency Program from the College of Community Health Sciences and DCH Regional Health System.

Such salaries are not intended as compensation for services rendered by the resident. Although it is believed that it is an essential part of residency that the resident will be assigned responsibility for care of patients under the supervision of faculty physicians and consistent with his/her skills and experience, receipt of the agreed upon salary shall in no way be conditioned upon, measured by, or related to any patient care service rendered by the resident incidental to the training program. Furthermore, the resident understands that receiving direct patient care compensation is considered “moonlighting,” which is subject not only to the rules of the University of Alabama Family Medicine Residency-Tuscaloosa Program and the ACGME, but also to various federal laws stipulated by the Centers for Medicare and Medicaid Services (CMS).

Paychecks: You are considered an exempt employee and are paid on the last day of each month. An email notification of your direct deposit will be sent a few days before the deposit is made. The first paycheck must be picked up at Rose Administration. The email notification will go to your MyBama email. You should forward your MyBama email to your CCHS email account for ease of reference.

F. Malpractice Coverage

For residency duties, The University provides an occurrence-based malpractice policy through the University of Alabama at Birmingham Professional Liability Trust Fund. This policy covers the resident during his/her official duties. **Moonlighting is not covered by this liability policy.**

G. Leave/Other

If there is no properly prepared leave request with the approval signature of the Residency Director or his/her designee, THERE IS NO LEAVE.

Summary:

1. Resident must be present for a minimum of 15 days to pass a one-month rotation (which normally has 20-22 working days).
2. Leave requests must be submitted at least 60 days in advance. No leave requests will be considered if they are less than 30 days in advance unless extraordinary circumstances can be demonstrated. The Residency Director must approve any exceptions. Vacation will not normally be approved at a time when it will reduce the call team to fewer than four. Cancellations of vacations must be made in writing.
3. Leave is not permitted on primary services except in extraordinary circumstances. In such situations, resident must provide written justification as to why the leave should be approved.
4. No one may take annual leave during the first two weeks of July OR the last two weeks of June. No exceptions.
5. Administrative or Educational leave requires a copy of the brochure/related email before request can be considered. No more than five days of educational or administrative leave will be granted per academic year and does not roll over if unused.
6. Coverage must be arranged for Family Medicine clinics if request is made less than 60 days and the clinic schedule is published (at Residency Director's discretion).
7. It is the responsibility of the resident to notify via email the rotation preceptor, Family Medicine suite, the Residency Office, the service, and clinic to which he/she is assigned of his/her forthcoming absence.
8. Cancellations and changes to approved leave must be made in writing. All clinic schedule changes must be approved by the Residency Director.
9. Once a resident has exhausted leave (annual/sick), additional time off may be taken as leave without pay.
10. Sick leave may only be used for illness of resident or other family member as outlined below. Sick leave may not be used as annual time. Once sick leave is exhausted a resident may use annual leave as sick leave.
11. NOTE: At any given time between 8:00 am and 5:00 pm Monday through Friday, residents should either be on rotation, in clinic, in academics, or have a properly prepared and approved leave request.

Total Absence from the Residency

In accordance with guidelines from the American Board of Family Medicine (ABFM), total time away from residency should not exceed 30 calendar days (20 work days) a year. This includes vacation time, sick leave, etc. Time in excess of 30 days must be made up

prior to graduation. In addition, residents may not be away from their continuity clinic for more than one month in the first year and two months in each of the second and third years. This total time away includes Supervised Practice Experiences and rural rotations in which residents do not continue their continuity clinic.

1. Vacation:

Each resident is permitted two weeks (10 working days) of paid vacation per year, plus one week at Christmas/New Year. Unused vacation time does not accrue from year to year. During the PGY-1 year, these weeks may be taken during following rotations: Geriatrics, Surgery, CM/PM, EKG/Vent. Any on-call weekend days requested as part of a vacation will not be considered unless coverage is arranged and listed on the request form.

- When anticipating leave while on a rotation associated with University Medical Center specialty clinics (Pediatrics, Psychology, Neurology, Sports Medicine), coverage arrangements must be made and listed on the request form.
- Other suggested vacation rotations include: Rural Medicine, Supervised Practice Experience, ED, Orthopedics, Cardiology, Procedures, Dermatology or other electives.
- Leave may not exceed one week during any rotation. Requests for two consecutive weeks of leave spanning two different rotations in two different months will be considered on a case-by-case basis. No leave will be allowed on split rotations or two week rotations.

2. Sick Leave:

Residents accrue sick days at one per month for a total of 12 a year. Sick leave is cumulative. On the morning of an absence, the resident must notify via phone or email his/her service and preceptor, his/her suite, and the Residency Office as soon as possible. Resident should arrange coverage for responsibilities as able.

Sick days may be requested in advance for physician appointments or scheduled medical procedures. Unexpected illness occasionally occurs. All days taken for sick must be claimed upon return to work. Any sick leave in excess of 72 hours must be accompanied a physician's statement and release to return to work.

Additional Guidelines for Use of Sick Leave:

Sick leave is not an earned right, but a privilege, and should be taken only for reasons provided in this policy. Residents may be required to provide documentation for absences.

Eligible residents may be granted sick leave when they:

- Are unable to perform their duties because of personal illness or injury.

- Must attend to the serious illness of relatives who reside in the immediate household.
- Must attend to the serious illness of their parents (including current step-parents or legal guardians).
- Must obtain health-related professional services that cannot be obtained after regular working hours.

When conditions within the work unit dictate the necessity, the supervisor may require a resident to reschedule an appointment.

3. Family and Medical Leave Act:

In accordance with the Family and Medical Leave (FML) Act of 1993, eligible residents may take FML as provided in the [University Policy Manual](#). The FML policy can be directly found [here](#).

FML provides up to 12 weeks of leave for the following reasons:

- Birth and care of the resident's child or the placement of a child with the resident for adoption or foster care.
- Serious health condition of the resident OR the serious health condition of the resident's spouse, dependent child, or parent.
- A military qualifying exigency OR military caregiver leave to care for the resident's spouse, child, parent, or next of kin.

Residents should be aware that protracted FML absences may affect time toward board eligibility. Interns should be aware that they will not qualify for FML and should seek guidance and assistance from the [Office of Disability Services](#).

4. Accommodation for Disabilities: Residents who have a physical or mental impairment that substantially limits one or more major life activities and who are able to perform the essential functions of their jobs are entitled to seek reasonable accommodations designed to assist them in the performance of their jobs without placing an undue hardship on the University or posing a direct threat to other individuals, including patients. The University's Department of Human Resources coordinates employee requests for workplace accommodations. Residents should make accommodation requests by completing an Employee Accommodation Request Form, available at www.hr.ua.edu/ada, which also has contact information for Human Resources' ADA Coordinator and other information about the University's compliance with Section 504 of the Rehabilitation Act of 1973 and the Americans with Disabilities Act.

5. Administrative Leave:

Residents may be granted administrative leave for activities whereby they directly represent the College of Community Health Sciences and the University of Alabama

Family Medicine Residency-Tuscaloosa Program (e.g., national and regional residency meetings, presentation of papers, residency fairs, etc.). Applications for administrative leave will be submitted and processed in the same manner as all leave requests. No administrative leave will be granted for more than five working days per academic year.

6. Holidays:

The eight holidays typically enjoyed by The University of Alabama are New Year's Day, Martin Luther King Jr. Day, Fourth of July, Labor Day, Thanksgiving Day, the Friday after Thanksgiving, Christmas Eve Day and Christmas Day. University Medical Center is closed on these days and hospital services operate on weekend schedules. UMC is open during the Christmas/New Year's holidays and residents should not make vacation/holiday plans until the CCHS establishes its annual holiday schedule.

Martin Luther King Jr. Day, Fourth of July, and Labor Day observe the following rules (see call schedule for details):

- Primary service interns and residents round, even if they are not on holiday call. If they are not on call, they go home after rounds and floor work.
- Call teams remain in-house (weekend-like staffing).

Night Float Teams are off the night before the holiday, but come in at 5:00 on the night of the holiday. Thus, the day before the holiday, the call team does a 24-hour shift.

7. Practice Site Visits:

A total of five days may be allowed in the PGY-2 and/or PGY-3 year for investigating available practice sites. Residents must apply for these days on the appropriate form, listing the name and location of the practice as well as the names and contact numbers of the personnel involved in the meeting. The Residency Office must approve the actual site visit day(s). Site visit days may not be approved if charts are not current, academic status is in questions, or if rotation attendance has been an issue. Cancellations of site visit days must be made in writing.

8. Educational Leave:

Educational leave will not normally be approved at a time when it will reduce the call team to fewer than four. A total of five days are available for both the PGY-2 and PGY-3 years, but cannot be carried over. Leave must be requested 60 days prior to the requested dates. A request form should be submitted with written documentation (e.g., brochure) of the conference. Residents may use CME funds for educational leave (e.g., ATLS, etc.).

Coordination and scheduling of USMLE Step 3 and the ABFM Boards is the responsibility of the resident, but leave for these exams must be approved before scheduling. Avoid scheduling during call or primary services. Time off a primary service will only be approved in extenuating circumstances.

9. Intern Retreat:

It has been the tradition at the University of Alabama Family Medicine Residency-Tuscaloosa Program for the upper level residents to provide the interns with a few shifts off near the conclusion of their internship. The Intern Retreat will occur during the last weekend of April. The location and other details for the retreat will be coordinated by the interns. The retreat starts at noon on Friday and ends at 7:00 pm on Sunday. The Chief Residents will coordinate call coverage.

Interns not participating in the official Intern Retreat activities will be expected to cover their own call shifts and clinics. Additionally, such interns may be assigned for daytime call coverage of primary services in lieu of their regular rotation.

10. Workplace Relationships:

Those who are romantically involved cannot be in the same reporting structure, and one party cannot have undue influence over the other's career and/or advancement. The University of Alabama has a [Consensual Relationship Policy](#) that residents are required to abide by.

H. Risk Management, Conversations with Attorneys, Safety Learning Reports:

If a resident receives communication from a lawyer, patient, or insurance company about possible litigation, the resident should immediately **telephone** the UAB Director of Risk Management (Claire Owens, 205-934-5551). Ms. Owens will instruct you who else to notify, and she will advise you to restrict your communications regarding a possible litigious situation to oral communications. **DO NOT address the specifics of any potential malpractice case in writing, email, text or social media content.** Also inform the Residency Director of your conversation with Ms. Owens. As appropriate, the Residency Director may ask you to update the Chief of the service directly related to the potential case, but here again, do so via oral communication only. Ms. Owens will be responsible for obtaining any documents she needs to review, as this allows her to protect certain confidential information and assists her in the discovery process. You are not to gather any information for her unless specifically requested by her. No resident should give any information personally or over the phone to an insurance carrier or lawyer other than our own without permission from Ms. Owens.

Early recognition and full reporting of potential claims will often lead to clarification and resolution of patient dissatisfaction and prevention of litigation. When this process reveals a legitimate error, early resolution of the issue often prevents long, drawn out, costly, and emotionally wearing litigation.

Sensitivity to dissatisfaction on the part of the patient, his or her family, or “significant others” is an essential skill for successful practice. Clear communication with patients and families, coupled with that sensitivity, is the best protection against professional liability claims.

Safety Learning (incident) Reporting is an opportunity to document instances where patients or families even hint that they are dissatisfied or that they are considering seeking legal advice. Suspicion of such reports will not be construed as evidence of poor performance on the part of the resident, but rather that the resident is sensitive and aware of patient and family attitudes that are not favorable to the doctor-patient relationship.

I. Immunizations

Hepatitis Immunization – Since residents are among the high-risk group for hepatitis B, they will be screened for susceptibility if they have not been screened previously. All individuals found to be susceptible will be notified and required to obtain hepatitis immunization. Capstone Health Services Foundation will pay for the immunization.

- TB Testing – Residents will receive free yearly PPD tests.
- Varicella Testing – All residents who have not had chickenpox will receive two doses of varicella vaccine (VARIVAX).
- MMR – All residents are required to have two doses of measles/mumps/rubella (MMR) vaccine since their first birthday. Residents who are unsure of their immunization will receive MMR.

N95 Mask Fitting – All residents will be required to be fitted for an N95 mask annually.

Flu Shot – Residents will receive free yearly flu shots. Those who choose not to have a flu shot will be required to wear a mask in the clinic areas throughout flu season in keeping with University Medical Center policy.

J. Chief Resident Selection:

As well as being a representative and leader among his/her peers, the Chief Resident position has many junior faculty level administrative responsibilities, often occurring after-hours. The Chief Residents will typically be chosen in January to facilitate work on the residency master schedule. The Chief Residents will be expected to attend quarterly Department meetings at DCH. The full transfer of responsibility will occur in April (after the match). The selection of the Chief Residents begins with resident nomination

and ranking. The faculty then reviews the resident ranking and they provide a ranking. The Residency Director makes the final selection, taking the final rankings into account. No resident will be considered for Chief Resident unless they are in good academic standing, as determined by the residency faculty.

The IT Chief will see that the resident computers and printers at the hospital are maintained, troubleshoot resident issues with remote desktop and NextGen, and work with DCH and UMC IT departments to continue to improve on our operating systems.

K. Committees:

Residents will be assigned to committees of the College and DCH. Once appointed, it is expected that residents will attend committee meetings and be active participants. After the training period ends, memberships on committees will be part of your normal work environment. Learning how to be an active participant and a contributor on committees is part of the training program and offers the resident an opportunity to demonstrate professionalism. Residents should expect their involvement on committees to be tracked and part of the routine discussions with their academic advisor.

L. USMLE Step3:

USMLE Step 3 should be taken and passed by January 1 of the PGY-2 year for those who are eligible. If not, the resident is subject to “Academic Probation” resulting in extension of the PGY-2 year or non-renewal of the contract. Residents will not be promoted to PGY-3 without passing Step 3. Failure of Step 3 twice is automatic consideration for dismissal from the program.

Coordination and scheduling of USMLE Step 3 is the responsibility of the resident, but leave for this exam must be approved before scheduling. DO NOT schedule your exam during call, night float or primary services. Time off a primary service will only be approved in extenuating circumstances and you will be responsible for finding your own call coverage (which must be submitted with your leave request). Due to the scheduling process for Step 3, we realize the 60 day notice may not be feasible. However, residents should submit their leave request to take Step 3 no fewer than 30 days before their intended test date.

M. Licensure

Medical-First-year residents are issued a limited license that is paid for by the University. This license limits the residents to activity within the supervision of the UAFMR-T only. After one full year of training and passing USMLE Step 3, the resident may apply for a full license paid for by the University. Thereafter, the license must be renewed annually by the resident. Resident CME funds may be used for this purpose.

NOTE: International medical graduates are not allowed to obtain a full license in the state of Alabama until they have completed residency.

N. Controlled Substance

Each resident is required to have an Alabama Controlled Substance Certificate. The University pays this fee. The resident is also required to have a Federal DEA Certificate in order to prescribe controlled drugs. The Residency Office makes arrangements for Federal DEA numbers when residents enter the program. The DEA certificates are good for three years. Approximately six months before completing the program, the DEA will send renewal information directly to PGY-3 residents who will then be responsible for the renewal fee. No resident will be allowed to work without an active and fully-unrestricted DEA certificate.

O. Miscellaneous

1. Mailing Address:

Business Address

850 5th Avenue East, D209
Tuscaloosa, AL 35401

Or

Box 870377
Tuscaloosa, AL 35487

Business mail arrives at UMC and is sorted. The Residency Office opens insurance and patient related mail. To avoid personal mail being opened by mistake, please use your home address. ALL LICENSES SHOULD BE SENT TO THE RESIDENCY OFFICE RATHER THAN YOUR HOME ADDRESS. All magazines must be sent to your home address and not University Medical Center to avoid cluttering of mailboxes. The residency will pay for residents' American Academy of Family Physician membership dues. All residents will thus receive a bi-monthly copy of the *American Family Physician journal*. This is REQUIRED reading and bi-monthly quizzes are a part of our required curriculum. An average quiz score of 80 percent is required for promotion from one post-graduate year to the next.

2. Phone Calls for Residents:

Friends or family members needing to reach a resident should first call the Residency Office Assistant (Stephanie Beers) or the Residency Program Coordinator (Alison Adams) at 205-348-1370. The staff of these offices will either page the resident (if it is an emergency) or email the resident a message.

The DCH Regional Medical Center operators are not asked to page a resident unless it is an emergency and the resident cannot be reached through the number above. At night, the resident can be reached by calling the Resident's Lounge at 205-750-5860 and asking that the resident be paged.

Please do not give these numbers to physician recruiters. Make arrangements to take recruiting calls at home.

VI. SIGNATURES

I hereby certify that I have received, read and reviewed the Sponsoring Institution policy manual and the University of Alabama Family Medicine Residency-Tuscaloosa Program Handbook (which may be amended periodically by the University, College and Program). I know these resources are maintained online and it is my responsibility to stay current via electronic access. I understand that I will be accountable for adhering to the policies and procedures both referenced and included herein and conducting my duties in the workplace in accordance with the information contained in this and other referenced policy manuals and/or handbooks.

Printed Name/Signature

Date