

The University of Alabama - Tuscaloosa Family Medicine Residency Handbook 2021-2022

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I. INTRODUCTION

This Handbook contains general and specific information regarding the 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 annually reaffirms its 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 - Tuscaloosa Family Medicine Residency

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 - Tuscaloosa Family Medicine Residency Program was started in 1974, and the first class of residents graduated in 1977. Today, one in seven family medicine physicians practicing in Alabama graduated from our program.

The University of Alabama - Tuscaloosa Family Medicine Residency Program 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 620-bed DCH Regional Medical Center in Tuscaloosa, which is the referral hospital for West Alabama. Our program 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, CCHS has developed fellowships through UATFMR to enhance the education of family medicine physicians. The College offers fellowships in sports medicine, hospital medicine, geriatric medicine, obstetrics, emergency medicine, pediatrics and rural public psychiatry.

In 2012, the program 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 resulting in a total of 48 residents as of 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, UATFMR has placed more than 500 physicians into practice in 30 states, including Alabama, Arkansas, Florida, Georgia, Louisiana, Mississippi, Tennessee, North Carolina, South Carolina, Oklahoma, Texas, and Virginia.

More than half of the program's 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 rural Alabama and the Southeast region through leadership in medical and health-related education, primary care and population health; the provision of high quality, accessible health care services; and research and scholarship.

To accomplish this mission, we will:

Strategic Priority 1: Shape globally capable, locally relevant and culturally competent physicians through learner-centered, innovative, community-based programs across the continuum of medical education.

Goal 1: Address the physician workforce needs of Alabama and the Southeast region by being the standard of excellence in medical student education and family medicine residency and fellowship education.

Residency and Fellowship Education

Metrics:

- Final report(s) from GME and LEAN consultants
- Number of fellowship training programs
- Board passage rates (target: above national average)
- Patient satisfaction results
- Resident evaluations of clinical experiences
- ACO quality scorecards
- Number of rural rotations
- Percentage of graduates practicing within AL and SE
- Number of presentations or poster sessions at regional and national meetings
- Number of residents on national boards/committees
- Resident and fellow graduation rates
- Resident/fellow evaluations of faculty
- Resident/fellow evaluations of training programs
- Ongoing and continuous accreditation without citation
- Track residency graduates over time (target: increase the number of primary care and community-based physician graduates and their geographic distribution)

Initiatives:

- Conduct a self-study on the current state of family medicine residency training through the engagement of external consultants focusing on ACGME compliance, continuity clinic efficiency, and response to the needs of Alabama's population.
- Conduct a needs assessment study to determine if we need additional family medicine-based residency or fellowship training programs targeted to address the needs of Alabama and the Southeast region.
- Provide excellent curricular and clinical experiences by enhancing resident training in the learning environments fostered within a culture of quality improvement and patient safety leading to superior clinical outcomes.
- Provide residents with rural and community-based experiences that will stimulate their inclusion and retention as primary care physicians addressing the needs of Alabama and the Southeast and monitor the impact.
- Provide regional and national scholarly experiences, challenging and "outside the box" leadership opportunities, along with unique electives.
- Continue to develop the integrated residency program.

2. Program AIMS

- Shaping globally capable, locally relevant and culturally-competent physicians through learner-centered, innovative, community-based programs across the continuum of medical education

- Addressing the physician workforce needs of Alabama and the Southeast region by being the standard of excellence in family medicine residency education
- Engaging communities as partners, particularly in rural and underserved areas, in efforts that improve the health of the people of Alabama
- Providing high quality, patient-centered and accessible clinical services delivered by health care professionals of all disciplines
- Being a leader in health equity and outcomes research by producing innovative, community-oriented research and scholarship focusing on improving population health.
- Fostering a diverse, equitable, and inclusive environment where everyone's contributions are valued
- Maintaining a culture of resident well-being and professional success of all residents, faculty and staff by providing the resources necessary to grow personally and professionally

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 (main), UMC-Northport (UMC-NP), and UMC-Demopolis clinics. UMC (main), 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 (main) primarily serves as a training site for medical students and our family medicine residents. Two of our clinical sites serve as ACGME accredited continuity clinics, UMC (main) and UMC-Northport. All three of our clinics operate under a common set of UMC-wide policies and procedures and fall under the oversight of CHSF and CCHS leadership personnel.

4. Faculty

CCHS has approximately 90 faculty members in the following departments:

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

C. Overview of Residency's Goals

1. ACGME Competencies

The residency program implements the family medicine milestones project and provides residents with biannual feedback regarding their progression in the six ACGME

competencies. 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:

- a. **Patient Care** that is compassionate, appropriate, and effective for the treatment of health problems and the promotion of health.
 - Care of the Acutely Ill Patient
 - Care of Patients with Chronic Illness
 - Health Promotion and Wellness
 - Ongoing Care of Patients with Undifferentiated Signs, Symptoms, or Health Concerns
 - Management of Procedural Care
- b. **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.
 - Demonstrates Medical Knowledge of Sufficient Breadth and Depth to Practice Family Medicine
 - Demonstrate appropriate critical Thinking and Decision Making
- c. **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 demonstrate competency in:
 - Patient Safety and Quality Improvement
 - System Navigation for Patient-Centered Care
 - Physician Role in Health Care Systems
 - Advocacy
- d. **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 demonstrate competency in:
 - Evidence-Based and Informed Practice
 - Reflective Practice and Commitment to Personal Growth
- e. **Professionalism**, as manifested through a commitment to carrying out professional responsibilities and an adherence to ethical principles, with expected demonstration of:

- Professional Behavior and Ethical Principles
- Accountability/Conscientiousness
- Self-Awareness and Help-Seeking Behaviors

f. Interpersonal and Communication Skills that result in effective information exchange and teaming with patients, their families, and other health professionals. Residents are expected to demonstrate competency in:

- Patient- and Family-Centered Communication
- Interprofessional and Team Communication
- Communication within Health Care Systems

Mental Health

CCHS provides residents and fellows access to no-fee, confidential counseling services for individual and/or relationship counseling. The only information that the counselor shares with us is the number of individuals served per month in order to determine whether or not to continue offering the service.

Who: Mona Ochoa-Horshok, LPC

What: Confidential Counseling

Cost: Free to Residents, Fellows, and UASOM-Tuscaloosa Medical Students

When: Two evenings a month, between 5:30 and 7:30 pm

Where: UMC - Please contact Mona for an appointment.

Appointments: mochoahorshok@gmail.com or Call/Text (205) 393-9029

Physicians have a higher frequency of drug abuse, burnout, 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 CCHS recognizes the potential for emotional difficulties among residents and the need for assistance. Physicians in training who are having difficulty may bring this to the attention of the Residency Director or their Advisor without fear of consequence or disapproval. Confidentiality is important. Residents are encouraged to consult with the psychiatry and behavioral medicine faculty in CCHS.

If there is interest in obtaining assistance outside the College, several professional resources are available. A brief directory of community resources includes:

The University of Alabama Employee Assistance Program (EAP)

The University of Alabama has contracted with American Behavioral to provide professionally trained counselors to give you options and resources for coping more effectively with a variety of life challenges.

[American Behavioral](#) is a full-service behavioral health care organization with a nationwide network of licensed and credentialed providers in 38 specialties. Eligible employees and dependents residing in Tuscaloosa, outside of Tuscaloosa, and even out-of-state have expanded access to highly-qualified EAP counselors.

To locate an EAP Provider in your area, find out more information about how the EAP may help you, or to schedule an appointment, contact American Behavioral at (800) 925-5327.

Other Resources

Indian Rivers Community Mental Health Center: (205) 345-1600

UMC Psychiatry Department: (205) 348-1265

Alcoholics Anonymous: <https://sites.google.com/site/tuscaloosaanon/>

Alabama Professionals Health Program: (334) 954-2596

D. Lines of Authority/Hierarchy

The University of Alabama – Tuscaloosa Family Medicine Residency Program (UATFMR)
RESIDENCY LEADERSHIP

Dr. Tamer Elsayed, Family Medicine Residency Director

Dr. Jane Weida, Chair, Family, Internal and Rural Medicine Department

Dr. John E. Burkhardt, Assistant Residency Director for Behavioral Science

Dr. Jared S. Ellis, Associate Residency Director for Inpatient Curriculum and Safety

Dr. Louanne Friend, Assistant Residency Director for Research and Quality Improvement

Dr. Anne D. Halli-Tierney, Assistant Residency Director for CLER Pathways of Excellence

Dr. Connie Leeper, Associate Residency Director for Curriculum

Alison Adams, Residency Program Coordinator

Genia Condra, Residency Program Coordinator

Jeremy Cole, Residency Program Administrative Assistant

SPONSORING INSTITUTION: The Residency's sponsoring institution is The University of Alabama's College of Community Health Sciences, whose Dean is Richard Friend, MD. Additionally, the program reports to the Associate Dean for Academic Affairs (Thad Ulzen, MD), and to the Designated Institutional Official (DIO), Daniel Walters. The Sponsoring Institution (SI) has an official Policy and Procedure Manual consistent with ACGME 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 policies, which is the set of program-specific and institutional policy requirements.

ADMINISTRATION STRUCTURE

The Graduate Medical Education Committee (GMEC) is the Residency oversight committee. It is chaired by the Residency Director with voting members including the DIO, Residency Director, Accredited fellowship directors, peer-selected residents and fellows, a Patient Safety/Quality Improvement Officer or designee and a representative from the Major Participating Site (DCH Regional Medical Center). This committee monitors and addresses institutional and accreditation issues that affect all graduate medical education programs of the College.

The Program Evaluation Committee (PEC) is responsible for educational changes that may affect the program. It is chaired by the Residency Director, with voting members including a faculty member from each major discipline contained within the curriculum and resident representatives. The PEC is responsible for the Annual Program Evaluation (APE) and 10-year Self-Study.

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 CCHS for resident salary and benefits.

ACCREDITATION

The Accreditation Council for Graduate Medical Education (ACGME) is the accrediting institution for Allopathic and Osteopathic residency programs in the United States. UATFMR 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 Family Medicine 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 uafmr@ua.edu.

II. POLICIES

As previously stated, the Sponsoring Institution (SI) has an official Policy and Procedure Manual consistent with ACGME requirements. UATFMR 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.

The SI Policy Manual is maintained online and accessible via the CCHS Intranet. 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. [Program Closures and Reductions](#)
16. [Drug and Alcohol](#)
17. [Probation-Remediation-Suspension](#)
18. [Professional Appearance Policy](#)
19. [Well Being, Fatigue Mitigation and Monitoring](#)

Residency Policies – These are policies that apply to UATFMR residents 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 UATFMR residents.

1. [Inpatient Medicine Guidelines](#)

The Residency Handbook is further divided into the following subsections containing information about our Clinical and Educational practices, as well as administrative issues residents 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 and responsible behavior 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(s). Each resident is assigned an advisor to mentor them with their educational goals. Residents will receive semiannual formative feedback from the Clinical Competency Committee (CCC) regarding their performance and progression according to the Family Medicine Milestones project.

C. Outpatient Clinical Duties

1. Overview

Residents' patient panels in continuity clinic are assigned for the duration of training. 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 our emergency departments. A resident may add family members of patients who are currently assigned to their panel at any time by notifying clinic nursing supervisor.

Expected average continuity clinic schedule for residents per PGY level

PGY-1	PGY-2	PGY-3
1-2 clinics per week	3 clinics per week	4-5 clinics per week

2. University Medical Center and UMC-Northport:

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

- i. Residents are not permitted to care for or write prescriptions for their own family.
- ii. CCHS nursing, administrative staff and other residents may not have a resident as their primary care provider.
- iii. Clinic schedules are determined by the assigned rotation, prepared by the Residency Office, and typically available three to six months in advance.
- iv. Residents are expected to be at clinic 15 minutes before clinic to allow for huddles with medical staff. If late for a scheduled clinic, the Residency Office and suite charge nurse must be notified via email and telephone so patient can be rescheduled or seen by another physician.
- v. Clinic cancellation requests must be received by the Residency Office via email or in writing 90 days in advance. Same-day cancellations may only occur due to emergency situations, such as acute illness, and must be done with a personal call to the charge nurse as well as the Residency Office.
- vi. Residents are responsible for completing and signing patient paperwork in the resident folder by the end of the business week.
- vii. Residents are responsible for completing and signing off all EMR PAQ by the end of the business week. Urgent items should be addressed within 1 business day.
- viii. Residents are to monitor their EMR task box daily and respond to patient request and staff messages within 1 business day.
- ix. Residents are expected to accommodate same day or work-in appointments for established UMC patients if they have capacity in their schedules.

b. Precepting Patients in Clinic:

- i. PGY-1 residents must consult with the attending about each patient. An attending must examine **EVERY** patient during the first six months of PGY-1.
- ii. During the second six months of PGY-1 residents continue to check-out **EVERY** patient encounter to an attending physician.
- iii. Residents will have an attending available to address questions.

- iv. With Medicare, Tricare and Federal BCBS insurances, residents are required to consult with an attending who **MUST** see all these patients.
- v. Residents are required to check out at least **one to two** patients per clinic session to an attending.
- vi. Residents are required to complete a clinic evaluation with the attending at the end of each clinic session.
- vii. Medicare telemedicine visits must be presented to the attending physician at time of visit and attending must directly interact with the patient. Other telemedicine visits must be presented to attending physician on the day of the visit.
- viii. Residents are expected to be present in clinic for regular business hours.

c. Release of Protected Health Information (PHI)

i. General Expectations and the Electronic Medical Record (EMR):

There is a 24-hour availability of electronic medical records systems (UMC/DCH) by computer. Residents are expected to comply with all UMC and DCH 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 releases 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. All attending faculty must personally see all Medicare patients, Tricare, and Federal BCBS patients.
2. All attending faculty must be present for all key portions of a procedure regardless of insurance to be able to bill appropriately.

iv. **Incomplete Charts**

Incomplete charts are defined as any clinic visit or procedure note not completed within 72 hours of the encounter. The Residency Office will inform residents of charts that have been incomplete for more than 48 hours. Residents will have 24 hours to complete all charts after receiving these notifications. If the resident has not completed the charts by 8:00 am of the next business day following notification, the resident will be pulled off their rotation and meet with the Program Director to discuss disciplinary action (e.g. Docked vacation time, additional inpatient call, etc.).

Timely completion of patient records is good patient care and required professional behavior for a practicing physician. 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. Residents should document the visits. Attendings will submit charges for billing. Residents shall be responsible for coordinating any questions or concerns about charges to patients. Specific policies are outlined below.

ii. **[Uninsured/Underinsured Policy:](#)**

Indigent or uninsured patients should be referred to Social Services at 348-7195.

e. **Other Clinical Procedures**

i. **Medical Transportation:**

Patients requiring transfer to DCH for emergency care or admission will be presented to an attending and will not be transported to DCH without attending authorization.

ii. **Transfer of Patients:**

All patients who request a change in their assigned physician should be referred to the nursing supervisor or Clinic Director.

iii. **Dismissal of Patients:**

UMC has a specific policy on the dismissal of patients. Residents may request that a physician-patient relationship be terminated. Residents must receive dismissal approval from an attending, who must review the patient's chart, ensuring compliance with the dismissal policy. There should be no omissions in the standard of care and no indiscreet remarks made in or removed from the chart. The attending will then initiate dismissal procedures as outlined in the policy. Patients have 30 days from the date on the dismissal letter to find a new physician. If urgent medical care or prescription refills are needed during this period, the resident on 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 within the EMR. 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.**

v. **Sensitive Physical Examination Process:**

A chaperone must be present and noted by name in the EHR for all sensitive examinations. A chaperone may assist the provider with the examination. Please refer to policy state for full details of the policy.

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 must perform and log a minimum of 2 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

Residents are assigned two nursing home patients at the beginning of PGY-2.

Residents will provide primary care to patients with indirect supervision during the PGY-2 and PGY-3 years. Residents are expected to visit nursing home patients monthly and must complete a total of 24 nursing home visits. Residents may see nursing home patients independently; however, an attending must be present with the resident in order to bill for the services rendered in the nursing home.

Minimum Required Nursing Home Visits per PGY

PGY-2	Must perform and log 6 nursing home visits by December 15th
PGY-2	Must perform and log 12 nursing home visits by June 15th
PGY-3	Must perform and log 18 nursing home visits by December 15th
PGY-3	Must perform and log 24 nursing home visits by June 15th

IV. EDUCATIONAL PRACTICES

A. Professionalism

Professionalism is one of the core competencies the ACGME has identified as being vital to the clinical practice of medicine and resident development. The Professionalism Policy must be signed and submitted to the Residency Office.

“Windfall” and Professionalism:

Occasionally, there will be rotations where the preceptor is absent or releases the resident to leave early. The preceptor being absent does not excuse the resident for the day. When this occurs, it is the resident's duty to immediately notify the Residency Office. The resident is expected to be reachable by pager during the workday, unless they have notified the Residency Office that they will be taking leave.

B. Curriculum

1. Overview of the Curriculum: 13 blocks per year

- **PGY-1**
 - **Call rotations**
 - FM Inpatient – 3 blocks
 - Inpatient OB/GYN – 2 blocks
 - Inpatient Peds – 1 block
 - Ambulatory Peds – 1 block
 - Medicine Night Float – 1 block
 - OB Night Float – 1 block
 - Geriatrics – 1 block
 - **Non-call Rotations**
 - Community Medicine – 1 block
 - EKG/Vent – 1 block
 - Surgery – 1 block
- **PGY-2 and PGY-3**
 - **Call rotations**
 - Mandatory
 - FM Inpatient – 2 blocks

- Medicine Night Float – 1 block
- GYN Clinic – 1 block (during PGY-2)
- IM Clinic – 1 block (during PGY-2)
- Ambulatory Peds – 1 block
- Selective Rotations: Upper-level residents may pick 4 of the following 5 rotations (provided that all 5 rotations are covered by an upper-level resident each block throughout the academic year).
 - FM Inpatient
 - OB Night Float
 - Peds Night Float
 - Inpatient Peds
 - Inpatient OB/GYN
- **Non-call Rotations**
 - Emergency Medicine – 2 blocks (1 during PGY-2 and 1 during PGY-3)
 - Orthopedics – 1 block
 - Psychiatry – 1 block
 - Rural Medicine 1 – 1 block (Resident will select rotation location from an approved list of preceptors provided by the Residency Office)
 - Rural Medicine 2 – 1 block (UMC – Demopolis)
 - Neurology – 1 block
 - Cardiology – 1 block
 - ENT/Urology/Ophthalmology (Surgical Subspecialties) – 1 block
 - Sports Medicine – 1 block
 - Practice Management – 1 block (during PGY-2)
 - Radiology/Evidence Based Pharmacotherapy – 1 block
 - Electives – 4 blocks

2. Rotations

a. Scheduling Rotations

The resident curriculum is 36 months (39 blocks). Chief Residents prepare a master schedule each academic year that is approved by the Residency Director. This schedule is subject to change by the Residency Director, Associate Director, Assistant Director, and/or Coordinators. **Any rotation change requests should be submitted 90 days in advance to the Residency Office for consideration.**

b. Elective/Subspecialty Rotations

Before starting an elective or subspecialty rotation, residents are required to contact the preceptor **TWO** months prior to the start date of the rotation to inquire about any requirements for the rotation.

c. Starting Dates

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 block. The Master Schedule and Block Dates for the year will be provided to the residents before July 1st of each academic year.

d. Incomplete Rotations

It is expected that rotations, including electives, will be completed in a satisfactory manner, including adequate attendance (minimal attendance requirement of 15 business days). Any rotation with less than 15 business days attended is incomplete. For incomplete rotations, residents will be given an incomplete grade and are required to repeat the rotation before receiving credit.

e. Passing Rotations

Residents must receive a passing recommendation by the Residency Director, Department Chair or preceptor to pass a rotation. In addition, PGY-1 residents must receive a recommendation of “Ready to be an Upper Level” before promoting to PGY-2. The Clinical Competency Committee will provide their recommendation to the Residency Director, who will review all evaluations and milestones to make a final determination.

f. Away Rotations

While away rotations including elective international rotations have been a major focus for residents in the past, it is anticipated that such rotations will not be able to be safely undertaken over the next academic year due to Covid-19 precautions. Consider developing alternative experiences for this year that do not require international travel.

Any interest expressed by a resident for an away rotation must be discussed with the Residency Director four (4) months in advance

i. Supervised Practice Experience (SPE)

Residents may choose to complete an (SPE) in a physician practice with prior approval of the Residency Director. The following criteria will be used to evaluate 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 SPE preceptor and ensure the environment meets ACGME regulations.
- After obtaining the necessary internal approvals, the Residency Office will obtain a Program Letter of Agreement from the SPE preceptor. The Residency Office may ask the resident to assist in this process.

- There must be a justifiable educational value for this experience.
- The SPE preceptor should have appropriate experience in medical education.
- The SPE preceptor agrees to evaluate the resident's activity and performance.
- The resident must be supervised during the rotation.
- CCHS will not provide money for travel, lodging or meals.
- There can be no conflict with the resident's duties with UATFMR. 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 ACGME requirements and be on track to meet all volume requirements for graduation, so leave can be granted for the away rotation.
- The SPE preceptor should be Board Certified in Family Medicine, unless previously discussed with the Residency Director.

ii. **Rural Rotations**

All residents are required to complete two rural rotations.

- Rural Rotation Block 1 – The resident will select the site from one of the 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 continuity of patient care. Occasionally, the Alabama Family Practice Rural Health Board provides a stipend to help defray the costs associated with rural site travel. This stipend is dependent upon the favor of the state legislature and is not guaranteed.
- Rural Rotation Block 2 – UMC – Demopolis

iii. **Elective International Rotation (EIR):**

International humanitarian experiences are allowed during PGY-2 and PGY-3. It is possible to receive academic (residency) credit for these experiences provided AAFP and RRC guidelines are met. An EIR must be supervised by a board-certified preceptor from a U.S. training program. (Exemption may only be provided by the Residency Director.) A resident must apply for an EIR a minimum of three months prior to the anticipated rotation. To complete the application, a proposal (see first bullet below) and leave request indicating international travel must be submitted in writing to the Residency Director. It is important to obtain Residency Director, CCHS and University approval for the international rotation and travel before incurring travel-related expenses. If approval is not granted, the resident is at risk for any expenses incurred. During this period, CCHS must determine the suitability and qualifications of the SPE preceptor and ensure the environment meets ACGME regulations.

Humanitarian trips/rotations may be considered for reimbursement up to \$1,500 subject to availability of funding. 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 EIR.
- A summary of the experience must be written and submitted to the Residency Director after the EIR.

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.

- **Supervised Practice Experience (SPE) and Elective International Rotation (EIR) may be suspended without notice at the discretion of the Residency Director due to safety issues, pandemic or local circumstances that may affect the program's accomplishment of its educational and patient care mission.**

3. Conferences and Scholarly Activity

a. Academic Afternoon and other Academic Conferences

Academic Afternoon, every Tuesday afternoon, and didactics are a required part of the curriculum. ATTENDANCE is MANDATORY, as well as tied to PGY promotion level and successful completion of the training program (See Promotion, Renewal, and Dismissal Policy in Section II of this handbook).

Resident attendance is required unless: 1) approved leave has been granted; 2) duty hours prohibit such involvement; 3) the resident is on an "away" rotation that does not include University Medical Center continuity clinic; 4) the resident is on the Parent Newborn Health Elective; 5) the resident is covering hospital/clinic/administrative duties as approved by residency directors, which includes residents on night float. Academic Afternoon should not be used for personal activities without having approved leave. If urgent patient care precludes attendance, please notify the Residency Office as soon as possible.

Other conferences, such as Academic Conferences, Grand Rounds, Morbidity and Mortality Conference, Journal Clubs, Emergency Medicine Series, Outpatient Teaching 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 required to meet with the Residency Director and/or other residency directors regarding the absence and is subject to disciplinary action.

Attendance and participation at Academic Afternoons, Grand Rounds, Outpatient Teaching Series, Emergency Medicine Series, etc.... (List not all inclusive) plays a vital role in your learning and professional development as a physician. Attendance logs will be maintained by the Residency Office. It is the resident's responsibility to confirm their attendance has been documented. Extenuating circumstances must be approved by the Residency Director.

Professional behavior during Academic Afternoon is expected and includes being respectful of the lecturer regardless of discipline or college affiliation. Cell phones and pagers should be set to vibrate during this time.

The purpose of Academic Afternoon is for growth and professional development, not to complete unfinished work tasks. Use of laptops and/or cell phones is prohibited during lectures unless used for viewing lecture material and approved by the Academic Afternoon attending.

Once a month (at least quarterly), a special-called meeting (Forum) of all residents and fellows within CCHS will be held during Academic Afternoon. The DIO, faculty members and other administrators should be absent from the Forum, unless invited by Residents/Fellows. 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;
- 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 Residency Director, or directly 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 require the attention of the DIO and/or GMEC.

b. Behavioral Medicine – PGY-3 Presentations (R3 Presentations)

The Behavioral Medicine PGY-3 or R3 Presentation is a required part of the curriculum. It involves each PGY-3 resident presenting a case in Behavioral and Family Medicine for discussion and dialogue. Preparation of the presentation topic is done under the direct guidance of Dr. John Burkhardt, the resident's family and/or

behavioral medicine advisors, and other supporting faculty of the resident's choice. These conferences will have their own orientation at the end of PGY-2.

c. Scholarly Activities and Research

All Residents are required to participate in scholarly/research activities during residency. These activities are required for graduation. Opportunities generally begin in PGY-2, but may begin as early as the intern year. If a resident would like to begin earlier, they may schedule time to discuss these projects at any time during intern year.

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. Residents are 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 following table shows the basic outline of the point system. Residents are required to accumulate 10 points to meet graduation requirements. The Research Director, Residency Director, and 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 PGY-2.

Approved Scholarly Activity Requirements

	<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
Acceptance (to peer review) of a manuscript describing a case report	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
Participating in a grant proposal or budget	3
Submission and acceptance of a podium or poster presentation at a state, regional, national, or international medical conference	3
Presentation of a podium or poster presentation at the CCHS Rural Health Conference	3
Participation in state, regional, or national committees of medical or educational organizations	3
Publication of a letter to the editor in a peer-reviewed medical	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
Presentation of a podium or poster presentation at a local medical or patient care conference (includes but not limited to CCHS Resident 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*
Attendance of IHRH Rural Health Conference	1/day
Presentation of a one-hour lecture for Global Health	1
Other activities deemed acceptable by the Research Director and Residency 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 (MOC) QI Chart Reviews. **All residents are required to participate in a QI project. This is a graduation requirement and is typically completed during PGY-2.**
- **Required committee attendance is a required part of ACGME practice management.**

See also sections on Home Visits and Nursing Home Visits.

C. Library and Learning Resources

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

D. Assessment

1. Evaluations

- a. Evaluations of Faculty and Rotations: Residents evaluate the faculty and rotations securely, anonymously, and electronically via New Innovations after each block. 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.
- b. Evaluations of Residents (Formative, Summative, and Final): Rotation preceptors evaluate residents securely and electronically via New Innovations after each block. Formative evaluations are made available securely and electronically through New Innovations four weeks after the completion of the block.

Residents are assigned a faculty Academic Advisor to assist them in obtaining their education goals. Residents are required to meet with their advisor to discuss their evaluations for each quarter. Any deficiencies or areas for improvement should be addressed during this time. The advisor will complete a Summative Evaluation on the resident and submit it to the Residency Office and Clinical Competency Committee. Advisors will meet with their resident advisees before CCC meetings to discuss their evaluations and again, after CCC meetings to advise residents on milestone evaluation and progress.

The Clinical Competency Committee will give recommendations to the Residency Director regarding milestone evaluations of each resident and advise the Residency Director regarding resident promotion and graduation.

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

2. Documenting Procedures

Residents should document all completed procedures in New Innovations. Various procedures are required to be performed and documented to meet graduation requirements. Residents are responsible for documenting procedures in a timely manner.

Each resident must perform and document a minimum of 40 deliveries during their three years of training, which must consist of a minimum of 10 continuity deliveries. In addition, at least 30 of the total deliveries must be vaginal deliveries and a minimum of 10 must be c-sections. 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.

Interns must perform and document 15 ICU patient encounters, 10 advanced airway procedures, and participate in 5 ACLS codes in order to promote to PGY-2.

Residents must attend at least one ACLS Emergency Simulation session. Sessions are typically held monthly and can be attended while on inpatient medicine, cardiology, and FM Clinic, but not limited to these rotations. Contact Genia Condra at 348-1373 to schedule.

Other procedural requirements are listed in the tables below.

UATFMR Required Procedures		
To be completed by June 1 of PGY-3 (except as noted)		
HOSPITAL PROCEDURES		
Procedure Name	Required	Comments
ABG	2	Perform
Adult Code/ACLS	10	Lead 2, Participate in 10
Circumcision	5	Except by prior statement of conscientious objection
Delivery of Bad News Discussion	2	Document with details at least 2 (Inpatient or Outpatient)
End of Life Discussion	2	
ICU Patients	15	By June 30 of PGY-1
IV Access – Venous	2	Perform or simulated
Intubation (Advanced Airway)	10	Perform or simulated By June 30 of PGY-1
Spinal Tap (Lumbar Puncture)	1	

CLINIC PROCEDURES		
Procedure Name	Required	Comments
Cerumen Disimpaction	5	
ECG	1	Perform (ECG reading is in curriculum)
Fluorescein Exam with Woods Lamp	2	
Home Visit (Continuity Patients)	2	Not visits made on Geriatrics rotation
I/D Abscess	5	
Ingrown Toenail	2	
Joint Aspiration/Injection	10	Includes all joints
Laceration Repair	10	
Meaningful Encounters/PCP Inpatient	≥ 50	May log up to 150, counting toward 1,800 visit continuity requirements
Nursing Home Visits (Continuity Patients)	24	During PGY-2/3
Orthopedics – Casting and Splints	4	
Removal of Foreign Body	1	From Any Orifice
Skin – Tag Removal/Destruction	2	
Skin – Biopsy/Excision	4	Punch, Shave, Scoop
Skin – Cryotherapy Destruction	3	Not Skin Tag
Spirometry	1	Observe & Interpret

OB PROCEDURES		
Procedure Name	Required	Comments
Contraceptive Subdermal Implant	≥ 3	At least 2 Insertions, 1 Removal
IUD – Intra Uterine Device	2	Except by prior statement of conscientious objection
Wet Mount/KOH Prep	2	Obtain sample

3. Requirements per PGY

Resident Requirements per Year for Advancement to Next PGY			
	PGY-1 Required by June 30	PGY-2 Recommended by June 30	PGY-3 Required by June 30
Continuity Patient FMC Encounters	150	650 - 750	1,650 – 1,800
Continuity Total (FMC, NH, Home)	*	*	1,800
Meaningful Encounters	*	25	≥ 50 (Max 150)
Total Deliveries	*	*	40
Vaginal Deliveries	*	*	30
Continuity Deliveries	10	*	10
C-Sections	10*	*	10
Nursing Home Visits (Continuity Patients)	*	By Dec. 15 – 6 By June 15 – 12	By Dec. 15 – 6 By June 15 – 24
Home Visits (Continuity Patients)	*	*	By June 15 – 2
Journal Club		Coordinate with advisor, present in Academics	1
Committee Attendance	*	75%	75%
R3 Presentation	*	*	1
Research Project Presentation	Identify research project	Begin working on project	Present at CCHS Research Day
USMLE Step 3/ COMLEX Level 3	By June 30	Must have full license by Dec. 31 (US Grads Only)	*
Board Exam Registration	*	*	By Dec. 31
Board Exam	*	*	Spring exam
AMA GME CEP Modules (See handout)	PGY-1 Series I by Dec 1 Series II by June 1	PGY-2 Series I by Dec 1 Series II by June 1	PGY-3 Series I – by December 1 Series II by June 1
ABFM MOC Points:	*	*	≥ 50 by Dec. 15
KSA = 10 Points	cKSA Asthma KSA		
QI Project (Performance Improvement Activity)	*	Diabetes QI Hypertension QI	*
cKSA (Continuous KSA)	25 questions each quarter/10 points per year		

Milestone Requirements (Not Graduation Requirements)			
	PGY-1 Required by June 30	PGY-2 Required by June 30	PGY-3 Required by June 30
Delivery of Bad News	1	2 total	*
End of Life Encounters	1	2 total	*
ITE Benchmarks	390	410	440

ACGME Required Inpatient Encounters (as per Meditech report of resident signature)			
	PGY-1 Required by June 30	PGY-2 Required by June 30	PGY-3 Required by June 30
Adult Inpatients	*	*	750
ICU (patients, not encounters)	15	*	*
Pediatric Hospital and/or Emergency Setting	*	*	250
Newborn Patients	*	*	40
Pediatric ER Encounters (admit or discharge)	*	*	75 (included in the above 250 pediatric inpatient)

4. 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 and to provide 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 UATFMR to create an environment that fosters scholarship and lifelong learning. Thus, preparation for the ITE and for the Board Exam is highly emphasized.

The following criteria are considered internal benchmarks for UATFMR:

- 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, formal assistance with examination preparation will be provided by the Director of Learning Resources and Evaluation (DLRE), who will design and implement a remediation study plan. It is the

resident's responsibility to seek assistance from the DLRE and to schedule a time to meet. The DLRE will report the resident's progress to the Residency Director and Clinical Competency Committee (CCC). Assistance with examination preparation will be provided via the remediation plan. (NOTE: This is NOT academic probation. It is anticipated that several residents may not meet this benchmark 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:

- Regular meetings with the Director of Learning Resources and Evaluation.
- Regular meetings with resident's academic advisor (at advisor's discretion).
- Advised to use CME funds on a board-review course. (NOTE: PGY-2s who remediate on the ITE will not be allowed to use their PGY-3 CME funds until successfully passing the PGY-3 ITE. If the PGY-3 ITE is not passed, the CME funds must be spent on an approved board-review course).

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 overall picture of the resident as a physician-in-training. Failure to work with academic advisor on the ITE will result in academic probation.

E. Working with Medical Students

CCHS 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 and engaged in the teaching/mentoring 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 ensure findings and assessments are accurate and to provide opportunity for necessary instruction. Residents and students present patients to faculty on Inpatient Medicine, OB/GYN and Pediatrics. Residents are expected to assist students with these presentations whenever time permits. In addition, residents should assess the students in accordance with the medical school's Entrustable Professional Activities (EPAs), and should observe student performance, give feedback, and record feedback electronically to monitor student progress. Students will be allowed to perform procedures under direct supervision of faculty. In all instances, orders are to be countersigned immediately by the resident responsible for the patient.

Residents should familiarize themselves with the rotation goals, objectives, and required clinical encounters 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 conduct reasonable readings and research on a patient. The student should be familiar with their patients' cases and should know all pertinent laboratory and clinical facts. Ideally, the student should present the patient to the attending for comments and guidance, with the aid of the resident on rounds. Both residents and medical students are to present patients during morning report on the Inpatient Medicine rotation, which serves as the students' Internal 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 PGY-3 resident and an 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 completed online and returned to the clerkship directors.

V. ADMINISTRATIVE PRACTICES

A. Residency Agreement

The Residency Agreement (contract) is issued prior to commencement of the initial training year (and only after successfully passing the preemployment Drug and Alcohol screening). This agreement covers the entire training period, provided the Resident receives a promotion letter to advance to the subsequent years of training. Residents receive a copy of the fully signed Agreement with originals kept in the Residency Office for reference. After the first Agreement is signed, any subsequent renewal is communicated in writing to the resident. Residents who do not wish to renew their Agreement must notify the Residency Office **60** 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, and Confidentiality Agreement:** CCHS requires mandatory training 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. UA Compliance Training:** Click the link below for detailed information on the current training requirements **which apply to all** University employees.
<https://compliance.ua.edu/compliance-training/>
- 3. Harassment and Grievance:** A resident may file a grievance subject to the Sponsoring Institution's applicable policy. Claims of harassment will be addressed pursuant to the University's policy on Harassment, located at <http://eop.ua.edu/harassment.html>. Complaints about harassment within CCHS should be directed to Angela Hunter. If the complaint is gender-based harassment, the claim will be pursuant to the University's policy on [Sexual Misconduct](#).
- 4. Sexually Explicit Material:** Pornographic material of any kind (videos, screen savers, posters, etc.) is prohibited in any portion of CCHS or other sites in which residents are assigned.
- 5. Working with Minors:** Residents' patient panels will include patients of all ages, including minor children. In addition, there is a possibility that residents will work with shadow students. In order to protect residents and minor children, all University training courses regarding child protection must be completed as required in a timely manner.
- 6. Other courses** may be deemed mandatory and required to be completed by residents as determined by CCHS and/or The University of Alabama. Timely completion is expected.

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 \$850
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 GME Competency Education Program (web-based program)
9. American Academy of Family Physicians membership
10. American Board of Family Medicine In-Training Assessment Exam Fees
11. American Medical Association membership fees
12. American Board of Family Medicine Board Exam Fees
13. University Medical Center will provide a discount on office visits for residents and their dependents who are covered by 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 Meal Stipend – Provided on inpatient blocks: on-call residents receive \$196 per block, night float residents receive \$252 per block. A maximum of \$20 per day may be deducted for food (approximate; subject to change). The total amount of dollars available for the resident will be placed on their card at the beginning of each academic year.
15. DCH Regional Medical Center Medical Staff privileges
16. Educational Reimbursement (CME funds) - up to \$1,000 for PGY-2 and PGY-3
17. Laptop – PGY-1 residents will be issued a laptop for use during residency training. Laptops must be returned to UATFMR prior to graduation.
18. UWorld Study Subscription – PGY-1 residents will receive a study subscription to UWorld for preparation for USMLE Step 3/COMLEX Level 3.
19. Examination and Board History Report
20. Federal Drug Enforcement Agency (DEA) license fees - one time only (Note: DEA Registration is good for 3 years. Resident is responsible for renewal fees during PGY-3.)
21. Lab Coats (2) and Scrubs (2)
22. Neonatal Resuscitation Program Certification (NRP)
23. Occurrence-Based Malpractice Insurance
24. Pager – to be returned at completion of residency
25. Pediatric Advanced Life Support Certification (PALS)
26. Relocation Reimbursement - up to \$1,500 (issued as a taxable sign-on bonus)
27. University of Alabama Business Cards
28. University of Alabama Parking Permit
29. University of Alabama Staff ACTION card
30. USMLE 3/COMLEX Level 3 Application fees

Residents should promptly submit any bill/statement for any of the above to the Residency Office for payment.

The University of Alabama offers an array of employee benefits with details located on the [UA Benefits website](#). UA has also provided a [Benefits Summary Guide](#), with a convenient one-page summary on page three.

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

Residents are responsible for paying:

1. Alabama Academy of Family Physicians Resident Chapter Dues – \$30 annually (optional)
2. Moonlighting Malpractice Insurance – PGY-2 and PGY-3, consistent with Moonlighting Policy
3. DEA Renewal – PGY-3
4. TFPRA Dues – \$125

E. Salary/Paychecks

The University of Alabama pays residents a graduated salary, subject to such withholdings as required by law or authorized by the resident. The current salary is specified in the Residency Agreement. Residents are paid in 12 equal monthly installments on the last day of each month, with the exception of the initial PGY-1 paycheck (details specified in the Residency Agreement). Any questions concerning monthly paychecks should be directed to The University of Alabama Payroll Office at (205) 348-7732. While paid a salary, residents are considered neither faculty nor staff of CCHS or The University of Alabama, but rather are generally classified by the University as post-doctoral graduate students with regard to athletic, social, and cultural events, use of University facilities, participation in University governance, parking privileges, and University services.

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 an essential part of residency includes resident assigned responsibilities for patient care, under the supervision of faculty physicians and consistent with their 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 – Tuscaloosa Family Medicine Residency and the ACGME, but also to various federal laws stipulated by the Centers for Medicare and Medicaid Services (CMS).

Paychecks: Residents, considered exempt employees, are paid by direct deposit on the last business day of each month. The first paycheck **must be picked up at Rose Administration**. The email notification of monthly payments will go to the resident’s myBama email. It is suggested that myBama email accounts be forwarded to UA email accounts for ease of reference (<https://oit.ua.edu/article/forward-email-o365/>).

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 official duties. **Refer to the Moonlighting Policy for an explanation of sites not covered by this liability policy. Non-covered sites require a malpractice policy paid for by the resident.**

G. Leave/Other

UATFMR is compliant with the ABFM leave requirements. If there is no properly prepared leave request with the approval signature of the Residency Director or ~~his/her~~ the designee, then THERE IS NO APPROVED LEAVE.

General Leave Guidelines:

1. Residents must be present for a minimum of 15 business days to pass a one-block rotation (which normally has 16-20 working days).
2. Leave requests must be submitted at least **90** days in advance. No leave requests will be considered 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 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 hospital call services except in extraordinary circumstances. In such situations, residents must provide written justification as to why the leave should be approved.
4. Annual leave is not permitted during the first two weeks of July **OR** the last two weeks of June.
5. Administrative or educational leave requires a copy of the brochure/email of the educational activity before the request will be considered. No more than five days of educational and/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 the leave request is made less than 60 days prior to clinic and there are patients already scheduled. Leave will be granted at the Residency Director's discretion.
7. It is the resident's responsibility to email the rotation preceptor, Family Medicine suite, Residency Office, inpatient service, and clinic to which the resident is assigned of any forthcoming absence.
8. Cancellations and changes to approved leave must be made in writing.
9. Sick leave may only be used for personal illness or the illness of a 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 in lieu of sick leave.
10. NOTE: At any given time between 8:00 am and 5:00 pm Monday through Friday, residents should either be on their assigned rotation, in clinic, in academics, or on leave with a properly prepared and approved leave request.

a. **Vacation:** Each resident is permitted two weeks (10 business days) of paid vacation per year, plus one week at Christmas/New Year. Unused vacation time does not accrue from year to year. During PGY-1, these weeks may be taken during the following rotations: Community Medicine, EKG, Geriatrics, and Surgery. 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, Psychiatry, Sports Medicine, Surgery Clinic), coverage arrangements must be made and listed on the request form.
- Other suggested vacation rotations include: Cardiology, Emergency Medicine, Neurology, Orthopedics, Rural Medicine, or other electives.
- Leave may not exceed one week during any rotation provided the resident completes the required 15 business days to pass the rotation. Requests for two consecutive weeks of leave spanning two different rotations in two different blocks will be considered on a case-by-case basis. No leave will be allowed on split/two-week rotations.

b. **Sick Leave:** Residents are permitted 12 sick days per year.

- Residents on hospital service who are sick must notify a Chief Resident and attending physician on call via phone and the Residency Office via email. Arrangement for the back-up resident to be called will be the responsibility of Chief Residents. (Text messaging is not acceptable).
- Residents scheduled for clinic who are sick must notify the nursing supervisor via phone ASAP and the Residency Office via phone and email. (Text messaging not acceptable).
- Residents scheduled with an outside preceptor who are sick must notify preceptor via phone and the Residency Office via phone and email. (Text messaging not acceptable)
- Resident taking sick leave during a weekend call shift is expected to pay back the weekend call shift to the back-up resident later during the year.

Sick days must be requested in advance for physician appointments or scheduled medical procedures. Unexpected illness occasionally occurs. All days taken as sick leave must be claimed upon return to work. Any sick leave that exceeds 48 hours must be accompanied by 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.

c. **Severe Weather Guidelines**

Enactment of severe weather guidelines will be governed by the University of Alabama's official closing decisions

Tornadoes

- Terms:
 - **Tornado watch** refers to weather conditions which are favorable for tornado formation
 - **Tornado warning** refers to a confirmed tornado in the area
- At Program Director's discretion, based off weather forecasts for the day, the severe weather coverage plan may be put into place. Should this occur, chief residents will contact residents on primary hospital services to help coordinate the coverage plan.
- The expected coverage will be as follows:
 - The upper level resident and intern who are scheduled to be on call when the severe weather plan is put into place, will be expected to remain in the hospital to provide patient care until night team is able to safely arrive
 - In the event that more than 1 intern and/or upper level resident are scheduled for a severe weather afternoon, **ONLY** the primary call intern and on-service upper level are to remain in the hospital; all others should be dismissed at noon
 - In the event of an active **tornado warning** in effect until 9pm or later, the residents providing care should remain in the hospital overnight for admitting and patient care. The night team should be in communication with day team/chief residents and should plan to arrive at hospital once tornado warning is no longer active (**UNLESS AFTER 9pm**).
 - If there is no active tornado warning at the time of the day-team to night-team transition, night-team is expected to arrive on schedule
 - In the event that day team residents must remain in the hospital overnight, rounding will occur as follows:
 - The off-service (geriatrics/peds clinic) interns will round in place of the interns who covered 24hr call the night before IF it does not interfere

with their continuity clinic schedule; in the event that continuity clinic schedule precludes off-service residents from covering, residents from any other rotation may be contacted to fill in based on clinic schedule

- The off-service (IM clinic/GYN clinic/Peds clinic) upper level residents will round in place of the residents who covered 24hr call the night before IF it does not interfere with their continuity clinic schedule; in the event that continuity clinic schedule precludes off-service residents from covering, residents from any other rotation may be contacted to fill in based on clinic schedule
 - Because there will be an extra off-service upper level for peds/OB, residents are expected to work this out among themselves and the chief residents
- It is expected that covering residents will receive formal checkout from the residents whose teams they will be covering
- The off-service residents will be excused from their clinical duties (Other than continuity clinic) for the morning that they are covering in order to round and finish hospital work; they will be expected to return to their normal schedule for the afternoon

Snow and Ice

- In instances where clinic is closed for snow/ice, those in the hospital should continue their normal call schedules and take extra time and caution when traveling; residents may consider utilizing call rooms at DCH
 - If anyone feels unsafe to travel, discussion should be had with chief residents and program director
- d. 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](#).

To be eligible for FML under this policy, an employee must have been employed by The University of Alabama for at least 12 months and must have worked 1,250 hours in the previous 12 months.

Reasons for Family and Medical Leave:

- Birth and care of the employee's child
- Placement of a child with the employee for adoption or foster care Family and Medical Leave Policy | Page 2 of 5
- Serious health condition of the employee
- Serious health condition of the employee's spouse, dependent child or parent

- Military Caregiver Leave to care for the employee's spouse, child, parent, or next of kin
- Military Qualifying Exigency

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

ABFM FAMILY LEAVE POLICY AND TIME AWAY FROM TRAINING

Family Leave provided under this new policy is intended to address leave related to:

1. The birth and care of a newborn, adopted, or foster child, including both birth- and non-birth parents of a newborn.
2. The care of a family member with a serious health condition, including end of life care.
3. A resident's own serious health condition requiring prolonged evaluation and treatment.

This policy does **not** apply to other types of personal leave and/or interruptions from a residency (e.g., prolonged vacation/travel, unaccredited research experience, unaccredited clinical experience, military or government assignment outside the scope of the specialty, etc.). This policy likewise does not apply to periods of time for which a resident does not qualify for credit by reason of resident's failure to meet academic, clinical, or professional performance standards.

ABFM policy **only** provides guidance about the maximum time for a resident to be away from training and remain board eligible without having to extend their training. *It does not replace local human resource policies for resident leave. It is also distinct and separate from, and should not be confused with, family leave as permitted by the Family and Medical Family Leave Act (FMLA), or specific leave policies as defined by your sponsoring institution human resource department.*

Additionally, this policy is **not** intended to prescribe decisions regarding time of resident graduation. At any point, a Residency Director and the CCC can make a decision to extend a resident's training based on their assessment that the resident is not ready for attestation of meeting ACGME requirements and entering autonomous practice.

TIME ALLOWED FOR FAMILY LEAVE OF ABSENCE

- **Family Leave Within a Training Year:** ABFM will allow up to (12) weeks away from the program in a given academic year without requiring an extension of training, as long as the Program Director and CCC agree that the resident is ready for advancement, and ultimately ready for autonomous practice. This includes up to (8) weeks total attributable to Family Leave, with any remaining time up to (4) weeks for Other Leave as allowed by the program.

There is no longer a requirement to show 12 months in each PGY for the resident to be board-eligible; however, by virtue of the allowable time, a resident must have at least 40 weeks of formal training in the year in which they take Family Leave. This policy also supplants the previous 30-day limit per year for resident time away from the program.

- **Total Time Away Across Training:** A resident may take up to a maximum of 20 weeks of leave over the three years of residency without requiring an extension of training. Generally speaking, 9–12 weeks (3–4 weeks per year) of this leave will be from institutional allowances for time off for all residents; programs will continue to follow their own institutional or programmatic leave policies for this.

If a resident's leave exceeds either 12 weeks away from the program in a given year, and/or a maximum of 20 weeks total, (e.g., second pregnancy, extended or recurrent personal or family leave) extension of the resident's training will be necessary to cover the duration of time that the individual was away from the program in excess of 20 weeks.

Additional Considerations:

- ABFM will allow Family Leave to cross over two academic years. In this circumstance, the Residency Director and sponsoring institution will decide when the resident is advanced from one PGY to the next.
- Other leave time may be utilized as part of approved Family Leave, or in addition to approved Family Leave. ABFM encourages programs to preserve a minimum of one week of Other Leave in any year in which a resident takes Family Leave. Consideration should be given to the importance of preserving some time away for resident well-being outside of a period of Family Leave.
- Residents are expected to take allotted time away from the program for Other Leave according to local institutional policies. Foregoing this time by banking it in order to shorten the required 36 months of residency or to retroactively "make up" for time lost due to sickness or other absence is not permitted.
- Time missed for educational conferences does not count toward the time away from training under the Family Leave time allowed in this policy.

For more details regarding ABFM FMLA policy, please refer to ABFM websites.

- e. 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 Reasonable Accommodations Policy designates a Department of Human Resources ADA Coordinator, who coordinates employee requests for workplace accommodations. Residents should make accommodation requests by completing an *Employee Accommodation Request Form*, which also has contact information for Human Resource's 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.
- f. Counseling and Support Services: Counseling and support services including education information about substance abuse and physician impairment, are available to residents via the Residency Director. See also the [Sponsoring Institution's Impairment Policy](#).
- g. Confidential Voluntary Self-Identification of Disability and/or Protected Veteran Status: The University's program of affirmative action invites employees to identify whether they are a covered veteran or an individual with a disability in order to receive the benefits of affirmative action. The information is used solely for affirmative action purposes and will not subject persons to any adverse treatment. Self-identification forms can be accessed at https://hr.ua.edu/wp-content/uploads/HR-Forms-Page/Voluntary-Self-Identification-of-Disability-Form_postHire.pdf.¹ Once employed, the University invites employees who fall into one of both categories to confidentially identify themselves by completing the Voluntary Self-Identification of Individuals with Disabilities and/or Voluntary Self-Identification of Protected Veterans forms that can be found on the Employee tab under Employee Services on myBama. Employees who have previously submitted this information do not have to submit it again, unless their status has changed. Employees may contact the HR Service Center at 348-7732 with questions.
- h. Administrative Leave: Residents may be granted administrative leave for activities whereby they directly represent CCHS and UATFMR (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.

Holidays: The holidays typically provided by The University of Alabama include New Year's Day, Martin Luther King Jr. Day, Memorial Day, Independence Day, Juneteenth, Labor Day, Thanksgiving Day, the Friday after Thanksgiving, Christmas Eve Day, Christmas Day and New Year's Eve 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 (typically including Christmas Eve Day and New Year's Eve Day) and residents should not make vacation/holiday plans until CCHS establishes its annual holiday schedule.

Martin Luther King Jr. Day, Memorial Day, Independence Day, and Labor Day observe the following rules (see call schedule for details): Night Float Teams are off the night before the holiday and come in at 5:00 pm on the night of the holiday.

- i. Practice Site Visits: A total of five (5) days may be allowed in PGY-2 and/or PGY-3 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.
- j. 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 (5) days are available for both PGY-2 and PGY-3 but cannot be carried over. Leave must be requested 90 days in advance. A request form should be submitted with written documentation (e.g., brochure) of the conference.

Coordination and scheduling of USMLE Step 3/COMLEX Level 3 and the ABFM Board Exam 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 during a primary service will only be approved in extenuating circumstances.

- k. Intern Retreat: UATFMR tradition has been 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. 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.

1. Workplace Relationships: It is the policy of the University that employees shall not engage in consensual romantic or sexual relationships with any student or employee over whom he/she exercises any academic, administrative, supervisory, evaluative, counseling, advisory, or extracurricular authority or influence. This prohibition includes employees engaging in consensual romantic or sexual relationships with other employees when one party to the relationship is an individual who supervises, evaluates, makes assignments for, or grades the other party (i.e. “supervisor/subordinate relationship”). Likewise, employees who have the authority to influence aid, benefits, or services provided to a student may not engage in consensual romantic or sexual relationships with a student seeking such aid, benefits, or services. Similarly, employees who have the authority to influence the academic progress of a student may not engage in consensual romantic or sexual relationships with that student. It is also the policy of the University that no employee shall exercise any academic, administrative, supervisory, evaluative, counseling, advisory, or extracurricular authority or influence over any student or employee with whom that employee has previously been involved in a consensual romantic or sexual relationship. The University of Alabama has a [Consensual Relationship Policy](#) that residents are required to abide by.

- m. Process for Confidential Reporting of Concerns or Unprofessional Behavior: Residents may submit an anonymous professional evaluation of peers, staff or faculty or submit a concern confidentially through New Innovations or directly to the Residency Director. The Residency Director will discuss the evaluation or concern with the Assistant Residency Director for Behavioral Medicine. Both the Residency Director and Assistant Residency Director for Behavioral Science will discuss the issue with the identified individual. The resident submitting the evaluation or concern will receive feedback from the Residency Director, if they choose to disclose their identity.

- n. Total Absence from the Residency

Continuity of Care

ACGME program requirements define continuity of care as providing care to a panel of patients in a continuous fashion. This is a foundational aspect of family medicine and is required in the residency program. To accomplish this, residents are expected to be assigned to one Family Medicine Practice site for all three years but required to do so at least throughout the second and third years of training. You will need to meet the defined minimum patient visits in the Family Medicine Practice site

and must be scheduled to see patients at that site for a minimum of 40 weeks during each year of your training.

Time Away From Training Allowances

It is very important that each resident consult with the Residency Director regarding time away from training including FMLA.

Residency Training Requirements for Board Certification Eligibility

Candidates for certification are required to complete 36 months of graduate medical education in an ACGME accredited Family Medicine residency program. In some situations, the training may be extended for additional time to meet the minimum requirements. All residents must have core clinical training that includes the breadth and depth of Family Medicine. These include, but are not limited to:

1. Residents are required to spend their PGY-2 and PGY-3 training at the same residency program's teaching practice, in order to provide sustained continuity of care to their patients.
2. Each year of residency must include a minimum of 40 weeks of continuity clinic experience.
3. Residents are required to complete a minimum of 1,650 in-person patient encounters in the continuity practice site to be eligible for ABFM certification.

The Residency Director is expected to sign, on behalf of the program, that the resident has met all requirements for board eligibility and is ready for autonomous practice.

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 inform the Residency Director and DIO and **telephone** the UAB Director of Risk Management (Claire Black, 205-934-5551). Ms. Black will instruct the resident on who to notify and who to restrict communications with 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 the conversation with Ms. Black. As appropriate, the Residency Director may ask the resident to update the Chief of the service directly related to the potential case, but here again, do so via oral communication only. Ms. Black 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. Residents 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. Black.

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. Submission 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 a free PPD test during orientation and thereafter as needed for rotations.

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 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 – March 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 Chief Residents begins with resident and faculty nomination and ranking. The Residency Director makes the final selection, taking rankings into account.

No resident will be considered for Chief Resident unless they are in good standing, as determined by the Residency Director.

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 CCHS and DCH. Once appointed, **residents are required to attend committee meeting and be active participants.** After the residency training period ends, committee memberships are a part of a physician's 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 Step 3/COMLEX Level 3

USMLE Step 3/COMLEX Level 3 should be taken and passed by October 30th of PGY-2. If not, the resident is subject to "Academic Probation" resulting in extension of PGY-2 or non-renewal of the contract. Residents will not be promoted to PGY-3 without passing Step 3. Failing Step 3 twice will result in consideration for dismissal from the program.

Coordination and scheduling of Step 3 is the responsibility of the resident. Leave for the exam must be approved before scheduling. DO NOT schedule the exam during call, night float, or primary services. Time off during a primary service will only be approved in extenuating circumstances and the resident is responsible for finding call coverage (which must be submitted with the leave request). Due to the scheduling process for Step 3, it is understood that the 90-day notice may not be feasible. However, residents should submit a leave request no fewer than 30 days before the intended test date.

M. Licensure

PGY-1 residents are issued a limited license. This license limits residents to practice within the supervision of the program. After one full year of training and passing USMLE Step

3/COMPLEX Level 3, residents must apply for an unrestricted license. Thereafter, the license must be renewed annually. Application and renewal fees are covered by the program.

NOTE: International medical graduates are prohibited from obtaining an unrestricted license in the state of Alabama until they have completed residency.

Residents who are graduates of US medical schools are required to obtain an unrestricted medical license by January 1st of PGY-2. Failure to obtain licensure will result in probation until an unrestricted medical license is obtained and may result in disciplinary action by the State Licensure Board.

N. Controlled Substance Certificates

Residents are required to obtain an Alabama Controlled Substance Certificate. Residents are also required to obtain a Federal DEA Certificate in order to prescribe controlled substances. The Residency Office submits applications for Federal DEA certificates when residents enter the program. The fees for the Controlled Substance and initial DEA Certificates are covered by UATFMR. DEA certificates are valid for three years. During PGY-3, residents are responsible for the DEA renewal fee (\$888). CME may be used to cover this fee. No resident will be allowed to work without an active DEA certificate.

O. Miscellaneous

1. Mailing Address:

Business Address

850 Peter Bryce Blvd.
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.**

- 2.** The residency program pays for residents' membership dues to the American Academy of Family Physician. 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 the required curriculum.

3. Phone Calls for Residents:

Residents are requested to ask friends or family members to limit the number of non-emergency calls. The Residency Office will attempt to reach a resident via pager or email when requested.

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 a personal cell or the Residency Office number. 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 policies and the University of Alabama - Tuscaloosa Family Medicine Residency Handbook (which may be amended periodically by the University, CCHS 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